

~~BEFORE THE OFFICE OF ADMINISTRATIVE HEARINGS~~
~~STATE OF OREGON~~
for the
OREGON HEALTH AUTHORITY

IN THE MATTER OF) **FINAL PROPOSED ORDER**
)
)
 Encompass Health Rehabilitation Hospital) OAH Reference No. 2020-OHA-11950
 of Oregon, LLC) Authority Case No. CN #679

HISTORY OF THE CASE

On March 13, 2020, the Oregon Health Authority (the Authority/OHA) issued a Proposed Decision granting a Certificate of Need (CN) to Encompass Health Rehabilitation Hospital (Encompass) (Proposed Decision CN# 679). That same day, the Authority issued another Proposed Decision granting a CN to Post Acute Medical PAM Squared at Portland, LLC (PAM) (Proposed Decision CN #680). Prior to the issuance of the Proposed Decisions, Legacy Health (Legacy) and Oregon Health Care Association (OHCA) had filed and been granted petitions with the Authority to participate in the matters as affected parties.

On May 5, 2020, the Authority issued an Order extending the deadline for Legacy and OHCA to request a contested case hearing to June 17, 2020, on Proposed Decision CN #680, and to June 22, 2020, on the Proposed Decision CN#679. On June 12, 2020 and June 15, 2020, OHCA requested contested case hearings to challenge the Proposed Decisions. On June 17, 2020 and June 18, 2020, Legacy requested contested case hearings to challenge the Authority's Proposed Decisions.

On August 14, 2020, the Authority referred the requests for hearing to the Office of Administrative Hearings (OAH). The OAH assigned Administrative Law Judge (ALJ) Kate Triana to preside at hearing.

On August 28, 2020, OHCA and Legacy Health filed petitions to participate as limited parties in the Encompass and PAM contested case hearings. Encompass and PAM also filed petitions to participate as parties in the Encompass and PAM contested case hearings.

On September 16, 2020, ALJ Triana convened a prehearing conference in both matters. Encompass, PAM, Legacy, OHCA, and the Authority participated. Senior Assistant Attorney General (AAG) Andrea Ogston represented the Authority. Attorney Peter Stoloff represented Encompass and out-of-state attorney Carey McRae¹ was also present for Encompass. Attorney

¹ Mr. McRae later received *pro hac vice* status.

Arden Olson represented PAM. Attorney Gwen Dayton represented OHCA. Attorney Joseph Greenman represented Legacy. The Authority indicated that it planned to issue limited-party rulings soon. At the prehearing conference, ALJ Triana granted the Authority's motion to consolidate the above captioned case with OAH Case No. 2020-OHA-11952 (the Proposed Decision granting a CN for PAM) for purposes of the hearing. The parties agreed to hold a five-day in-person consolidated hearing, beginning on February 8, 2021.

On September 23, 2020, Encompass filed a Motion to Dismiss the affected parties' requests for contested case hearings with the OAH; PAM joined in the motion. On October 7, 2020, the Authority filed a response. On October 23, 2020, OHCA and Legacy filed responses. On October 29, 2020, Encompass filed additional authority to support its Motion to Dismiss. On November 20, 2020, ALJ Triana issued a letter, remanding the motion to the Authority without further action by the OAH.

On September 25, 2020, the Authority issued four rulings on party status in this matter each of these two matters.

The Authority issued a Ruling Granting Petition to Participate as a Full Party – Encompass Health, granting its petition in #679.

The Authority issued a Ruling Granting Petition to Participate as a Full Party-PAM, granting its petition in application #680.

The Authority issued a Ruling Granting Petition to Participate as a Limited Party – Oregon Health Care Association, limiting granting OHCA's participation petition in #679 and #680, in part, but limiting OHCA's participation in the case to issues regarding the potential overlap between existing nursing facility rehabilitation services and the below areas:

1. Does the service area population need the proposed project?
2. Will the proposed project result in an improvement in patients' reasonable access to services?
3. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?
4. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?
5. Will the impact of the proposal on the cost of health care be acceptable?

The Authority issued a Ruling Granting Petition to Participate as a Limited Party – Legacy Health, granting Legacy's petition in #679 and #680 in part, but limiting Legacy's participation to the potential overlap with its personal interest in competing services and the below areas:

1. Does the service area population need the proposed project?

2. Will the proposed project result in an improvement in patients' reasonable access to services?
3. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?
4. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?
5. Will the impact of the proposal on the cost of health care be acceptable?

In addition, the Authority issued a Ruling Granting Petition to Participate as Limited Party – PAM, finding that PAM's participation in the Encompass case was limited to the overlap between the grant of Certificate of Need in application #679 and the below areas:

1. Does the service area population need the proposed project?
2. Will the proposed project result in an improvement in patients' reasonable access to services?
3. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?
4. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?
5. Will the impact of the proposal on the cost of health care be acceptable?

In addition, the Authority issued a Ruling Granting Petition to Participate as Limited Party – Encompass, finding that Encompass' participation in the PAM case was limited to the overlap between the grant of Certificate of Need in application #680 and the below areas:

1. Does the service area population need the proposed project?
2. Will the proposed project result in an improvement in patients' reasonable access to services?
3. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?
4. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?
5. Will the impact of the proposal on the cost of health care be acceptable?

On October 7, 2020, OAH issued an Amended Ruling on the Ruling Granting Petition to Participate as a Full Party – Encompass Health to correct an inadvertent omission.

On October 13, 2020, Encompass submitted *Pro Hac Vice* admission applications for out-of-state attorneys Jennifer Clark, Carey McRae, and Tiffany deGruy. On October 28, 2020, the OAH granted the *Pro Hac Vice* admission applications.

Also on October 13, 2020, Encompass filed a Motion for Discovery and Issuance of Third-Party Subpoena and Inspections with the Authority. On October 15, 2020, the Authority forwarded the motion to the OAH for a ruling. On December 11, 2020, ALJ Triana issued a Ruling on Motion for Discovery and Issuance of Third-Party Subpoena and Inspections, denying Encompass' Motion. On December 21, 2020, Encompass filed Encompass' Request for Review of the Administrative Law Judge's December 11, 2020 Ruling on Motion for Discovery and Issuance of Third-Party Subpoena and Inspections.

On October 30, 2020, PAM and Encompass requested that the scheduled in-person hearing be converted to a video teleconference hearing. On November 20, 2020, ALJ Triana granted PAM and Encompass' motion to convert the hearing to a video teleconference hearing.

On December 14, 2020, Encompass filed a Motion for Procedural Order and Motions in Limine. PAM joined in the motions. On January 4, 2020, Legacy and OHCA filed responses to Encompass' motions.

ALJ Triana held ~~another~~ a second prehearing conference on January 14, 2021. All parties appeared and agreed to withdraw all pending Motions to Compel Discovery² and to reschedule the consolidated hearing to March 29 through April 2, 2021. In response to PAM and Encompass' Motion for Procedural Order, ALJ Triana set a timeline for presentation of evidence by the parties. ALJ Triana issued a ruling on the record during the March 29, 2021 hearing, denying PAM and Encompass' Motions in Limine.

On March 29, 2021, ALJ Triana convened a hearing via WebEx video conference. The hearing took six days: March 29, March 30, March 31, April 1, April 2, and April 5, 2021. At the hearing, AAG Ogston represented the Authority. AAG Erin Williams also appeared as a representative for the Authority. Mr. Stoloff, Ms. DeGruy, Ms. Clark, and Mr. McRae represented Encompass at the hearing. Mr. Olson represented PAM. Ms. Dayton represented OHCA. Mr. Greenman represented Legacy.

At the hearing, the following witnesses testified:

For the Authority:

- Steve Robison, OHA Surveillance Epidemiologist; and
- Matt Gilman, OHA Facilities Planning & Safety Manager.

For OHCA:

² Starting on October 13, 2020, Encompass filed motions to compel discovery from OHCA, Legacy, and third parties. Legacy filed motions to compel discovery from Encompass. OHCA filed motions to compel discovery from Encompass and the Authority. For the sake of clarity, the dates and names of the exact motions are not set forth in the History of the Case, although they are available in the hearing record. Encompass' withdrawal also included with withdrawing Encompass' Request for Review of the Administrative Law Judge's December 11, 2020 Ruling on Motion for Discovery and Issuance of Third-Party Subpoena and Inspections.

- Steven Fogg, Chief Financial Officer of Marquis Companies/Consonus Healthcare/~~AgeRight~~ AgeRight and OHCA Board Chair;
- Michael Billings, Chief Strategy & Business Development Officer for Infinity Rehab;
- Jonalyn Brown, Vice ~~president~~ President of Operations for Consonus Healthcare; and
- Zachary Fogg, Vice President of Operations for Marquis Companies.

For Legacy:

- Jody Carona, Principal of Health Facilities Planning & Development;
- Jennifer Lawlor, M.D. with Legacy's Rehab Institute of Oregon (RIO);
- Jeanne Button, M.D. with RIO; Pamela Kilmurray, Health Care Administrative Director at RIO; and
- Denise Fraley, Nurse Manager for RIO.

For PAM:

- Kristen Smith, MFA, PT, Executive Vice President and President of Clinical Innovation and Business Intelligence for PAM;
- Adam Burick, M.D., Executive Vice President and Chief Medical Officer for PAM; and
- Nancy Lane, President of PDA, Inc.

For Encompass:

- Elissa Charbonneau, M.D., Chief Medical Officer at Encompass;
- Elizabeth Mann, AIA, PMPO, LEED AP, Director of Design and Construction at Encompass;
- Richard (Dick) Stenson, FACHE, FACMPE, Former President and CEO of Tuality HealthCare and Tuality Health Alliance; and
- Marty Chafin, FACHE, President and Founder of Chafin Consulting Group, Inc.

The evidentiary record closed at the conclusion of the April 5, 2021 hearing. ALJ Triana gave the parties until May 14, 2021 to file written closing arguments, and until May 28, 2021 to file written responses to the closing arguments. On April 30, 2021, Legacy filed a motion to extend the filing deadline for written closing arguments. ALJ Triana denied the motion. All parties timely submitted written closing arguments on May 14, 2021.

On May 26, 2021, the Authority submitted a motion to extend the deadline to file written responses to the closing arguments, after the Authority discovered an error in a calculation. ALJ Triana convened a status conference on May 27, 2021. All parties appeared. The deadline to file written responses to the closing arguments was postponed, pending the Authority filing a Motion to Reopen the Record.

On May 28, 2021, the Authority filed a Motion to Reopen the Record, along with a Declaration of Steven Robison. ALJ Triana held a status conference on June 16, 2021 to take

oral arguments on the Motion to Reopen the Record. AAG Ogston represented the Authority. AAG Williams also appeared as representative for the Authority. Mr. Stoloff, Ms. deGruy, Ms. Clark, and Mr. McRae represented Encompass. Mr. Olson represented PAM. Ms. Dayton represented OHCA. Mr. Greenman represented Legacy. ALJ Triana granted the Motion to Reopen the Record. AAG Ogston agreed to provide additional discovery to the parties, once a Protective Order was put in place.

After the grant of OHA's motion to reopen the record, OHA proposed that Legacy and OHCA have the opportunity to cross-examine the Authority's witness on the May 27, 2021 declaration and attachments. Both Legacy and OHCA declined to cross-examine Mr. Robison or call their own witnesses. OHA's counsel, Andrea Ogston, stated "to the extent that this is at all prejudicial to any party the solution is that they have an opportunity to cross-examine the evidence and the Oregon Health Authority does not object." (Minute marker 21:17.) Counsel for Legacy, Joe Greenman, responded "I don't know that we necessarily need to reconvene the hearing to call Mr. Robison as a witness and cross examine him. I think we can get our response done via an inspection of the underlying assumptions, material, and data submitted with the motion. (Minute marker 32:07.) Counsel for OHCA, Gwen Dayton, concurred with Legacy through its counsel Gwen Dayton. (Minute marker 33:11.)

Reason for modification: Legacy and OHCA raised several exceptions regarding OHA's reliance on Mr. Robison's May 27, 2021 declaration and supporting affidavit. The evidence in the record demonstrates that both parties had an opportunity to cross-examine Mr. Robison on the evidence, and both declined to do so.

On May 28, 2021, Encompass provided copies of the transcripts to the OAH.³

On June 22, 2021, the Authority filed a Motion for Order to Disclose; Qualified Protective Order, and ALJ Triana signed and issued a Ruling on Order to Disclose; Qualified Protective Order, granting the motion. That same day, AAG Ogston provided the requested discovery to the parties.

On July 14, 2021, Legacy and Encompass timely filed rebuttal exhibits. On July 30, 2021, all parties timely submitted written closing responses. ALJ Triana closed the record at that time and took the matter under advisement.

On November 10, 2021, the ALJ issued a Proposed Order recommending that the Oregon Health Authority (OHA) reverse its decision granting a Certificate of Need to applicant Encompass to construct a freestanding 50 bed inpatient rehabilitation facility in Washington County, Oregon.

OHA directed Encompass to file exceptions to the Proposed Order with OHA and Encompass timely filed its exceptions. OAR 137-003-0650(2). The Amended Proposed Order

³ Encompass provided a copy of the transcript to all other parties once it was available, following the contested case hearing.

was served on all parties February 9, 2022, and both Legacy and OHCA filed timely exceptions to the Amended Proposed Order.

In accordance with ORS 183.650(2) and (3) and OAR 137-003-0665(3) and (4), OHA modifies the Proposed Order and identifies and explains herein those modifications. OHA has made other changes to fully, adequately, or correctly set forth the material evidence in the record, to clarify, correct, or amend the proposed findings of the ALJ, or to explain OHA's proposed findings, conclusions, and opinion.

Supplemental findings of fact and revisions to legal conclusions are underlined. Removed language is indicated by strikethrough text.

ISSUE

Whether Encompass Health should be granted a Certificate of Need to build a freestanding 50-bed specialty acute inpatient rehabilitation hospital in Washington County, Oregon. OAR Chapter 333, Divisions 545, 550, 580, 585, 590, 645, and 670.

EVIDENTIARY RULINGS

Exhibits A1 through A93,⁴ including A1a, were submitted jointly by the Authority and PAM. Exhibits A94 through A182 were submitted jointly by the Authority and Encompass. The Authority submitted Exhibits A183 and A184 during the hearing.⁵ Encompass also submitted Exhibits B001 through B080. During the hearing, Encompass submitted Exhibits B201 through B204. At the hearing, Encompass withdrew Exhibit B076. PAM also submitted Exhibits C1 through C5. OHCA submitted Exhibits D1 through D176. During the hearing, OHCA submitted Exhibits D177 through D179. Legacy submitted Exhibits E1 through E159. On March 29, 2021, before the hearing started, Legacy submitted Exhibits E160 through E167. During the hearing, Legacy submitted Exhibit E168. At the hearing, Legacy withdrew Exhibit E56.

The following Exhibits were admitted into evidence without objection: A1 through A182; A1a; B001 through B033; B035 through B074; B078 through B080; B201 through B204; C1 through C4; D1 through D81; D102 through D179; E1 through E55; E57 through E140; and E142 through E168.

⁴ Ex. A73 includes both a one-page PDF document and an Excel file with multiple "sheets." To avoid confusion, when citing Exhibit A73, this order will refer to it as either "Ex. A73.pdf" or "Ex. A73.xlsx at Sheet (sheet title)."

⁵ Exhibits A184 is an Excel spreadsheet file containing multiple "Sheets" within the file. Those sheets do not have specific page numbers. For clarity, Exhibit A184 will be cited using the exhibit number, followed by the sheet name.

The ALJ admitted Exhibits A183 and A184 into evidence over Legacy and OHCA's timeliness objection. The ALJ admitted Exhibits B034 and B077 into evidence over OHCA's relevancy objection. The ALJ admitted Exhibit B075 into evidence over Legacy's relevancy objection. The ALJ admitted Exhibit C5 into evidence over OHCA's objection that it was not relevant. The ALJ excluded Exhibits D82 through D101 (one exhibit with multiple exhibit numbers) because it was incomplete. OHCA submitted Exhibits D177 through D179 as a complete copy of the Exhibit. The ALJ then admitted Exhibits D177 through D179. Finally, the ALJ admitted Exhibit E141 over PAM's and Encompass' objection that the document was a legal brief written by a non-lawyer.

Following the hearing, the Authority submitted the May 27, 2021 Declaration of Steven Robison with attachments. The ALJ admitted the declaration and attachments into evidence over Legacy and OHCA's objection to the untimely filing and alleged prejudicial nature of the declaration.

Legacy submitted Exhibits E169, E170, and E171 in response to OHA's Declaration of Steven Robison. Encompass submitted B205 in response to OHA's Declaration of Steven Robison. The ALJ admitted Exhibit E169 into evidence without objection and admitted Exhibits E170 and E171 over the objections of the Authority, Encompass, and PAM that they were not supported by sworn testimony, unreliable hearsay, irrelevant as to both exhibits, and unduly repetitious as to Exhibit E171. The ALJ also admitted Exhibit B205 into evidence over the objections of OHCA and Legacy that it was not a rebuttal exhibit.

The transcripts were also admitted into the hearing record.⁶

STIPULATIONS

The Authority and Encompass⁷ stipulated to the following:

1. Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project? OAR 333-580-0050(2).
 - a. OHA and Encompass stipulate that this criterion, as set forth in OAR 333-580-0050(2), is met with respect to the Encompass Proposed Decision. There will be qualified personnel, adequate land, and adequate financing. The specific findings under these general findings, found on pages 14-15 of Exhibit A001 are incorporated by reference.

⁶ While the official record of the hearing is the digital recording, a court reporter transcribed the hearing at Encompass' request. Encompass submitted a copy of the transcripts, which were admitted into the record without objection. For ease of reference, this order includes citations to the written transcript. However, any conflicts between the transcript and the recording shall be resolved by relying on the digital recording.

⁷ Legacy, OHCA, and PAM did not participate in the stipulations because they are limited parties to the case and their participation did not include the criteria set out below.

2. Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area? OAR 333-580-0050(4).

- a. OHA and Encompass stipulate that this criterion, as set forth in OAR 333-580-0050(4), is met with respect to the Encompass Proposed Decision. The proposed project does conform with relevant state physical plant standards, and will represent an improvement in regard to conformity with such standards. The specific findings under these general findings, found on page 16 of Exhibit A001, are incorporated by reference.

3. Criterion: Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project? OAR 333-580-0060(1).

- a. OHA and Encompass stipulate that this criterion, as set forth in OAR 333-580-0060(1), is met with respect to the Encompass Proposed Decision. The financial status of the applicant is adequate to support the proposed project and it will continue to be adequate following the implementation of the project. The specific findings under these general findings, found on pages 16-19 of Exhibit A001, are incorporated by reference.

FINDINGS OF FACT⁸

Procedural Timeline

(1) On August 15, 2018, Encompass filed a Letter of Intent to build a new 50-bed inpatient rehabilitation hospital⁹ (IRF) in Hillsboro, Oregon. (Ex. A104 at 1.) On August 30, 2018, the Authority notified Encompass that its Letter of Intent contained sufficient information to determine that the proposed IRF was subject to the issuance of a CN, and also that the proposed facility was subject to full review under the CN law. (Ex. 106 at 1.)

(2) On September 10, 2018, PAM submitted a Letter of Intent to develop a new freestanding 50-bed IRF in Tigard, Oregon. (Ex. A20 at 1.) On September 25, 2018, the Authority notified PAM that its Letter of Intent contained sufficient information to determine that the proposed IRF was subject to the issuance of a CN, and also that the proposed facility was subject to full review under the CN law. (Ex. A23 at 1.)

(3) On September 10, 2018, OHCA submitted a request to the Authority to be designated as an Affected Party in the Encompass and PAM CN review. OHCA represents 52

⁹ Inpatient rehabilitation facilities are specialty hospitals that provide an intense rehabilitation regime for a specific group of patients who are able to benefit from the treatment. The patients generally require around-the-clock nursing services, physician supervision, and daily therapy/rehabilitation. (Ex. A24 at 138; Ex. A113 at 41; Ex. A118 at 64; Ex B006 at 12.)

skilled nursing facilities (SNFs) in the Portland metro area who, according to OHCA, “provide similar health services in the same general service area as the proposed [facilities].” (Exs. A21 at 1, A107 at 1.) On March 19, 2019, the Authority granted OHCA affected party status finding that OHCA had demonstrated a public interest in the outcome of the proceedings. (Ex. A77.)

(4) On November 1, 2018, Encompass submitted an application for certificate of need to authorize a 50-bed, freestanding IRF in Hillsboro, Oregon. (Ex. A113 at 3-4.) On July 23, 2019, the Authority determined the Encompass application to be complete. The Authority began review of the application on July 24, 2019. (Ex. A162 at 1.)

(5) On December 14, 2018, PAM submitted a Certificate of Need Application for New 50-bed Comprehensive Inpatient Rehabilitation Hospital to the Authority. The Authority received the application on December 17, 2018. (Ex. A24 at 1-2.) On August 21, 2019, the Authority determined the PAM application to be complete. (Ex. A38 at 1.)

(6) On October 4, 2019, Encompass submitted an amendment to its application, adding an alternate site for the IRF. (Ex. A162 at 1.)

(7) On October 15, 2019, the Authority held a public meeting regarding the Encompass application. (Ex. A50.)

(8) On January 10, 2020, the Authority issued a ~~proposed~~ Draft Recommendation.¹⁰ (Ex. A145 at 1.) The Authority proposed approving Encompass’ application, finding that Encompass met its burden of proof for justifying the need for a 50-bed IRF. (*Id.* at 2.)

Reason for Modification: ORS 442.315(4)(a) specifies that “The authority shall issue a draft recommendation in response to an application for a certificate of need.” For clarity, OHA omits the word “proposed” to align with the statutory language.

(9) On January 17, 2020, Legacy requested Affected Party status for both the PAM and Encompass applications. In support of its request, Legacy claimed a personal interest in the outcome of the proceedings based on owning and/or operating hospitals, primary care locations, specialty clinics, and an inpatient rehabilitation facility ~~attached to~~ within one of its general hospitals. (Ex. A56 at 1; Tr. 747.) That same day, Legacy requested an informal hearing on the ~~Proposed~~ Draft Recommendation to approve Encompass’ and PAM’s applications. (Ex. A57 at 1.)

(10) On January 21, 2020, OHCA requested an informal hearing on the ~~Proposed~~ Draft Recommendation to approve Encompass’ and PAM’s applications. (Ex. A59 at 1.)

(11) On January 31, 2020, the Authority granted Legacy affected party status for the Encompass and PAM applications. (Ex. A63.)

(12) On February 10, 2020, the Authority held an informal hearing regarding the Encompass application. (Exs. A64, A65.) That same day, the Authority also held an ~~information~~ informal hearing regarding the PAM application. (Ex. A66.) At the informal hearings, OHCA raised concerns about how the Authority determined the service area for the proposed IRFs. Specifically, OHCA asserted that the Authority did not do a zip-code analysis as required under OAR 333-590-0050 and that erred in concluding that the Encompass IRF would draw patients from a six-county service area. (Exs. A65 at 10-12, A66 at 5-6.) OHCA also raised concerns about the Authority's bed need analysis, discharge analysis, lack of consideration of alternatives to the proposed project, and lack of discussion regarding how many public-pay patients the IRFs will accept. (Exs. A65 at 14, 16, 17, 22; Ex. A66 at 6-8, 12.) Legacy also raised concerns about the Authority's determinations of the service area, bed need, availability of sufficient qualified personnel to staff the proposed facility, and the payer mix the proposed facility will serve. (Exs. A65 at 24-38, A66 at 14-26.)

(13) On February 21, 2020, Encompass submitted follow up information to the informal hearing record. It responded to many of OHCA's and Legacy's concerns and included the following information:

The age 65+ population in HSA I¹¹ is projected to grow 22.9% between 2018 and 2021 which is a growth rate of over four times greater than the under age 65 age group. The age 65+ population is the primary population served by specialty acute inpatient rehabilitation hospitals. * * *

(Ex. A70 at 3.)

(14) On March 13, 2020, the Authority issued a Proposed Decision regarding Encompass' application. (Ex. A162 at 1.) In the Proposed Decision, the Authority proposed approving the application, finding that "Encompass has met its burden of proof for justifying the need for a 50-bed inpatient rehabilitation facility." (*Id.* at 2.)

(15) On March 13, 2020, the Authority issued a Proposed Decision regarding PAM's application. (Ex. A76 at 1.) In the Proposed Decision, the Authority proposed approving the application, finding that "PAM has met its burden of proof for justifying the need for a 50-bed inpatient rehabilitation facility." (*Id.* at 2.)

(16) Prior to receiving and ultimately approving the Encompass and PAM applications, the Authority had never granted a certificate of need for a freestanding IRF. (Ex. A162 at 5; Ex. A76 at 5; Tr. 187, 647.)

¹¹ "HSA I" (~~also referred to as "HSA 1"~~) stands for Health Service Area one. Health Service Areas were created by Oregon under the 1974 National Health Planning and Resources Development Act which mandated regional health planning. Health Service Areas were designed to facilitate health planning and health services development between urban and non-urban areas. (OHA's Hearing Memo at 26.) Described in more detail below.

Encompass Health and its Proposed IRF

(17) As of June 30, 2019, Encompass Health owned and operated 131 IRFs (46 of which were joint ventures) across 32 states and Puerto Rico. It also owned and operated 222 home health locations and 59 hospice locations across 31 states. (Ex. A48 at 2.) As of the date of the hearing in this matter, Encompass Health operated 137 IRFs nationally. (Tr. at 1037.)

(18) At its IRFs, Encompass provides the following services: rehabilitation physicians, rehabilitation nurses, physical therapists, occupational therapists, speech-language therapists, respiratory therapists, pharmacists, case managers, and post-discharge services. (Ex. A48 at 3.)

(19) When compared to other IRFs nationally, Encompass has a lower average length of stay (ALOS) than industry benchmarks, and patient's functional improvement is greater during their stay. Encompass' ALOS is 12.7 days nationally. Encompass also has a higher percentage of patients who are discharged to the community (their home), compared to other national IRFs. (Ex. A113 at 92-98.)

(20) Compared to IRFs nationally, Encompass has a lower average estimated cost and receives less reimbursement per discharge. (Ex. A113 at 99-100.)

(21) Encompass has been successful obtaining high occupancy rates nationally, including in locations with payor mixes similar to Oregon. (Tr. at 1268-1272.)

(22) In 2018, 90 percent of patients admitted to Encompass Health IRFs were from acute care hospitals (general hospitals), eight percent were from physician offices and/or the community, and two percent were from SNFs. (Ex. A48 at 4.) In 2018, the primary diagnosis of patients admitted to Encompass health were:

Diagnosis	Rehabilitation Impairment Category (RIC)	2018 percentage of admissions
Stroke	RIC 01	18.0%
Brain dysfunction	RIC 02/03	10.3%
Spinal cord dysfunction	RIC 04/05	3.8%
Neurological conditions	RIC 06	21.0%
Fracture of lower extremity	RIC 07	7.7%
Replacement of lower extremity joint	RIC 08	3.9%
Other orthopedic	RIC 09	9.0 %
Amputation	RIC 10/11	2.6%
Cardiac	RIC 14	4.5%
Major multiple trauma	RIC 17/18	5.3%
Other disabling impairments	RIC 20	11.1%

All other RICs	n/a	2.8%
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(Ex. A48 at 4.) Also in 2018, Encompass discharged 79.9 percent of its patients to the community, 12.3 percent to SNFs, and 10.4 percent to acute care hospitals. (*Id.*)

(23) Encompass has no prior ventures in Oregon. Encompass operates 137 IRFs facilities around the country, including six IRFs in California and Nevada which are profitable. (Tr. 1037; Ex. A113 at 113.)

(24) Prior to submitting its application, Encompass discussed partnerships with Portland area hospitals, including Salem Hospital, Willamette Valley Medical Center, Legacy Health System, Providence Health System, OHSU, Vibra Specialty Hospital, and Kaiser Westside Hospital. No facilities were interested in opening or expanding an IRF with Encompass. (Ex. A113 at 30, 32.) Encompass demonstrated that the need for IRF beds cannot be met by utilization of available IRFs or at existing inpatient facilities within 50 miles by road of the proposed Encompass location in Hillsboro as described under OAR 333-590-0060(9). (Ex. A118 at 59-60.)

(25) Prior to submitting its application, Encompass met with colleges and universities in the Portland-metro area in an attempt to develop educational relationships to “expand the number of health professionals * * * [to] support IRFs serving the tri-county Portland area.” (Ex. A113 at 65.)

(26) Encompass’ proposed IRF would be located at NE Belknap Court in Hillsboro, Oregon. (Ex. A113 at 3-4.) It would be 52,300 square feet and had a projected cost of \$36 million. The location of the proposed IRF would be adjacent to the US 26 interchange and 0.2 miles away from the Hawthorn Farms MAX station. (Exs. A113 at 4, A162 at 8.)

(27) The proposed IRF would be located in Washington County, Oregon. Washington County is one of three counties in the “tri-county” area that make up the Portland-metro area [Washington, Clackamas, and Multnomah counties]. (Ex. A113 at 4.) Encompass determined that the tri-county area was the proper service area for the proposed IRF, with the majority of patients coming from Washington County. (*Id.* at 13.)

(28) In its application, Encompass determined there would be a need for 91 IRF beds in the tri-county area in 2028. (Ex. A113 at 11.) When conducting a need analysis in its application, Encompass went through the steps outlined in OAR 333-590-0050, OAR 333-590-0060, OAR 333-645-0030, and OAR 333-580-0040. (*Id.* at 11 – 71.) In the application, Encompass raised concerns about the general acute inpatient bed need analysis set out in the rules as follows:

The facts are clear – overall [hospital] use rates are declining based on the *reported* utilization. Whether this is a curious case of incomplete data reporting, changing practice patterns, or a larger issues, reliable utilizations cannot be gleaned from the data.

Another significant and on-going data forecasting situation is creating serious barriers for Encompass (or any applicant): data reporting factors, hospital utilization and long-term care hospital utilization are included at the beginning of the 10-year data period, and then *excluded* from the data at the end of the data period. Moreover, the analyst's comments with respect to the aging within the age 65 and older cohort leading to *higher* bed need is similarly significant.

Oregon ranks 50th out of 50 states in Medicare fee for service referrals to IRF services. Oregon lacks a single freestanding IRF, compared to the nation as a whole in which over one-third of IRF beds are in freestanding facilities. Given Oregon's long term deeply-rooted data reporting issues, it is not surprising that Oregon ranks at the bottom because underreporting produces a barrier to new facilities that national data demonstrates does not exist in other states. These issues largely affect specialty services such as IRF, long term care hospitals (LTCH) and psychiatric hospital use. * * *

* * * * *

Having identified our core concerns about developing general bed need forecasts in the fact of missing utilization data as well as the fact that Oregon has the lowest utilization rate for IRF in the nation, this application will comply with the bed need methodology and all remaining steps will be carried out per the methodology. Shortcomings in the data will also be identified to document that need for IRF should be independently calculated because missing data renders any forecast and any conclusion based on the availability of general, acute care bed need to be unreliable.

(*Id.* at 17-18.)

Encompass evaluated IRF historical use patterns and estimated patient inflow from outside of its IRF tri-county service area as approximately 40 percent. (Ex. A118 at 65; Ex. A113 at 10, 42.)

(29) Encompass provided two reports from Edward Stall, an expert in health planning and CN. (See Ex. B006 and Ex. A75.) In Mr. Stall's 35 years of experience evaluating CN applications, he found OHA's methodology conservative and rooted in valid assumptions that align with the experiences of Encompass in other IRF markets. (Ex. A75 at 11; Ex. B006 at 13.)

30) Encompass plans to add specialty services in stroke and at least one additional condition. (Ex. A113 at 41; Ex. A118 at 65.) A preponderance of the evidence in the record supports a finding that Encompass proposed a specialty rehabilitation service.

(31) Encompass anticipates obtaining an annual occupancy rate of 75 percent unit

capacity within three years of certificate of need approval. (Ex. A113 at 105-106.)

(32) In designing the proposed IRF, Encompass consulted with an architect registered in Oregon, who is familiar with the costs of building health care facilities in Oregon. (Ex. A113 at 114.)

(33) The proposed facility will accept both Medicare and Medicaid patients. (Ex. A113 at 64.) Encompass expects to have a significant portion of its patient population be covered by Medicare, which has specific payments based on the patient's diagnosis. (Ex. A113 at 113.) Encompass plans to "develop contractual relationships with are mutually beneficial for the Medicare, commercial insurance and Medicaid segments of the insurance marketplace." (Ex. A113 at 64.)

(34) Encompass will employ clinical outreach and discharge planners to educate local physicians on the benefits of an IRF and the need for timely patient evaluations. (Ex. A113 at 64, 72; tr. at 1055-1056.)

(35) The proposed IRF will have an open medical staff¹² and credentialing process. (Ex. A113 at 19.)

(36) The proposed IRF will initially seek The Joint Commission¹³ accreditation. When eligible, it will apply for a Stroke Rehabilitation Disease-Specific Certification. (Ex. A113 at 5.)

(37) At the proposed IRF, patients would receive three hours of intensive daily therapy; oversight by a rehabilitation physician, including at least three weekly face-to-face visits; availability of 24/7 nursing care by registered nurses; and physical, occupational, speech, and other needed therapy. (Ex. A113 at 5-6.)

(38) In its application, Encompass addressed five alternatives¹⁴ to the proposed 50-bed freestanding IRF in Washington County. The five alternatives include: not building an IRF (alternative 1); building a freestanding 50-bed IRF in Multnomah County (alternative 2); building a 25-bed IRF in Washington County in a joint venture with a hospital (alternative 3); building an IRF in another Oregon county in a joint venture with a hospital (labeled as

¹² A hospital with an open medical staff is one that does not restrict its medical staff privileges to a limited group of physicians.

¹³ The Joint Commission is an independent nonprofit organization that provides accreditation to health care organizations. Most states require that a healthcare organization receive Joint Commission accreditation as a condition for licensure and Medicaid and Medicare reimbursements. (Information taken from The Joint Commission website, which can be found at www.jointcommission.org.)

¹⁴ In the application, Encompass references seven alternatives. However, it appears that alternative number five was removed from the application but the numbering was not updated. Additionally, one of the listed alternatives (number 4) is the proposed IRF. Thus, Encompass discusses a total of five alternatives in the application.

alternative 6); or building a 40-bed freestanding IRF in Clackamas County (labeled as alternative 7). (Ex. A113 at 81.)

(39) Building an IRF with fewer than 40 beds would be less costly to build but would result in higher operating costs. (Ex. A113 at 81, 85, 86.)

PAM's Application and its Proposed IRF

(40) On December 14, 2018, PAM submitted an application for a 50-bed freestanding IRF in Washington County. (Ex. A24 at 2.) PAM's proposed IRF would be located in Tigard, Oregon, near the intersection of Interstate 5 and Interstate 217. (Exs. A24 at 7; A30 at 4.)

(41) PAM found an unmet need of "approximately 100 to 200 beds in 2017 and significantly more in subsequent years, as the population grows and its average age increases." (Ex. A24 at 8.) PAM intended its proposed IRF to serve primarily the Portland-Vancouver-Hillsboro Metropolitan Service Area but defined the Service Area to include the following counties: Clatsop, Columbia, Tillamook, Washington, Yamhill, Multnomah, Clackamas, Cowlitz (in Washington), and Clark (in Washington). (*Id.* at 8, 13-14, 45.)

(42) PAM's proposed IRF would be "available to any person in need." (Ex. A24 at 8.)

(43) In its application, PAM conducted a general acute inpatient bed need analysis under OAR 333-645-0030590-0050 and 333-590-0060. (Ex. A24 at 421-43.) Using a zip code methodology for general acute inpatient beds PAM arrived at a seven-county general acute hospital service area comprising Clatsop, Columbia, Tillamook, Washington, Yamhill, Multnomah, and Clackamas counties. (*Id.* At 13.)

PAM applied the 14-step analysis in OAR 333-590-0050 and the 10-step analysis under OAR 333-590-0060 and concluded that there would be a need for 475 general acute inpatient beds in its seven-county service area. (Ex. A24 at 11 to 36.)

PAM requested and was provided five-year utilization data for hospitals with IRF beds by the Oregon Health Authority Office of Health Analytics from its Hospital database. (Ex. A24 at 13.) That data indicated there were two facilities in Portland that currently offer inpatient rehabilitation services or as having an "operational IRF DPU [distinct part unit]." (Ex. A24 at 13.)

The data provided to PAM from OHA's Office of Health Analytics show that "the two facilities in Portland that offer inpatient rehabilitation services draw approximately 85 to 95 percent of their patients from a seven-county Oregon area; two counties in the State of Washington, Clark and Cowlitz, account for approximately 10.1 percent of patients." (Ex. A24 at 13.)

In addition to analyzing general acute inpatient bed need PAM analyzed IRF bed need pursuant to OAR 333-645-0030. As part of its analysis under OAR 333-645-0030, - PAM conducted a bed need analysis using Division 590 rules to arrive at the IRF service area and IRF bed need, ~~including completing a bed need analysis using Division 590 rules.~~ (Ex. A24 at 1437-44.)

PAM plans to add specialty services in stroke, brain injury and cancer. (Ex. A24 at 41, 59; Ex. A37 at 7.)

(44) In its application, PAM argued that “the service area is over utilizing skilled nursing facility (SNF) rehabilitation services for patients that would be candidates for IRF services. Patients who receive care at an SNF have poorer clinical outcomes than patients who receive care for the same condition at an IRF.” (Ex. A24 at 8.)

The Authority’s Proposed Decision

(45) As set out above, the Authority issued a Proposed Decision approving Encompass’ application and finding a need for the proposed IRF on March 13, 2020. (Ex. A162.)

(46) Steve Robison has worked for the State of Oregon as a surveillance epidemiologist since 2001. (Tr. at 68.) He has conducted a bed need analysis for approximately 20 certificate of need applications over the past 30 years. (Tr. at 70-71.) Certificates of Need and interpreting certificate of need rules for the Authority since 2001. (Tr. at 70-71.) He is a peer reviewer for a number of medical journal publications. (Tr. at 179.) He was responsible for conducting the calculations and making the findings for the Authority regarding bed need. (Tr. at 70, 72.) He reviewed multiple relevant peer-reviewed articles regarding the benefits of IRFs. (Tr. at 89, 100, 101, 102.) Mr. Robison testified that to discern the relevant service area he reviewed the Certificate of Need administrative rules, data provided by applicants, and peer reviewed literature. (Tr. 100-104.) He testified that each applicant provided a thorough bed need analysis pursuant to OAR 333 Division 590 and Division 645. (Tr. 1463.)

(47) He determined that the majority of patients admitted into an IRF come directly from acute inpatient facilities (general hospitals). (Tr. at 89.)

(48) For the economic analysis under OAR 333-580-0060(1),¹⁵ the Authority contracted with the firm Moss Adams. (Tr. at 1079-1080.) Moss Adams determined that the financial status of Encompass would be adequate to support the proposed project. (Ex. A162 at 14-18.) Subsequently, in the Proposed Decision, the Authority determined that the cost estimate to build the proposed IRF, provided by Encompass in its application, was “consistent with industry standard.” (Ex. A162 at 9.)

(49) In the “Need” section of the Proposed Decision, the Authority found that the service area population needed the proposed project. Regarding the Service Area, the Proposed Decision stated:

¹⁵ OAR 333-580-0060 discusses the economic evaluation that must be conducted by an applicant in their application for a certificate of need. Subsection (1) of that rule includes the following criterion that must be answered in the affirmative to be granted a certificate of need: “Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project?”

The applicant has proposed siting a new, freestanding IRF in Washington County, Oregon. In summary, OHA finds there is a sufficient population-based unmet need for inpatient rehabilitation services among discharges from general inpatient hospitals in Northwest Oregon to support the proposed facility. From its proposed site it is expected that the proposed facility will serve a combination of local and regional inpatients. IRFs draw their patient population from the discharges of other inpatient facilities. In turn, Portland metropolitan and surrounding area hospitals draw their general inpatient population [f]rom a ~~winder~~ wider swath of Oregon. Therefore, OHA has determined that the appropriate population base and service area for IRFs should be based on discharges from the inpatient facilities within the region, though not statewide. Under OAR 333-590-0030, such a regional service area is represented by a Health Service Area. OHA has determined Health Services Area I (HSA I), as defined in OAR 333-545-0000(15)(a),^[16] is the appropriate service area for the proposed facility as it encompasses the larger geographical unit from which the facility may reasonably be expected to draw from based on the above analysis. * * *

(Ex. A162 at 3-4.)

(50) Regarding the Bed Need Calculation, the Proposed Decision stated:

While the applicant, in an abundance of caution, provided a bed need methodology that included an assessment of general acute care inpatient bed need, OHA has determined that the rules do not require a finding of general acute care inpatient bed need. CN rules for rehabilitation services state that a determination of hospital service area must be consistent with OAR 333-590-0040 or with historical use patterns for rehabilitation services if these are demonstrably different from a defined service area. OAR 333-645-0030(1)(a). CN rules are also intended to promote rational decisions about balancing the allocation of resources across different categories of inpatient care. A central assumption behind the demonstration of inpatient need for CN purposes is that on a local basis, there should be a fixed pool of licensed beds, relative to population size and composition, and out of this bed total, providers can make decisions about the allocation of beds for various and specialized purposes.

There are two crucial components in the CN rules for assessing IRF bed need. The first component is that total need shall not exceed seven beds per 100,000 general population. OAR 333-645-0030(1). This means that the applicant and OHA must determine the total number of IRF beds currently available, and that will be available if the proposed project is approved, against the service

¹⁶ ~~OAR 333-545-0000 does not have a subsection 15, nor does it define HSA I. This appears to be a typo. The correct citation is OAR 333-545-0020(15)(a) which provides that “Health service area I includes Clackamas, Clatsop, Columbia, Multnomah, Tillamook, and Washington Counties[.]”~~

area population. If the total bed need calculated is more than seven bed[s] per 100,000, the application cannot be approved. If the total bed need calculated is less than seven beds per 100,000, the review can proceed. This does not mean that extra beds must be approved when the available total is below seven beds per 100,000. Rather, it indicates that extra beds may be needed, and allows the consideration of the application to continue. The applicant has demonstrated to OHA that if this project is approved there will not be more than seven IRF beds per 100,000 general population in Health Services Area I.

The second component is the instruction at OAR 333-645-0030(4) to assess bed need in a manner “*consistent where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.*” The rule makes it clear that the entire in-patient bed need methodology for general acute care inpatient beds found at OAR 333-590 need not be applied to IRFs. Instead, applicants are directed to calculate a population-based need for IRF services that takes into account existing capacity across a broad service area. General acute care inpatient bed need calculations are based on geographic populations and hospital admission rate for specific zip codes or other demographic units. In contrast, total need for IRF services, as stated in the previous paragraph, shall not exceed seven beds in 100,000 general population. OAR 333-645-0030(1). Additionally, IRF need is based on hospital discharges, which reflect both location of hospitals and geographic populations. Thus, service areas for IRFs are substantially larger than for general acute care inpatient bed need, and consideration of discharges is a more accurate method to calculate IRF need than analysis of need based upon zip codes.

The applicant has identified a net need in 2023 for 82 rehabilitation beds and net need bed need in 2028 of 91 rehabilitation beds in its proposed service area.

Additionally, in its application, the applicant highlighted the fact that the senior population in the service area (and in Oregon) is increasing. Senior populations are at a higher risk for stroke, and therefore, have a greater need for stroke, brain injury, and related neurological issues care. Oregon’s senior population is growing at a rate that outpaces the rest of the country, and seniors outside of the state are choosing Oregon as a retirement destination. Oregon Department of Human Services (DHS) estimates that by the end of 2020, Oregon will be home to approximately 500,000 people between the ages of 65 and 74 that across the last decade there has been a 35 percent increase in the number of people between the ages of 75 and 84.

There is no historical CN precedent for * * * determining need for inpatient rehabilitation beds. Therefore, OHA used a combination of patient-level discharge data provided by the OHA’s Health Policy and Analytics Division

as well as information from peer-reviewed literature addressing the use of IRFs in the treatment of specific conditions. This literature indicates strong support for the use of IRFs, versus a skilled nursing facility (SNF) for the treatment of stroke, brain injury and other neurologically related conditions.

To conduct its analysis OHA reviewed hospital discharge data for the five-year period of 2013 to 2017 for all licensed Oregon hospitals, including diagnosis related group (DRG) identifiers. OHA filtered out hospitals based on their geographical locations, so only hospitals within the previously defined Health Service Area I remained. Sixteen hospitals fall within the geographical boundaries of Health Service Area I. The discharges from these hospitals were analyzed, counting only DRGs related to stroke, brain injury, and other neurological conditions. The specific DRGs included in this calculation were: 61-66, 68-74, and 82-90. Data available from Healthcare Cost and Utilization Project (HCUP) support the selection of these stroke DRGs. Of the top ten conditions and procedures with discharges to a post-acute care (PAC) facility, 32.6 percent of stroke patients (DRGs 61-66) were to an IRF and 40 percent were discharged to a skilled nursing facility.

Between 2013 and 2017, there were a total of 26,283 stroke, brain injury, and other related neurological hospital discharges by hospitals in Health Service Area 1. In order to determine the bed need for these discharges, OHA made the following calculations:

- Total number of days as an inpatient, assuming an average length of stay (ALOS) of 12.7 days = 333,794.
- Total bed need, assuming 100 percent occupancy and an ALOS of 12.7 = Average of 183 beds per year.

In order to ensure the availability of an IRF bed 95 percent of the time across the year, the 183 beds per year was adjusted.^[17] This adjustment resulted in an identified * * * need for 208 IRF beds. To account for current capacity, OHA subtracted all 57^[18] inpatient rehabilitation beds at existing hospital-based facilities. This resulted in an identified need for 151 IRF beds. This number was further reduced, based on literature review that stated most, but not all,

¹⁷ The statistical adjustment applied was the Poisson Distribution. (Tr. at 130-131.)

¹⁸ While the Proposed Decision found there were 57 IRF beds in HSA I, the testimony at hearing revealed there were 57 licensed beds in HSA I, but only 54 useable IRF beds in HSA I (~~excluding pediatric beds~~). (Tr. at 112.) The Authority used both figures in its various calculations. (Exs. A162 at 6, A184.xlsx at Sheet 1, A183, Declaration of Steven Robison at 1-2.) Reason for modification: There are no licensed pediatric IRF beds in HSA I. The CMS Cost Report for the fiscal year of April 1, 2019 to March 31, 2019, for Legacy Emanuel Hospital & Health Center shows no IRF beds. (Ex. B202.) OHA takes official notice that there is no entry for IRF beds at Legacy Emanuel Randall Children's Hospital. (Id.)

stroke, brain injury, and other related neurological condition diagnosed patients who would not qualify for nor benefit from IRF placement. Therefore, the calculated need has been reduced by an additional 25 percent or 37 beds. With this reduction, OHA estimates a current unmet need of 114 IRF beds.

(Ex. A162 at 4-7; footnotes omitted; emphasis in original.)

(51) In the “Need” section of the Proposed Decision, the Authority also found that the proposed project would result in an improvement in patients’ reasonable access to services. It stated:

This criterion looks at issues related to accessibility of the facility, including traffic patterns, restrictive admissions policies, access to care for public-paid patients; and restrictive staff privileges or denial of privileges. The applicant has identified several areas that demonstrate its project will improve patients’ reasonable access to services[.]

The applicant states they will have clinical liaisons who will work closely with hospital discharge planners to discuss the best placement for IRF-eligible patients, as, according to the applicant, approximately 70 percent of IRF admissions are from hospitals. In addition, the applicant intends to participate in a CMS risk sharing demonstration process to serve Medicaid patients.

During the informal hearing process, affected parties expressed concerns regarding the applicant’s payor mix, including their ability to contract with Medicare Advantage members and their ability to serve the Medicaid population. The applicant estimates ten percent of their patients will be from the Medicaid-eligible population. OHA finds that this is consistent with available MedPac data and also notes that of the 41.7 percent of patients discharged to PAC, 8.1 percent were Medicaid, which is consistent with the applicant’s estimates.

The applicant discussed and provided data in its application to demonstrate that its proposed facility can be easily accessed by patients and their families. The applicant has included tables that illustrate both the drive time and the number of miles between the location of its proposed facility and the existing hospitals with IRF units located in Multnomah County. The proposed site is 0.2 miles from the Hawthorn Farm MAX station.

During the informal hearing, affected parties stated that OHA did not address patient access and transportation issues. In its analysis, OHA excluded the possibility of direct IRF admissions from home or community setting[s]. Instead, OHA analysis focused on IRF patients being admitted directly from area hospitals. Thus, IRF placement for most inpatients has identical issues of

family access as does their inpatient placement. As the combination of inpatient and IRF placement ~~and~~ can provide for better long-term outcomes, it is also reasonable to expect that this will provide for the least amount of time away from family and home in the long run for patients receiving IRF services. This is due to the fact that IRFs have an average length of stay of 12.7 days, and the rehabilitation services they receive while in an IRF is focused on returning them to their activities of daily living as quickly as possible. In addition, IRF locations are readily accessible from mass transit services for family members.

There is evidence in the record that this proposed facility will improve access to care for patients. For example, a Washington County Disability, Aging and Veteran Services Program Supervisor at the public meeting stated that older adults and people with disabilities should have choices when it comes to their health care and that a freestanding inpatient rehabilitation hospital would provide a much-needed service to the larger community.

The statements above are reinforced by written letters of support provided to OHA by Portland Community College School of Nursing and Pacific University, indicating that * * * the schools are committed to working with the applicant to provide interns and qualified professionals.

(Ex. A162 at 6-8.) (Footnotes omitted.)

(52) In the “Availability of Resources and Alternative Uses of Those Resources” section of the Proposed Decision, the Authority found that the proposed project was the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs. It stated:

This criterion requires an applicant to, in short:

- Demonstrate that the best price for the proposal has been sought and selected.
- Demonstrate that the proposed project represents the best solution from among reasonable alternatives, both internal alternative sand external alternatives.

Related to demonstration that the best price for the proposal has been sought and selected, the applicant has provided documentation in its application that it consulted with an architect registered in the state of Oregon who is familiar with the costs of building health care facilities in the state. OHA has determined that the applicant’s cost estimates are consistent with industry standards.

OHA considered several possible alternatives to the proposed IRF. First, OHA looked at skilled nursing facilities (SNF). While SNFs and the services they provide are similar to an IRF, there are important differences.

For an IRF to qualify for Medicare reimbursement, it must meet specific criteria. First, patients must have a preadmission screening to determine if they are likely to benefit significantly from an intensive rehabilitation program. Second, to be reimbursed, the facility must provide rehabilitation, nursing, physical therapy, and occupational therapy services. Third, facilities must have a medical director of rehabilitation who provides services in the facility on a full-time basis. Next, the facility must use an interdisciplinary team to coordinate the treatment of each patient. This team is led by a rehabilitation physician and includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline. Finally, the facility must meet compliance thresholds that state no less than 60 percent of all patients admitted to their facility have a primary diagnosis within the 13 conditions specified by the Centers for Medicare and Medicaid Services (CMS).

By contrast, SNFs are designed to focus on long term care for patients that would not recover quickly nor be able to endure the more extensive rehabilitation requirements provided in an IRF. For this reason, the requirements for admission to an SNF are different from those of an IRF. As described above, patients admitted to an IRF require active and ongoing intervention of multiple therapy disciplines (physical therapy, occupational therapy) and require an intensive rehabilitation program of three hours per day at least five days per week. In a SNF, the requirement is for one or more therapies per day for an average of one to two hours per day.

During the informal hearings, affected parties stated that SNFs in Oregon are different from SNFs nationally. Affected parties noted that patients stays [*sic*] in SNFs in Oregon were overall shorter than stay in SNFs nationally.

In its analysis, OHA finds that for stroke and related patients, the length of stay needs to be considered in relation to not only the length of inpatient stay, but also with regard to when rehabilitation services were initiated. It is difficult-to-impossible to draw conclusions from the finding of shorter Oregon SNF stays without further data on stroke patients and actual levels of rehabilitation services provided.

Additionally, affected parties stated during the informal hearing that referrals for rehabilitation services in SNFs come from hospitals and this practice was likely to continue. OHA does not dispute that hospitals will refer some of their patients to existing SNFs. However, OHA notes that, with literature referenced through this Proposed Decision, some patients will benefit from

the services provided by an IRF. Further, the literature states that early and intense intervention of the services offered by an IRF will likely result in better outcomes for those patients, when compared to placement at an SNF. In addition, not all patients being discharged from a general acute inpatient care facility will meet the stringent criteria for admission into an IRF and will instead be discharged to an SNF.

OHA received written testimony and letters of support that highlight the advantages of IRF placement over SNF placement for some patients.

It is also important to note the differences in the type of licensure required of an IRF versus a SNF. In Oregon, IRFs are licensed by OHA as Special Inpatient Care Facilities (SICFs), which are required to follow physical environment, licensing, and nurse staffing rules for hospitals. On the other hand, SNFs are licensed by the Department of Human Services and required to follow rules specific to nursing facilities. Unlike IRFs, SNFs cannot provide hospital-level services. With regard to cost arguments, it is likely that higher short-term costs of IRFs are related to lower long-term costs due to increased functionality of patients.

OHA also looked at the expansion of existing capacity at the two hospital-based rehabilitation units currently in use. The applicant contacted these facilities to discuss an expansion but neither facility was interested in building on their current capacity. Additionally, the applicant interviewed three general hospitals located in Washington County to inquire about the possibility of collaborating on an IRF. As stated in their application, none of the hospitals contacted by the applicant had plans to add an IRF at their site. During the Encompass public meeting, one of the inpatient rehabilitation units stated it only had a 60 percent occupancy rate. There are many factors that may influence occupancy at hospital based IRF units. A 2016 MEDPAC report to Congress stated that, “hospital-based IRFs are typically smaller and have lower occupancy rates compared to free-standing IRFs[.]” Additionally, an individual facility’s occupancy at a hospital-based rehabilitation unit and the utilization patterns commonly are not related to underlying population need.

The applicant has provided cost-comparison data that compares the costs of its facilities to other free-standing (non-Encompass) facilities as well as hospital-based inpatient rehabilitation units. The data shows that the applicant’s costs to provide care are less than care provided at these other facilities.

The applicant provided analysis and information on seven options for providing IRF services, including their proposal. These options include:

- Do not develop an IRF

- Build a 50-bed IRF in Multnomah County
- Proceed with a joint-venture for a 25-bed IRF with another hospital in Washington County
- Build a 50-bed IRF in Washington County
- Proceed with a joint venture with a hospital in another county
- Build a 40-bed IRF in Clackamas County

Upon conclusion of its analysis the applicant determined that the option to build a 50-bed IRF in Washington County was the best option to meet current population needs. OHA finds that the proposed location within the service area and size of facility will provide reasonable access for patients being discharged from hospitals as well as to patients' home communities. The option chosen by the applicant appears to be the best solution among the alternatives listed above.

(Ex. A162 at 8-12.) (Footnotes omitted.)

(53) In the “Availability of Resources and Alternative Uses of Those Resources” section of the Proposed Decision, the Authority also found that the proposed project would have an appropriate relationship to its service area and would limit unnecessary duplication of services and negative financial impacts. It stated:

This criterion requires the applicant to identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population. The applicant must address any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. The applicant must also demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to ensure that patients will have the necessary continuity in their health care.

OHA has already addressed the service area and patient need within the service area above. As stated above, there is a population need, particularly for patients who have a stroke, brain injury, or who suffer from other neurological conditions. These patients benefit from earlier and more intense rehabilitation services that can be provided at alternative discharge options, such as discharges to home or to SNF. Early and intense services could also be offered at existing general hospitals if they created new or expended IRF units, using existing licensed bed capacity. These services would be the only comparable alternatives to the proposed freestanding IRF.

There is opposition to the applicant's proposal, centered on two main issues. First, that this need is currently being met at existing facilities, such as SNFs. Second, current utilization at one exhibiting hospital based IRF is low in relation to its licensed capacity. As stated above, while services provided in a SNF are similar to those that would be provided in an IRF, additional resources available at IRFs for the treatment of stroke, brain injury, and other neurological conditions may lead to better outcomes, and long-term costs associated with IRF care can be more efficient because there is a reduced chance of readmissions. As also stated above, OHA does not believe that underutilization at one hospital unit IRF is evidence that patient need in the service area is met. There is a need for IRF beds despite a localized pattern of limited admissions to the existing IRF.

(Ex. A162 at 13-14.) (Footnotes omitted.)

(54) In the "Economic Evaluation" section of the Proposed Decision, the Authority found that the impact of the proposed project on the cost of health care would be acceptable. It stated:

Under this criterion the applicant must discuss:

- Impact on overall patient charges
- Proposal's impact on the gross revenues and expenses
- Impact the proposal will have on related patient charges and operating expenses
- Proposed or actual charges for the proposed service
- Projected expenses for the proposed service
- Architectural costs of the proposal

The applicant must discuss the impact of the proposal on both overall patient charges at the institution and on charges for services affected by the project. OAR 333-580-0060(2)(a).

The applicant states the impact on patients will benefit the population due to economies of scale that can be achieved by IRFs, particularly due to the relative portion of the population expected to be covered by Medicare. OHA finds this is a reasonable assumption, however the selection of patients based on their insurance providers (i.e. governmental vs. private insurance companies) would have an impact on the economies of scale which can be achieved if a lesser majority of Medicare/Medicaid patients are covered. The

consolidated financial statements of Encompass Health do show that Medicare represents 82 percent of its gross revenues.

The applicant included a copy of its charity care application which includes the company's policy of charge reductions for those individuals making less than 400 percent of the Federal Poverty Levels. Most payors of the applicant are government payors, so the expectation of charity care is reduced to a smaller pool of patients. Encompass Health indicated it is estimated that this would represent less than one percent of revenues.

Under OAR 333-580-0060(2)(b), the applicant must discuss both the proposed or actual charges for the proposed service and the profitability of the proposed service, compared to other similar services in the state (if any).

Although this is the first application by Encompass Health for a venture in Oregon, its operating experience with facilities in California and Nevada provide it with valid data to forecast local jurisdiction data and rates. While regulations vary by state, the forecasting process and knowledge of the costs and projection methods are industry knowledge which Encompass Health would be expected to maintain.

OAR 333-580-0060(2)(c) states that the applicant must discuss the projected expenses for the proposed service and demonstrate the reasonableness of these expenses' forecast.

Attachment 1 addresses this further. In addition, contractual adjustments are based on those experienced by Encompass health. Deductions are generally standard for major payors. Due to the expected concentration of large payors for the applicant, the standard deduction rate is considered appropriate for use in calculating expenses for margin calculations. Other expenses below the line are based on individual assumptions and projections.

Under OAR 333-580-0060(2)(d), if the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings.

OHA expects that patients will be transported upon discharge from an acute care facility. Families of patients and staff have reasonable access to public transportation within a reasonable distance in the geographic area the facility will serve. Public transportation (light rail system and bus) has a stop 300 feet from the planned admissions door to the facility. The property is also reasonably adjacent to US 26, a major highway, and a significant population exists within a reasonable distance of the facility. Other public transportation options are available in the affected community and within a reasonable distance from the facility.

Parking for patients and their families will be available as planned in the construction of the facility, however the light rail and bus system currently exists and will not change as a result of this proposal.

OAR 333-580-0060(2)(e) requires the applicant to discuss the architectural costs of the proposal.

Form CN-3 submitted by the applicant details the architectural estimates, which were prepared and estimated with the assistance of an architect registered in Oregon. The use of a local architect familiar with costing, estimation, and building requirements assures the pricing and construction costs are appropriate. The applicant provides input into the cost of equipment necessary to outfit the building based on services to be provided, which is reasonable given their expertise in the industry. While the estimated useful life for financial statement purposes is 25 years, the building and internal fitting for patient service[s] are expected to last far in excess of the depreciable life. The building facility incorporates designated areas for occupational and physical therapy, patient beds, kitchen, dining room, activity space, office space, etc. necessary to effectively treat patients.

(Ex. A162 at 19-21.) (Footnotes omitted.)

The Authority's Bed Need Analysis

In preparation for the hearing in this matter, the Authority submitted Exhibit A73, showing the data used to perform calculations for the Proposed Decision. The Authority included an Excel version of the data and a PDF version of the data.¹⁹ ~~The PDF version of the data is as follows:~~

Hospital	Sum of Count Discharge	County
Adventist Medical Center	1069	Multnomah
Columbia Memorial Hospital	134	Clatsop
Kaiser Sunnyside Medical Center	3149	Multnomah
Kaiser Westside Medical Center	390	Washington
Legacy Emanuel Medical Center	2147	Multnomah
Legacy Good Samaritan Hospital	1883	Multnomah
Legacy Meridian Park Medical Center	1537	Clackamas

¹⁹ "A73.pdf" does not include the underlying data but instead comprises a one-page summary chart. The Authority did not address the differences in data between the pdf and Excel versions, so the findings set out the pertinent data and calculations in both versions. "A73.xlsx" was offered into evidence to demonstrate the agency's general method and approach to establishing bed need and was used by the agency to run various scenarios and includes the several pages of data produced by OHA's Office of Health Analytics. (Tr. 116-34; Tr. 1469.) The pdf of the spreadsheet A73 (what Legacy has coined "A73.pdf") was provided as a placeholder and there is no evidence in the record that those numbers were relied on by the agency. OHA takes official notice that some data differences between the spreadsheet and pdf reflect changes that occurred after OHA issued its Proposed Decision in March 2019. (Tr. 1442.)

Legacy Mount Hood Medical Center	863	Multnomah
OHSU Hospital	5265	Multnomah
Providence Milwaukie Hospital	350	Multnomah
Providence Portland Medical Center	3090	Multnomah
Providence Seaside Hospital	188	Clatsop
Providence St Vincent Medical Center	4350	Washington
Providence Willamette Falls	402	Clackamas
Tillamook Regional Medical Center	167	Tillamook
Tuality Community Hospital	1299	Washington
Grand Total	26283	
Total Days at ALOS 12.7	333794	
Total Bed Need assuming 100% occupancy and ALOS 12.7	915	
Number of beds needed per year	183	
Adjustment factor to ensure bed availability	208*	
Less current bed capacity	168*	
Less not eligible	42*	
Assumed need	126*	

*numbers are estimates

(Ex. A73.pdf.) The Excel version of the data is as follows:

Hospital	Sum of Count Discharges	County
Legacy Meridian Park Medical Center	1376	Clackamas
Providence Willamette Falls	460	Clackamas
Columbia Memorial Hospital	155	Clatsop
Providence Seaside Hospital	98	Clatsop
Adventist Medical Center	1196	Multnomah
Kaiser Sunnyside Medical Center	2140	Multnomah
Legacy Emanuel Medical Center	2290	Multnomah
Legacy Good Samaritan Hospital	880	Multnomah
Legacy Mount Hood Medical Center	929	Multnomah
OHSU Hospital	2953	Multnomah
Providence Milwaukie Hospital	394	Multnomah
Providence Portland Medical Center	2664	Multnomah
Tillamook Regional Medical Center	167	Tillamook
Kaiser Westside Medical Center	457	Washington
Providence Newberg Medical Center	257	Yamhill
Providence St Vincent Medical Center	3315	Washington
Willamette Valley Medical Center	298	Yamhill

Tuality Community Hospital	720	Washington
Grand Total	20749	
Total Days at ALOS 12.7	263512	
Total Bed Need assuming 100% occupancy and ALOS 12.7	722	
Number of beds needed per year	144	
Adjustment factor to ensure bed availability	169	
Less current bed capacity	112	

(Ex. A73.xlsx at Sheet 1.)

(55) Ex. A73.xlsx demonstrates that the 20,749 discharges were based on suppressed data provided to OHA from the Office of Health Analytics (reporting data groups limited to those of nine or more discharges). (See also Ex. A183.) The unsuppressed data in paragraph 5 of Mr. Robison’s Declaration dated May 27, 2021, demonstrates that there were 25,224 discharges in HSA I from 2014 to 2018, which results in an IRF bed need of 100 beds in HSA I in 2018 based on the narrow set of DRGs, instead of the broader set of discharge DRG codes. The Authority finds by a preponderance of the evidence that using unsuppressed data, and either a narrow or broader set of DRGs, there is a need for at least 100 IRF beds in HSA I in 2018. The Authority finds by a preponderance of the evidence that OAR 333-590-0050(6) also allows a 10-year projection of population and census from the date of submission of the application, which is 2028 at the time of application, and 2030 during the contested case process.

The age 65+ population is projected to grow 22.9% between 2018 and 2021. The Authority finds by a preponderance of the evidence that the need for IRF beds in HSA I in 2028 will be in excess of 100 beds. The population estimate in 2030 in HSA I is 2,230,371, which is a 12.5% increase from the 2020 population. (Ex. B006 at 16 and 17.) The Authority finds by a preponderance of the evidence that the age 65+ population in HSA I from 2018 to 2028 will grow in excess of 12.5%. (Ex. A70 at 3; Ex. B006 at 16 -17.)

The Authority takes official notice that the HIPAA statute and regulations required the Office of Health Analytics to suppress facility DRG combinations with fewer than nine discharges. (Ex. A183.) (See CMS Data Disclosures and Data Use Agreement Last Modified 12/1/2021; CMS Cell Suppression Policy dated 1/1/2020.)

(56) When applying OAR 333-645-0030(1), Mr. Robison interpreted the phrase that IRF beds “shall not exceed seven beds in 100,000 general population” to mean that there shall not be eight beds per 100,000 general population but could be up to 7.99 beds per 100,000. (Tr. at 109-110.)

(57) To conduct the Bed Need analysis, the Authority requested hospital discharge data from the Office of Health Analytics for a five-year period. The data provided covered the period of 2013 through 2017 (the last year for which complete data was available at the time of the request) for aggregated counts for facility DRG combinations with nine or more discharges. It included all hospital discharges (except for VA facilities) for individuals aged 40 and older in

HSA I with a primary diagnosis of diagnosis related groups (DRG)²⁰ 61 through 66, 68 through 74, and 82 through 90. (Tr. at 113, 124, 127; Ex. A1a at 7.) It excluded any individuals who had died while at the hospital. (Tr. at 221.)

(58) During the hearing, Mr. Robison testified, in part, as follows:

Q: And at the top [of Exhibits A1 page 5 of 40], it reads, “Applicable review criteria” and then it lists three rules [OARs 333-580-0040, 333-590-0050, and 333-645]. Can you describe those three rules and what you’re looking at under those rules?

A: Yes. I mean, the principle is, is there a need in the population within the defined service area for the project. That’s (inaudible) piece pertaining to bed need. And the [OAR Chapter 333, Division] 590 rules more specifically deal with acute inpatient need. And then [OAR Chapter 333, Division 645] is the specific set of rules governing inpatient rehabilitation, which has a redirect in those rules back to the 590 with some directions about how to interpret 590.

Q: And in this case, if you go to the first criteria, it says, “Does the service area population need a proposed project?” And it cites a rule. And can you describe sort of how you approached, whether you had the information you needed and sort of the next steps you took?

A: Yeah. Determining service area population of need is done through the specifics of [OAR Chapter 333, Division 645] and [OAR 333-590-0030 to 333-590-0060]. And if this was a general patient acute care bed, it would be directed by the 590 rules entirely. In this case, the specialty inpatient rehabilitation rules included in [OAR Chapter 333, Division 645] provide some criteria to be met, and also provides an instruction to use the inpatient acute care bed rules [OAR Chapter 333, Division 590], but with some modification. The directions say to apply the 0030 to [0]060 rules or to use a methodology that is consistent with that where applicable. Elsewhere in the rules, if it wanted to us to follow the 590 rules exactly, you know, such as in

²⁰ According to the Centers for Medicare and Medicaid Services:

Prospective payment rates based on Diagnosis Related Groups (DRGs) have been established as the basis of Medicare’s hospital reimbursement system. The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. The design and development of the DRGs began in the late sixties at Yale University. * * * In 1983 Congress amended the Social Security Act to include a national DRG-based hospital prospective payment system for all Medicare patients.

[https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_\(DRGs\).pdf](https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf)

the psychiatric bed need rules²¹, it says to exactly -- basically to follow those rules. Here, they carved out that it needs to be a method that is consistent with -- where applicable, you know, I think that recognizes -- and I took that as an instruction to consider what is reasonable as an application of the 590 rules to this general situation.

Q: So, if you have OAR 333-645-0000 handy, it's also Exhibit -- let's see here -- A-17. Let me know when you have that up.

A: Okay. I have the 645 rules pulled up right now.

Q: So, if we look at [OAR 333-645-0030(1)], is that the rule you applied here?

A: The 645-0030(1), this is the section that -- detailing how to calculate bed need for inpatient rehabilitation services. Yeah. So, the 645-0030 is the set of rules that pertain here.

Q: Okay. And how -- what aspect of the rule did you use in deciding service area?

A: The service area for this, the applicants -- the application from this case proposed a multi- county service area. The 590 inpatient acute care bed rules generally specified using continuous sets of ZIP codes to build population areas, though it is possible to use only a single ZIP code if you're talking about a postage stamp-sized facility. But it's -- generally, it's collections of ZIP codes that are organized into continuous and a recognized demographic unit. Metropolitan areas, counties or a health service area, those are collections of ZIP codes and counties, recognized demographic areas for which population data is available. So, the priority is to -- to do that. The applicants -- the applicant in this case did -- the piece I was a little -- you know, there's a little -- you know, for this sort of a service, there's a little -- some question to me whether it's a referral service, a specialty service that is forgoing patients from a wide area, either using a small ZIP code base is not representative of the population of need. And the -- the rule section there, you know, [OAR 333-645-0030(1)(a)] states that determination of hospital services to be [consistent] with OAR 333-590-0040, and there is a statement in there -- let's see -- let's see. There is a statement in there to the effect that a hospital -- hospital service area is more accurate for assessing population need than the data from any one project. In looking at what was an appropriate service area for the population and for these applications, it initially was concerned with -- you know, that the two applicants here both were using multi-county areas with slight differences. The bulk of patients are going to

²¹ OAR 333-615-0030 (4)(a) states "The principles and methods in division 590 shall apply in reviewing applications for psychiatric beds to the extent that the issues involved are not addressed in this division."

come from the Portland metropolitan area, which is Washington, Clackamas, Multnomah and Yamhill. Our rules state that, you know, the data from hospital -- from a healthcare service area, healthcare service area one, is northwest Oregon, is -- is more accurate to use for forecasting need. So, I considered that we should probably use that. The inclusion or exclusions of Yamhill County was -- data was a little bit troublesome. And we looked at it both ways, because Yamhill County is part of the larger Portland MSA, but it's not part of the health service area one, and our final answer excluded Yamhill County,^[22] though the applicant, in one case, included it. But the service area, it should be a collection of units, demographically recognized units, which includes counties. And in this case, case health service area one had some preference in our rules to use where a health service area had a preference to use in our rules over using ZIP code or county data for accuracy purposes.

* * * * *

Q: I'm looking at Exhibit A-17, which is the certificate of need rule [OAR 333-645-0001(a)]. Is that the rule you used in evaluating the asserted area for the Encompass application?

A: Yes, it is. Yes.

Q: And can you walk us through which portions you applied and why?

A: For determination of service area?

Q: Just service area.

A: Yeah. The service area -- well, if you look at the -- the evidence asks you to consider [OAR 333-590-0040] * * * titled determination of service area for existing hospitals. Now, that directs clients and - - and as you'll remember, [OAR 333-645-0030(4)] is a use method that is consistent where applicable. [OAR 333-590-0040] starts with directing you to use ZIP code units, but they can be -- you're instructed to also create a contiguous service area that reflects recognized demographic units for which population data is available, such as counties or collections of counties, the emphasis in the language that this section, to me, is that it says "units" not "unit". So, it does not -- so I thought it was appropriate to use a collection of counties. The other piece from this service area -- I don't want to jump ahead in talking about calculation of need,

²² While Mr. Robison testified originally at hearing that his calculations and Exhibit "A73.xlsx" (~~both versions~~) did *not* include Yamhill County discharges, he later corrected this statement and provided new data without Yamhill County discharges (Exhibits A183 and A184). Exhibits A183 and A184 are based on suppressed discharge numbers.

but, you know, there was an issue do you use patient origin data when patients are -- or this type of service appropriately are being discharged from an inpatient service. So, where someone lives is relevant, but maybe where they're discharged from is more relevant in considering what a service area should be.

Q: So, in looking at a -- it sounds like you decided that [OAR 333-590-0040] applied to existing hospitals, and then you -- did you look at the second clause?

A: Under the [0]040?

Q: No. So, I'm still at [OAR 333-645-0030(1)(a)] and just how you arrived at service area as it relates to that rule.

A: In that case, we did not pay a lot of weight or put a lot of weight on that second portion, because calculation of need here, while there's a very limited number of inpatient rehabilitation facilities in the State of Oregon, it's a very specialized service that should be on a regional or state-wide basis, and there is -- by the calculations we could do using discharge data for stroke and related neurological conditions, only a very small number are treated in an inpatient rehabilitation facility. So, trying to project the experience from only one or two facilities to the entire population is -- is not necessarily accurate. You know, the experience of any one facility can be different than the overall population need that we need to look at in this case.

Q: And did you look at historical use patterns for rehabilitation services?

A: We now have good data on the full spectrum, historically, of rehabilitation services. We do have the data as applicants provided regarding some of that. But again, if there is a very large unmet need, it's difficult to assess how applicable that historical pattern is.

Q: And in your -- in the proposed decision under service area, you refer to [OAR 333-590-0030] for support of selecting health service area one. Can you describe how that -- how the general acute inpatient bed need methodology there supports that finding?

A: Yeah. Well, under [OAR 333-590-0030], it states the annual patient days needed by the population of a health service area can be more confidently forecasted than the demand in a single hospital or local market area. So, that's kind of the direction too, when applicable use a larger unit and consider the population rather than trying to apply very small service areas or to focus on

the experience of individual providers. So, that was a bit of guidance for using a health service area or for using a larger demographic basis.

Q: And did you look at where the patients were likely to come from?

A: We -- what I did on this -- you know, the applicant looked at patient origin, because the direction under [Division] 645 is to use a methodology for a part of the [Division] 590 rules, not the whole part, you know, 003[0] to 0060, that is consistent where applicable. Considering that the appropriate population for this type of service are inpatients being discharged for stroke and related neurological conditions to an IRF, one it -- or what I did was I looked at the hospital discharge as the patient origin rather than trying to track those inpatients back to the communities that they lived in. * * * And part of the rational[e] for that too is the evidence for an unmet need is that there is a -- in the literature, a great benefit for the rapid initiation of rehabilitation, of intense rehabilitation services. The easiest way to accommodate that rapid and intense rehabilitation by a fairly complex multidisciplinary team is to have specialty sites that are close to where people are being discharged from so that there's a very easy transfer of patients to those sites. There would not be an advantage to, say, trying to locate little micro rehabilitation units across the wider service area. You could not get the specialization and the concentration of services you needed there so that it was just appropriate to consider the discharge, you know, the place of discharge that patients are discharged as opposed to following a more general [OAR Chapter 333, Division 590] approach where you would look at patients by their community of residence, where do they go to, and then do some adjustments for inflow from other communities that are outside the immediate service area.

Q: So, you testified that under both 590 and 645, on some level you're looking at discharges, correct?

A: Yes. We are looking at patient discharges with a diagnosis -- a DRG, diagnosis-related grouping, for stroke and related neurological conditions that --

Q: And so I just want to focus, just for this first part, on just service area and how you decided the service area. So, if they both depend on discharge data, can you sort of walk us through how a straight 590 analysis for discharge data would differ from what -- you know, what you've said is a less localized analysis?

A: Yeah. A straight 590 analysis, you're directed to consider patient origin. The assumption there is almost that -- the assumption is that you are coming from your residence, your community, to an inpatient acute hospital setting.

You know, you're going from home to hospital, for example. And so you look at the ZIP code areas or the -- or if the population of the service area is considered as a county, you would look at the county and you would look at the patient origins for the proposed facility by where -- where are those people are living. And then as a second step, general step, you have an inflow adjustment where you would look at potentially people living outside of that immediate service area, and this is very relevant when you're talking about a specialized service, who live outside of that immediate service area who are going to come into that. So, you know, for example, you may have a stroke in Prineville and you end up in a Portland hospital for whatever reason. You have come from outside of the immediate metropolitan service area that the applicants have applied for. So, that's an inflow adjustment and you need, you know, data from across the state to make those sorts of adjustments. If you focus instead on discharge -- patients that are discharged from the hospitals within this larger health service area, you are, in effect, putting actually the two together into one step, both people that live in that service area and people who have had an inflow from outside of the service area. So, effectively you should come up with a very similar perspective to -- if you were using discharges in this case as opposed to using ZIP code or county-level residents plus inflow adjustments. For general hospital acute bed need, there are some good reasons why you would want to do the patient origin within the service area plus an inflow adjustment due to complexities of where people may be coming from and going to and local market share consideration. For a specialty service such as this, there is not as much motivation to do that.

Q: The market share that you just referenced, is that sometimes described as the 1020 rule?

A: Yes. Yeah. Yes, it is. The -- normally, you would -- you would want to look at ZIP code areas where the hospital is pulling either 10 percent of its total volume from or where they'll have a 20 percent market share for the service. And you think of this as a specialty care with a large amount of unmet need potentially. I think the current applicant would have no trouble satisfying the rule requirement of pulling 20 percent market shares throughout any -- from almost all sub areas. So, it -- somewhat of a moot point.

Q: Can you explain that further?

A: Yeah. That if we're proposing that the actual need for services, for IRF-type services, is substantially greater than is what is currently being served in IRFs in almost all localities, there is a great unmet need. And if -- it should not be a challenge mathematically or practically for the applicant to achieve a 20 percent market share in most of the areas within a county, within -- or the health service area.

Q: And in sort of arriving at this underlying assumption regarding where a rehab facility would draw its patients, what data are you relying on?

A: The data that we were relying on is the hospital discharge data that is collected by Oregon's Office of Health analytics. It's for all inpatient data exclusive, I believe, of the VA.

Q: And so in deciding where an acute rehab facility will draw its population base, what dataset do you look at for that analysis?

A: Again, it's the discharge data. Since we're proposing -- we propose looking at the discharges for stroke constitute the population base for which we can show that there is a need for a -- a potentially unmet -- a great unmet need.

(Tr. at 80-94.)

(59) Mr. Robison had concerns that applying the Division 590 rules to the bed need calculation would not show an accurate level of need. He was concerned that the assumption that hospital use rates will decline over time is no longer true and concerned that it is "hard with the 590 numbers to show that there is a need for general inpatient beds in Oregon where the population is increasing." (Tr. at 117, 228.) He determined, on behalf of the Agency, that the "where applicable" portion of OAR 333-645-0030 was "an instruction to consider what is reasonable as an application of the 590 rules to this general situation." (Tr. at 82.) When testifying about using OAR 333-590-0030 to OAR 333-590-0060 as it applied to IRF beds methodology, Mr. Robison testified, in part, as follows:

A: * * * Again, the 590 methodology for acute inpatient beds is really -- following it just in a straightforward interpretation of 590 without considering the 645 direction to be consistent [where] applicable, and to -- you know, to attempt to develop a variation on the 590 that is more applicable and accurate for the problem of IRF use. That general 590 acute care bed analysis I think is interesting, but I do think that our discharged-based approach is superior.

Q: And why do you think it ended up being a better measure of need?

A: Largely because the origin of patients at a hospital, that's the point at which you need to consider that they need a fairly rapid transition to intense inpatient rehabilitation environment, that our population -- we're not saying it's people out in the community, but it instead -- it's a population that is coming right out of the hospital, or is in the hospital and needs a very quick placement for rehabilitation for this level of intense service to show a good benefit.

(Tr. at 147 -148.) He went on to explain:

[T]he principle of the 590 rules is to look at population need defined by some type of area, and by some form of utilization as a ratio in the population. It's a rational calculation method. I interpreted [OAR 333-645-0030(4)] as the direction to be consistent where applicable is best done by sticking to those principles of doing a service area-based population-based calculation for specific need for a service that focuses on patient days and discharges.

* * * * *

The approach and principle and -- of looking at patient discharge as determining need is really, you know, the same across the two methodologies -- or even the -- the original OAR [Chapter 333, Division 590] and this. If there were substantial volumes of existing IRFs, that might change some of the consideration, or in other settings that change the consideration of the [OAR 333-590-0060] portion, but, you know, the -- the direction to do this in a consistent manner, I believe that we did do that in a consistent manner, that we're trying to have a rational determination of need base[d] on hospital discharges across a particular area for particular services.

(Tr. at 207, 209.)

OHA finds by a preponderance of the evidence that hospital use rates will no longer decline over time because the aging population of Oregon will increase hospital use rates. (Ex. A113 at 6; Ex. A70 at 3.)²³

(60) When asked by Mr. Greenman about the presumption that hospital use rate will decline over time, Mr. Robison testified:

Q: In your Direct testimony, and again here with me, you did mention that Division 590 contains within it a presumption that hospital use rates decline over time. And you're sharing with us that I guess based on your personal opinion and perhaps also your professional observations of data, et cetera, that that might not be the case. What practical impact on bed need analysis does the 590 presumption have on an assessment of bed need for acute care hospital beds; does it impact the analysis in a way that drives the presumption lower?

A: Well, the largest impact, I think, of some of this is that the rules direct applicants to use data that doesn't exist to try to assess that declining rate anymore, that we have exceeded the window that was originally envisioned with the specifications of data for that declining use rate, that's kind of

²³ OHA takes official note that beginning in approximately 2006 OHA directed CN applicants to not use declining hospital use rates. CN No. 646 (Sacred Heart Medical Center, CN No. 648 (Kaiser Westside Hospital), and CN #654 (Ascend Health Corporation).

embarrassing to me when I do an analysis. For the last number of applications before these IRFs, we've been telling -- I've been telling with the -- understanding both prior and current CN managers that we will want to entertain and will look at reasonable alternatives from applicants regarding use rates. Other than that, we have a long period of declining use rates in Oregon and then it flattened out. So, I usually tell people that if you can make a reasonable argument, I want to hear it. Otherwise, I'm going to apply a flat use rate assumption. And that's the best I can do, given we don't have the data, it doesn't really exist anymore and reality seems to have gone in a different direction after a long period of success in reducing hospital use rates in this State.

* * * * *

Q: So, rather than advise your -- I don't know, your coworkers, or I don't know if it's a client relationship, or you're on the team, or you're a consultant or what, but rather than advise them to disregard or ignore certain provisions because of their impracticality, have you ever advised them to entertain the concept of proposing amendments to the rule and promulgating revisions to reflect the reality that's developed the years that have intervened since the rule was originally promulgated?

A: Honestly, I have recommended for 20 years that we rewrite the rules to address that and to fix that issue. I wish that had happened long, long ago.

(Tr. at 236-238.)

(61) As addressed in Mr. Robinson's testimony above, when conducting the bed need analysis, the Authority did not explicitly follow those portions of the Division 590 methodology that the Authority found inapplicable or inconsistent to IRF bed need.

Reason for modification: The ALJ's legal conclusion that OHA did not apply the methods and principles of OAR 333-590 is fully addressed in the Conclusions of Law *infra*.

The Authority instead developed and used a "service area-based population-based calculation for specific need for a service that focuses on patient days and discharges." (Tr. at 207.) Also as indicated above, the agency did not assume a declining hospital use rate. Mr. Robison further testified:

A: * * * You know, I was very concerned about what this [OAR 333-645-0030(4)] means when it says consistent to that. I checked the definition of that term in a number of dictionaries actually when I first started looking at this to get some sense of what does this actually mean. And consistent does not mean identical. That's the language that I really -- or the concept that I was thinking

of when I wrote that it's not the same, that it is not -- it's directed to be similar, but not identical to [Division] 590. And that similarity is when it's applicable. The assumption that we -- either we follow the identical 590 methodology, because consistent does not mean identical.

Q: And did you identify criteria and factors for these applications that made them not applicable with the methods and principles of Division 590?

A: Well, I identified factors that allowed us to follow a consistent methodology. You know, the largest factors are that the patients are -- in IRF are originated as a hospital discharge, as opposed to someone who is going from home directly into an inpatient acute setting.

(Tr. at 287-288.)

(62) During the hearing in this matter, Mr. Robison determined that he erroneously included Yamhill County hospital discharges in his original calculations. He removed those discharges and performed an updated bed need calculation as follows:

Hospital	Sum of Count Discharges	County
Legacy Meridian Park Medical Center	1376	Clackamas
Providence Willamette Falls	460	Clackamas
Columbia Memorial Hospital	155	Clatsop
Providence Seaside Hospital	98	Clatsop
Adventist Medical Center	1196	Multnomah
Kaiser Sunnyside Medical Center	2140	Multnomah
Legacy Emanuel Medical Center	2290	Multnomah
Legacy Good Samaritan Hospital	880	Multnomah
Legacy Mount Hood Medical Center	929	Multnomah
OHSU Hospital	2953	Multnomah
Providence Milwaukie Hospital	394	Multnomah
Providence Portland Medical Center	2664	Multnomah
Tillamook Regional Medical Center	167	Tillamook
Kaiser Westside Medical Center	457	Washington
Providence Newberg Medical Center	0	Yamhill
Providence St Vincent Medical Center	3315	Washington
Willamette Valley Medical Center	0	Yamhill
Tuality Community Hospital	720	Washington
Grand Total	20194	
Total Days at ALOS 12.7	256464	
Total Bed Need assuming 100% occupancy and ALOS 12.7	703	

Hospital	Sum of Count Discharges	County
Number of beds needed per year	141	
Adjustment factor to ensure bed availability	166	
Less current bed capacity	109	
Total beds approved (proposed)	100	
Total beds in HSA I with approval of applications	157	
Total Population in HSA I	1995420	
Ratio of beds	7.86802E-05	

(Ex. A184.xlsx at Sheet 1.) Ex. A184.xlsx is based on suppressed data and is based on 2020 population in HSA I. (Id.)

(63) During the hearing, Mr. Robison also conducted a bed need calculation assuming 100 percent, 75 percent, and 50 percent of discharged patients (age 40 and older and excluding VA patients, discharges from federal facilities, and patients who died) utilized IRFs as follows:

Calculations	100%	75%	50%
Discharges per year (average)	5,084	3,813	2,542
Patient days at ALOS = 12.7	64,656	48,424	32,282
ADC (100% occupancy)	175	133	88
Poisson upper bound (at 95% CI)	205	158	109
Added beds for 95% availability	28	25	21
Existing beds	54	54	54
Unmet bed need (2020)	151	104	55

(Ex. A183.) Ex. A183 is for the period of 2013 to 2019, age 40 and older, and is based on suppressed data. (Id., Tr. 1456.)

Legacy witness Jennifer Lawlor, MD testified at hearing that age was a poor predictor of who would benefit from IRF services:

“If anything, [more of those getting stroke] but they had some, you know, partial recovery and there’s more potential there. So, I just don’t see correlation with age. I mean, maybe there’s the older patients that don’t have the endurance to do three hours and then they can go to sub-acute, but in my - - in my experience, I’m not seeing a relationship there. (Tr. 724-725.)

Question: “And I think I may have heard you say that some of the younger patients actually might be more likely qualified because they can withstand the three hours of therapy versus the older patients might be more frail; is that correct?”

Answer: “Yeah.”

(Tr. 756.)

OHCA witness Michael Billings, CEO of Infinity Rehab testified that focusing on individuals over the age of 40 was inconsistent with his experience:

“And I had an opportunity to practice (indecipherable) inpatient rehab earlier in my career, and in my experience, the kind of patients that go to inpatient rehab compared to the ones I’ve seen in most of my career in skilled nursing tend to be younger, tend to have fewer comorbidities than the patients that we see, and to allow them to tolerate the three hours of therapy required in inpatient rehab.”

(Tr. 411.)

8.3% of post-acute discharges to IRFs were between the ages of 0 to 44. (Ex. A24 at 157.)

Literature review suggests that eight percent of all stroke patients are under the age of 44. (Tr. 1050.)

(64) Following the conclusion of the hearing, the Authority filed a Motion to Reopen the Record to correct some testimony provided by Mr. Robison. The Authority submitted a Declaration of Steven Robison that provided, in part:

1. I am an epidemiologist for the Oregon Health Authority. I conducted the bed need analysis for the certificate of need program.
2. I testified on behalf of the Oregon Health Authority on March 29, 2021 and April 5, 2021. After the hearing a discrepancy between my testimony and the data came to my attention.
3. During my testimony I stated that OHA’s bed need analysis arrived at 26, 283 discharges based on evaluating diagnosis related groupings (DRGs) of 61-66, 68-74, and 82-90.
4. On or about May 21, 2021, I became aware of a question raised regarding one of the calculations presented at hearing. I reviewed the spreadsheet and realized that the 26,283 discharges listed on Exhibit A73 page 1 of 1 corresponded to a broader set of discharge DRG codes related to stroke, brain injury, and other neurological conditions, including DRGs 52-66, 68 to 74, and 82-94.

5. To provide accurate data regarding DRGs 61-66, 68-74, and 82-90, I have attached two tables reflecting the number of discharges for those DRGs for all ages in the years 2014 to 2018 and 2013 to 2017 without suppressing smaller groupings of discharges. Attachment A, Table 1 includes the number of discharges listed by the 16 hospitals in health service area 1. The total number of discharges for the above listed DRGs for all ages in the years 2014 to 2018 is 25,224 and in 2013 to 2017 is 24,867.

6. Following the same methodology outlined in my testimony, I multiplied total discharges by 12.7 days, divided by 365 years, divided by 5 years, applied the Poisson Distribution, subtracted 57 beds of existing capacity, and then reduced that number by 25% to arrive at the number of beds in Table 2.

(Declaration of Steven Robison at 1-2.) Table 1, titled Number of Discharges in Hospital Service Area 1 for DRGs 61-66, 68-74, and 82-90, attached to Mr. Robison’s Declaration provided:

Facility	2014-18	2013-17
Adventist Medical Center	1443	1417
Columbia Memorial Hospital	215	209
Kaiser Sunnyside Medical Center	2459	2609
Kaiser Westside Medical Center	568	690
Legacy Emanuel Medical Center	3051	3070
Legacy Good Samaritan Hospital	1047	1021
Legacy Meridian Park Medical Center	1666	1752
Legacy Mount Hood Medical Center	1103	1100
OHSU Hospital	3976	3975
Providence Milwaukie Hospital	454	433
Providence Portland Medical Center	3142	3203
Providence Seaside Hospital	141	140
Providence St Vincent Medical Center	3941	3916
Providence Willamette Falls	558	517
Tillamook Regional Medical Center	216	234
Tuality Community Hospital	887	938
Total	24867	25224

(*Id.* at 3.) Table 2, titled Number of Approvable beds in Health Service Area 1, attached to Mr. Robison’s Declaration provided:

DRG Range	2013 to 2017	2014 to 2018
61-66, 68-74, 82-90	98 ²⁴	100

(*Id.*)²⁵

Oregon Population, Hospitals, and IRFs

(65) As of July 1, 2018, Portland State University (PSU) estimated the total population of HSA I to be 1,956,500. (Ex. A184 at PSU 2019.) As of July 1, 2019, PSU estimated the total population of HSA I to be 1,977,140. (*Id.*) As of July 1, 2020, PSU estimated the total population of HSA I to be 1,995,420. (*Id.* at PSU 2020.) PSU forecasted HSA I's population will be 2,230,371 in 2030. (Ex. B006 at 17.)

(66) The population of Oregon is rapidly aging. Previous assumptions that hospital use rates will decline over time are no longer applicable because the aging population of Oregon will increase, not decrease, hospital usage rates. (Tr. at 110, 117, 229, 239.) The population in the Portland metropolitan area for individuals age 65 and older will likely grow by 48 percent from 2017 to 2030. (Ex. A113 at 6.)

(67) A preponderance of the evidence in the record is that there are currently two IRFs in HSA I: three Legacy Good Samaritan's Rehabilitation Institute of Oregon (RIO) and, Providence Portland, and Randall's Children Hospital. (Tr. at 211, 212, 590; Ex. A24 at 8.)

Reason for modification: See finding of fact No. 69.

(68) RIO is run by Legacy and connected to Legacy Good Samaritan, a general acute inpatient hospital. It has 36 IRF beds. (Tr. at 793-794; Exs. E141 at 9-10, A50 at 53.) RIO has an average occupancy rate of approximately 60 percent. According to informal testimony from Legacy's outside counsel, the occupancy rate has been declining over time. (Ex. A50 at 53.) Approximately 50 percent of the patients at RIO have a primary diagnosis of stroke. Approximately 25 percent of the patients at RIO have a primary diagnosis of traumatic brain injury (TBI). (Ex. A50 at 57.) The ALOS for a patient at RIO is 12.9 to 13.6 days. (Exs. A50 at 58, A75 at 2.)

(69) Providence Portland has 18 IRF beds. (Exs. E141 at 9-10, A50 at 53.) Providence Portland operates at a 76 percent average occupancy rate. (Ex. A113 at 31.) The ALOS for a patient at the Providence IRF is 13.1 days. (Ex. A75 at 2.)

Legacy Emanuel Randall Children's Hospital was alleged by Legacy witness, Jody Carona, and in a Legacy document, to have has 12 IRF beds. It serves primarily children and young adults. (Ex. A47 at 5, Ex. E141 at 10; Tr. At 590.) The preponderance of the evidence is that there are 54 IRF beds in HSA I. (Ex. B202; Ex. B204).

Reason for modification: The ALJ cited transcript pages 211-12, 590, and Exhibit A24 at 8 for the assertion that there are three IRFs in HSA I. The transcript citation page 590 is to testimony of Legacy witness Jody Carona discussing her company's bed need calculation in Exhibit E141. She testified that she ran her company's calculations excluding and including the population

²⁵ Using the updated IPPS exclusion list 54 IRF beds need would be 101 (2013 to 2017) and 103 (2014 to 2018).

under the age of 15, depending on whether the 12 beds at Legacy Emanuel Randall Children's Hospital are included. She does not provide any testimony or information regarding the nature of the services offered by Legacy Emanuel Randall Children's Hospital. Later in Ms. Carona's testimony, she stated that she doesn't know whether Randall Children's Hospital is an "inpatient rehabilitation unit" (Tr. 651) and that she is "not the best person to answer this question." (Tr. 653.) Exhibit A24 at 8 makes no mention of the Legacy Emanuel Randall Children's Hospital.

Exhibit A47 is a letter from Legacy's Interim VP of Legal Affairs Anne Greer. A review of that letter demonstrates that the author does not include Legacy Emanuel Randall Children's Hospital where she describes the services offered by Legacy Good Samaritan (RIO) that qualify it as an IRF. (Ex. A47 at 2.) She provided no information regarding who is served at Legacy Emanuel Randall Children's Hospital or what rehabilitation services are offered for the approximate "six patients" it serves per day. (Id.)

Exhibit A24 at 8 does not address the services offered at Legacy Emanuel Randall Children's Hospital.

Mr. Robison testified that the two IRFs in HSA I are Legacy Good Samaritan (RIO) (36 beds) and Portland Providence (18 beds) based on the IPPS list. (Tr. 211-212, 1463). Neither Legacy or OHCA in response to OHA's witness as to the reason OHA did not include the Legacy Emanuel Randall Children's Hospital beds in the IRF bed ratio calculation offered any direct evidence at hearing concerning the nature of the rehabilitation services offered at Legacy Emanuel Randall Children's Hospital.

OHA's witness Steve Robison testified that the DRGs that were initially chosen by OHA to evaluate need were applicable to "age 40 and up" and he was "not certain what the DRG range would be for someone at Randall." (Tr. 213.)

Exhibit B202 is Legacy Emanuel's most recent Medicare Cost Report filed with U.S. Centers for Medicare and Medicaid Services. Under "subprovider IPF" ("inpatient psychiatric facility") the report lists 107 beds. Under "subprovider IRF" the report lists "zero."

Exhibit A204 contains the publicly available HCRIS database of submitted cost reports and shows the IRF beds as those at Legacy Good Samaritan-RIO (36 beds) and Providence Portland Medical Center (18 beds).

Legacy's Director of Rehabilitation Pam Kilmurray testified on October 14, 2019 at PAM's public hearing that "Legacy only has one rehabilitation hospital and that's RIO . . ." (Ex. A46 at 50.)

Legacy's counsel Joe Greenman testified on October 15, 2019 at Encompass' public hearing that there are currently "two IRFs providing services, one with 36 beds, the other one 18." (Ex. A 50 at 53.)

Mr. Greenman later confirmed in a November 4, 2019 letter to OHA, stating that there are “two existing providers” and reproduced Encompass’ bed need calculation showing two IRFs. (Ex. E53 at 3.)

(70) In its application, PAM indicated:

OHA data and discussion with the two IRF units in Portland suggest that their admission policies are very conservative. Most admissions appear limited to the 13 medical conditions that Medicare requires of the 50 percent of admission. In fact, data for one of the two suggest an even more limited admission policy. This conservative approach eliminates a significant group of patients from the IRF benefit, for example, those who may be recovering from cancer treatment, or persons recovering from cardiac or pulmonary conditions.

(Ex. A24 at 79.)

Medicare

In September of 2019, Oregon had a Medicare Advantage penetration rate of 41.8 percent. (Ex. A50 at 26.) Patients with Medicare Advantage must receive preapproval before admission to an IRF. (Tr. at 809; Ex. A50 at 27.)

Nationally, Medicare patients represent 60 to 66 percent of IRF patients. (Ex. A24 at 79.)

Medicare requires a minimum of 60 percent of IRF admissions have one medical diagnosis or functional impairment from a list of 13 compliant conditions (CMS-13) that include: stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; fracture of femur; brain injury; neurological disorders; burns; active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies; systemic vasculidities with joint inflammation; severe or advanced osteoarthritis; and/or knee or hip joint replacement for patients 85 or older, underwent bilateral knee or hip joint replacement, or had a BMI of 50 or greater at the time of acute care admission. (Tr. at 354, 398; Exs. A24 at 138, A48 at 16.) If an IRF fails to meet the 60 percent threshold, they may be subject to increased scrutiny from Medicare or may be required to repay some revenue received from Medicare reimbursements. (Tr. at 264.)

(71) According to the Medicare Benefit Policy Manual, an IRF patient must: (1) need close medical supervision; (2) require nursing care 24 hours per day, seven days per week; (3) require at least two types of therapies, one of which must be physical therapy or occupational therapy; (4) be able to tolerate a minimum of three hours of therapy five days per week; (5) demonstrate the ability to make “practical and significant improvement;” and (6) have the goal to discharge home. (Ex. A51 at 4.)

IRF and SNF Characteristics

(72) When a patient experiences a stroke or TBI, quick intensive interventions, including rehabilitation, improves their long-term recovery including quality of life, functional ability, and lower caregiver burden. (Ex. A50 at 69.)

(73) For admission to an IRF, the patient must be admitted by a rehabilitation physician. (Ex. A48 at 8.) A rehabilitation physician must see each patient in person at least three times per week. (*Id.*)

(74) All IRF patients must be reasonably medically stable and have the ability to participate in a minimum of three hours of rehabilitation therapy a day, five days per week. (Ex. A48 at 7.)

(75) IRFs are required to use a coordinated interdisciplinary team (IDT), led by a rehabilitation physician. The IDT includes a rehabilitation nurse, a case manager, and a licensed therapist from each therapy discipline. The IDT must meet weekly to discuss each patient's care. (Ex. A48 at 8.)

(76) IRF patients receive rehabilitation nursing care 7 days per week, 24 hours per day. (Ex. A48 at 7.)

(77) Approximately 72 percent of IRF patients are 65 years or older. (Ex. A48 at 16.)

(78) Nationally, the average patient length of stay at an IRF is 12.7 days. (Ex. A48 at 8.)

(79) Freestanding IRFs tend to have lower operating costs than IRFs connected to a general acute inpatient hospital. (Ex. A113 at 113.)

(80) Nationally, the average number of IRF beds per 100,000 general population is 11.11. Oregon's average is 3.38. (Ex. A113 at 51.)

(81) Occupancy rates at IRFs can vary based on the location of the facility, admission practices, insurance approvals or denials, and facility accommodations and equipment. (Tr. at 1045, 1055, 1171-1175.)

(82) Prior to being admitted to an SNF, Medicare patients must spend at least three days in a general hospital. (Ex. D66.) There is no hospital length of stay requirement for admission to an IRF. (Tr. at 202.)

(83) Some Oregon SNFs have "short-stay" beds where patients can stay following discharge from an acute inpatient facility, such as a general hospital. These stays are under 90 days in length. (Ex. D34.) Oregon SNFs may provide the following services to short-stay patients: medical treatment; physical, speech, and occupational therapy; assistance with ADLs; case management; and social services. (Ex. D8.)

(84) Nationally, the ALOS for SNF patients is 38.5 days. (Ex. A113 at 90.) The ALOS for a “short-stay” patient in Oregon in 2017 was 19 days. (Ex. D34 to D36.)

(85) For admission to a SNF for rehabilitation, the patient must have a physician order. (Ex. A50 at 49.) The admission requirements applicable to SNFs impose no requirement that there be a reasonable expectation that there will be a measurable improvement in the SNF resident’s functional capacity. (CMS Transmittal 179 (January 14, 2014 at page 1)). In contrast, IRFs must demonstrate prior to the admission of the patient to an IRF that the patient can be expected to benefit significantly from the intensive rehabilitation therapy program and make measurable improvement in the patient’s functional capacity as a result of the rehabilitation treatment. (Tr. 434; 42 CFR Section 412.29(d).)

(86) SNFs have no minimum requirements for the number of rehabilitation therapy hours any given patient must receive. (Tr. at 387-388.)

(87) Oregon SNFs care for, on average, higher acuity patients than the rest of the country. The majority of stays in Oregon SNFs are short-stays. Eight-two percent of short-stay patients in SNFs receive five days per week of physical therapy, and of that group, 77 percent receive occupational therapy services as well. (Ex. A50 at 48-49.)

(88) Marquis Company, a member of OHCA, operates 11 licensed SNFs in HSA I, with 705 beds. The occupancy rate at those facilities is approximately 81 percent. Ninety-five of its skilled nursing facility admissions are short-stay, lasting 30 days or less. On average, its facilities provide two or more hours of therapy, six to seven days per week, for patients in the “ultra-high rehabilitation category,” which comprises the majority of Marquis’ short-stay patients. (Ex. A45 at 20.) For Medicare Advantage patients, the ALOS at a Marquis facility is 19.5 days. (*Id.* at 21.) Marquis employs three physicians and 11 nurse practitioners and physician assistants across their 11 facilities. (*Id.* at 22.) Thirty-seven percent of short-stay patients at Marquis have a primary diagnosis that aligns to the CMS-13. (Ex. A47 at 20.)

(89) Scientific literature shows that rapid initiation of intense rehabilitation services, such as those provided at an IRF, leads to better outcomes for patients who experience a stroke. (Tr. at 89, 101.)

(90) Eligible patients treated at an IRF, compared to clinically similar patients treated at a SNF, have an eight percent lower risk of death over a two-year post-acute care period, live in their home an additional 51 days, and have fewer emergency room and hospital readmissions. (Ex. A113 at 7, *citing* Assessment of Outcomes in Rehabilitation Care in Rehabilitation Facilities and After Discharge, Al Dobson, PhD., Joan DaVanzo, PhD., *et al*, ARA Research Institute, 2014. Page 2.)

(91) The American Stroke Association and American Heart Association strongly recommend that, whenever possible, stroke patients be treated at an IRF rather than a SNF. (Exs. A48 at 9, A50 at 75, A113 at 7-8.)

(92) At both an SNF and IRF, a physician-directed plan of care is prepared for each patient. At SNFs, physicians must review and update them every 30 days. At IRFs, physicians must review and update the care regimen daily. (Ex. A24 at 51.)

(93) Readmission rates to general acute inpatient hospitals are higher from SNFs than from IRFs. (Tr. at 176.)

(94) The number of beds in a freestanding ~~IFR~~ IRF impacts operating costs, with smaller IRFs (1 to 10 beds) costing \$4,100 more per patient per stay than an IRF with 50 beds. (Ex. A24 at 24.)

(95) Costs of care on a daily basis are higher at an IRF compared to a SNF. However, the higher cost “reflects the higher level of care, which generally results in shorter stays with better outcomes.” (Ex. A51 at 10.) Medicare pays a fixed price per patient discharge to an IRF, based on the patient’s diagnosis. (Ex. A24 at 79.) In 2016, for an ultra-high therapy patient, Medicare would pay \$932 per day for a stay at an SNF (\$12,116 for a 13 day stay, \$28,892 for a 23 day stay) or the fixed price of \$10,810 for an IRF admission. (*Id.* at 11.)

(96) When comparing IRFs to SNFs nationally:

	IRFs	SNFs
Discharge Rate to the Community	76%	38.8%
Readmission Rate to Acute General Hospitals	13.06%	23.5%
ALOS (for matched conditions)	12.4 days	26.4 days
Two-Year General Hospital Re-Admissions per 1,000	957.7	1,008.1
Two-Year Mortality Rates (for matched conditions)	24.30%	32.30%
Average Days Alive After Two Years (on matched conditions)	621 days	569 days

(Ex. A24 at 73.)

Community Response to IRF Applications

(97) On September 14, 2018, Daniel Wright, DC, with SpineCare Chiropractic, sent a letter of support to the Authority on Encompass’ behalf. He wrote, in part:

I have been a chiropractic physician in Hillsboro Oregon for the past 20 years and have worked extensively with local occupational medicine clinics in that time along with physicians from Tuality Healthcare. Research has shown that inpatient rehabilitation hospitals have significantly improved outcomes in several areas as compared to skilled nursing facilities, including a significant reduction in length of inpatient care, decrease in two year mortality rates, decrease in the number of annual emergency room return visits, and decreased need for additional return to inpatient care following initial release of the patient. Unfortunately, skilled nursing facilities often offer only enough care to keep the patient’s condition stabilized rather than to significantly improve

their overall function. * * * Unfortunately, advanced multidisciplinary rehabilitative care is currently limited in this area even though there is a significant need for this type of service. * * *

(Ex. A108 at 1.)

(98) Keith Pagel, a physical medicine and rehabilitation physician practicing in Oregon for 25 years believes there is a “lack of high intensity inpatient rehabilitation in the [Portland] metropolitan area.” (Ex. A47 at 1.) Dr. Pagel believes that the Encompass and PAM proposed IRFs would “greatly benefit” the residents of the region who sustain catastrophic neurologic or musculoskeletal injuries. (*Id.*)

(99) Sherry Stock, a neuro-gerontologist and executive director of the Brain Injury Alliance of Oregon, believes there are not sufficient IRF beds in Oregon and Southern Washington. (Ex. A46 at 16-17.)

(100) EmpRes Healthcare Management LLC, which operates SNFs in Oregon, believes that the opening of the Encompass and/or PAM facilities will disrupt the health care marketplace, specifically the ability to find qualified nurses and other health care providers. EmpRes asserts that it is “a daily struggle to fill all shifts and the EmpRes nursing facilities in the service area have all recently had to resort to contracting with national temporary employment agencies to fill shifts.” (Ex. A47 at 28.)

(101) Marquis Advantage, Inc. dba: AgeRight Advantage Health Plan (AgeRight) provides Medicare Advantage insurance coverage for nearly 500 individuals receiving care in long-term care facilities in Oregon. In response to learning about Encompass’ and PAM’s applications for a Certificate of Need, AgeRight provided written testimony that read, in part:

The Authority should reject these applications because they propose a care and reimbursement model that is not sustainable and that we, and most other managed care entities, would not choose to contract with.

The greater Portland Tri-County service area maintains one of the highest Medicare Managed Care penetrations in the nation, at 57%. Encompass indicates it expects to accept only 7.7% Medicare Managed Care and Post Acute Medical will accept only between 5% and 7%. This level of acceptance means neither applicant is prepared to accept sufficient levels of Medicare Managed Care to meet the needs of the members the plans serve.

Further, Medicare Advantage plans would be challenged to contract with them because inpatient rehabilitation facilities provide much the same rehabilitation care we pay for now in nursing facilities but at a much higher price. * * * Further, even if we were to agree to pay a higher price for no better care, our members would suffer because higher costs to plans typically also bring higher copays and coinsurance for our members.

* * * * *

Because it is unlikely these applicants would receive any significant Medicare Advantage contract, we believe they would either face quick closure or would push a disproportionate share of higher risk Medicare Advantage members to area nursing facilities for care. Either scenario is not good for member of the Portland Tri-County health care marketplace.

(Ex. A52 at 1-2.)

(102) On November 5, 2019, Rob Nosse, Oregon State Representative and Chair of the Ways and Means Subcommittee on Human Services, along with Andrea Salinas, Chair of the House Committee on Health Care, submitted a letter to the Authority regarding the Encompass and PAM applications that read, in part:

These applications appear to be in direct conflict with Oregon's Triple Aim and legislative direction regarding the role that nursing facilities are to play in our health care marketplace.

These applications come from out of state corporations that are not in tune with how health care is provided in our state. The legislature has specifically directed that we promote independence in our older and vulnerable citizens by directing them to community-based care as much as possible. As a result, Oregon's nursing facilities care for a much higher acuity level than found in other states and, because of the needs of their patients, provide significant rehabilitation therapy services. These services are similar to those provided in an inpatient rehabilitation facility and the duplication of services is not a good use of our health care dollars.

Oregon's health care sector is already facing acute workforce shortages and these applications would only serve to exacerbate the challenges providers are having to hire and retain qualified caregivers.

Further, we are concerned that both applicants have stated they would accept less than 5% Medicaid patients in a market where nursing facilities have case mixes of 50% Medicaid or more. Similarly, Encompass indicates it will accept less than 10% Medicare managed care and Post Acute Medical has not addressed that issue at all. Oregon has one of the highest Medicare managed care rates in the nation. These facilities would not be available to most Oregonians as the applicants clearly intend to skim higher reimbursement patients out of the market.

(Ex. A53 at 1.)

103) In response to Rob Nosse and Andrea Salinas' letter, PAM wrote a letter to the Authority that stated, in part:

PAM's Application Is Not "in Direct Conflict with Oregon's Triple Aim."

The Oregon Health Authority's formulation of the Triple Aim, in OAR 409-055-000, [*sic*] is "a healthy population, extraordinary patient care for everyone, and reasonable costs, shared by all." PAM shares all of those values, and believes that its hospitals deliver better health outcomes, extraordinary care, and costs that compare favorably on a pre-case basis. The idea that nursing facilities alone, which are not licensed as hospitals or staffed to accomplish extraordinary care, are superior on those goals to the kinds of specialized care that PAM delivers reflects a serious misunderstanding of the medical and economic facts.

PAM's Application is Not in Conflict with "the Role that Nursing Facilities Are to Play in Our Health Care Marketplace."

Nowhere in Oregon statutes or regulations is there a principle that skilled nursing facilities have been given by this state a monopoly on post-acute care, for any class of the person who might benefit from it. Skilled nursing facilities are licensed differently and authorized to provide a different level of care than inpatient rehabilitation hospitals. * * *

Skilled Nursing Facilities Are Not "Community-Based Care."

The legislators' suggestions that "our older and more vulnerable citizens" should be directed to "community-based care," and that proposition means that Oregonians should not have inpatient rehabilitation hospitals available to them as an option, are based on the false premises that a SNF is "community-based care" and that an IRH is not. Both, however, are facilities in which care is rendered in the facility, not in the community. Among their differences are that the care delivered in an IRH tends to be of shorter duration and more intensive, whereas care in SNFs tends to be for longer periods of time and SNFs are not licensed to offer the level of care that IRHs offer. * * *

* * * * *

As anyone can verify by reviewing available public filings, the OHCA has given Reps. Nosse and Salinas thousands of dollars in contributions. * * *

(Ex. A54 at 1-2, 4.) (Emphasis in original.)

Encompass replied with similar arguments. (Ex. B001 at 1 to 18.)

Oregon Senator Chuck Riley, then of Senate District 15 (Washington County) testified that there is a need for the Encompass inpatient rehabilitation hospital, and that Oregon has the lowest use of IRF services in the United States. Senator Riley further testified that the proposed Encompass IRF would greatly improve the prospects for returning IRF patients to independent living. (Ex.

A141 at 32.)

CONCLUSIONS OF LAW

A preponderance of the evidence shows Encompass has satisfied the criteria specified in OAR 333-645 et seq. and demonstrated that all applicable criteria in OAR 333-580 et seq. can be answered in the affirmative. OHCA and Legacy have not demonstrated by a preponderance of the evidence that OHA's grant of a Certificate of Need failed to meet any relevant criteria. OHA's grant of a Certificate of Need to applicant is affirmed.

~~The Authority failed to determine the need for the proposed IRF in accordance with the rules it promulgated. Based on the Authority's failure to evaluate need in accordance with the applicable provisions of OAR Chapter 333, Division 645, the Proposed Decision is reversed and the matter is remanded to the Authority for further evaluation and review.~~

Reason for modification: As outlined below, OHA does not adopt the ALJ's ultimate legal conclusions in this matter.

OPINION

Burden of Proof

Encompass submitted an application for a Certificate of Need to build a freestanding 50-bed IRF. The Authority reviewed the application and issued a Proposed Decision, granting the Certificate of Need. Subsequently, Legacy and OHCA appealed the Proposed Decision, arguing that the Authority improperly granted the Certificate of Need.

When a hearing is requested, the agency "gathers evidence to support its position and presents that evidence at the hearing." *VanGordon v. Oregon State Bd. of Dental Examiners*, 63 Or App 561, 566-567 (1981). An agency's decision must be supported by substantial evidence a preponderance of the evidence. *Dixon v. Oregon State Board of nursing*, 291 Or App 207, 214. *Id.* at 567. Thus, the Authority must first make a showing that its decision was supported by substantial evidence. Then, the burden shifts to the appellants (Legacy and OHCA) to prove, by a preponderance of the evidence, that the Department improperly granted the Certificate of Need. *See* OAR 333-670-0140; *See also* ORS 183.450(2); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely true than not. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

Reason for modification: The Proposed Order cites the wrong legal standard. Applying the substantial evidence prior to OHA's issuance of the final order is legal error. ORS 183.482(8)(c).

Certificate of Need

Pursuant to ORS 431.120(4), the legislature mandates that the Authority shall:

Control health care capital expenditures by administering the state certificate of need program under ORS 442.325 to 442.344.

ORS 442.315(1) and OAR 333-550-0010 require that any new hospital (including specialty inpatient care facilities such as an IRF) obtain a CN prior to development.

OAR 333-545-0000 provides:

(1) * * * The certificate of need program of the Public Health Division has as its purpose the achievement of reasonable access to quality health care, at a reasonable cost. Therefore, decisions regarding proposed new health services and facilities shall be made for reasons having to do with the most urgent community health needs in the various parts of the state. The burden of proof for need and viability shall be on the applicant[.]

* * * * *

(2) * * * [T]he certificate of need program shall be administered with the goal of containing capital investment and the objectives of:

(a) Promoting development of more effective methods of delivering health care;

(b) Improving distribution of health care facilities and services;

(c) Controlling increase of health care costs, including the promotion of improved competition between providers;

(d) Promoting planning for health care services at the facility, regional and state levels;

(e) Maximizing the use of existing health care facilities and services which represent the least costly and most appropriate levels of care; and

(f) Minimizing the unnecessary duplication of health care facilities and services.

(3) The division recognizes that:

(a) The objective of reasonable access must be tempered by acknowledgment that decentralized services may not be safe, effective, or economical if utilization is below identified standards;

(b) The objective of reasonable cost in any part of the state requires consideration of the actual and potential capacity of all facilities and services available or feasible to serve persons resident in that part of the state, so as to maximize the use of existing capacity, minimize unnecessary duplication, and give priority to the least costly alternatives feasible to meet significant health needs;

(c) Realistically, price competition among providers of any given type of institutionally-based care is limited and may jeopardize quality, so that regulation of market entry through certificate of need, and maintenance of quality through strict licensure standards, is necessary;

(d) Market competition between providers of institutional and alternative care contributes to the objective of reasonable access to quality health care at reasonable cost by reducing the likelihood of utilization of higher cost care when lower cost care would meet health needs, and should, therefore, be encouraged;

(e) Public and private funds available for health care and related social services are limited by available revenues and by demand for other expenditures. Therefore, institutionally-based health care capacity should be regulated so that the proportions of available funds, whether publicly or privately paid, committed to less or more intensive service levels are determined by the balance of needs among the population to be served, rather than by pressure to fully utilize excess institutional capacity;

(f) Health care regulatory, planning, and public and private reimbursement mechanisms should be coordinated so as to give incentives to providers to select the least costly treatment consistent with acceptable risk, and to give necessary care in the least costly setting;

(g) Specific projects to modernize facilities at a particular facility do not necessarily contribute to the statewide objective of reasonable access to quality health care at a reasonable cost, and must be carefully reviewed against that standard.

OAR 333-580-0030, regarding CN applications, provides:

(1) The applicant must demonstrate in narrative form that its proposal satisfies the criteria specified in OAR 333-580-0040 to 333-580-0060 and the

applicable service-specific need methodologies and standards in divisions 585 through 645. * * *

(2) The division will make findings and base its decision on the extent to which the applicant demonstrates that the criteria and standards referenced in section (1) of this rule are met. **Criteria will be considered to have been met if the applicant can demonstrate that the questions posed in the criteria can be answered in the affirmative.** An application will be decided in accordance with the statutes and rules in effect at the time of filing of a completed letter of intent for that application. * * *

* * * * *

(5) Applicants must demonstrate to the division that a proposal is approvable. All other application sections are supportive of this section.

(Emphasis added.)

Pursuant to CN rules promulgated by the Authority, an applicant must show in their application that they meet the enumerated ~~criterion~~-criteria to be eligible for a CN. The Authority has broken the ~~criterion~~ criteria into three general categories: (1) Need; (2) Availability of Resources and Alternative Use of Those Resources; and (3) Economic Evaluation. OARs 333-580-0040, 333-580-0050, and 333-580-0060.

To meet the Need standard, an applicant must show: (1) that the service area population needs the proposed project (*i.e.*, the bed need calculation), and (2) that the proposed project will result in an improvement in patients' reasonable access to services. OAR 333-580-0040. To meet the standard regarding the availability of resources and alternative use of those resources, an applicant must show: (1) that the proposed project represents the most effective and least costly alternative; (2) that sufficient qualified personnel, adequate land, and adequate financing would be available to develop and support the project; (3) that the proposed project would have an appropriate relationship to its service area (including any unnecessary duplication of services and any negative financial impacts on other providers); and (4) that the proposed project conforms to relevant state physical plant standards and that it will represent an improvement in regards to conformity to such standards, compared to other similar services in the area. OAR 333-580-0050. Finally, to meet the economic evaluation standard, an applicant must show that: (1) the financial status of the applicant is adequate to support the proposed project and will continue to be adequate following implementation of the project; and (2) the impact of the proposal on the cost of health care will be acceptable. OAR 333-580-0060. Each criterion is discussed below.

I. Need

a. Does the service area population need the proposed project?

OAR 333-580-0040, titled “Need,” provides:

- (1) Criterion: Does the service area population need the proposed project?
 - (a) The applicant must identify the service area’s need for the proposal in the past, present and future;
 - (b) In establishing the magnitude of present and future need for each service element, the applicant will:
 - (A) Use appropriate indicators of a population’s need (i.e., population-based use-rates, population-based “medical necessity” rates, or established productivity standards);
 - (B) Use the standards and need methodologies specified in divisions 585 through 645 of OAR chapter 333 applicable to the services or facilities being proposed;
 - (C) Consider industry standards and historical experience as appropriate comparisons where plans are silent[.]

* * * * *

Division 645 of Chapter 333 is titled “Demonstration of Need for Rehabilitation Services.” OAR 333-645-0000 provides:

- (1) The purpose of this division is to assure provision of accessible, quality care with the least incremental impact in overall community health care costs. Rehabilitation services assist people with a wide range of physical disabilities, focused on gaining optimum mobility and functioning. Least costly alternatives will be considered in determining an appropriate level of care.
- (2) The applicant, in providing information to the Public Health Division to demonstrate need for inpatient rehabilitation services, must satisfy the criteria specified in the Certificate of Need Application Instructions (division 580) and in this division (division 645).

* * * * *

To establish the Need for the proposed IRF, Encompass was initially required to show 1) the service area from which it would draw potential patients, and 2) there was a need for at least the proposed number of IRF beds within that service area. As outlined below Encompass made the requisite showing.

Reason for modification: The ALJ improperly states that the burden fell on PAM and on Encompass "to show 1) the service area from which it would draw potential patients, and 2) there was a need for at least the proposed number of IRF beds within that service area." In granting Encompass' Certificate of Need, OHA found that all the necessary criteria for approval of the proposed IRF were met and could be answered in the affirmative. (OAR 333-580-0030(2).) The burden of proof then shifted to appellants OHCA and Legacy. The evidence in the record demonstrates that Legacy and OHCA have failed to show by a preponderance of the evidence that any criteria was unmet. (OAR 333-670-0140.)

i. Service Area

OAR 333-545-0020(24) defines Service Area as:

“Service Area” means a group or area from which the applicant expects to draw a substantial portion of patients. Such area must be identified in the application, and its use must be substantiated. Service areas of other applicants and health care facilities may overlap. Not all patients in the applicant’s service area need to be expected to receive their health services from the applicant.

OAR 333-645-0030(1), in the rule titled “Elements in Calculating Need for Rehabilitation Services,” provides:

Total need for inpatient rehabilitation services is such that inpatient facilities shall not exceed seven beds in 100,000 general population:

(a) Determination of hospital service area is to be consistent with OAR 333-590-0040, or with historical use patterns for rehabilitation services if these are demonstrably different from a defined hospital service area;

(b) Adjustments to this standard can be made where a specialty rehabilitation service is proposed, if the applicant submits information demonstrating the sizes of populations at risk in the proposed service area; the current and historical rates of hospitalization in Oregon for those groups; and the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups in Oregon. An example of a specialty rehabilitation unit would be a unit specializing in strokes.

* * * * *

(4) Bed need calculation and minimal occupancy rate for rehabilitation services is to be consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.

OAR 333-590-0040, titled “Determination of Service Area for Existing Hospitals,” is applicable to existing hospitals, not to proposed new hospitals. It provides:

For purposes of divisions 545 through 670 of OAR chapter 333, the service area for an existing general hospital will be defined as including those zip codes from which either ten percent or more of the hospital’s discharges originate, or in which the hospital has at least a 20 percent market share. Minor adjustments to the boundaries of the hospital service area may be made to create a contiguous service area or to conform more closely to the boundaries of demographic units for which census data are reported (county, county census division, enumeration district, or zip codes if conversion has been done).

(1) Discharge and patient day market shares in the service area of the applicant facility should be calculated from the most recent statewide patient origin studies. Changes in relative market shares should be examined if two or more such studies are available. Appropriate steps should be taken to adjust for comparability between these studies if they differ in number of hospitals included, and/or other pertinent factors. More recent patient origin data on a less than statewide basis may also be considered if a method of adjustment for balance-of-state origins and utilization acceptable to the division and the applicant can be developed prior to filing the application.

(2) Federal (V.A.) hospitals may be excluded from the calculation of discharge and patient day market shares, and from other steps in this methodology, but if federal hospitals are excluded from any step, they must be excluded from all steps. For instance, market shares cannot be calculated using nonfederal patient days when the service area use-rate is calculated based on combined federal and nonfederal patient days. If explicit adjustments for projected declines in users eligible for care in federal facilities acceptable to the division and the applicant can be developed prior to filing the application, this factor must be considered.

(3) In the absence of evidence to the contrary, current market shares will be expected to be stable. Factors to which consideration may be given include population shifts; different rates of population growth among subareas within the hospital service area; changes in hospital location service mix, age mix, reimbursement mix, transportation patterns, locations of physician specialists; projected changes in amount or types of utilization among other providers

with market shares in the hospital service area; and documented commitments to develop procompetitive initiatives such as alternative delivery systems, selective contracting, successful competitive bidding, and other market oriented changes.

OAR 333-590-0030 (“Assumptions”) establishes the assumption applied by the Authority that “annual patient days needed by the population of a health service area can be more confidently forecasted than the demand at a single hospital or local market area.”

Reason for modification: OHA relied on OAR 333-590-0030 in arriving at the appropriate population-based methodology for evaluating IRF bed need. (Tr. 88, 203; B017 at 7.)

In its application, Encompass defined the Service Area for its proposed IRF to be primarily Washington County, with some inflow of patients from Clackamas County and East Multnomah-County. (Ex. 118 at 65.) In conducting its analysis consistent with OAR 333-590-0040, the applicant found that once it received accreditation as a specialty stroke center, net inflow from outside of the three county-service area would reach approximately 40 percent. (Ex. A118 at 65.)

Reason for modification: Additional information added regarding specialty services proposed by Encompass.

In granting the CN, the Authority determined that the historical use patterns for IRFs meant Encompass’ proposed IRF would serve patients who were discharged from inpatient facilities (general hospitals). (Ex. B017 at 7 to 8; OAR 333-580-0040(1)). Based on that decision OHA reviewed the zip code service area analysis conducted by applicants and the Authority determined that the appropriate Service Area was Health Service Area (HSA) I.²⁶ HSA I reflected the tri-county service area arrived at by Encompass inclusive of counties that contributed to in-flow, and the service area arrived at by PAM exclusive of out of state residents and Yamhill County.²⁷ The Authority determined that while some patients may use the proposed IRF from Yamhill County, Yamhill County should be excluded from the Service Area as it was not part of HSA I.

Reason for modification: Added citations from the record to clarify the basis from which OHA discerned the appropriate service area from which to assess IRF bed need.

²⁶ OAR 333-545-0020(15) defines HSA I as including Clackamas, Clatsop, Columbia, Multnomah, Tillamook, and Washington Counties. Reason for modification: The typographical error has been corrected.

²⁷ While the applicable laws and rules do not explicitly prohibit using out-of-state populations, the rules do generally refer to the Oregon population (*i.e.*, ORS 442.310(4) discusses the “needs of the people of Oregon”). Additionally, Mr. Robison testified that the Authority has “directed applicants to not include out-of-state patients where * * * possible.” Transcript at 161.

OAR 333-645-0030 is the rule that specifically governs calculating bed need for IRF facilities. Section (1)(a) of that rule states that determination of the service area “is to be consistent with OAR 333-590-0040, or with historical use patterns for rehabilitation services if these are demonstrably different from a defined hospital service area.” OAR 333-590-0040 is the rule governing how to determine the service area for an existing general hospital. It provides that the service area be “those zip codes from which either ten percent or more of the hospital’s discharges originate, or in which the hospital has at least a 20 percent market share” (the 10/20 methodology). OAR 333-590-0040.

Reason for modification: “Specifically” was added to clarify that OAR 333-645-0030 is the applicable rule for calculating bed need for IRFs. Legacy’s exceptions incorrectly state that the ALJ ruled that the general acute care inpatient rules must be applied first, and only if those requirements are met, does OHA proceed to OAR 333-645 to evaluate need for inpatient rehabilitation services.²⁸ It is unclear if Legacy’s new counsel’s confusion is sincere, but in either event, Legacy mischaracterizes the ALJ’s conclusions of law.

Pursuant to OAR 333-645-0030, the Authority could either 1) determine the service area consistent with the 10/20 methodology prescribed in OAR 333-590-0040, or 2) determine the service area using historical use patterns of existing IRFs if shown to be demonstrably different from a defined hospital service area service area under option 1. ~~Under either option, the Authority would first have to determine the service area in a manner consistent with the 10/20 methodology prescribed in OAR 333-590-0040.~~ The Authority did not conduct any sort of the zip code analysis using the 10/20 methodology but determined to focus on historical use patterns in selecting the HSA where the proposed IRF would be located. ~~Rather, the Authority used the health service areas defined in rule, selecting the HSA where the proposed IRF would be located.~~ ~~Despite being called a health service area, the health service area where a facility is located, as defined in OAR 333-545-0020(15), is not the same as the service area for a proposed health facility that must be determined using OAR 333-645-0030.²⁹~~ The preponderance of the evidence in the record demonstrates that historical use patterns are demonstrably different from a hospital service area under a methodology consistent with the 10/20 zip code methodology provided in OAR 333-590-0040.

Reason for modification: OHA does not dispute that HSA I, II, and III, refers to areas in which the State of Oregon has been divided for health planning purposes. OAR 333-545-0020(15). However, the service area to be determined under OAR 333-645-0030(1) for a proposed new

²⁸ Legacy Exceptions at 19; *see also* Legacy Witness Jody Carona: “I think you go to 590 first, and then if you pass certain tests, you’re directed to 645. And in 645, you can run an alternative methodology that is -- that is generally consistent with 590 to drill down further. That’s how I interpret the rule.” Tr. 646.

²⁹ ~~For example, OAR 333-590-0050(3), which discusses the bed need methodology for proposed new hospitals, directs the applicant to “[d]etermine current year hospital service area and historical health service area population based discharge and patient day use rates from statewide patient origin studies.” The rule specifically differentiates between the two, using the distinct terms of ‘hospital service area’ and ‘health service area.’~~

IRF means the same thing as “service area” in OAR 333-590-0060. Given the utilization patterns applicable to existing IRF within the service area, OHA was within its discretion to determine that the appropriate hospital service area for Encompass’ and PAM’s proposed new facilities is HSA I as defined in OAR 333-545-0020(15).

~~The Authority failed to properly define the service area by conducting a zip code analysis consistent with the 10/20 methodology described in OAR 333-590-0040, as required by OAR 333-645-0030(1)(a). Based on the Authority’s failure to properly determine the service area, and for reasons discussed in more detail below, the matter is remanded to the Authority for further determinations consistent with this order.~~

Both applicants applied the 10/20 zip code methodology to arrive at the defined hospital service area for their proposed IRF. PAM conducted a zip code analysis consistent with OAR 333-590-0040 that arrived at a 7 county-service area that included counties in Washington state and Yamhill County. Encompass conducted a zip code analysis consistent with OAR 333-590-0040 that arrived at a hospital service area of Multnomah, Clackamas, and Washington County with significant in-flow. Encompass’ analysis notably demonstrated that 40 percent of patients for its proposed three-county service area would originate from outside the three counties comprising its proposed service area. (Ex. 118 at 65.) In contrast, a general acute hospital experienced inflow outside its hospital service area of approximately 10 percent. (Ex. A24 at 31-40.)

In evaluating the appropriateness of the two proposed service areas, OHA compared the hospital service areas with historical use patterns for IRF facilities. The use patterns at both Portland Providence and Legacy’s Good Samaritan RIO existing IRFs shows use patterns consistent with HSA I. (Ex. A24 at 40; Ex. E141.) Use patterns show that IRFs draw from other acute inpatient facilities and that specialized services draw from a larger demographic area. (Tr. 83-84.) A preponderance of the evidence in the record demonstrates that historical use patterns for IRFs are demonstrably different from a defined hospital service area. (Ex. B017 at 8.)

As allowed under its rules, OHA made minor adjustments to the hospital service area in arriving at Health Service Area I as the service area for the proposed projects based on historical use patterns for inpatient rehabilitation facilities. (OAR 333-590-0040.) Health Service areas are a demographic unit historically used for health planning purposes and provided for in rule and are a preferred demographic from which to evaluate specialty acute inpatient bed need. (OHA Hearing Memorandum at 26; OAR 333-590-0030(1); Tr. 208.)

A preponderance of the evidence in the record demonstrates that HSA I is the appropriate population-based demographic unit from which to calculate IRF bed need. (OAR 333-580-0040(1).) OHA testified that they reviewed the calculations performed by the applicant and found their methodology sound. (Tr. 1482 to 1484.) OHA indicated to the applicants that they had properly conducted their analysis under OAR 333-590 *et seq.* and that OHA had the necessary information to evaluate the criteria required of the applicant. OAR 333-580-0000(10). OHA herein adopts the applicants’ calculation of service area consistent with OAR 333-590-

0040 that shows that IRF historical use patterns are demonstrably different from hospital service areas.

Reason for modification: A preponderance of the evidence supports the proposition that IRF services draw from a wider area than is contemplated by the zip code analysis specified in OAR 333-590-0040 for a general acute inpatient hospital, which focuses on the proximity of patient residences to an existing general acute hospital rather than on the likely referral patterns of patients for a specialty service. Legacy's Exhibit E142 detailed the sources of Legacy's patients for its fiscal years from 2018 through 2021 by referring facility and by zip code. The numbers for Fiscal Year 2019 demonstrate that 89% of Legacy's IRF admissions have come from the counties designated in OAR 333-545-0020(15)(a) by OHA as HSA I, with 62% from Multnomah County and 27% from the remaining four counties.

ii. Bed Need

Division 580 (titled “Certificate of Need Application Instructions and Forms”) of Chapter 333 is broadly applicable to all facilities applying for a certificate of need. OAR 333-580-0040, titled “Need,” provides, in relevant part:

- (1) Criterion: Does the service area population need the proposed project?
 - (a) The applicant must identify the service area’s need for the proposal in the past, present and future;
 - (b) In establishing the magnitude of present and future need for each service element, the applicant will:
 - (A) Use appropriate indicators of a population’s need (i.e., population-based use-rates, population-based “medical necessity” rates, or established productivity standards);
 - (B) Use the standards and need methodologies specified in divisions 585 through 645 of OAR chapter 333 applicable to the services or facilities being proposed;
 - (C) Consider industry standards and historical experience as appropriate comparisons where plans are silent[.]

Division 645 of Chapter 333, titled “Demonstration of Need for Rehabilitation Services,” discusses how to calculate need for an IRF.³⁰ OAR 333-645-0030, titled “Elements in Calculating Need for Rehabilitation Services,” provides:

(1) Total need for inpatient rehabilitation services is such that inpatient facilities shall not exceed seven beds in 100,000 general population:

(a) Determination of hospital service area is to be consistent with OAR 333-590-0040, or with historical use patterns for rehabilitation services if these are demonstrably different from a defined hospital service area;

(b) Adjustments to this standard can be made where a specialty rehabilitation service is proposed, if the applicant submits information demonstrating the sizes of populations at risk in the proposed service area; the current and historical rates of hospitalization in Oregon for those groups; and the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups in Oregon. An example of a specialty rehabilitation unit would be a unit specializing in strokes.

(2) Expansion of existing rehabilitation units shall be given priority over creation of new rehabilitation units for comparable services, unless it can be demonstrated that the applicant is offering the least costly service.

(3)(a) Rehabilitation units must have an annualized occupancy rate of at least 85 percent prior to expansion of any bed capacities, and expansion should be such that the unit can maintain a minimal occupancy rate of 75 percent on unit capacity, within 1-1/2 years of certificate of need approval;

³⁰ OAR 333-645-0010(2)(a) provides that:

(a) “Comprehensive Inpatient Rehabilitation Facilities (CIRFs)” are hospital-based inpatient departments which are medically directed, supervised and coordinated to deliver rehabilitation services to patients with simple or multiple severe disabilities. A facility of this scope must include, but is not limited to, the following rehabilitation interdisciplinary services:

(A) Psychiatrist or other medical doctor with two years of experience in a comprehensive inpatient rehabilitation program for physical disabilities;

(B) Intensive skilled rehabilitation nursing care;

(C) Social worker/discharge planner;

(D) Physical therapy;

(E) Occupational therapy;

(F) Speech/language pathology (as prescribed);

(G) Psychology.

(b) A new rehabilitation unit must demonstrate that it will be able to achieve and maintain a minimal annual occupancy rate of 75 percent of unit capacity within three years of certificate of need approval.

(4) Bed need calculation and minimal occupancy rate for rehabilitation services is to be consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.

OAR 333-645-0030(1) limits the total number of IRF beds in the service area to not exceed seven IRF beds in 100,000 general population. This portion of the rule does not prescribe the formula for calculating the bed need for IRFs, but rather sets an upper limit that the bed need calculation cannot exceed. At hearing, Mr. Robison testified that he considers the rule to mean that there shall not be eight beds per 100,000 general population (that is, up to 7.99 beds per general population is acceptable). However, given the basic rules of rounding in mathematics, I question the plausibility of reading “shall not exceed seven” to mean that up to 7.9 beds per 100,000 general population is allowed. The plain reading of the rule could plausibly allow one of two interpretations: (1) that the total beds per 100,000 should not exceed 7.0, or (2) that the total beds per 100,000 should not exceed 7.4 (which would round down to 7). On remand, the Authority should carefully consider its interpretation of this rule.

The un rebutted preponderance of the evidence established that there are currently 66-54 IRF beds in HSA I – 18 beds at Providence Portland and 36 beds at Legacy Good Samaritan’s RIO. RIO is part of Legacy Good Samaritan, and 12 beds at Randall’s Children Hospital. While the Authority concluded that there were 54 or 57 IRF beds (between RIO and Providence Portland) in HSA I, this calculation did not include the beds at Randall’s Children Hospital. Under the plain language of OAR 333-645-0030(1), the beds at Randall’s Children Hospital should also be counted in the IRF bed limit, because that limit refers to the general population, not to individuals over a certain age. OHA presented evidence at hearing that it relied on the Centers for Medicare and Medicaid (CMS) Inpatient Prospective Payment (IPPS) Exclusion database in establishing that HSA I had 54 IRF beds. (Tr. 212 and 1463.) An inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital is “excluded” from the IPPS and is eligible for payment under the separate “IRF IPPS” if it meets all of the criteria specified in 42 C.F.R. § 412.25. (Ex. A24 at 101 and 138; Tr. 940); 42 C.F.R. § 412.1(a)(3).³¹ Qualifying as an IRF for Medicare purposes requires a showing that the IRF unit meets “applicable state licensure laws.” 42 CFR §§ 412.25(1)(a)(5) and 412.29. Hospitals are required to report changes in the number of beds eligible for IPPS exclusion at least annually. 42 CFR 412.25(b).

Legacy operates Legacy Emanuel Hospital which includes Randall Children’s Hospital. (Ex. A47 at 2.) Legacy participates in Medicare. (Ex. E128; Tr. 813.) As a condition of receiving reimbursement for services provided to any Medicare beneficiary, the hospital is

³¹ Children’s hospitals are also excluded under the IPPS if they serve predominantly individuals under the age of 18. (42 CFR § 412.23(d).) A hospital or unit can be eligible for an IPPS exclusion on more than one basis with some narrow exceptions not applicable here. (42 CFR § 412.22(a).) OHA takes official notice of the federal regulations governing the inpatient prospective payment system.

required to file an annual cost report that designates facility characteristics, inclusive of whether a bed qualifies as an IRF. 42 C.F.R. §§ 413.20(b); 412.25(a)(1)(12). This information is reported via the annual hospital Medicare cost reports (Form 2552-10) and federal regulations mandate the non-discretionary disclosure of whether a hospital operates an IRF unit.³² CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS) to allow public access to the information.³³

Chapter 40 of CMS's Provider Reimbursement Manual – Part 2 (“PRM”) provides further instruction regarding the requirements for reporting IRF beds for purposes of a hospital’s annual cost report. CMS Pub. 15-2, 04-10 § 4004.1 Hospitals are directed to select the facility type that “best corresponds with the type of services provided.” PRM § 4004.1. If more than one IPSS exclusion category applies, the hospital is directed to select “other.” Id. PRM,04-10 § 4004.1;³⁴ *Id.*

The Medicare cost report for Legacy Emanuel for the fiscal period of April 1, 2019 to March 31, 2020 was submitted into evidence. (Ex. B202.; Ex. A75 at 8 to 10.) The Cost Report for Legacy Emanuel showed that it had reported no IRF beds for the most recent fiscal year.³⁵ (Ex. B202.) There are no beds listed as qualifying as “Other – Special.” *Id.* Also admitted into evidence was the 2019 Healthcare Provider Cost Reporting Information System (HCRIS) in which Providence reported 18 IRF units and Legacy Good Samaritan (RIO) reported 36 IRF units. (Ex. A204 at 7.)

The un rebutted evidence in the record is that the most recent IPSS exclusion list reported 36 IRF beds at Legacy Good Samaritan RIO and 18 IRF beds at Portland Providence. Legacy witnesses testified that this is an accurate count of their IRF beds. (Tr. 793, Ex. E141, Ex. E616.) Given the highly regulated area of Medicare participation and reimbursement, OHA reasonably relied on the information provided to CMS from Legacy as to whether it had beds that qualified as IRF beds at Legacy Emanuel. It also reasonably modified the number of beds based on the more recent reports presented at hearing. Exhibit A47 is cited by the ALJ for support that Legacy Emanuel Randall Children’s Hospital contains IRF beds. A review of that letter demonstrates that the author, Interim VP of Legal Affairs Anne Greer, is careful to not include the Legacy Emanuel Randall Children’s Hospital where she describes the services offered by Legacy Good Samaritan (RIO) that qualify it as an IRF. (Ex. A47 at 2.) The testimony of Jody Carona, also cited by the ALJ as supporting evidence, specifically disavows knowledge as to whether the Legacy Emanuel Randall Children’s Hospital are licensed as IRF beds. (Tr. 651.) Ms. Carona is also careful to state that the beds may or may not be licensed as IRF beds. (*Id.*) The evidence cited by the ALJ does not provide a basis to conclude that Legacy Emanuel Randall Children’s

³³ OHA takes official notice of <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>

³⁴ Official notice is taken by OHA of Centers for Medicare and Medicaid [The Provider Reimbursement Manual - Part 2 | CMS](#)

Hospital offers the required services to qualify it as an IRF under OAR 333-645-0010 and by extension, OAR 333-645-0030.

Furthermore, in Oregon, general acute care hospitals are licensed and allowed to provide rehabilitation services for patients occupying inpatient acute care hospital beds. ORS 442.015(14) (“rehabilitative services”); and ORS 442.015(15)(a) (“Hospital” may provide “health services” which are “rehabilitative services.”). However, if a general acute care hospital seeks reimbursement as an IRF by Medicare, its inpatient rehabilitation unit must be certified as an IRF distinct part unit. 42 CFR § 412.29. For a hospital or unit to qualify as an existing rehabilitation facility under OAR 333-645-0010(2)(a), it must include the following rehabilitation interdisciplinary services: (a) physiatrist or other medical doctor with two years of experience in a comprehensive inpatient rehabilitation program for physical disabilities; (b) intensive skilled rehabilitation nursing care; (c) social worker/discharge planner; (d) physical therapy; (e) occupational therapy; (f) speech/language pathology (as prescribed); and (g) psychology. OAR 333-645-0010(2)(a). Additionally, depending on the needs of the patients served, the rehabilitation program must provide (or make formal arrangements for) the following services: (a) audiology; (b) driver education; (c) orthotics; (d) prosthetics; (e) rehabilitation engineering; (f) respiratory therapy; (g) 8 therapeutic recreation; and (h) vocational rehabilitation. OAR 333-645-0010(2)(b).

For OHCA or Legacy to have met their burden to demonstrate that Legacy Emanuel-Randall Children’s Hospital provides existing inpatient rehabilitation services, they needed to establish, by a preponderance of the evidence, that it offers the services detailed above. However, both parties failed to offer any evidence concerning the scope and nature of the services offered at Randall Children’s Hospital. Offering rehabilitation services as allowed under Oregon inpatient rules is insufficient to meet the criteria for this rule.

Reason for modifications: The ALJ’s conclusion that a “plain reading” of OAR 333-645-0030(1) requires inclusion of Legacy Emanuel Randall Children’s Hospital 12 bed is based on the unsupported legal conclusion that they qualify as IRF beds. Legacy and OHCA did not present evidence sufficient to rebut OHA’s conclusion that there are 54 IRF beds in HSA I.

Legacy’s exceptions to the exclusion of the 12 beds at Legacy Emanuel Randall Children’s Hospital conflate the ALJ’s findings. As a preliminary matter, Legacy concedes that the beds at Legacy Emanuel Randall Children’s Hospital are not IRF beds, but instead now argues that the beds should be included because they constitute an unnecessary duplication under OAR 333-580-0050. (Legacy Exceptions at 6.) There was no evidence admitted into the record that these beds duplicate IRF services.

Legacy’s Exceptions supplied website links in support of its contention that the Legacy Emanuel Randall Children’s Hospital beds duplicate IRF services. (Legacy Exceptions at 6.) None of these arguments are raised anywhere in the record and are not properly before OHA. However, even considering Legacy’s arguments and new evidence, as outlined the below, they

fail to meet the burden that for purposes of OAR 333-645-0030 the Legacy Emanuel Randall Children's Hospital beds should be included.

First, CARF accreditation does not demonstrate that the Legacy Emanuel Randall Children's Hospital beds are sufficiently comparable rehabilitation services. A considerable portion of the contested case hearing and hundreds of pages of evidence was dedicated to OHCA's unsuccessful attempt to demonstrate that Skilled Nursing Facilities offer sufficiently similar services to constitute a duplication of services. Now, after the close of the record, Legacy seeks to vaguely assert via an accreditation applicable to many providers across the state means Legacy Emanuel Randall Children's Hospital is a duplication of services by virtue of being an "acute inpatient bed." Even if this argument were properly raised in the record it fails.

Second, Legacy Emanuel Randall Children's Hospital status as a "Trauma Center" does not demonstrate status as an IRF nor does it indicate the caliber of rehabilitation services offered. OHA takes official notice that Level 1 pediatric trauma center categorization requires only that it have a rehabilitation "program" or a transfer agreement.³⁶ OHA does not "license" trauma centers although there are trauma hospital categorization resource standards for hospitals that voluntarily participate in the Oregon Trauma System.

In the currently defined service area for Encompass' proposed IRF, HSA I, there is a general population of 1,977,140.³⁷ Using the most logical interpretation of Under OAR 333-645-0030(1), that the bed need the ratio of IRF beds to general population cannot exceed 7.99 beds per 100,000 general population. That means the total bed need number of IRF beds for the service area cannot exceed 159.157 beds in 2019 and 159 beds in 2020.³⁸ OHA epidemiologist Steve Robison based this assessment on context and his knowledge of the other CN rules that specify numbers after the decimal point when they are to be considered. (e.g., OAR 333-615-0020(5) setting a standard that the psychiatric inpatient bed ratio shall not exceed .40 beds per 1,000.) He testified that he looked at the ratio as applying to whole integers. (Tr. 109-110.) Thus, regardless of the bed need calculated by the Authority, OHA it cannot approve IRF beds if doing so would create more than 159 IRF beds in the service area. Therefore, with 66 IRF beds in the service area and OAR 333-645-0030(1) prescribing a limit of 159 IRF beds, the Authority, in accordance with its own rules, OHA cannot approve more than 103 to 105

³⁶ The requirements for a Level I Pediatric Trauma Center are found [here](#). Tag 10-7: requirement for a rehabilitation "program" not a "unit."(p. 15) and Tag 12-1: Rehabilitation services must be available within the hospital's physical facilities or as a freestanding rehabilitation hospital, in which case the hospital must have transfer agreement.(p. 26).

³⁷ The Authority provided data showing population data for 2018, 2019, and 2020. This order uses the 2019 and updated 2020 population data because that is what the Authority used in the Proposed Decision. Using the 2018 or 2020 data would only change this calculation by approximately three beds. Reason for modification: 2020 population date is the most current, available data.

³⁸ 1,977,140 ÷ 100,000 x 7.99 = 159.8, 157.97 rounded down to 159 157 beds. Utilizing 2020 population numbers: 1,995,420 ÷ 100,000 x 7.99 = 159.43, rounded down to 159 beds.

IRF beds in HSA I.³⁹ ~~It should be noted that the calculation and allowable number of approvable beds will inevitably change once the Authority defines the service area for the proposed IRF in a manner consistent with OAR 333645-0030(1)(a) (as discussed above).~~

Reason for modification: OHA does not adopt this legal conclusion. The ALJ cites to “the basic rules of rounding in mathematics.” However, there is no basis in law or fact for the assertion that lay rounding principles apply and is legally insufficient as a basis for overriding OHA’s interpretation of its own rule. OHA epidemiologist Steve Robison has participated in over 20 CN applications and described in length his contextual reading of this rule compared to other CN calculations to discern his evaluation that that calculation considers whole integers. (Tr. 71.)

As an example of the inapplicability of lay principles to evaluation of ratios, the Centers for Medicare and Medicaid directs hospitals to round to the 6th decimal point when evaluating ratios. (CMS PRM 10-18, § 4000.2.) The Provider Reimbursement Manual then provides that after rounding: “Where a difference exists within a column as a result of computing costs using a fraction or decimal, and the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.” (Id.) As demonstrated here, lay principles of mathematics have no relevance without evidence demonstrating that they apply. There is no such evidence in the record.

OHA's interpretation here that "not more than seven" means "less than 8" is not an implausible interpretation by OHA of OHA's own rule. It sets a general limit, designed as a threshold standard to be applied before turning to the more nuanced bed need analyses provided elsewhere in the regulations. It is at least as plausible as the ALJ's own interpretation that "not more than seven" could plausibly mean "not more than 7.4." OHA has the responsibility for interpreting the meaning of OHA's rules. (*Zach v. Chartis Claims, Inc.*, 279 Or App 557, 569 (2016).) Under OHA's plausible interpretation, the preponderance of the evidence is that, assuming the 100 beds for which PAM and Encompass have applied are approved, that will not result in as many as eight beds per 100,000 general population in the relevant service areas.

Reason for modification: The ALJ’s legal analysis that the "plain meaning" of the rule supports two interpretations entirely undermines the conclusion that the rule has only one "plain meaning." In describing two possible interpretations of the rule, the Proposed Order neither explained why "7.4" was warranted by "plain meaning" rather than 7.499, which would also "round" down to "seven" using her rationale. She also did not acknowledge that even using her 7.4 number supports an allowance of 100 or more beds, whether or not you count the Randall

³⁹ OAR 333-645-0030(1)(b) discusses when the Authority can modify the 7 beds per 100,000 standard. ~~However, the~~ The language of that rule reads that the ratio can be modified “where a specialty rehabilitation service is proposed.” In this case, ~~while~~ PAM plans to seek several accreditations, ~~the proposed facility is a general IRF, caring for any patient who needs and qualifies for IRF services. It will not and will specialize or only accept~~ in stroke patients, brain injury and cancer. Thus, ~~no~~ ~~even~~ if the ratio is exceeded a modification to the standard is appropriate under OAR 333-645-0030(1)(b). (Modification explained in text)

beds, and regardless of whether you take 2022 population numbers or those five and ten years into the future.

Even if the ratio were exceeded (which OHA maintains it is not) a modification to the standard is appropriate under OAR 333-645-0030(1)(b). OAR 333-645-0030(1)(b) discusses when the Authority can modify the 7 beds per 100,000 standard, allowing that the ratio can be modified “where a specialty rehabilitation service is proposed.” Adjustments to the standard are justified if the applicant submits information demonstrating: the size of population at risk in the proposed service area; the current and historical rates of hospitalization in Oregon for those groups; and the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups in Oregon.

After calculating the 7 per 100,000 ratio in PAM’s proposed service area, PAM went on to say “PAM plans to add specialty services in stroke, brain injury, and cancer justifying using a factor larger than 7/100,000.” (Ex. A24 at 41.) PAM estimated that 43.6 percent of its proposed IRF beds will serve specialty populations which calculates to an adjustment of 21 beds. (Ex. A24 at 24). Regarding its stroke specialty, PAM submitted evidence that stroke accounts for 20 percent of its IRF-eligible patients, that neither existing IRF has been so certified, and all of those patients are hospitalized either in general acute hospitals or in the existing IRF beds in Oregon. (Ex. A24 at 24, 78, 721.)

Similarly, Encompass stated in its application that it:

“anticipates seeking a stroke rehabilitation specialty certification, and plans to add one or more other specialty certifications during its first three years of operation for diseases that will make up approximately 20-30% of the total IRF population. These specialty certifications will be sought after obtaining a comprehensive understanding of local clinical practice, population health factors, and service area needs from outreach by EHRHO liaisons and medical staff to patients, physicians, care teams, and payers. Examples of other potential specialty programs include brain injury rehabilitation, spinal cord injury rehabilitation, amputee rehabilitation, and oncology rehabilitation, among many others.”

(Ex A113 at 41.) Thus, Encompass also documented that it will offer specialty programs that currently do not exist in the area as contemplated by OAR 333-645-0030(1)(b) as to 20-30% of its patients, which calculates to an additional adjustment of between 10 and 15 beds. No evidence was offered by OHCA or by Legacy to dispute these intentions, these numbers, or Encompass' ability to deliver these specialized services.

Reason for modification: After finding that a “plain reading” of OAR 333-645-0030(1) meant that the ratio was exceeded, the Proposed Order concluded that no adjustment was necessary because the applicants had not indicated they would exclusively serve stroke patients. Both PAM and Encompass indicate they intend to specialize in stroke and other conditions in a manner that does not currently exist in the marketplace. OHA does not adopt the legal conclusion that

“specialize” means “exclusively.” (Compensation of Jensen, 150 Or App 548, 552, 946 P2d 689 (in construing administrative rules, courts are not permitted to omit what has been inserted or insert what has been omitted).) Here, the rule does not require that a facility exclude other conditions in order to be considered a "specialty rehabilitation service." The preponderance of the evidence, therefore, is that both PAM and Encompass will offer specialty IRF services, warranting an adjustment (were one necessary) in the application of the 7 bed per 100,000 general population standard of between 31 and 36 beds.

There was no evidence of any applications for expansion of existing rehabilitation units in HSA I. Thus, OAR 333-645-0030(2) (prioritizing expansion of existing units over creation of new units) is not applicable in this case. Legacy presented no evidence of any current plan to expand its unit.

In its application, Encompass showed that it anticipated obtaining an annual occupancy rate of 75 percent unit capacity within three years of certificate of need approval, as required by OAR 333-645-0030(3)(b). While Legacy argued that occupancy rates at RIO and Providence Portland below this threshold showed that it would be unlikely for Encompass to meet this threshold, this argument was not persuasive. The evidence showed that there are multiple factors that can influence occupancy rates at an IRF, including among others, location of the facility, admission practices, insurance approvals, and facility accommodations and equipment. Appellants failed to show that Encompass would be unable or unlikely to obtain a 75 percent occupancy rate within three years of approval.

OAR 333-645-0030(4) directs an applicant to calculate bed need and minimal occupancy rates for IRF services “consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060” (the rules regarding demonstration of need for acute inpatient beds and facilities). OAR 333-590-0030 discusses certain assumptions that should be considered when balancing bed capacity and anticipated future utilization. OAR 333-590-0040 discusses the determination of a service area for existing hospitals. OAR 333-590-0050 addresses the bed need methodology for new hospitals. And OAR 333-590-0060, in turn, discusses the “Relationship of Proposed New Hospitals to Existing Health Care System.”

In its application, Encompass conducted a bed need analysis under OAR 333-590-0050, and found a need for at least 50 IRF beds in its defined service area of Washington, Multnomah, and Clackamas counties. Similarly, in its application for a proposed IRF, PAM did a bed need analysis under OAR 333-590-0050 and found a need for at least 50 IRF beds in its multi-county service area in Oregon and Washington.

In the Proposed Decision, the Authority noted that OAR 333-645-0030(4) “makes it clear that the entire inpatient bed need methodology for general acute care beds found at ORS 333-590 need not be applied to IRFs. Instead, applicants are directed to calculate a population-based need for IRF services that takes into account existing capacity across a broad service area.” Exhibit A1 at 6-7. Mr. Robison, on behalf of the Agency, determined that the “where applicable” portion of OAR 333-645-0030(4) was “an instruction to consider what is reasonable as an application of the

[Division] 590 rules to this general situation.” Tr. at 82. When conducting its bed need analysis, the Authority used “a combination of patient-level discharge data provided by the OHA’s Health Policy and Analytics Division as well as information from peer-reviewed literature addressing the use of IRFs in the treatment of specific conditions.” Exhibit A1 at 5. The Authority contrasts the bed need calculation for an IRF with the bed need calculation of a general acute care hospital, based on the prohibition that IRF beds shall not exceed seven per 100,000 general population, and based on the premise that IRF need is based on hospital discharges, resulting in a “substantially larger” service area for IRFs. *Id.* at 5.

At hearing, Mr. Robison explained his process for conducting the bed need analysis. The Authority gathered DRG discharge data related to stroke, brain injury, and other neurological conditions from all hospitals in HSA I during the period of 2013 through 2017, for patients age 40 and older. Using that data, the Authority found that there were 26,283 relevant discharges. From those discharges, the Authority calculated the total number of IRF beds required, assuming every patient discharged went to an IRF and every IRF had 100 percent occupancy. Due to fluctuations in admissions, and to ensure an IRF bed was available 95 percent of the time, the Authority applied a statistical analysis (the Poisson distribution⁴⁰) to the data, resulting in an addition of 25 beds. From that number, the Authority removed the 57 IRF beds⁴¹ currently available in HSA I and then reduced the resulting number by 25 percent, to account for patients that may not qualify for or benefit from IRF services. Using this approach, the Authority determined there was a current unmet need of 114 IRF beds in HSA I.⁴²

Reason for modification to footnote 38: Legacy submitted evidence which represented that Step 9 of OAR 333-590-0050 is the Poisson Formula. (Ex. E141 at 8.) OHA takes official notice that

~~⁴⁰ No evidence was provided at hearing regarding the exact method or formula for conducting a Poisson Distribution calculation. Interestingly, each time the Authority applies the Poisson Distribution to the data (as described below, this calculation was run multiple times), it resulted in an addition of 25 beds. (The only exception was when the Authority ran the Poisson Distribution in Exhibit A83. In that situation, the number of beds subtracted changed, based on the previous calculation.) It is possible that applying the Poisson Distribution to each situation results in a rounded figure of 25 beds. However, it is also possible that the Authority only did this calculation one time and continued to use the same figure erroneously throughout all calculations, regardless of changes in other data sets. Without more details about how the Poisson Distribution was calculated, it is impossible to know which is the case.~~

⁴¹ In the Proposed Decision, the Authority found there were 57 IRF beds in HSA I. However, the testimony at hearing revealed there were 54 IRF beds in HSA I (excluding pediatric beds). ~~The Authority used both figures in its various calculations.~~ Reason for modification: A preponderance of the evidence at hearing demonstrates there are 54 IRF beds in HSA I.

⁴² The calculation was as follows: 26,283 discharges ÷ 5 years ÷ 365 days per year x 12.7 (ALOS for an IRF patient) = 182.9 beds, rounded up to 183 beds. The Poisson Distribution calculation was applied, resulting in a need for an additional 25 beds. From that number, the existing 57 inpatient IRF beds were subtracted, resulting in an identified need for 151 IRF beds. (183 beds + 25 beds from the Poisson distribution – 57 current IRF beds = 151 beds.) Reducing the number of beds by 25 percent results in a total unmet need calculation of 114 IRF beds. (151 – 25% = 113.25 beds, rounded up to 114 beds.)

Legacy then submitted additional evidence in the form of an unsworn set of new calculations from Jody Carona utilizing a different formula for Poisson. (Ex. E171 at 2.) Furthermore, she does not apply the Poisson consistent with the sequence under which OHA performed their calculation. (Id., Tr. 699.) The evidence in the record shows that OHA provided un rebutted testimony that epidemiologist Steve Robison applied a Poisson adjustment to allow for the availability of a bed 95% of time. There is no basis to conclude that a 25-bed adjustment across small changes in the Average Daily Census (ADC) is incorrect or otherwise questionable. The calculation supplied by Legacy demonstrates that Legacy applied the adjustment at a different point in their computation and used a different calculation than the one provided in rule. (Id.) Moreover, Ms. Carona's citation provides insufficient information to justify that her methodology is superior to that of OHA or a reason to deviate from the rule's calculation. (Ex. E171 at 2.) Both OHCA and Legacy had the opportunity to cross-examine Mr. Robison on his calculation and his application of the Poisson. Moreover, it is incorrect that OHA arrived at a 25-bed adjustment each time it calculated the Poisson. A review of exhibit A183 demonstrates that with larger fluctuates in the Average Daily Census (ADC) OHA's Poisson calculation resulted in an adjustment of 28, 25, and 21 beds. OHA strikes this commentary because there is no analysis weighing the evidence offered by OHA against Legacy's unsworn calculations.

In its closing argument, Legacy argues that the Proposed Decision adopts a new bed need methodology where there is already an existing methodology prescribed in the rules. Legacy's concern is two-fold: first, that the Agency failed to follow already promulgated rules, and second, that the Agency created and applied an unpromulgated methodology or rule when issuing the Proposed Decision. The Authority ~~argues that it followed the intent of the its rules, and that it is entitled to deference on its interpretation of its own rules. Because~~ Legacy challenges the Authority's reading and application of OAR 333-645-0030 in this case, ~~the question becomes whether~~ for the reasons set out below, OHA's the Authority's interpretation is plausible and consistent with the law.

It is well established that “an agency has only those powers that the legislature grants and cannot exercise authority that it does not have.” *SAIF Corp. v. Shipley (In re Shipley)*, 326 Or 557, 561, (1998). See also *SIF Energy, LLC v. State*, 275 Or App 809 (2015). Once properly promulgated, an agency must follow its own rules. *Moore v. Oregon State Penitentiary, Corrections Div.*, 16 Or App 536, 537 (1974). ~~When an agency limits its own discretion by rule, it must “act in accordance with its self imposed limitations.” *Wyers v. Dressler*, 42 Or App 799, 807 (1979), overruled on other grounds, 148 Or App 586 (1997).~~ An agency’s plausible interpretation of its own rule, including an interpretation made in the course of applying the rule, will be given deference if that interpretation is not “inconsistent with the wording of the rule itself, or with the rule’s context, or with any other source of law.” See *Don’t Waste Oregon Com. v. Energy Facility Siting*, 320 Or 132, 142 (1994). Thus, an agency’s interpretation will not always prevail if found to be implausible, inconsistent with the wording of the rule itself, inconsistent with the rule’s context, or inconsistent with any other source of law.

Reason for modification: This case has been overruled on the holding for which it is offered. *Mendieta v. Division of State Lands*, 148 Or App 586, 596 (1997). In *Mendieta*, the Court rejected the reasoning in *Wyers* that concluded that the agency had acted outside of its discretion or improperly, which had formed the basis for providing relief under ORS 183.490.

In *Tye v. McFetridge*, 342 Or 61, 69 (2006), the Oregon Supreme Court held as follows:

In interpreting an administrative rule * * *, our task is the same as that involved in determining the meaning of a statute, which is to discern the meaning of the words used, giving effect to the intent of the body that promulgated the rule. *Abu-Adas v. Employment Dept.*, 325 Or. 480, 485, 940 P.2d 1219 (1997). And in so doing, we follow the same methodology for interpreting rules as for construing statutes. *Id.* That is, we begin by examining the text of the rule itself, together with its context. *Marshall’s Towing v. Department of State Police*, 339 Or. 54, 62, 116 P.3d 873 (2005). Context includes other provisions of the same rule, other related rules, the statute pursuant to which the rule was created, and other related statutes. *Abu-Adas*, 325 Or. at 485, 940 P.2d 1219. If the promulgating body’s intent is clear after that inquiry, the court does not proceed further. *Id.*

Pursuant to ORS 431.115(4), the legislature directed the Authority to “[c]ontrol health care capital expenditures by administering the state certificate of need program.” Similarly, ORS 442.315(2) directed the Authority to “adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.” Pursuant to these enabling statutes, the Authority promulgated rules for administering the certificate of need program in Chapter 333, Divisions 545 through 670 of the Oregon Administrative Rules. Division 590 contains the rules relating to demonstration of need for acute inpatient beds and facilities. Division 645 contains the rules relating to demonstration of need for rehabilitation services. Specifically, OAR 333-645-0030 is the rule that sets out how to calculate need for rehabilitation facilities. As discussed above, OAR 333-645-0030(4) states that the bed need calculation for an IRF “is to be consistent,

where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060.” OAR 333-590-0030 to OAR 333-590-0060 set out a number of considerations and a detailed, methodical multi-step process for calculating bed need.⁴³

As set out in OAR 333-590-0050(13), “[a] Certificate of Need will be issued to meet the need indicated in Steps 11 and 12, if also supported by the provisions of OAR 333-590-0060 and in

⁴³ The rules found in Division 590, including OAR 333-590-0030 to OAR 333-590-0060, are lengthy and complex. OAR 333-590-0030 sets out a number of assumptions that should be applied when conducting a bed need analysis. OAR 333-590-0040 discusses how to determine a service area for an existing hospital by determining the zip codes from which either ten percent or more of the hospital’s discharges originate, or in which the hospital has at least a 20 percent market share.

~~OAR 333-590-0050 sets out the bed need methodology for proposed new hospitals in a 12-step process, as follows:~~

- ~~• Step 1: determine the service area using the zip codes from which either ten percent or more of the hospital’s discharges are expected to originate or in which the hospital is expected to have at least a 20 percent market share.~~
- ~~• Step 2: determine the estimated population for the service area for 1970, 1980, 1990, and 1995, as a basis to estimate population for past and future years.~~
- ~~• Step 3: determine the current year and historical population based discharge and patient day use rate for the service, using statewide patient origin studies.~~
- ~~• Step 4: develop consistent and reasonable assumptions regarding appropriate use rates from Step 3, regarding new utilization versus replacement utilization at existing facilities.~~
- ~~• Step 5: analyze the advantages and disadvantages of new versus replacement utilization for both the proposed facility and existing facilities.~~
- ~~• Step 6: use information from all preceding steps, as well as five and ten year population estimates, to compute the range of possible future patients days in five and ten years at the proposed facility.~~
- ~~• Step 7: convert the previously calculated forecasted patient days to average daily census (ADC).~~
- ~~• Step 8: use the ADC to calculate the estimated statistical variability, or standard deviation, of the daily census.~~
- ~~• Step 9: calculate the expected daily census at the facility using an appropriate multiplier (set out in the rule) to the results of Step 8, and add that product to the results of Step 7.~~
- ~~• Step 10: use a ten year projection and the analysis in Steps 4 and 5, to select from Step 7 the most likely average daily census, noting a number factors to consider.~~

~~As set out in OAR 333-590-0050(13), “[a] Certificate of Need will be issued to meet the need indicated in Steps 11 and 12, if also supported by the provisions of OAR 333-590-0060 and in Division 580.” Pursuant to OAR 333-590-0050(14), a Certificate of Need will not be issued if the number of beds proposed by the applicant cannot be justified, unless an adjustment is needed because beds cannot be converted to meet specialty bed need.~~

~~OAR 333-590-0060 discusses the relationship of a proposed new hospital to the existing health care system. It requires, among other things, that the applicant weigh the need for the proposed facility against the availability of beds at existing, reasonable accessible facilities and against the feasibility of development of alternative facilities and services. It sets forth the steps to develop a quantitative estimate in detail.~~

Division 580.” Pursuant to OAR 333-590-0050(14), a Certificate of Need will not be issued if the number of beds proposed by the applicant cannot be justified, unless an adjustment is needed because beds cannot be converted to meet specialty bed need.

~~The Authority acknowledges that it did not OHA followed the methodology in Division 590 exactly as written as applicable and consistent with OAR 333-645-0030.~~

~~The Authority argues that the methods it OHA used to determine need for the proposed IRF complied with OAR 333-645-0030(4) because it developed a method consistent with the principles of OAR 333-590-0030 to OAR 333-590-0060 that used a “service area-based population-based calculation for specific need for a service that focuses on patient days and discharges.” Tr. at 207. For the reasons set out below, the Authority’s interpretation is not entitled to deference.~~ As outlined below, it utilized a method consistent with the principles of OAR 333-590-0030 to OAR 333-590-0060 and OHA’s interpretation is entitled to deference.

Reason for modification: OHA does not adopt this legal conclusion because OHA promulgated rules that appropriately reserved to the agency discretion in evaluating need for inpatient rehabilitation facilities that it applied to the proposals. The limitations of "plain meaning" interpretations were thoroughly discussed by Justice Linder in *State v. Gonzalez-Valenzuela*, 358 Or 451, 365 P3d 116 (2015). The Court explained:

... When assessing the plausibility of competing interpretations, we consider dictionary definitions, among other potential sources of meaning, to determine whether an offered interpretation is permitted. "Dictionaries, after all, do not tell us what words mean, only what words can mean, depending on their context and the particular manner in which they are used."

Id. at 461-63 (citations omitted, emphasis in original). Here, the entirety of the legal reasoning is the ALJ’s assessment that the directive that OHA “adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities” is a misplaced reliance on the dictionary’s definition of “specify.” OHA’s application of OAR 333-590-0030 to 333-590-0060 to assessing specialized rehabilitation services preserved to OHA the necessary flexibility to apply the rules to different rehabilitation services, exactly as OHA did here.

In *Talbott v. Teacher Standards and Practices Commission*, 260 Or App 355, 373-374 (2013), the Oregon Court of Appeals held that:

When an agency’s interpretation of its rule conflicts with the intent of the legislature in enacting the statutory provision, the agency’s interpretation must give way to the statutory limitation. *See, e.g., Bergerson*, 342 Or. at 311–12, 153 P.3d 84 (interpreting the inexact statutory terms “gross neglect of duty” and “professional duty” in keeping with their ordinary meanings and concluding that those meanings conflicted with the TSPC’s interpretation of its administrative rule); *Franklin v. Employment Dept.*,

254 Or.App. 656, 664, 294 P.3d 554 (2013) (the scope of the Employment Department’s interpretation of the term “failure to maintain a license,” as used in its administrative rule, was limited by the legislative intent embodied in the statutory term “misconduct”).⁴⁴

In the present case, the legislature made their intent clear in ORS 442.315(2) – the Authority was given broad authority to promulgate rules “specifying criteria and procedures for making decisions as to the need” for health care facilities.⁴⁵ ~~Thus, ORS 442.315(2) requires that the Authority promulgate rules that explicitly or precisely state a standard upon which, and the steps involved in, determining the need for an IRF.~~ When promulgating the rules in Division 590, the Authority clearly set out the steps to be used when determining bed need for general acute hospitals. It incorporated several of the Legislative findings and policies in the Division 590 criteria and procedures, such as incentivizing the use of less costly and more appropriate alternatives or incentivizing use of existing capacity. *See* ORS 442.310.⁴⁶ The Authority also specified in OAR 333-645-0030(4) that the decision regarding the need for a proposed rehabilitation facility is to be determined using Division 590 criteria, where those criteria were applicable. Thus, in promulgating Division 590 and Division 645 rules, the Authority followed the intent of the legislature. Those same considerations were brought to bear on OHA’s analysis as applied herein as applicable and consistent.

⁴⁵ The term “specify” means “to mention or name in a specific or explicit manner : tell or state precisely or in detail.” *Webster’s Third New Int’l Dictionary* at 2187. “Criterion” is defined as “a standard on which a decision or judgement may be based.” *Id.* at 538. “Procedure” is defined as “a particular way of doing or of going about the accomplishment of something” or “a series of steps followed in a regular and orderly definite way.” *Id.* at 1807.

⁴⁶ ORS 442.310, titled “Findings and policy,” provides, in part:

- (1) The Legislative Assembly finds that the achievement of reasonable access to quality health care at a reasonable cost is a priority of the State of Oregon.
- (2) Problems preventing the priority in subsection (1) of this section from being attained include:
 - (a) The inability of many citizens to pay for necessary health care, being covered neither by private insurance nor by publicly funded programs such as Medicare and Medicaid;
 - (b) Rising costs of medical care which exceed substantially the general rate of inflation;
 - (c) Insufficient price competition in the delivery of health care services that would provide a greater cost consciousness among providers, payers and consumers;
 - (d) Inadequate incentives for the use of less costly and more appropriate alternative levels of health care;
 - (e) Insufficient or inappropriate use of existing capacity, duplicated services and failure to use less costly alternatives in meeting significant health needs; and
 - (f) Insufficient primary and emergency medical care services in medically underserved areas of the state.

* * * * *

Reason for modification: The Authority did not interpret its rule in conflict with the intent of the legislature for the reasons outlined in the text of the final order.

However, in this case, the Authority failed to follow the plain language of its own rules. If the Authority's interpretation of OAR 333-645-0030(4) in this case were to stand, it would directly contradict the legislature's directive that the Authority promulgate rules with specific criteria and procedures for how need will be determined. The Authority has not promulgated a rule setting out the methodology for demonstrating need for a proposed IRF as utilized by Mr. Robison in this matter. Thus, any future applicant or other interested party would not have a place to look for the standards and criteria to be used to determine need. Had the Authority developed this alternative method for determining need and found that there was *not* a need for additional IRF beds in the service area, the applicant would have been prejudiced by not having advance notice of the procedures and criteria upon which the Authority's decision would be made. The decision would appear arbitrary and capricious in the absence of clear standards upon which an application would be evaluated. Because the Authority's interpretation of OAR 333-645-0030(4) conflicts with the legislature's directive in ORS 442.310(2), it is not entitled to deference.⁴⁷

Reason for modification: OHA does not adopt this legal conclusion because OHA has promulgated rules applicable to this facility type which specify that the criteria in OAR 333-590-0030 to 0060 are to be applied, as applicable and consistent to rehabilitative services. OHA applied those methods and principles consistently here, as applicable. The ALJ fails to properly defer to the agencies expertise in what it means to specify criteria in the context of IRF verses general acute inpatient facilities and does not provide sufficient reasoning for the conclusion that applying OAR 333-590 *et seq.* as OHA did here fails in its specificity to establish criteria for IRFs. The ALJ provides no support for her assumption that specifying criteria in the context of IRFs should or can reflect the same level of specificity reflected in general acute inpatient care bed need. The legislature granted the agency broad authority to specify criteria for each setting type and the agency made a policy decision that the best approach was to apply the 333-590 criteria as applicable and consistent to IRFs. Given that the IRF setting type allows for specialty beds, such flexibility is necessary for evaluation of need as the analysis allows application to different specialty rehabilitation proposals. Moreover, a preponderance of the evidence demonstrates that the agency did follow the methods and principles of OAR 333-590-0030 to OAR 333-590-0060 as applicable and consistent. In its analysis, OHA considered several of the legislative guideposts including effective use of specialized acute inpatient rehabilitation services, containing costs, narrowing use to those DRGs where evidence demonstrated improved outcomes, and avoiding unnecessary duplication of services. (Ex. B017; ORS 442.315(2).)

OAR 333-590-0050 sets out the bed need methodology for a proposed new general acute care hospital in a 14-step process. A summary of OHA's application of OAR 333-590 *et seq.* to rehabilitation services under OAR 333-645-0030(4) could be expressed in a format that aligns with the ALJ's preference. However, OHA was not required to express its application in this

manner and these critiques in how OHA presented its methodology are inadequate to supplant OHA's thoughtful and detailed analysis:

- Step 1: determine the service area using the zip codes from which either ten percent or more of the hospital's discharges are expected to originate or in which the hospital is expected to have at least a 20 percent market share. Each applicant completed this step and OHA determined that under OAR 333-645-0030 historical use patterns of IRFs is demonstrably different from the service area reached under the 10/20 methodology performed by both applicants. (Tr. 83-85, 91-92; B017.)
- Step 2: The Authority determined that the best figures to use were recent Portland State CPRC population estimates as of 2019, rather than the outdated population figures in the rule. Although the rule otherwise requires a 5-year and 10-year future projection (OAR 333- 590-0050(6)), OHA applied a three-year projection (Tr 205), to be intentionally conservative. (see also Step 2 and Step 10).
- Step 3: determine the current year and historical population-based discharge and patient day use rate for the service, using statewide patient origin studies. The Authority used hospital discharge data for a 5-year period, rejected the assumption that use rates are declining in light of the aging population, and concluded that actual use rate data doesn't exist. (Tr 117-18, 237.)
- Step 4: develop consistent and reasonable assumptions regarding appropriate use-rates from Step 3, regarding new utilization versus replacement utilization at existing facilities. The Authority examined whether SNF utilization and existing IRF utilization are useful measures of need in the service area and rejected both as determinative. (Tr. 194, 212.)
- Step 5: analyze the advantages and disadvantages of new versus replacement utilization for both the proposed facility and existing facilities. The Authority examined whether SNF utilization and existing IRF utilization are useful measures of need in the service area and rejected both as determinative. (Tr. 194, 212.)
- Step 6: use information from all preceding steps, as well as five- and ten-year population estimates, to compute the range of possible future patient days in five and ten years at the proposed facility. The Authority determined that the best figures to use were recent Portland State CPRC population estimates as of 2019, rather than the outdated population figures in the rule. At hearing updated population data for 2020 was admitted into evidence and also establishes need for the projects. Applying the ALJ's "plausible" interpretation of 7.4 beds per 100,000 for those years the result in 2022 will be 115 beds allowed, in 2027 125 beds will be allowed, and in 2032 134 beds will be allowed. (Ex. A24 at 39-41).⁴⁸ Using 7.00 beds per 100,000 the result in 2022 will be 105 beds allowed, in 2027 116 beds allowed, and in 2032 124 beds allowed. Encompass projected to 2030 and concluded that there would be a net bed allowance under the 7 to 100,000 rule, even without applying OHA's interpretation of that rule, of 102 beds allowed. (Ex B204 at 15.)
- Step 7: The Authority calculated average daily census (ADC) at 100% occupancy to

⁴⁸ These forecasts are arrived at by subtracting Yamhill County population numbers and assumes 54 IRF beds. Yamhill population numbers are at Exhibit A24 at 39.

show how many beds would be required to handle all of the discharges at 12.7 ALOS. (Ex A183.)

- Step 8: use the ADC to calculate the estimated statistical variability, or standard deviation, of the daily census. The Authority applied the “Poisson” calculations in accord with accepted epidemiological principles. (Ex A183, Tr 130-31.)
- Step 9: calculate the expected daily census at the facility using an appropriate multiplier (set out in the rule) to the results of Step 8 and add that product to the results of Step 7.
- Step 10: use a ten-year projection and the analysis in Steps 4 and 5, to select from Step 7 the most likely average daily census, noting a number of factors to consider. Instead of using a ten-year projection, the Authority used a three-year projection to be conservative. (Tr 205) Although the rule otherwise requires a 5-year and 10-year future projection (OAR 333- 590-0050(6)), OHA applied a three-year projection (Tr 205), to be intentionally conservative.
- Step 11: select from Step 9, the peak daily census associated with the results of Step 10. If the number of beds exceeds the present number of acute inpatient beds within 50 road miles of the population, evaluate the extent to which admissions scheduling could alleviate the need for new beds and evaluate the extent to which the procedures/treatment could be completed on an out-patient basis. This step focuses on acute inpatient beds and outpatient treatment and is inapplicable.
- Step 12: review the outcome of Step 11 and, if it shows that additional beds may be needed, conduct an analysis weighing the proposal against the availability of beds at other facilities and against the feasibility of alternative health care services. The Authority determined that “alternative health care services” in the nature of SNFs are not viable alternatives to IRFs (Tr 298.)
- Step 13: A certificate of need will be issued to meet the indicated need based on sections (11) and (12) of this rule, if supported by provisions of OAR 333-590-0060 and the division's findings on the criteria in Division 580. OHA found Encompass would have an appropriate relationship with the service area and that this proposal represented the best external and internal alternative.
- Step 14: If the number of beds proposed at the applicant facility cannot be justified under these general acute inpatient rules, a certificate of need for new specialty beds will not be issued unless an adjustment is indicated because conversion of other beds to sufficient specialty beds to meet calculated specialty bed need is not architecturally and economically feasible. OHA found that conversion of other beds to meet calculated specialty bed need is not architecturally and economically feasible. (OAR 333-590-0060(9)).

~~Not only did the Authority improperly interpret OAR 333-645-0030(4), the Authority also failed to act in accordance with its self-imposed limitations. At hearing, Mr. Robison testified regarding several concerns he had about applying the Division 590 rules in this case, particularly the effect of the assumption under OAR 333-590-0030(3) that the use rate for acute inpatient facilities in Oregon will likely decline for the next ten year.~~

Reason for modification: OHA does not adopt this legal conclusion because OHA properly interpreted OAR 333-645-0030(4). Furthermore, it is a mischaracterization of Mr. Robison's testimony to suggest that a primary concern was the use of a declining use rate provided for in OAR 333-590-0030(3). His testimony on this point was one of many areas in which the Division 590 provisions did not apply or were not consistent with a proposal for an IRF. Moreover, OHA has consistently directed applicants to deviate from a declining use rate, as allowed under their rules. (OAR 333-590-0030(3)(b); See also Kaiser Westside, CN Application No.648 (2006) and all subsequent Certificate of Need approvals.)

~~The Authority has promulgated a rule that directly addresses what should be done if the adopted rule(s) appear inapplicable to a particular application. OAR 333-585-0000(2) provides, in part, that “[i]n the event that an applicant, at the time of filing a letter of intent, is proposing a service for which the division has not adopted, as rule, a methodology for demonstration of need; or for which the adopted methodology may appear to require modification or clarification; the applicant may request, or the division or the applicant may initiate, rulemaking procedures under the state Administrative Procedure Act.” (Emphasis added.) The rule goes on to say that “[i]n such circumstances, the division will make reasonable efforts to complete rulemaking procedures prior to the first possible filing date for the proposed application under this chapter.” OAR 333-585-0000(2). Rather than reject the bed need methodology in Division 590 in favor of a new (unpromulgated) methodology for determining need, the Authority could have initiated rulemaking procedures with rules that better reflect the current healthcare conditions.~~

Reason for Modification: OHA does not adopt this legal conclusion because it is unsupported by a plain reading of the rules. First, in the example given of a declining use rate, OAR 333-590-0030(3)(b) specifically addresses the agency's ability to modify the assumption of a declining use rate where a specialty center is proposed or where the applicant otherwise offers evidence that the population served is no longer in decline. Second, OHA did not reject the bed need methodology but as described below, applied it as applicable and consistent. Each step was evaluated, and the applicable provisions were then applied to the proposal. To aid in clarifying this process OHA has designated its application of OAR 333-590 as consistent and applicable with its assessment of IRF bed need. (See supra.)

~~Finally, the Authority's interpretation is not entitled to deference because it failed to follow the plain language of its own rule. In *Gafus v. Legacy Good Samaritan Hospital*, 344 Or 525 (2008), an action in which employees sought wage compensation for denied rest periods, the Oregon Supreme Court found that the Bureau of Labor and Industries' (BOLI) interpretation of OAR 839-020-0050, that “work” did not include rest periods, was inconsistent with the wording of the rule and its context. *Id.* at 536. The Court found that the rule at issue, related statutes and other related administrative rules defined “work” to include rest periods. *Id.* at 534-535. Additionally, in the past, BOLI had never sought wages as compensation for employees denied a rest period. Instead, BOLI had only sought civil penalties against the employer. *Id.* at 537. Therefore, BOLI's interpretation was contrary to its own administrative rule's definition for the word and its prior administrative actions when it enforced the administrative rule. Therefore, the Court gave BOLI's interpretation no deference. *Id.*~~

~~— In *DeLeon, Inc. v. DHS*, 220 Or App 542 (2008), the Oregon Court of Appeals found the Department of Human Services’ (DHS) interpretation of OARs 333-054-0010(28) and 333-054-0050(3)(b)(C) to be inconsistent with the “clear and unequivocal” language of the administrative rule. *Id.* at 550. In that case, DHS interpreted an “authorized shopper” to include a DHS representative performing compliance buys for the purpose of pursuing violations of vendor agreements. *Id.*~~

~~In *Anderson v. Dep’t of Human Servs.*, 286 Or App 27, 31-32 (2017), the Oregon Court of Appeals rejected, as implausible, DHS’s interpretation of the phrase “failure to participate” as the inverse of “participation” (a term defined in another rule). The Court of Appeals reviewed the dictionary definition of “failure” and determined that failure to participate is the absence of participation, not merely incomplete participation. *Id.* at 32. The Court of Appeals also found that DHS’ interpretation conflicted with other administrative rules. Therefore, the Oregon Supreme Court gave the agency’s interpretation no deference. *Id.*~~

Reason for modification: Agencies are permitted to “define and apply delegative statutory or regulatory terms in the context of deciding contested cases.” *Martini v. Oregon Liquor Control Comm’n*, 110 Or App 508, 509, 823 P.2d 1015, 1017 (1992 (internal citations omitted).) This is particularly true where an agency is charged with evaluating broad, complex, and often competing interests. (*Johnson v. Employment Dept.*, 187 Or.App. 441, 447 (2003).⁴⁹)

OAR 333-645-0030 appropriately reserved to OHA necessary flexibility to apply specific criteria as applicable and consistent to a proposed IRF, including specialty IRFs. ORS 442.315(2) provides that “(2) The authority shall adopt rules specifying criteria and procedures for making decisions as to the need for the new services or facilities.” ORS 442.315 (5) provides that “It is the purpose of this chapter to establish area-wide and state planning for health services, staff and facilities in light of the findings of subsection (1) of this section and in furtherance of health planning policies of this state.” The Court of Appeals held that where standards cannot by their nature be precisely defined in advance of their application, the agencies must have certain latitude in applying these criteria to conflicting interests. (*Id.* Citing *Sun Ray Drive-In Dairy v. OLCC*, 20 Or. App. 91, 95, 530 P.2d 887 (1975) (*Sun Ray II*) (“So many variables exist, that we have declined to require mathematical precision, so long as the agency provides notice to applicants and others of the criteria upon which what are often judgment calls are to be made * * *.”)

Here, the contested case hearing afforded the interested parties the opportunity to demonstrate that OHA failed to properly consider a provision of OAR 333-645-0030 or overlooked a critical policy consideration under ORS 442.315. Instead, the limited parties have focused entirely on OHA’s methodology often narrowing in on minor discrepancies in the number of beds. That level of precision is inconsistent with OHA’s charge of evaluating whether

⁴⁹ “Therefore, our interpretation should show significant deference to the agency's own interpretation if it “is within the range of its responsibility for effectuating a broadly stated statutory policy.” *Johnson v. Employment Dept.*, 187 Or.App. 441, 447 (2003).

the service area needs the project and fails to properly weigh whether OHCA and Legacy have met their burden rebutting the evidence. Moreover, it deprives these applicants of the right to have the evidence evaluated against the required criteria. The ALJ reads into ORS 442.315(1) a requirement that specific criteria equates with having alternate rules to apply where the methods and principles in OAR 333-590-0030 to 333-590-0060 do not apply. Such a reading is unsupported by a plain reading of the rule and fails to properly situate the Certificate of Need laws within the broad statutory delegation and complex task before OHA. *Martini v. Oregon Liquor Control Comm'n*, 110 Or App 508, 509, 823 P2d 1015, 1018–19 (1992).

~~In the present case, if the term “where applicable” was removed from OAR 333-645-0030(4), it would provide that~~The IRF bed need calculation for rehabilitation services is to be consistent with the methods and principles established in OAR 333-590-0030 to 333-590-0060. As Mr. Robison pointed out in his testimony, the term “consistent” does not mean identical. ~~It does, however, mean with coherence or showing no contradiction or significant change.~~⁵⁰ Thus, ~~while the~~In other words, the plain language of the rules does not require the Authority to follow the Division 590 rules exactly as written in determining the need for an IRF under Division 645, ~~the Authority is required to calculate bed need in a manner that is both applicable and does not contradict or significantly change the methods and principles established in OAR 333-590-0030 to OAR 333-590-0060.~~ The addition of the phrase “where applicable” OAR 333-645-0030(4) ~~only~~ allows the Authority to not apply specific methods and principles in OAR 333-590-0030 to OAR 333-590-0060 if the Authority finds that the specific method or principle is not applicable ~~or consistent~~ to the bed need calculation of the proposed IRF facility. ~~The Authority’s development of an entirely new methodology for conducting the bed need analysis significantly changes the bed need calculation and the steps an applicant would need to follow. Thus, the Authority cannot claim that its new methodology was consistent with the methods and principles established in OAR 333-590-0030 to 333-590-0060.~~

~~Furthermore, to claim that certain portions of the rules are not applicable to a proposed IRF, the Authority would could first need follow the steps outlined in OAR 333-590-0050. If the Authority then found that a certain step or portion of a step (such as Step 11 of OAR 333-590-0050 that has an applicant evaluate whether admission scheduling could alleviate the need for new beds) was not applicable to calculating need for an IRF, the rule would allow the Authority to disregard that specific portion of the rule. However, because the Authority did not it cannot claim that certain portions of those rules were not applicable to this situation. Thus, the Authority’s interpretation of OAR 333-645-0030(4) (as authorizing the Authority to develop a different methodology for determining bed need) is implausible and not entitled to deference.~~

⁵⁰ “Consistent” is defined as: 1) “marked by unchanging position or by firmness, stiffness, solidarity, or coherence : stationary, changeless, and enduring,” 2) “marked by harmony, regularity, or steady continuity throughout : showing no significant change, unevenness, or contradiction,” 3) “marked by agreement and concord : coexisting and showing no noteworthy opposing, conflicting, inharmonious, or contradictory qualities or trends,” 4) “showing steady regular conformity to character, profession, belief, or custom,” or 5) “jointly assertable so as to be true or not contradictory : compossible.” *Webster’s Third New Int’l Dictionary* at 484 (unabridged ed 2002).

To summarize, the Authority utilized an unauthorized methodology in evaluating the need for PAM's proposed IRF and issuing the Proposed Decision approving the certificate of need. The plain reading of OAR 333-645-0030(4) requires that when conducting the IRF bed need calculation, the Authority follow the methods and principles established in OAR 333-590-0030 to 333-590-0060, including the steps set forth in several of those rules, except when a particular section or subsection is not applicable to the proposed IRF. This interpretation is supported by the fact that both Encompass and PAM also interpreted OAR 333-645-0030(4) to require following the Division 590 methodology. The Authority did not follow the methods and principles established in OHA followed OAR 333-590-0030 to OAR 333-590-0060 when conducting the IRF bed need analysis, but rather created an entirely new bed need methodology. The Authority should have conducted the bed need methodology following the methods and principles established in OAR 333-590-0030 to 333-590-0060, and, if a particular step or portion of the rule appeared inapplicable to rehabilitation facilities, it has the authority under OAR 333-645-0030(4) to disregard that specific portion or step. The Authority does not, however, have the authority to disregard the specific methods and principles established in OAR 333-590-0030 to OAR 333-590-0060.

In evaluating Encompass' proposal OHA looked at the data in multiple ways and each time concluded that there was a need for at least 100 IRF beds in HSA I.

Also concerning is the Authority's use of varying and sometimes conflicting data, use of various methodologies for calculating bed need, and multiple errors in calculations. The Authority submitted Exhibit A73, purporting to show the data used by Mr. Robison when conducting the bed need analysis. Exhibit A73.pdf uses the same number of discharges as the Proposed Decision—26,283—but arrives at the conclusion that there is a current unmet need of 126 IRF beds in the service area. This appears to be an error in math when subtracting the number of IRF beds currently available in the service area (subtracting 40 beds instead of 57). Exhibit A73.xlsx uses a discharge number of 20,749, ultimately arriving at an unmet IRF bed need of 112. The calculation fails to reduce the number of beds by 25 percent, to account for patients who would not be candidates for IRF care. If that 25 percent reduction had been done, the total anticipated need becomes 84 beds.

On the final day of hearing, the Authority submitted additional exhibits (A183 and A184) and recalled Mr. Robison for additional testimony. Mr. Robison testified that he erroneously included Yamhill County discharges in the data used in the Proposed Decision (Ex. "A73.xlsx"), but subsequently removed it from the data, as updated in Exhibit A184, Sheet 1, for a total number of discharges in HSA I of 20,194. Performing the same calculation as before, he determined an anticipated bed need of 109 IRF beds. Similarly to the calculation done in Exhibit A73.xlsx, this figure failed to reduce the number of beds by 25 percent, to account for patients who would not be candidates for IRF care. If that 25 percent reduction had been done, the total anticipated bed need would have been 82 beds.

In Exhibit A183, Mr. Robison pulled updated patient discharge data for the period of 2013 to 2019⁵¹, and ran the bed need calculation assuming 100 percent, 75 percent, and 50 percent utilization of IRFs. The percentage of utilization was subtracted from the yearly discharges, not later in the calculation as he had done previously. Assuming 75 percent IRF utilization, Mr. Robison calculated an unmet need for 104 IRF beds in the service area. ~~It is unclear where Mr. Robison pulled the data to create Exhibit A183 from, as the average yearly discharge number (5,084) does not match the discharge data in Exhibit A184.~~

Reason for modification: Where an affected entity granted party status offers testimony at hearing the agency may rebut that evidence.) *Friends of Parrett Mountain v. Nw. Nat. Gas Co.*, 336 Or 93, 106 (2003).⁵² In *Friends of Parrett Mountain*, the affected party offered testimony at a contested case hearing contradicting the evidence relied on by the agency's geologist. The applicant and agency rebutted that evidence at hearing which was relied on by the agency in its final order. (*Id.*) The Oregon Supreme Court relied on that evidence in upholding the agency action insofar as it was needed to close any alleged "evidentiary gap" asserted by the affected party in its petition for review. As demonstrated in *Friends of Parrett Mountain*, an agency is permitted to rebut data or testimony offered at hearing and properly did so in this matter. (ORS 183.450(3)).

The testimony on rebuttal regarding A183 and A184 was as follows: Exhibit A184 was admitted into evidence for the limited purpose of updating the number of discharges in HSA I and to rebut testimony offered by the interested parties that the ratio was exceeded under OAR 333-645-0030(1). (Tr. 1466-1468.) Ex. A184 did not contain a final bed need calculation. (Cf. Ex. A73. Xlsx.) The ALJ ruled that Ex. A184 was admitted for the purpose of demonstrating the ratio and could not be considered for purposes of the bed need calculation. (Tr. 1466-1468.) Exhibit A183 was offered on rebuttal to demonstrate that there was a need for the beds applying the Poisson adjustment at a different point in the calculation and to respond to evidence presented at hearing that OHA had overstated bed need by 3 to 5 beds, used out of date data, had included Washington residents, deceased residents, and veterans. (Tr. 699 and 1454 to 1457.) OHA responded to the evidence offered at hearing on rebuttal by repulling data that covers the period of 2013 to 2019. (Tr. 1482.)

⁵¹ ~~It is unknown why the Authority decided to update the date range for the data set. It could be an attempt to use more current data available for making a decision. OHA Witness Steve Robison testified that he updated the data to include the "newest current discharge data we have, so it reflects now a range of 2013 to 2019." (Tr. 1455). The addition of updated data does not represent a change in methodology. However, the multiple changes in the data (discharge numbers, date ranges, DRGs included, etc.) undermines the reliability of the calculations.~~

⁵² "In any event, even if we were to assume, without deciding, that the Parrett Mountain expert indeed did create an "evidentiary gap" in the record when he testified before the council, we could not say the same after Northwest Natural's expert responded. Neither Northwest Natural's engineering firm nor the council dismissed out of hand the concerns contained in the Parrett Mountain expert's testimony-the unused groundwater study, the undiscovered landslide sites, and soil creep in the area. The record shows that Northwest Natural's experts reviewed **877 the groundwater study, physically reexamined the area proposed for locating the pipeline, and subsequently presented evidence garnered from those endeavors to rebut the geologist's testimony."

Following the conclusion of the hearing and after the first set of closing briefs were due, the Authority requested to reopen the record and submit additional evidence to correct evidence in the record. Based on Legacy's closing brief, The Authority determined that the hospital discharge numbers Mr. Robison testified to relying on when conducting the bed need calculation in Exhibit A73 xlxs contained a larger set of DRGs than those he intended to rely on when conducting the bed need analysis. At hearing, Mr. Robison testified to using 26,283 discharges to conduct his bed need calculation. He testified that the discharge number included DRGs 61 to 66, 68 to 74, and 82 to 90 for patients over the age of 40. In actuality, that number also included DRGs 52 to 60 and 91 to 94. Both groupings involve DRGs related to stroke, brain injury, and other neurological conditions.

Reason for modification: Revised to reflect evidence in the record. The narrow clarification on the DRGs reflects OHA's conservative methodology as reflected in DRGs used in its need analysis.

Based on this error, the Authority submitted new data and Mr. Robison calculated the bed need analysis based on that data. The new data included "DRGs 61-66, 68-74, and 82-90, * * * for *all ages* in the years 2014 to 2018 and 2013 to 2017." (Declaration of Steven Robison at 1.) (Emphasis added.) For 2014 to 2018, Mr. Robison used a discharge number of 25,224, calculating an anticipated bed need of 100 IRF beds, an increase of two beds over the data for 2013 to 2017. ~~Mr. Robison used a discharge number of 24,867, calculating an anticipated bed need of 98 IRF beds. However, the discharge data used included discharges for patients of all ages. As it had done previously, the Authority should have either removed the discharges for patients under the age 40, or included the IRF beds at Randall's Children Hospital when conducting the calculation. Doing so would have further reduced the anticipated bed need. The applicants and the affected parties offered evidence at hearing that age is not predictive of IRF use for individuals experiencing stroke, brain injury or other neurological conditions which supports evaluating the DRGs inclusive of discharges for those below age 40.~~⁵³

Reason for modification: OHA does not adopt this legal conclusion because the rule requires OHA to evaluate need based on general population. Second, the testimony at hearing was that OHA relied on the CMS' Inpatient Prospective Payment Exclusion list in evaluating the number of IRFs in HSA I, it was then Legacy and OHCA's burden to demonstrate that the Legacy Emanuel Randall Children's Hospital had qualifying IRF beds, and both failed to meet their burden. Applicants and interested parties offered testimony at hearing as to why limiting the discharges to individuals over the age of 40 was inconsistent with who utilizes IRF services for the relevant discharges used by OHA in its analysis. There is no evidence in the record that the DRGs used by OHA are used for the pediatric population such that inclusion of those below age 40 also necessarily captured pediatric discharges. OHA's inclusion of all ages is supported by a preponderance of the evidence.

The evidence in the record demonstrates need for the project and all relevant criteria can be answered in the affirmative. OHA finds that a preponderance of the evidence demonstrates need for the projects and OHCA and Legacy failed to rebut that evidence by a preponderance of the evidence.

As Legacy points out in its closing brief, the “sum of the evidence providing how the Authority developed its bed need analysis is disquieting.” Legacy’s Reply Brief at 21. The changes in data and methodologies used by the Authority throughout the process and the errors noted above show a failure to carefully and accurately conduct a thorough bed need analysis.

Reason for modification: OHA does not adopt this legal conclusion because each of the Authority’s bed need calculations showed a present and future need for at least 100 IRF beds in HSA I, the combined number of IRF beds PAM and Encompass are proposing for their IRFs.

While each of the Authority’s bed need calculations showed a need for at least 50 IRF beds in HSA I, the number of IRF beds PAM is proposing for its IRF⁵⁴, the bed need calculations completed by the Authority do not support a finding that the certificate of need application should be approved. Based on the numerous errors in the Authority’s calculations and the failure of the Authority to comply with the applicable rules, appellants have shown that the criterion “does the service area population need the proposed project” cannot, at this time, be answered in the affirmative. As such, the matter is remanded to the Authority to conduct a Division 590 analysis or to promulgate new rules regarding the determination of need for a proposed IRF.

Reason for modification: The evidence and data in the record demonstrates need for at least 100 beds in the service area based on the methodology used by the agency. The data was appropriately updated on rebuttal and the interested parties were given an opportunity to cross-examine the evidence. Each of OHA’s bed need calculations showed a need for at least 100 IRF beds in HSA I, the combined number of IRF beds Encompass and PAM are proposing for their IRFs. A preponderance of the evidence demonstrates OHA properly approved the applications that were consolidated for hearing. OHA declined to exercise its discretionary authority to conduct simultaneous review under OAR 333-560-0030.

⁵⁴ While Legacy and OHCA argue that the bed need methodology failed to show a need for 100 beds in the service area, this order only looks at PAM’s application to build an IRF with 50 beds. However, on remand, the Authority will be tasked with the decision of how to proceed if the bed need calculations show a need for less than 100 beds in the service area, and taking into consideration the requirements of OAR 333-645-0030(1) that bed need cannot exceed 7 beds per 100,000 general population (or 158 IRF beds in HSA I including the IRF beds at Randall’s Children Hospital) and the Authority’s decision to not conduct a simultaneous review of the Encompass and PAM applications under OAR 333-560-0030. Reason for modification: OHA declined to exercise its discretionary authority to conduct simultaneous review under OAR 333-560-0030.

- b. Will the proposed project result in an improvement in patients' reasonable access to services?⁵⁵

OAR 333-580-0040(3) provides:

Criterion: Will the proposed project result in an improvement in patients' reasonable access to services? The applicant will identify any potential problems of accessibility including traffic patterns; restrictive admissions policies; access to care for public-paid patients; and restrictive staff privileges or denial of privileges.

Currently, there are no IRF beds in any county in HSA I, except for Multnomah County. Based on the national figures, Oregon has a low number of IRF beds for its population. The proposed facility will be located in the Portland-metro area, near major freeways. It will be 0.2 miles away from a MAX station. Encompass will employ clinical outreach and discharge planners to educate local physicians and help facilitate timely patient evaluations, likely resulting in increased admissions to the IRF.

The proposed facility will accept both Medicare and Medicaid patients. There is no evidence that Encompass will have restrictive admission policies that exceed industry norms. Encompass has also developed relationships with local colleges and universities to increase the number of health care professionals available to work at the proposed facility. The proposed IRF will have an open medical staff and credentialing process. Thus, the evidence shows that the proposed project will likely result in an improvement in patients' reasonable access to services.

II. Availability of Resources and Alternative Uses of Those Resources

- a. Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?

OAR 333-580-0050, titled "Availability of Resources and Alternative Uses of Those Resources," provides:

Applicants must provide a narrative discussion of each of the following:

(1) Criterion: Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs?

(a) The applicant must demonstrate that the best price for the proposal has been sought and selected;

~~⁵⁵This order ultimately reverses the Authority's proposed decision and remands it for further investigation. However, to aid on remand, all additional relevant criteria are also addressed in this order.~~

(b) The applicant must demonstrate that proposed solutions to identified needs represent the best solution from among reasonable alternatives:

(A) Internal alternatives:

(i) The applicant must list the major internal operational adjustments considered which could lower the cost and improve the efficiencies of offering the beds, equipment or service;

(ii) The applicant must demonstrate that the alternative considered represents the best solution for the patients, and discuss why other alternatives were rejected;

(iii) If the proposal is for an inpatient service, whether new or expanded, applicant must demonstrate this method of delivery is less costly than if done on an outpatient basis;

(iv) The applicant must demonstrate that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified needs.

(B) External alternatives:

(i) If the proposed beds, equipment or services are currently being offered in the service area, applicant must demonstrate:

(I) Why approval of the application will not constitute unnecessary duplication of services;

(II) Why the proposal is an efficient solution to identified needs;

(III) Why the proposal represents the most effective method of providing the proposal; and

(IV) That the applicant can provide this proposal at the same or lower cost to the patient than is currently available.

(ii) If paragraphs (A)(i) to (A)(iv) of this subsection cannot be demonstrated, the applicant must show that without the proposal, the health of the service area population will be seriously compromised.

(C) Less costly alternatives of adequate quality:

(i) If a less costly and adequately effective alternative for the proposal is currently available in the area, the applicant must demonstrate why its proposal is:

(I) Not an unnecessary duplication; or

(II) A more efficient solution to the identified needs.

(ii) Applicants must demonstrate that the identified needs of the population to be served cannot be reasonably served under current conditions, or by alternative types of service or equipment or equal quality to the proposal. “Alternatives of adequate quality” does not imply that they need be exactly like those being proposed, but only that they meet identified needs at state approved levels.

(D) If there are competing applications for the proposal, each applicant must demonstrate why theirs is the best solution, and why a certificate of need should be granted them.

* * * * *

OAR 333-645-0020, addressing the principles underlying demonstration of need for rehabilitation services, provides:

(1) Given the diversity of services possible, rehabilitation units should provide the least restrictive and most cost-effective setting possible to meet patient needs. Applicants shall demonstrate that their proposed services are the least costly of any reasonable alternatives.

(2) Available resources shall be coordinated by the provider to insure linkages among various levels and settings of rehabilitation services.

* * * * *

(4) CIRFs shall demonstrate that they participate in sharing of services or any other programs which result in efficient cost containment.

In determining if the proposed project is the most effective and least costly alternative, OAR 333-580-0050(1) sets out a number of considerations that must be address.

(a) The applicant must demonstrate that the best price for the proposal has been sought and selected;

Encompass consulted with an Oregon architect who is familiar with the costs of building health care facilities in the state. The Authority determined that the cost estimate provided by Encompass was “consistent with industry standard.” (Ex. A162 at 9.)

(b) The applicant must demonstrate that proposed solutions to identified needs represent the best solution from among reasonable alternatives:

(A) Internal alternatives:

(i) The applicant must list the major internal operational adjustments considered which could lower the cost and improve the efficiencies of offering the beds, equipment or service;

(ii) The applicant must demonstrate that the alternative considered represents the best solution for the patients, and discuss why other alternatives were rejected;

In its application, Encompass addressed five alternatives to the proposed 50-bed freestanding IRF in Washington County. The five alternatives included not building an IRF (alternative 1); building a freestanding 50-bed IRF in Multnomah County (alternative 2); building a 25-bed IRF in Washington County in a joint venture with a hospital (alternative 3); building an IRF in another Oregon county in a joint venture with a hospital (alternative 6); or building a 40-bed freestanding IRF in Clackamas County (alternative 7).

If Encompass did not build an IRF (alternative 1), it would not compete with any IRFs or SNFs currently in the service area, ~~but~~ area but would not address any current or future shortage of IRF beds available to the service area population. Building a freestanding 50-bed IRF in Multnomah County (alternative 2) would put all IRFs in the service area in a single county, failing to improve access to IRF services for patients residing outside of Multnomah County. Building a 25-bed IRF in Washington County in a joint venture with a hospital (alternative 3) could meet some, but likely not all of the anticipated bed need in the service area. This option would decrease the capital costs of building an ~~IRF, but~~ IRF but would also result in higher operating costs. Additionally, there is no evidence that any hospitals in Washington County were open to a joint venture IRF with Encompass. Building an IRF in another Oregon county in a joint venture with a hospital (alternative 6) could meet the current and future bed needs of the service area. However, like with Washington County, there is no evidence of any hospitals being open to a joint venture IRF with Encompass. Finally, building a 40-bed freestanding IRF in Clackamas County (alternative 7) would increase accessibility to an IRF for Clackamas County residents. However, no adequate site for this alternative was identified and a 40-bed freestanding IRF is not as financially favorable for Encompass as a larger IRF. Additionally, this would not meet all future anticipated IRF bed need in the HSA I service area.

(iii) If the proposal is for an inpatient service, whether new or expanded, applicant must demonstrate this method of delivery is less costly than if done on an outpatient basis;

Patients who meet the criteria for admission to an IRF typically require inpatient acute-level care. Thus, providing the care on an outpatient basis is not feasible given the 24-hour care needs of these patients.

(iv) The applicant must demonstrate that the selected architectural solution represents the most cost effective and efficient alternative to solving the identified needs.

As discussed above, Encompass consulted with an Oregon architect who is familiar with the costs of building health care facilities in the state. The Authority determined that the cost estimate provided by Encompass was “consistent with industry standard,” making it the most cost effective and efficient alternative. (Ex. A162 at 9.)

(B) External alternatives:

(i) If the proposed beds, equipment or services are currently being offered in the service area, applicant must demonstrate:

(I) Why approval of the application will not constitute unnecessary duplication of services;

In its application, Encompass defined the service area for its proposed IRF to be Washington County, Oregon. It did not address this section, as no IRFs are located in Washington County, Oregon. The Authority defined the appropriate service area to be all of HSA I. There are currently two IRFs in HSA I, with a total of 54 beds that service the adult population. The proposed IRF would therefore ~~would~~ not be a duplication of services already available in the service area as defined by the Authority.

OHCA’s primary contention at hearing was that the Authority failed to consider SNFs as an adequately effective, less costly alternative to the proposed IRF. OHCA argued that existing SNFs provide services similar to an IRF, and that those existing SNFs had the capacity to accept additional patients in need of rehabilitation. Thus, OHCA’s argument is, essentially, that the proposed IRF would also constitute an unnecessary duplication of SNF rehabilitation services within the service area.

While SNFs in the area provide short-stay beds and rehabilitation for patients who suffer strokes and other neurological conditions, the evidence at hearing showed that the services offered by an IRF are preferable for certain patients over the services of an SNF. Patients with acute-level care receive more rehabilitation therapy per day in an IRF than a SNF. Thus, while many of the services offered at an SNF are similar to those offered an IRF, they are not exactly

the same and thus do not constitute an unnecessary duplication of services within the service area.

Furthermore, while there are other IRF beds in the service area, the evidence shows that there is a need for additional IRF beds in the service area (~~though the exact number needed is unknown, as discussed above~~), and thus the proposed IRF would not constitute an *unnecessary* duplication of services.

Reason for modification: OHA does not adopt this legal conclusion because a preponderance of the evidence in the record is that there is a need for at least 100 beds in the service area.

(II) Why the proposal is an efficient solution to identified needs;

Nationally, ALOSs for patients at an IRF are shorter than national ALOSs for patients at SNFs. Patients receive more therapy hours per day at an IRF. When compared to other IRFs, Encompass has a lower ALOS, and patients' functional improvement is greater during their stay. Encompass also has a higher percentage of patients who are discharged to the community (their home), compared to other IRFs nationally. Finally, existing IRFs in the service area are not open to a joint venture with Encompass. The proposed IRF is an efficient solution to the likely need for additional IRF beds in the service area.

(III) Why the proposal represents the most effective method of providing the proposal; and

As discussed above, the proposed freestanding 50-bed IRF in Washington County is the most ~~cost-effective~~ cost-effective proposal Encompass found. It provides more beds to patients in HSA I to meet current and potential future need and is located outside of a county with existing IRF beds.

(IV) That the applicant can provide this proposal at the same or lower cost to the patient than is currently available.

Compared to IRFs nationally, Encompass has a lower average estimated cost and receives less reimbursement per discharge. Encompass also has a lower ALOS than either of the IRFs currently in the service area. Medicare patients represent 60 to 66 percent of IRF patients. Medicare pays a fixed price per patient discharge to an IRF, based on the patient's diagnosis. Thus, Encompass would be paid the same as other IRFs for caring for the same acuity of patients. Compared to SNFs, IRFs tend to cost less per patient discharge with greater functional improvement per patient. Thus, the appellants failed to show that Encompass could not provide services to patients at the same or lower cost than is currently available in the service area

(ii) If paragraphs (A)(i) to (A)(iv) of this subsection cannot be demonstrated, the applicant must show that without the proposal, the health of the service area population will be seriously compromised.

Since paragraphs (A)(i) to (A)(iv) of this subsection were met, as discussed above, it is not necessary to address this paragraph.

(C) Less costly alternatives of adequate quality:

(i) If a less costly and adequately effective alternative for the proposal is currently available in the area, the applicant must demonstrate why its proposal is:

(I) Not an unnecessary duplication; or

(II) A more efficient solution to the identified needs.

Legacy and OHCA have not shown that there are less costly and adequately effective alternatives for the proposed IRF in the service area. Therefore, it is not necessary to address this section.

(ii) Applicants must demonstrate that the identified needs of the population to be served cannot be reasonably served under current conditions, or by alternative types of service or equipment or equal quality to the proposal. “Alternatives of adequate quality” does not imply that they need be exactly like those being proposed, but only that they meet identified needs at state approved levels.

While there are currently two adult IRFs in the service area, the number of IRF beds in HSA I is well below the national average. There is strong scientific evidence that the use of IRFs versus other post-acute care services for strokes and other select conditions leads to better outcomes for patients. While SNFs in the service area provide valuable care, as discussed above, the services provided by SNFs cannot be considered “alternatives of adequate quality” for certain patients.

(D) If there are competing applications for the proposal, each applicant must demonstrate why theirs is the best solution, and why a certificate of need should be granted them.

~~Both Encompass and PAM submitted applications to build IRFs in Washington County. As discussed above, to comply with OAR 333-645-0030(1) (the requirement that IRF beds cannot exceed 7 in 100,000 general population), the Authority cannot approve more than 92 additional IRF beds in HSA I. At the hearing, the parties presented no evidence that one applicant’s proposal was superior to the other applicant’s proposal. Thus, on remand, the~~

Authority will be tasked with determining how to proceed with the two applications considering this factor.⁵⁶

Reason for Modification: OHA declined to exercise its discretionary authority to review these applications under OAR 333-560-0030.

Conclusion

~~While a~~ Appellants presented no persuasive evidence that the proposed project was not the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified need, ~~on remand the Authority must readdress this criterion in light of their updated need calculations and total approvable IRF beds in the service area.~~

Reason for modification: OHA finds that a preponderance of the evidence supports the need calculation as outlined herein obviating the need to readdress this criterion.

- b. Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project?

OAR 333-580-0050(2), titled “Availability of Resources and Alternative Uses of Those Resources,” provides:

Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project? The applicant must demonstrate that there are, or will be sufficient physicians in the area to support the proposal; sufficient nurses available to support the proposal; sufficient technicians available to support the proposal; adequate land available to develop the proposal and accommodate future expansion; and the source(s) and availability of funds for the project.

As indicated above, Encompass and the Authority stipulated that this criterion has been met.⁵⁷

- c. Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?

OAR 333-580-0050(3), titled “Availability of Resources and Alternative Uses of Those Resources,” provides:

⁵⁷ This criterion was not within the scope of the limited parties’ participation.

Criterion: Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers?

(a) The applicant must identify the extent to which the proposal and its alternatives are currently being offered to the identified service area population, or, in the case of acute inpatient beds, could be offered on the basis of an analysis under division 590 of this chapter;

(b) The applicant will discuss to the best of his or her knowledge, any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. Areas to be discussed are utilization, quality of care, and cost of care;

(c) The applicant must demonstrate that jointly operated or shared services between the applicant and other providers have been considered and the extent to which they are feasible or not;

(d) The applicant must demonstrate that all necessary support services and ancillary services for the proposal are available at acceptable levels to insure that patients will have the necessary continuity in their health care.

There are no IRFs in Washington County, and the IRFs in HSA I are uninterested in establishing a joint venture with Encompass. In its application, Encompass asserted that without the proposed IRF beds, the existing IRFs would be unable to meet future need. Encompass identified no negative impacts the proposed IRF would have on facilities currently offering or reimbursing for similar or alternatives services. In its application, Encompass indicated that it typically purchases the following services: laboratory; imaging; medical equipment support; pastoral care; security; and waste/recycling management.

Legacy argues that there are currently unfilled IRF beds in the service area. OHCA argues that SNFs provide the same or similar services to those offered by IRFs. Thus, both appellants argue, in essence, that the proposed IRF will create an unnecessary duplication of services. Legacy's argument regarding the need for additional IRF beds is addressed above. OHCA's argument is also addressed above. Thus, while there may be some duplication of services for some patients, the duplication is not *unnecessary*. Legacy and OHCA have not shown that the proposed IRF will not have an appropriate relationship to the service area, including unnecessary duplication of services.

d. Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area?

OAR 333-580-0050(4), titled “Availability of Resources and Alternative Uses of Those Resources,” provides:

Criterion: Does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area?

As discussed above, Encompass and the Authority stipulated that this criterion has been met.

III. Economic Evaluation

- a. Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project?

OAR 333-580-0060, titled “Economic Evaluation,” provides:

(1) Criterion: Is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project?

As discussed above, Encompass and the Authority stipulated that this criterion has been met.

- b. Will the impact of the proposal on the cost of health care be acceptable?

OAR 333-580-0060, titled “Economic Evaluation,” provides:

(2) Criterion: Will the impact of the proposal on the cost of health care be acceptable?

(a) The applicant must discuss the impact of the proposal both on overall patient charges at the institution and on charges for services affected by the project:

(A) An applicant must show what the proposal’s impact will be on the gross revenues and expenses per inpatient day and per adjusted patient day;

(B) When a health service is affected by the proposal, an applicant must demonstrate what impact the proposal will have on related patient charges and operating expenses. Expenses and patient charges for individual health services will be compared to historical and forecasted rates of increase for the facility as a whole.

- (b) The applicant must discuss both the proposed or actual charges for the proposed service and the profitability of the proposed service, compared to other similar services in the state (if any);
- (c) The applicant must discuss the projected expenses for the proposed service, and demonstrate the reasonableness of these expense forecasts;
- (d) If the proposed service is currently not being provided in the area, the applicant should identify potential travel cost savings by:
 - (A) Establishing what the existing travel costs are to patients;
 - (B) Establishing what the travel costs will be to patients after implementation of the proposal; and
 - (C) Showing what the difference is between the figures in paragraphs (A) and (B) of this subsection.
- (e) The applicant must discuss the architectural costs of the proposal:
 - (A) An applicant must demonstrate that the existing structure will last long enough to derive full benefits from any new construction or remodeling;
 - (B) General construction costs must be within reasonable limits (within high/low range as described in the most current issue of the Dodge Research Report adjusted for location).

Freestanding IRFs tend to have a lower operating cost than IRFs connected to a general acute care hospital. Encompass expects to have a significant portion of its patient population covered by Medicare, which has specific payment standards based on the patient's diagnosis. Encompass has no prior ventures in Oregon. Encompass operates facilities around the country, including six IRFs in California and Nevada which are profitable. While there are currently two adult IRFs in the service area, patients currently have to travel to Multnomah County for access to an IRF. An IRF in Washington County will reduce travel time and costs for patients located west of the Multnomah County IRFs. Finally, Encompass showed in its application that the architectural costs of the proposed IRF were developed with an architect registered in Oregon.

In the Proposed Decision, the Authority determined that the impact of Encompass' proposed IRF on the cost of health care would be acceptable. Legacy and OHCA provided no persuasive evidence that the impact of the proposed IRF on the cost of health care would not be acceptable. As such, this criterion has been met.

Ultimate Conclusion

In summary, the record in this case establishes that the criteria under OAR 333-580-0040(1) (does the service area population need the proposed project); under OAR 333-580-0040(3) (will the project result in an improvement in patients' reasonable access to services); under OAR 333-580-0050(1) (does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs); under OAR 333-580-0050(2) (will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project); under 333-580-0050(3) (will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers); under OAR 333-580-0050(4) (does the proposed project conform to relevant state physical plant standards, and will it represent any improvement in regard to conformity to such standards, compared to other similar services in the area); under 333-580-0060(1) (is the financial status of the applicant adequate to support the proposed project, and will it continue to be adequate following implementation of the project); and under OAR 333-580-0060(2) (will the impact of the proposal on the cost of health care be acceptable) have all been answered in the affirmative.

~~However, the record does not establish that the criteria under and have all been answered in the affirmative. can be answered in the affirmative and therefore must be re-evaluated in accordance with and consistent with the Division 590 rules (or the Authority must undertake rulemaking procedures to update the relevant rules). The Proposed Decision is reversed and the matter is remanded back to the Authority for reevaluation in accordance with the provisions of ORS Chapter 333, Divisions 590 and 645 and for a new decision, consistent with this order.~~

FINAL ORDER

The Authority's March 13, 2020, Proposed Decision granting a Certificate of Need to ENCOMPASS, LLC is AFFIRMED ~~and the matter is REMANDED to the Authority for further evaluation consistent with the applicable provisions of ORS Chapter 333, Divisions 590 and 645.~~

~~On remand, the Authority must determine if the service area population needs the proposed project in a manner consistent with its administrative rules. The Authority must also reevaluate if the proposed project represents the most effective and least costly alternative of meeting the identified need based upon any changes to the identified need.~~

/s/ Dana Selover

Dana Selover, MD, MPH
Oregon Health Authority

APPEAL PROCEDURE

NOTICE TO THE PARTIES: This is the Oregon Health Authority's Final Order. You are

entitled to judicial review of this order. Judicial review may be obtained by filing a petition for review within 60 days of the service of this order. Judicial review is pursuant to the provisions of ORS 183.482.

CERTIFICATE OF MAILING

On the 10th day of May, 2022, I served the foregoing FINAL ORDER in Reference No. **2020-OHA-11952** to the following parties.

BY ELECTRONIC MAIL:

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