LEGACY HEALTH

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November 4, 2019

Matt Gilman, MPPA
Pam Krecklow
Certificate of Need Program
Health Care Regulation and Quality Improvement Program
800 NE Oregon Street, Suite 465
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Dear Mr. Gilman and Ms. Krecklow:

We are submitting our public comments on Certificate of Need ("CON") applications submitted by Encompass Health Rehabilitation Hospital of Oregon, LLC ("Encompass") and Post Acute Medical – PAM Squared at Portland, LLC ("PAM"). Oregon's CON law and related regulations have been developed with the purpose to ensure that health services are adequately distributed around the state without unnecessary duplication of services or excessive costs to patients. The two applications for inpatient rehabilitation facility ("IRF") projects, both in Washington County, OR, do not meet the burden of proof for justifying the need for a 50 bed IRF, which each applicant proposes.

Legacy Health owns and/or operates six hospitals, 27 primary care locations throughout the Portland Metro area and 90 specialty clinic locations that span from Southwest Washington to the Willamette Valley. Legacy's hospitals include Legacy Emanuel Medical Center, a tertiary/quaternary hospital with a Level 1 trauma designation. Randall Children's Hospital is also part of Legacy Emanuel.

Most relevant to this CN application is Legacy Good Samaritan ("Good Sam"). Good Sam was founded in 1875 on exactly the same land that it operates on today in Northwest Portland. In addition to being one of the region's most advanced medical centers and a magnet for specialty services, it operates the Legacy Rehabilitation Institute of Oregon ("RIO"), an inpatient rehabilitation facility offering the highest level of care available.

In its 36 beds, RIO provides 24/7 rehabilitation nursing care, a team of board-certified physiatrists (rehabilitation doctors), certified rehabilitation registered nurses and certified stroke therapists, physical, occupational, recreational and speech therapists and neuro-psychology services for emotional support. The Program also includes state-of-the art equipment including the Zero-G gait and balance training system and an internationally recognized Horticulture Therapy program.

RIO is accredited by the Commission on the Accreditation of Rehabilitation Facilities, and treats a comprehensive array of diagnoses.

Both applicants noted meeting with Legacy and that Legacy rejected the opportunity to collaborate with them in the creation of a new freestanding IRF. In fact, we declined involvement in either of the proposed applications only after considerable due diligence and determining the need in this service area fails any analysis of need for additional rehab beds.

The CN Process

The CN process is governed by a number of rules adopted by the Oregon Health Authority ("OHA") under ORS 442.315(2), found at Oregon Administrative Rules ("OAR") 333, Divisions 545 through 670. The burden of proof for justifying need and the viability of the proposal rests with the applicants. In order for a CN to be granted, OHA must find that the applicants satisfied all the criteria in OAR 333-580-0040 to 333-580-0060. The criteria incorporate the applicable service-specific methodologies and standards in OAR 333, Divisions 590 (Demonstration of Need for Acute Inpatient Beds and Facilities); and the applicable service–specific methodologies and standards in Division 645 (Demonstration of Need for Rehabilitation Services).

In order to approve the applications and issue CONs, the applicants must demonstrate the criteria and standards referenced in OAR 333-580-0030(1) 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. OAR 333 590-0050 provides a 14-step methodology to determine if need for additional acute beds exists, and if it does how the beds should be allocated.

In the two current applications each proposing a new acute rehabilitation hospital, each hospital referenced 333-590-0030, but did not follow the prescribed methodology. Even absent a precise application of 333-590-0030, one of the applicants, Encompass, reached the conclusion that numeric need for additional beds does not exist (page 14-15 of their application).

The Service Area Population Does Not Need Either Proposed Project

This criterion requires the applicant to use particular indicators and specific standards and methodologies to determine the appropriate service area and to determine whether there is a need for both general acute care beds and IRF beds within the service area. The applicants have not met their burden with regard to the bed-need within the proposed service area. The current and historical rates of hospitalization do not support a conclusion of need for additional supply. The availability, accessibility, quality and levels of utilization of the existing IRF services address the medical needs of the applicable patient groups.

Both applicants state that 333-645-0030 anticipates seven acute rehabilitation beds per 100,000 population; in fact, the rule states that total need for inpatient rehabilitation services is such that inpatient facilities *shall not exceed seven beds in* 100,000 general population. Moreover, OAR 333-645-0030 also requires that an applicant demonstrate consistency with historical use patterns for rehabilitation services. It does allow adjustments if the applicant submits information that demonstrates, among other factors *the availability, accessibility, quality, and levels of utilization*

of existing inpatient services addressing the needs of those groups. While each applicant made general statements comparing lower use rates in Oregon to other states, absolutely no data was given to suggest that availability, accessibility; quality and occupancy are barriers to care.

According to a March 2018 AHA Fact Sheet: IRFs have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services ("CMS") in recent years, which has led to multiple interventions, including strict criteria for IRF patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have reshaped the population treated in IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients. The volume of IRF discharges has dropped significantly from 2004 through 2013 – 122,000 fewer cases per year.[1]

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. The RIO unit at Good Sam operates at 64% average annual occupancy. Data included in the Encompass application (table restated below), shows that neither of the two existing providers operate their acute rehabilitation units at 85%, simply because demand does not exist to do so. The record should reflect that not one of the letters of support nor those testifying in support of one or both of the applications provided data nor otherwise suggested any impact on patient outcomes as a result of the current acute rehabilitation bed supply. Rather, the letters generally hypothesized that "a *freestanding inpatient rehab hospital will potentially provide better outcomes.*

Table 1
Tri-County Hospital Rehabilitation Beds, Patient Days and Occupancy, 2016-2017

Hospital	**Legacy Good Samaritan Medical Center**	**Providence Portland Medical Center**	**Tri-County Portland Total**
Service Area County	Tri-County	Tri-County	Tri-County
2017 Population (CPRC)			1,811,860
Beds (2016/2017)*	36	18	54
Discharges*	640	402	1,042
Length of Stay*		9	10
Patient Days*	8,385	4,999	13,384
Average Daily Census	23	14	37
Occupancy*	**64%**	**76%**	**68%**

Source: Encompass Table 1, Attachment B, January 2019 Completeness Response

While each applicant has projected patient days that suggest they will achieve 75% capacity within three years of opening (but, inconsistent with rule, not within three years of CN approval), these estimates are unreliable. The unreliability is due to fundamental underlying assumptions errors—and especially those that employ an artificial standard requiring 7 IRF beds per 100,000 and

[1] See Fact Sheet: Inpatient Rehabilitation Facilities (IRFs) at https://www.aha.org/factsheet/2018-03-19-fact-sheet-inpatient-rehabilitation-facilities-irfs

reliance on Oregon, despite its decades of commitment to lower use of high cost facilities, to begin "looking like" the rest of the nation vis-à-vis acute rehabilitation utilization.

The Proposed Projects Will Not Result in an Improvement in Patients' Reasonable Access to Services

Both applicants have overstated current and future demand and they have failed to perform any analysis of idle licensed beds and shelled space at these three existing IRF providers. As previously outlined here, total need for IRF services is such that inpatient facilities *shall not exceed seven beds in* 100,000 general population. This standard is set as a maximum standard, or population based cap because merely demonstrating that the cap has not been exceeded in a service area is not sufficient to meet the applicable standard.

OAR 333-645-0030 also requires that an applicant demonstrate consistency with historical use patterns for rehabilitation services. It does allow adjustments if the applicant submits information that demonstrates, among other factors *the availability, accessibility, quality, and levels of utilization of existing inpatient services addressing the needs of those groups.* While each applicant made general statements comparing lower use rates in Oregon to other states, absolutely no data was given to suggest that availability, accessibility; quality and occupancy are barriers to care.

Notably, OAR includes a provision mandating expansion of existing rehabilitation units 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. 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 CON approval.

Our experience operating RIO and another small 12 bed IRF at Randall conclusively demonstrates that patients within the applicants' proposed service area currently have reasonable access to IRF services. In fact, our experience illustrates the existence of excess access to IRF beds; we consistently have capacity to serve over 10 additional patients at RIO, and several more at Randall. RIO is licensed to operate 36 of the 140 IRF beds in Oregon. RIO's Case Mix Index (Acuity) is 1.44, and compared to the Region (1.37) and Nation (1.38), RIO's is the highest in Acuity. A higher Case Mix Index suggests RIO handles a higher acuity patient mix than average. Despite RIO's high acuity, RIO's average length of stay is 13.6 days, for our Region it is 14.6 days and the National figure is 13.9. On average RIO's daily census is 25 patients a day – 11 below our licensed capacity.[2]

Over the past decade, RIO's average daily census has remained relatively unchanged, however the length of stay (LOS) a decade ago was on average 23 days compared to LOS stay of 13.6 today. This means the patient population is growing, however as technology and treatment has continued to improve and more patients are referred to Inpatient Rehab, they require less inpatient Rehab days and no additional inpatient beds are currently needed with our excess capacity able to meet projected demand into the foreseeable future.

[2] Randall operates at an average of roughly six daily patients per day.

OAR 333-645-0020 established, "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." RIO has the highest acuity of patients compared to the region and nation with the best discharge rate to the community (89.5%), compared to the Region (83.5%) and Nation (78.5%) as reported by the Uniform Data System for Inpatient Rehabilitation Facilities (UDSPRO). RIO's Overall Likelihood of recommending facility, patients prepared to function at home, prepared to function in the community and overall care ratings rank higher than Top Box score according to the Hospital Consumer Assessment of Healthcare Providers and Systems, patient satisfaction survey required by CMS, Centers for Medicare and Medicaid Services.

RIO serves Legacy's seven hospitals, Kaiser, OHSU (with a Level 1 trauma designation), and Tuality. In addition, RIO receives high acuity referrals from other rehab centers in Oregon and Vancouver, WA, along with out of state referrals. Both applicants included the Kaiser population as those lacking adequate access; however, Legacy has an exclusive contract with Kaiser. The applicants did not provide documentation to suggest that Kaiser will choose to send patients to their proposed facilities. This error is significant because Kaiser's market share ranges from 15 to 24 percent. Both also included the VA population in their calculations of need, even though the VA operates inpatient acute rehabilitation beds in Vancouver.

Given the abundance of Inpatient Rehab beds, if additional Inpatient Rehab beds were added to the community, this would jeopardize the long-term viability of RIO and create a negative impact on patients in the proposed service area. In addition, there is no other facility with the capability to rehabilitate the high acuity patients, keeping those patients in hospital beds for a longer period. RIO is the most comprehensiveness Inpatient Rehabilitation Center in Oregon and Southwest Washington.

Regulatory Defects of the Encompass Application

Consistent with OAR 333-590-0040, the CON Program has a long and consistent history of requiring applicants to demonstrate numeric need for acute care beds before specialty beds can be added. Encompass proposes a three (3) County service area, which includes three existing providers of IRF beds and services.

Encompass, after stating that the methodology is flawed, itself concurs that there is no need for acute care beds under the existing bed need methodology and related data showing overall use rates that are declining. In terms of the bed need methodology, it has been prescribed in rule for decades and no applicant, including Encompass, has petitioned OHA for any rule amendment to address alleged defects in the data when it is not helpful to applicants with demonstration of need.

Encompass included the Kaiser population, even though Legacy has an exclusive contract with Kaiser. Encompass provided no documentation to suggest that Kaiser will send patients to its facility. This error is significant as Kaiser's market share ranges from 15% to 24%. Additionally, Encompass included the VA population in its calculation of need, even though VA operates inpatient acute rehab beds in Vancouver.

Encompass asserts that the lack of IRF services places a financial strain and resource burden on patients and their families that requires the Oregon Department of Human Services ("DHS") to intervene with the provision of services funded through Medicaid, increasing obligations of our state's general fund. Approving the Encompass application is more likely to cause an increase in avoidable nursing home care costs. As previously noted, RIO currently has an average daily availability of 11 beds, resulting from excess supply in the service area. Roughly, half of our daily patients have their services paid by traditional Medicare. Our review of the Encompass application does not indicate that they will be willing to serve the Medicaid population, nor does Encompass name any commercial or Medicare insurance payors as supporters of this application. It is reasonable to conclude that Encompass will be limited to serving patients in the traditional Medicare program, also called fee-for-service ("FFS").

By choosing to limit their scope to FFS, permitting either application will cause segmenting of an already scarce patient population. This will impair RIO by pushing its case mix into imbalance, increasing its proportional share of Medicaid and Medicare Advantage. RIO is an essential community provider to patients of the Oregon Health Plan in this service area. The dual hardship of introducing one or two IRFs into our over-supplied service area, coupled with their focus on FFS patients places our entire program in potential financial jeopardy. Given the faulty underlying assumptions, the project's conformance to applicable financial feasibility criteria cannot be confirmed due to overstatement of potential patient days per OAR 333-580-0060.

Encompass has encountered some regulatory enforcement penalties casting doubt on its ability to reasonably assure that care will be that care will be provided in accord with applicable Federal and State laws as required by OAR 333-580-0040 and 333-580-0050. In June 2019, Encompass entered into a settlement agreement with the Department of Justice for a settlement payment of $48 million following a seven-year investigation.

Regulatory Defects of the PAM Application

Consistent with OAR 333-590-0040, the CON Program has a long and consistent history of requiring applicants to demonstrate numeric need for acute care beds before specialty beds can be added. PAM proposed a seven (7) County service area that already includes three providers of acute rehabilitation. In its application, PAM cited historical data for the existing inpatient rehabilitation facilities as the rationale for its selected geography. No data was provided to support this assumption. At the same time that it selected its seven County service area, it noted in its application that the Department limited Ascend in its specialty hospital CN decision to a single zip code service area.

PAM did not use the required population data (Center for Population Research and Census) as outlined in OAR 333-590-0050. PAM provided no data to suggest that residents of the seven Counties are not able to timely access the care they need.

The patient days and subsequent use rates provided by PAM included in Table 4 of the methodology (Section B, p. 18) are in error. The patient days in Table 4 are lower than the discharge data in Table 3. The use rates in Table 4 cannot be calculated with the population data

in Table 1 and the patient day data in Table 4 and are significantly overstated. In addition, if the correct use rates were applied, there is no need for additional acute care beds. Given the faulty underlying assumptions, the project's conformance to applicable financial feasibility criteria cannot be confirmed due to overstatement of potential patient days per OAR 333-580-0060.

On page, 54, the PAM application offers very little with respect to serving Oregon's Medicaid population or provision of charity care. PAM projects Medicaid service at 2% of its planned patient capacity, despite also suggesting that it plans to form a partnership with Care Oregon and its 175,000 Medicaid clients in the service area. PAM assumes no charity care. In fiscal year 2019, the combined percentage of patients covered by Medicaid and/or benefiting from charity care served by RIO totaled 47.85%. Like Encompass, PAM intends to focus its services on serving a high percentage of Medicare FFS patients.

PAM's assertion that it will be superior on rates, access and patient satisfaction is incorrect. RIO is superior on all metrics and currently has sufficient capacity to serve more patients and meet patient need. RIO has previously expanded to accommodate patient need in the service area. RIO has capacity and access to sufficient financial resources to implement additional expansions should it become apparent that patient need supports an increase in supply.

PAM's recent history creates some doubt of its ability to meet OAR standards related to its history of demonstrated noncompliance with all applicable federal and state rules given its August of 2018 execution of a corporate integrity agreement ("CIA") with the US Office of Inspector General ("OIG") for the US Department of Health and Human Services.[3] OIG imposed the terms of the CIA resulting from a settlement where PAM agreed to pay the federal government, Texas, and Louisiana a total of $13,168,000 to settle allegations that they violated the False Claims Act, and the Texas and Louisiana false claims statutes, by knowingly submitting claims to the Medicare and Medicaid programs that resulted from violations of the Anti-Kickback Statute and the Physician Self-Referral Law.

Oregon's Uniquely Efficient Health Care Delivery System

Both applicants rely heavily on the documented dual observations that Oregon ranks 50th out of 50 states in Medicare FFS referrals to IRF service and 50th in hospital beds per 1,000 people. The applicants employ this data in an effort to demonstrate a deficit of patient access to IRF services and to justify approval of their projects. These cherry-picked points of data fail to demonstrate that there is a lack of alternatives to the high cost new services proposed by the applicants. In fact, the opposite is true; any close observer of public policy governing health care services in Oregon over the past several generations knows that Oregon has conscientiously promoted inpatient alternatives and patients have used them to positive effect to their personal health while improving aggregate efficiency of our system.

Oregon embarked on health care transformation nearly 20 years prior to the Affordable Care Act ("ACA"). In the early 1990s, Oregon moved its 240,000 Medicaid recipients into the newly formed Oregon Health Plan. Under this plan, Oregon contracted with managed care organizations

[3] To review the CIA, see: https://oig.hhs.gov/fraud/cia/agreements/Post_Acute_Medical_LLC_et_al_08132018.pdf

to provide care for members. It was also able to expand enrollment and control costs using a prioritized list of covered services.

In 2012, Oregon's next substantial proposed Medicaid waiver was approved, with the state receiving nearly $2 billion in federal funding to be an early adopter of transformation, and in accepting the funds, it committed to improving health care access and quality – and reduce health care spending – by focusing on prevention and primary care. The state and its Medicaid administrator, OHA, committed to accomplishing the triple aim of better health, better quality and lower costs by forming coordinated care organizations ("CCOs"). They were a new type of health plan charged with coordinating the physical, behavioral and oral health needs of people on the Oregon Health Plan. The CCOs were contractually obligated to make improvements in care while operating within a fixed global budget, which could grow, by no more than 3.4 percent per year, which was was two percentage points below the projected growth rate in federal health care spending. It is important to note that while the initial efforts were related to the Medicaid program, the transformation has ultimately affected care delivery and utilization for all residents, regardless of payer.

According to Oregon's five-year report card, during the period of 2012-2017, the State's Medicaid reforms have saved taxpayers an estimated $2.2 billion. An independent analysis of Oregon's 2012-2017 Medicaid waiver shows that Oregon has spent less per Medicaid member than neighboring Washington has, and that it has reduced emergency room visits and "low value" care.

Both applicants suggest that Oregon's acute rehabilitation use rate somehow precludes accessibility and quality care, but as data shows, the Western US in general, and Oregon in particular enjoy lower use rates for many services:

1. A Kaiser Family Foundation (KFF) report entitled "State Health Facts" identifies community hospital beds in each of the 50 states ranks beds per 1,000 population. The US average is 2.5 beds per 1,000. The high is 4.8 beds per 1,000 and the low is 1.7 beds per 1,000. Two states—Washington and Oregon–are tied at 1.7 beds, or more than 30% below the average.[4]

2. The same KFF report includes community hospital emergency room visits per 1,000 population. The US average is 445 visits per 1,000. The high is 698 visits per 1,000. Here, and at 378 visits per 1,000, Oregon ranks 43rd.[5]

In addition, the same KFF report provides data on average total nursing hours in certified nursing facilities by State. The report shows that in 2017 the US average was 4.0 nursing hours per patient day (PPD). The high was 5.2 PPD. Oregon tied for second highest at 4.8, and the lowest was 3.6. This reinforces that Oregon's Skilled Nursing Facilities are equipped to manage higher acuity patients. This demonstrates that Oregon's system is efficient in delivering services to the right patients, at the right time, using the right level of services.

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[4] See https://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

[5] *Id.*

Finally, Oregon has high Medicare Advantage penetration. Medicare Advantage is a managed care product that often use a network of specific providers and requires enrollees to secure prior authorization services. Many plans may cover care outside of the network, but it requires the enrollee to pay more out of pocket. A KFF report on 2018 Medicare Advantage Enrollees as a Percent of Total Medicare Population shows that the US average is 34%. The highest State penetration is 56%. Oregon is third highest at 43%. The low is 1%.[6] The service area proposed by the applicants has Medicare Advantage enrollment rates of roughly 60%.

Conclusion

The CON applications of PAM and Encompass will not have an appropriate relationship with its service area, will result in an unnecessary duplication of services and will have a negative financial impact on other providers, failing the required standard under OAR 333-580-0050(3). If OHA approves either application, RIO and Randall will suffer significant negative financial impact with resulting harm to Oregon's patients receiving Medicaid or charity care.

The applicants failed to accurately address any negative impact the proposal will have on those presently offering or reimbursing for similar or alternative services. As noted previously, the applicants have not met their burden of establishing that the proposed IRFs will result in an improvement in patients' reasonable access to services. There are IRF beds available in the service area and concerted efforts underway to vigorously assess prospective patients to assure that they are appropriate for IRF services or receive lower cost and more effective alternatives to IRF services designed to prevent the need for hospitalization and to shorten lengths of stay.

Both proposed facilities would add unneeded beds resulting in an unnecessary duplication of services. We urge OHA to deny approval of the CON applications CN #679 and CN #680, each proposing a 50-bed IRF in Washington County.

Sincerely,

Anne Greer

Anne T. Greer
Interim Vice President, Legal Services

[6] See https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/?currentTimeframe=0&sortModel=%7B"colId":"Overall","sort":"desc"%7D

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November 4, 2019

By Delivery

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Re: Written Comments of Encompass Regarding the Encompass Public Meeting on October 15, 2019

Dear Mr. Gilman:

This letter sets forth the written comments of Encompass Health ("Encompass") with respect to the testimony at the October 15, 2019 public meeting regarding the Encompass certificate of need ("CON") Application No. 679.

Enclosed with this letter are a number of documents, some of which are currently in the record of the Encompass CON application. The enclosed documents are referenced throughout this letter, and are listed at the end of this letter as enclosures. Among the documents is a written transcript of the October 15, 2019 public meeting prepared by Naegeli court reporters, so that you can access the references to the transcript in this letter.

A. URGENT NEED FOR THE ENCOMPASS PROJECT

1. The Encompass CON application dated November 2, 2018, and the January 7, 2019 and July 16, 2019 responses by Encompass to OHA's screening questions demonstrate and document that there is clearly an urgent need for at least 91 specialty acute inpatient rehabilitation hospital beds in the Encompass service area.

2. The Encompass service area includes not only the 10/20 service area as defined in OAR 333-590-0050(1), which comprises zip codes 97006, 97123, and 97124,[1] but also includes Washington, Multnomah and Clackamas Counties and in addition, includes inflow from other counties in Oregon into Washington, Multnomah and Clackamas Counties because the Encompass CON application is for a specialty acute inpatient rehabilitation hospital which will serve population groups with special needs, i.e. medically complex acute care patients such as

[1] Contiguous zip codes are to be added to these zip codes under OAR 333-590-0040.

stroke, brain injury, spinal cord injury, and amputation patients.[2] OAR 333-590-0050(1) (last sentence), OAR 333-590-0040 (last sentence), and OAR 333-645-0030(1)(a) and (b), collectively provide that the 10/20 service area is expanded, as described above, where specialty acute inpatient rehabilitation services are proposed.

3. Encompass has documented that it will provide specialty acute inpatient rehabilitation hospital services. Bill Heath, an Encompass Vice President, testified that the Encompass specialty acute inpatient rehabilitation hospital in Hillsboro will have a specialty stroke rehabilitation certification from The Joint Commission. See Transcript at page 9, lines 16 to 18.[3] The Encompass response to OHA dated July 16, 2019 at pages 5 and 6 documents that Encompass will initially offer a Joint Commission certified stroke rehabilitation specialty program and intends to offer two to three additional specialty programs certified by The Joint Commission over a two to three year period after CMS certification. These additional specialty programs will include brain injury, spinal cord, amputee, and oncology rehabilitation, among others.

3.1 Pam Kilmurray (RIO) testified on page 52 that Legacy Good Samaritan Hospital is "stroke accredited" by The Joint Commission. However RIO, which is the 36 bed IRF within Legacy Good Samaritan, does not have a separate disease specific stroke rehabilitation certification by The Joint Commission.

4. The need for at least 91 specialty acute inpatient rehabilitation hospital beds is documented in the Encompass CON application in full compliance with, and consistent with, OHA's general bed need methodology in OAR Chapter 333 Division 590, and the specialty inpatient rehabilitation hospital rules in Division 645. See, Attachment 2 and Attachment 3 to the January 7, 2019 Encompass response to OHA's first set of screening questions. Attachment 2 shows in Table 11 on page 20 shows a general acute care bed need of 265 beds in 2028. Attachment 2 further documents in Steps (12) through (14) that Encompass has also met the exception in OAR 333-590-0050(12) through (14) because the conversion of general hospital beds to specialty acute inpatient rehabilitation hospital beds is not architecturally and economically feasible for any of the three Washington County hospitals and the hospitals in the tri-county metropolitan Portland area, and any hospitals within 50 miles by road from the proposed Encompass specialty acute inpatient rehabilitation hospital.

5. Enclosed are the letters sent from Encompass to area hospitals which document the meetings and other contacts which Encompass representatives had with those hospitals. Encompass' July 16, 2019 response to OHA's second set of screening questions at pages 7 and 9 documents the contacts which Encompass has had with the area hospitals. These contacts are

[2] See the testimony of Joseph Stillo, M.D. on pages 13 and 15 of the transcript of the October 15, 2019 public meeting ("Transcript").

[3] Mr. Heath also testified that 117 of the 133 Encompass acute inpatient rehabilitation hospitals in the U.S. have a specialty stroke certification from The Joint Commission. Transcript at page 9, line 14. The Encompass hospitals in the U.S. hold 289 disease specific specialty certifications. Id. at line 20. Joseph Stillo, M.D., a physiatrist employed by Encompass, also testified to these facts on page 15 of the Transcript.

also documented in the Encompass CON application on pages 26 to 29, 31, 32, 34, 51, 61, 62, 75, 79-82, and 104-105.

6. Joe Greenman incorrectly testified on page 48, lines 2 to 12, that the 7 inpatient rehabilitation beds per 100,000 general population in OAR 333-645-0030(1) is a "maximum". The rule is clear that upward adjustments to the 7 inpatient rehabilitation beds per 100,000 general population "can be made where a specialty rehabilitation services is proposed", and that "An example of a specialty rehabilitation unit would be a unit specializing in strokes."

6.1 Attachment 3 to Encompass' January 7, 2019 response to OHA fully documents the need for a minimum of 91 specialty acute inpatient rehabilitation hospital beds in the Encompass service area (defined on page 2 of Attachment 3 as Washington, Multnomah, and Clackamas Counties, plus inflow from other counties in Oregon). Page 32 of Attachment 3 documents that there is a need for at least 107 specialty acute inpatient rehabilitation hospital beds in the 3 county area. This number of needed beds is in fact higher because the Encompass hospital will be providing specialty acute inpatient rehabilitation services, and because there will be inflow into the Encompass hospital from counties throughout Oregon.

7. The PAM, LLC CON application is for a 50 bed acute inpatient rehabilitation hospital to be located in the Tigard Triangle area near the intersection of I-5 and Highway 217. The PAM project and the Encompass project are located in different service areas as defined in OHA's rules. Encompass has calculated a need for at least 91 to 107 specialty acute inpatient rehabilitation hospital beds in the Encompass service area. Encompass agrees that there is a need for at least 121 acute inpatient rehabilitation beds in the PAM, LLC service area. The PAM, LLC 10/20 service area is zip code 97223, plus the 7 Oregon counties identified by PAM, plus adjustments for inflow and any specialty services. There is an overwhelming and urgent need for both projects in the region, and there will still be a need for additional acute inpatient rehabilitation hospital capacity after both projects are implemented. Mr. Stoloff testified to this effect at the October 14, 2019 PAM, LLC public meeting and in a letter to OHA dated October 14, 2019.

B. SNF BEDS ARE NOT CONSIDERED OR COUNTED IN DETERMINING THE NEED FOR ACUTE INPATIENT REHABILITATION HOSPITAL BEDS

8. Shannon O'Fallon at page 30 of the Transcript asked Peter Stoloff whether or not SNF beds are counted in determining the need for acute inpatient rehabilitation beds. The answer is "no". Under Oregon law, SNF beds are not counted in determining the need for acute inpatient rehabilitation beds for the following nonexclusive reasons, which establish the "line of demarcation" between hospitals and SNFs, and the services which can be lawfully provided by hospitals and SNFs:

8.1 First, SNFs are in a different licensure classification or category than acute inpatient rehabilitation hospitals. SNFs are licensed by the Oregon Department of Human Services in OAR 411-085-0110. Hospitals are licensed by the Public Health Division of OHA under OAR 333-500-0020.

8.2 SNFs, unlike hospitals, are not licensed to provide acute care. Specifically, OHA's CON rules in OAR 333-590-0010(1) provide that:

> "'Acute inpatient care' means care provided in hospital beds involving at least one overnight use of a bed. Acute inpatient care does not include skilled nursing facility, intermediate care facility, long-term care or supportive routine care for chronic disease or disability, convalescent care, or rest cures." (Emphasis supplied).

8.3 OHA's CON rules in OAR 333-610-0010(19) define "SNF" as follows:

> "(19) "Skilled Nursing Facility (SNF)" means a licensed long-term care facility providing care for persons with severe and/or unstable health problems which cannot be managed at the intermediate care level, requiring the availability of a registered nurse 24 hours daily, seven days a week, but not requiring the levels of nursing, physician and specialized services available in a hospital." (Emphasis supplied).

8.4 OHA's CON rules in OAR 333-645-0000(3) which govern the need for acute inpatient rehabilitation hospitals, provide that:

> "Division 645 is not intended to apply to rehabilitation beds in long-term care facilities."

8.5 The Medicare regulations in 42 CFR Section 424.20(a)(1)(i) provide that among the conditions for Medicare payment for SNF care are that:

> "The individual needs on a daily basis skilled nursing care or other skilled rehabilitation services that, as a practical matter, can only be provided in a SNF."

8.6 SNFs do not have patients. Instead, occupants of SNFs are "residents", as provided in OAR 411-085-0000 and 42 CFR 483.15. Occupants of hospitals are "patients". See, OAR 333-500-0010(35), OAR 333-071-0410, and 42 CFR Section 412.29.

8.7 According to CMS, "IRFs are a specialized type of hospital", and that IRFs are "acute care hospitals". See August 7, 2009 Federal Register at page 39793 (columns 2 and 3). Every IRF patient requires complex hospital-level care and intensive inpatient rehabilitation. Id. at column 3. IRFs are required to provide "acute" inpatient rehabilitation in one of the 13 categories or conditions listed in 42 CFR Section 412.29(b)(2). Patients who have only chronic conditions are not eligible for admission to an IRF. Id.

8.8 The line of demarcation between the services which SNFs are licensed to provide to residents of SNFs, and the services which IRFs are licensed to provide to patients, is clear. SNFs are not licensed to provide acute care services to their residents, whereas IRFs are licensed to provide acute inpatient rehabilitation hospital services to their patients.

8.9 However, Gwen Dayton testified on page 43 lines 2 and 3 that "all rehab patients, most of them, are being cared for in nursing facilities. That's just the reality of it." On page 44, Ms. Dayton testified on lines 2 to 6 that: "we assuredly have higher acuity, much higher acuity, in our nursing facilities than the rest of the nation."

On page 45 Ms. Dayton testified on lines 15 and 16 that: "Nursing facilities are the most cost effective alternative" to the services being offered by Encompass.

8.9.1 This testimony strongly implies that the SNFs which OHCA is representing are providing acute care services, including acute care rehabilitation services, which those SNFs are not licensed to provide. Ms. Dayton further stated in her October 15, 2019 letter to OHA that: "existing nursing facilities currently care for the very therapy patients that might go to the applicant's facility if approved." This statement is incorrect, because the type of patients who can be admitted to the Encompass facility are mutually exclusive from the type of residents that SNFs are licensed to provide skilled nursing care to. Simply put, SNFs are not licensed to provide the specialized acute inpatient rehabilitation hospital services provided by Encompass.

8.9.2 Ms. Dayton cited in her October 14, 2019 letter with respect to the PAM, LLC public meeting a study by Oregon State University. That study states on pages 7, 38, 39, and 40 that 60% of SNF stays in Oregon involved residents with at least one acute medical condition. This study also strongly implies that SNFs in Oregon are providing services to their residents which the SNFs are not licensed to provide.

8.10 In addition, the SNFs which appeared at the October 14, 2019 and October 15, 2019 public meetings "lack standing in this matter for any purpose." See, October 11, 2019 order by Dana Selover, M.D., Section Manager of OHA's Division of Health Care Regulation and Quality Improvement.

8.11 Furthermore, the SNFs which appeared at the October 14, 2019 and October 15, 2019 public meetings strongly implied that they are providing acute rehabilitation services, which would mean that they are providing services outside the scope of their SNF license. It also would mean that they are providing acute rehabilitation services in violation of Oregon's certificate of need laws. Specifically, ORS 442.315(1) requires any SNF which provides new SNF services to obtain a CON prior to offering any such services. OAR 333-550-0010(3)(b) provides that:

> "A change in the services of an existing long-term facility is not considered to constitute the establishment of a new facility or service, unless the new services are not within the scope of services allowable under a long-term care facility license and

require licensure under a hospital licensure category." (Emphasis supplied).

Assuming, arguendo, that the SNFs which appeared at the October 14, 2019 and October 15, 2019 public meetings are providing acute care rehabilitation services to their residents, such services are not within the scope of services allowable under a SNF license, and require licensure under a hospital licensure category, and require a certificate of need.[4]

8.12 In conclusion, there is a clear statutory and regulatory line of demarcation between the chronic care services that can be lawfully provide by SNFs, to be distinguished from the complex acute care rehabilitation services that can be provided by acute inpatient rehabilitation hospital. OHA's rules are clear that SNF beds are not considered or counted in determining the need for acute inpatient rehabilitation beds.

C. EXCLUSIONARY CRITERIA

9. In the October 14, 2019 PAM, LLC public meeting, Kathryn Kolonic, D.O., who is the CMO of Marquis Companies, testified that the 10 SNFs operated by Marquis provide 2 or more hours per day of "ultra high rehabilitation". Dr. Kolonic further testified in response to a question from Dana Selover, M.D., that the Marquis SNFs "do not have any standard exclusionary criteria." Dr. Kolonic's response further demonstrates that SNFs in Oregon are accepting residents who need acute inpatient rehabilitation services, and that those SNFs are actually providing acute rehabilitation services to those residents, which services are not within the scope of the services which can lawfully be offered by SNFs in Oregon, and which services are being provided without a certificate of need, despite the fact that certificate of need is required to provide such services.

10. On the other hand, the Encompass acute inpatient rehabilitation hospitals, including the proposed Encompass rehabilitation hospital in Hillsboro, have very strict exclusionary criteria. Every patient, in order to be admitted to an IRF, must require both hospital-level acute care and intensive rehabilitation. See, August 7, 2009 Federal Register at page 39793 (col. 3). See also 42 CFR Section 412.622 and 42 CFR Section 412.29, which were discussed at length in Encompass' responses to OHA dated July 16, 2019 at pages 4 and 6, and in Peter Stoloff's letter to Matt Gilman dated February 20, 2019. This distinction between services which may be lawfully provided by SNFs and the services which are provided by acute inpatient rehabilitation hospitals is fundamental, and demonstrates that the Encompass acute inpatient rehabilitation hospital will have very strict exclusionary criteria compared to the SNFs which have "no standard exclusionary criteria".

[4] To be clear, Encompass does not agree that the rehabilitation services provided in a SNF are in any way comparable to the intensive acute care inpatient rehabilitation services provided in the Encompass hospitals. We note, however, that the SNFs strongly implied that they are providing comparable services, and to the extent SNFs are providing acute rehabilitation services, such services are outside the scope of a SNF license. Simply put, SNFs are not a substitute for the acute inpatient rehabilitation hospital services provided by Encompass.

11. Joseph Stillo, M.D. testified at page 12 that "there is a substantial difference between an inpatient rehabilitation facility or IRF, as we call it, versus the skilled nursing facility". Dr. Stillo further testified on page 13 that the Encompass facility will be designated as an acute care hospital which will provide "intensity of services" to medically complex patients, such as stroke, spinal cord injury, amputation and brain injury patients. These patients have comorbidities, such as diabetes, hypertension, COPD, congestive heart failure, and kidney diseases which "require the level of medical oversight that we have in our hospitals." Dr. Stillo elaborated on page 14, where he testified that IRFs are "very, very much different" from SNFs, because of the intensity of services provided in IRFs, and the medical complexity of the patients. Edward Stall's slide #8 documents the different level of services provided by an acute inpatient rehabilitation hospital compared to a SNF.

12. Dr. Stillo further testified on page 18, with respect to slide #12, that IRFs discharge patients back home twice as successfully as SNFs discharge their residents to home. Moreover, Dr. Stillo testified on page 18 that residents of SNFs are re-hospitalized at a rate which is over four times higher than rehospitalization of IRF patients. See slide 12.

13. In response to Shannon O'Fallon's question on page 31 of the Transcript as to whether Oregon is different on how care is delivered, Edward Stall testified, correctly, at pages 32 and 33 that the 13 specific acute medical conditions which must comprise at least 60% of the inpatient population of IRFs (see 42 CFR Section 412.29(b)(1) and (2)), are "a very complex patient and that is our specific and specialized population." Mr. Stall further testified on page 32 that "And we are not trying to take care of anybody that just needs a little extra time to recover. We are talking about people that need therapy that cannot function by themselves elsewhere."

13.1 Mr. Stall further testified at page 20 that Oregon has the lowest number of IRF beds per 1000 for the 65+ population of any state in the U.S. See slide 21. He further testified on page 21 that in Washington County, there are no IRF beds. Washington County is the second largest county in the U.S. with no IRF beds. See slide 25. Clackamas County is the ninth largest county in the U.S. with no IRF beds. Id.

13.2 Mr. Stall further testified on page 24 that Oregon, California, and Pennsylvania have almost identical Medicare Advantage penetration rates (40%, 41.8%, and 40% respectively), but California has twice the number of IRF beds per 1000 population than Oregon, and Pennsylvania has over four times the number of IRF beds per 1000 population than Oregon. See slide 20.

13.3 As Tom Hughes testified on page 66, "Things are different in Oregon because we don't have this facility here". Mr. Hughes is the former mayor of Hillsboro and the former President of the metro regional government.

13.4 Joseph Stillo, M.D. testified on page 12, lines 12 to 14, that "patients' rehabilitation needs don't vary from state to state. What does vary is the availability and accessibility of acute inpatient rehabilitation."

13.5 In conclusion any difference between Oregon and other states with respect to the lack of sufficient specialized acute inpatient rehabilitation hospital beds in Oregon, and in particular, Washington County, should be and can be remedied by OHA by approving the Encompass CON application for 50 such beds.

D. OCCUPANCY OF RIO AND PROVIDENCE IRFs

14. Shannon O'Fallon asked on page 32 of the Transcript for an explanation of why Legacy RIO had such a low occupancy of 60%. What prompted Shannon O'Fallon's question is that at the PAM, LLC public meeting on October 14, 2019, Joe Greenman testified that the Legacy RIO IRF operates at 60% occupancy. Mr. Greenman's testimony is incorrect. The Legacy RIO IRF operated at 69.44% occupancy for the fiscal year ended March 31, 2019, based on the Medicare cost report submitted by Legacy RIO to CMS. A copy of the pertinent pages of the Legacy RIO Medicare cost report is enclosed.

14.1 Providence's IRF operates at 79.3% occupancy for the year ended December 31, 2018, based on the Providence Medicare cost report. A copy of the pertinent pages of the Providence IRF cost report is enclosed.

14.2 After Shannon O'Fallon asked her question at the October 15 public meeting (Transcript at page 32), Mr. Greenman repeated the incorrect testimony he had given at the October 14 public meeting, by stating at page 48, lines 15 to 16, in the Transcript of the October 15 public meeting that:

> "You know, when you look at the actual service area, we currently have two IRFs providing services, one with 36 beds, the other with 18. Both have an average occupancy of roughly 60 percent."

14.3 Legacy RIO's reported occupancy rate would be significantly higher than 69.44% if it had all private rooms. Legacy RIO has only four private rooms and 16 semi-private rooms. It is well documented in the hospital industry that it is extremely difficult to have occupancy significantly above 70% with semi-private rooms because of gender, noisy or combative patients, and infectious patients. In addition, Ms. Kilmurray testified on page 54, lines 22 to 25 that Legacy RIO has ventilator and burn patients, who will need their own rooms, even if it means taking up a semi-private room. Providence's IRF has all private rooms, which explains its higher occupancy rate of 79.3%.

14.4 Legacy RIO actually has a need for 43 beds, and the Providence IRF actually has a need for 28 beds in order to meet the minimum bed need at each respective IRF based on their respective average daily census, using Oregon's bed need methodology which applies an estimate of the standard deviation of the average daily census, in OAR 333-590-0050(8). Enclosed are two tables which document this need.

14.5 In conclusion, Legacy RIO's occupancy is 69.44%, not 60%. Legacy RIO would have an 80% or higher occupancy if it had all private rooms, and if it engaged in outreach.

Legacy RIO engages in virtually no outreach. See the Encompass CON application at pages 28, 31, 51, 61, 75, and 79 regarding the lack of outreach by Legacy RIO, and that it has no plans to expand the size of its IRF unit to meet the urgent need for additional IRF beds.

E. OHCA TESTMONY

15. Encompass Location. Gwen Dayton asked at page 41, lines 13 to 14: "What actual location is Encompass putting before you for consideration?"

15.1 The Encompass site is at the Hawthorn Farm site located at Northeast Belknap Court, Hillsboro, OR 97124. Encompass has a binding Purchase and Sale Agreement to purchase the Hawthorn Farm site. On October 4, 2019, Encompass amended its CON application to add an alternate site located at 9830 Northeast Eckert Drive, Hillsboro, OR 97006. The two sites are 3 miles apart and serve the same service area. Zip codes 97124 and 97006 are adjacent to each other. Encompass filed the amendment in the spirit of full transparency to bring to OHA's attention that Encompass is simultaneously pursuing the Amberglen site as an alternative location for the project in the event the development process at the Hawthorn Farm site does not allow the implementation of the project in a timely manner. Encompass similarly has a binding Purchase and Sale Agreement for the Amberglen site. The filing of the amendment was precautionary, i.e., it was made for the purpose of informing OHA of an alternate site in the same service area in the event of any substantial delays. Encompass reasonably believes that the Hawthorn Farm site will be approved by the Port of Portland and the FAA, because the proposed Encompass hospital is one story, and because it is at the far periphery of a flight vector for takeoff and landing at the Hillsboro airport. The buildings and other structures surrounding the Hawthorn Farm site are in fact substantially higher in elevation that the proposed one story Encompass hospital.

16. Encompass Amendment. Ms. Dayton asked on page 41, line 22 to 25, when the Encompass CON application was deemed complete by OHA. The answer is that the Encompass CON application was declared complete on August 21, 2019, because Encompass filed the amendment within 45 days of the August 21, 2019 declaration by OHA that the Encompass application is complete. OAR 333-570-0050(2) and OAR 333-580-0000(11) both provide that an applicant has the absolute right to amend its CON application within 45 days following submission of a complete application.

16.1 In addition, PAM, LLC testified that it supports Encompass' assessment that there is a need for the Encompass facility at either the Hawthorn Farm site or the Amberglen site. See page 56, lines 2 to 7 of the Transcript, and the October 15, 2019 letter to OHA from Arden J. Olson.

17. Gwen Dayton testified on page 42, lines 18 to 24, that the "core question" is the extent to which SNF beds can be considered in assessing the need for acute inpatient rehabilitation hospital beds. The clear answer to that question, as set forth in detail in Section B, paragraphs 8 through 8.11 above, is that under Oregon law, SNF beds are not considered or counted in determining the need for acute inpatient hospital rehabilitation beds.

18. Gwen Dayton testified on page 43 that "Oregon is different", and on page 44 she admitted that Oregon "has much higher acuity in our nursing facilities than the rest of the nation." This admission is surprising, because it corroborates the inescapable fact that the SNFs which appeared at the public meetings are providing acute care rehabilitation services to their residents, which is beyond the scope of the subacute services permitted under a SNF license. Moreover, those SNFs are providing such acute care rehabilitation services without having obtained a certified of need. These facts are all documented in paragraphs 8 through 13.4 above.

19. Gwen Dayton testified on page 44, lines 10 to 18, that most of the SNF stays are short stay. She stated on line 13 that 70% of patients had a 10 day stay. This testimony is incorrect. The Oregon State University report cited by Gwen Dayton in her October 14, 2019 letter to OHA, provides on page 7 that 72% of Oregon SNF stays lasted 30 days or less. Moreover, the OSU report further provides on page 34 that SNF length of stay in Oregon for stroke patients is 47 days, and is 42 days for stays linked to hospital discharges. By contrast, the Encompass length of stay for all patients is 12.7 days. See, the Encompass response dated January 7, 2019 at page 8 in response to Q10.

20. On page 45, lines 15 to 16, Gwen Dayton testified that "Nursing facilities are a cost effective alternative". This is incorrect. The residents of SNFs, and the patients who qualify for an IRF stay, are mutually exclusive. SNFs cannot lawfully provide services to individuals who need the acute inpatient rehabilitation hospital services provided by an IRF. Moreover, the Encompass slides 12, 13, and 27 demonstrate that patients in IRFs have better outcomes and lower mortality rates than SNF residents. Slide 27 documents that complex stroke patients in IRFs incur lower costs when compared to the cost which would be incurred if the individual was a resident of a SNF because of the far higher hospital readmission rate for SNF residents. See slide 12.

21. Encompass Settlement. Gwen Dayton testified on page 46, lines 5 to 9 that Encompass paid a settlement to settlement to settle a False Claims Act case, and that: "The claims were inappropriate." Enclosed is the affidavit of Carey B. McRae, which documents that the DOJ investigation produced no evidence of falsity or fraud, and that CMS and the DOJ never challenged Encompass' coding or billing, and never denied any claims based on the investigation. Encompass was not asked to enter into a Corporate Integrity Agreement, and did not enter into a Corporate Integrity Agreement. The settlement confirmed all past and current coding and billing practices of Encompass, and did not require Encompass to change any of its practices. Encompass settled the matter because of the cost of litigation of the underlying six qui tam suits.

22. Gwen Dayton testified on page 46, lines 11 and 12, that Encompass "is only going to take three percent Medicaid". This testimony is incorrect. Encompass has projected a payer mix consisting of 11% Medicaid in year 1 and 10% Medicaid in years 2 through 5. See, the Encompass response to OHA dated January 7, 2019 at page 14 in response to Q #16.

F. JOE GREENMAN (LEGACY HEALTH) TESTIMONY

23. Joe Greenman testified on page 47, lines 19 to 22, that the Encompass CON application and project may not satisfy the CON criteria in OAR 333-580-0050(3), which provides that the applicant must provide a narrative discussion as to whether the project will have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers.

23.1 Encompass provided a full narrative discussion regarding this criterion on pages 102 to 105 of its November 2, 2018 CON application, which narrative discussion will not be repeated here. Moreover, the Encompass CON application on pages 77 through 105 thoroughly addressed all of the OAR 333-580-0050 criteria. It is clear that there is an urgent need for at least 91 additional specialty acute inpatient rehabilitation hospital beds in the Encompass service area, and that the additional beds will not result in a duplication, much less an unnecessary duplication, of the 54 existing IRF beds in Multnomah County, because of the severe deficit of IRF beds in the Encompass service area.

24. Joe Greenman testified on page 48 line 6 that the 7 beds per 100,000 population standard is a "maximum" or "the top threshold". This testimony is incorrect, as explained in paragraph 6 above.

25. Joe Greenman testified on page 48 line 16 that both the Legacy RIO IRF and the Providence IRF "have an average occupancy of roughly 60%." This testimony is incorrect, as documented in paragraphs 14 through 14.5 above. In fact, RIO's occupancy increased from 66% to 69.4% from 2018 to 2019, and the occupancy of the Providence IRF increased from 76% to 79.3% from 2017 to 2018.

25.1 Joe Greenman admitted on page 49, lines 8 to 9, that overall admissions and discharges to IRFs "might overall start to see an increase". Joe Greenman further admitted on page 50, lines 5 to 7, that Legacy Health is "sympathetic to the fact that it would be good to have medical services in close proximity to people's homes." Bob Terry, the former Washington County Commissioner for 26 years, testified on page 73, lines 22 to 25, and page 74 lines 1 through 21 that it is imperative that Washington County residents have an acute inpatient rehabilitation hospital located in Hillsboro, and that it is not practical for Washington County residents to travel to Portland or Multnomah County for such services. Tom Hughes, the former Mayor of Hillsboro and former President of Metro Regional Government, testified at page 65, lines 6 to 19, of the need for an acute inpatient rehabilitation hospital "close to home", i.e., in Washington County.

26. Joe Greenman testified on page 50, lines 13 to 24 that if Legacy RIO applied for a CON to expand its 36 IRF beds, there would not be sufficient grounds to grant the expansion. This is incorrect. Legacy RIO, as an incumbent hospital can expand its IRF unit without a certificate of need. OAR 333-550-0010(2) (a new hospital does not include an expansion of an existing hospital at its current site). The actual facts are that RIO does not have the space at its current site to expand the number of IRF beds, and that Legacy RIO told Encompass that it had

no interest in expanding its IRF beds. See, the Encompass CON application at pages 26, 27, 31, and 79.

G. PAMELA KILMURRAY TESTIMONY

27. Ms. Kilmurray testified on page 52 lines 17 to 21, that RIO "handles a more severe patient population than on average." She testified that RIO's case mix acuity is 1.44, that the Encompass case mix is 1.24, and the national case mix is 1.38. Ms. Kilmurray's testimony is rebutted by the fact that the Encompass case mix acuity is 1.28 (see slide #5) and that the U.S. IRF case mix acuity is 1.25. RIO's case mix may be elevated because Ms. Kilmurray testified at page 54, line 23, that burn and ventilator patients are treated in the RIO IRF. The salient point is that Encompass has a higher case mix than freestanding IRFs, hospital-based IRFs, and the national average, as demonstrated in slide #5.

28. Ms. Kilmurray testified incorrectly on page 52, lines 22 to 25, that RIO's ALOS is 13.6, and that it is the lowest ALOS in the region and the nation. In fact, the Providence IRF has an ALOS of 13.05, and the Encompass ALOS is 12.7 days. See paragraph 19 above.

29. Ms. Kilmurray testified on page 53 lines 15 to 16 that Encompass' operating margin is negative until year four. In fact, when the operating margins of the operating company (EHRHO) and the property company are combined, the Encompass operating margin is positive in year 2.

30. Ms. Kilmurray testified on page 53, lines 19 to 25, that Encompass would provide 75% less Medicaid and charity care than RIO. This is incorrect. 13% of RIO's patient days for the year ended March 31, 2019 were Medicaid. Encompass has projected that its payer mix will be 11% Medicaid. See paragraph 22 above.

H. PATIENT-DRIVEN PAYMENT MODEL (PDPM)

31. CMS implemented the PDPM for SNFs effective October 1, 2019. In the CMS final rules implementing the PDPM, which were published in the August 8, 2018 Federal Register, CMS observed that the PDPM is expected to decrease payments to SNFs for ultra-high rehabilitation by 9.8%, whereas payments to SNFs for chronic care will increase. See the August 8, 2018 Federal Register at page 39259 (col. 3). CMS further stated that observed trends under the former Resource Utilization Groups (RUG) payment system in effect until September 30, 2019 "strongly suggest that SNF providers may be basing rehabilitation service provision on financial reasons rather than resident need." Id. At page 39185 (col. 1).

31.1 Modern Healthcare reported on October 2, 2019 that: "Thousands of physical, occupational and speech therapists have been laid off as skilled nursing facilities transition to the new PDPM payment model that kicked in Tuesday October 1, 2019." The article further stated that: "The former reimbursement model encouraged potentially unnecessary therapy services, the CMS said, adding that CMS aims to eliminate that motivation while reducing SNF providers' administrative burdens."

31.2 Skilled Nursing News reported on October 3, 2019 that the rehabilitation division of Marquis Companies, which is one of the SNFs which testified at the PAM, LLC public meeting, "cut about 10% of its jobs in response to the PDPM shift."

31.3 In conclusion, CMS and policy experts agree that the CMS PDPM payment system effective October 1, 2019 will reduce the use of SNF beds for high intensity rehabilitation. However, these same PDPM rules will encourage SNF use for residents who have chronic medical conditions that require long term nursing support.

I. ADDITIONAL MATTERS

32. Letters of Support. Encompass requests that OHA, in evaluating the Encompass CON application, and in weighing the testimony, take into account the 28 letters of support for the Encompass project, which are contained in the enclosed bound volume. These letters of support independently demonstrate that there is an urgent need for the Encompass specialty acute inpatient rehabilitation hospital.

32.1 Physiatrist (PM&R) Testimony. In particular, among the letters of support are three letters written by physicians specializing in physical medicine and rehabilitation: Martin Bomalaski, M.D., Eric Ensrud, M.D., and Keith Pagel, M.D. Richard Stenson's letter dated October 15, 2019 summarizes on page 5 these three letters. Each of these three PM&R specialists testified in their letters that there is a lack of high intensity acute inpatient rehabilitation hospital beds in the tri-county area. These three physicians are independent observers, and have no economic or other interests involved with respect to Encompass or this CON proceeding. Their testimony should outweigh the testimony from OHCA and Legacy Health, which testimony was misleading and factually incorrect in many respects, as demonstrated in this letter.

32.2 Bob Terry's Testimony. Bob Terry, a former Washington County Commissioner for 24 years, testified on page 74, lines 14 to 17, that in six to eight years, Washington County will be the largest county in population in Oregon. Mr. Terry testified on page 74, lines 12 to 14, that it is "imperative" that Washington County provide for its residents the specialty acute inpatient rehabilitation hospital services proposed by Encompass. Mr. Terry's letter, which is enclosed with this letter, states that it is not practical for Washington County residents to travel to Portland for IRF services, and that such services need to be accessible in Washington County for Washington County residents. Mr. Terry's testimony with respect to Washington County is fully supported by research studies submitted with the CON application, Attachments 8-A, 8-B, 8-C and 8-D, which show that distance to an IRF, and outreach support to discharge planners, are critical to assure optimal services to patients who on average are in their 70s.

33. Competition. OHCA and Legacy Health had representatives who testified against the Encompass CON application. However, Encompass wishes to bring to OHA's attention that the certificate of need laws do not create an entitlement to Legacy RIO or any other hospital to a

"government sanctioned monopoly" or a "de facto monopoly" over acute inpatient rehabilitation hospital services. Moreover, the certificate of need laws do not create an entitlement to the SNFs to a government sanctioned monopoly over the provision of SNF services which are lawfully within the scope of a SNF license, which SNF licensure specifically excludes acute inpatient rehabilitation hospital services. See, Mercy Medical Center v. Office of Health Policy, 121 Or. App. 587, 592-593 (1993) (the CON laws do not create a "government sanctioned monopoly" or "de facto monopoly").

33.1 Furthermore, Encompass wishes to bring to OHA's attention ORS 442.025(6) which was cited with approval in Mercy Medical Center, supra. In ORS 442.025(6), the Oregon legislature declared that: "hospital costs should be contained through improved competition between hospitals."

CONCLUSION

In conclusion, the Encompass public meeting has demonstrated that there is an urgent need for the specialty acute inpatient rehabilitation hospital being proposed by Encompass in its CON application. Encompass presented verbal testimony in support of its project by at least 12 individuals, and written testimony by at least 28 individuals. Encompass respectfully requests that OHA take this testimony into account, and approve the Encompass CON application based on the evidence in the record, which overwhelmingly demonstrates the need for the Encompass project. The evidence in the record includes not only the aforementioned verbal and written testimony, but also includes without limitation the Encompass CON application, the January 7, 2019 and July 16, 2019 responses of Encompass to the OHA screening questions, and this letter.

Sincerely,

Peter F. Stoloff

PETER F. STOLOFF

PFS:cs
Enclosures:

1. Transcript of 10/15/19 Encompass public meeting
2. Letters of Support in bound volume entitled "Written Testimony and Letters Supporting CON for EHRHO", presented by Dick Stenson on October 15, 2019.
3. September 15, 2019 Letter of Support from Robert Terry, former Washington County Commissioner
4. September 5, 2019 Letter of Support from Mjere Simantel, Program Supervisor, Washington County Disability, Aging and Veteran Services
5. Letters to Hospitals Within 50 miles by Road
6. Affidavit of Carey B. McRae dated October 31, 2019
7. Medicare Cost Report for Legacy Good Samaritan RIO IRF for 2019 and 2018
8. Medicare Cost Report for Providence Portland IRF for 2017 and 2018

9. Regional 2019 OAR 333-590-0050(8) Bed Capacity for Legacy RIO and Providence Portland IRF at Current Average Daily Census

Exhibit 1

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VIDEOCONFERENCING

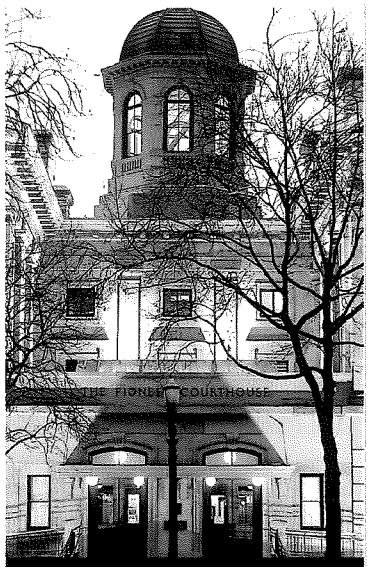
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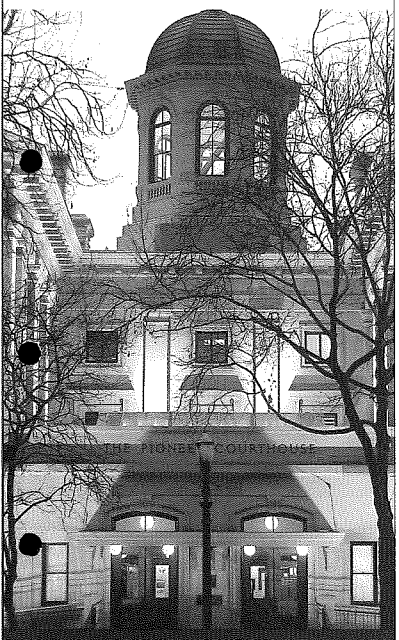
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ENCOMPASS MEDICAL
CERTIFICATE OF NEED APPLICATION #679

OREGON HEALTH AUTHORITY
PUBLIC MEETING
TUESDAY, OCTOBER 15, 2019
1:32 P.M.

2850 NORTHEAST BROOKWOOD PARKWAY
HILLSBORO, OREGON 97124

ENCOMPASS MEDICAL

CERTIFICATE OF NEED APPLICATION #679

OREGON HEALTH AUTHORITY

PUBLIC MEETING

TUESDAY, OCTOBER 15, 2019

1:32 P.M.

MR. GILMAN: Good afternoon, everybody. Welcome to the OHA public meeting. My name is Matt Gilman. I'm the Certificate of Need Program Manager with the Oregon Health Authority. I wanted to welcome you all here.

The OHA initiated this meeting to hear public comments regarding Encompass' application for their 50-bed rehabilitation facility in Hillsboro. Just a reminder that if you missed the meeting yesterday, we're not going to be taking any testimony, recommendations, or decisions will be made in this meeting, and any questions will be directed to OHA staff. Therefore, the meeting is not subject to the Administrative Procedures Act or Public Meeting law.

We will have -- I know that we have -- we'll have numerous digital recordings available as long as -- as well as the transcript after the

meeting is over, which we can make available to the folks here. Hopefully, in the back you saw the sign-up sheet and you signed up on at least one sheet. One is one is for attendance. If you would like to submit public comment or give public comment, there was a sign-up sheet for that as well. We do ask that if you do want to make public comment that you sign up on that sheet.

We've got an agenda. You should have all gotten that when you walked in. The Applicant should have about 30 minutes to provide their summary of the application, and then we can open the meeting to public comment. I'll call upon people, upon individuals. If you would like to co-present with somebody else, please let me know that. And then depending on how many public comments or folks we have signed up for public comment, we'll just divide that time up to fill that time.

So when I call your name, please raise your hand. Lisa, who is at the back, will be racing around with the microphone. So for the recording and for our stenographer, please make sure that you wait until you got the mic until you start talking.

Finally, just to answer questions, if you want to submit written comments, you may do so at

any time during our application review process. And the public meeting record will remain open until November 4th. So you have until then to submit any written comments you might have. So with that, I think what I'd like to do is kind of let folks introduce themselves from both Department of Justice, OHA and then from Encompass.

MS. KRECKLOW: Hi, I'm Pam Krecklow with the Oregon Health Authority. I'm the part-time Certificate of Need Coordinator.

MS. SELOVER: Dana Selover, I am the Section Manager for Health Care Regulation Quality Improvement. That's where all these programs are. And I'm with the Oregon Health Authority.

MS. O'FALLON: Shannon OFallon with the Oregon Department of Justice, and I advise the State's Public Health Division, including the CM programs.

MS. SELOVER: And in absentia, I'm going to introduce Steve Robison he's on his way. He is our technical bed need analyst at the Public Health division.

MR. STOLOFF: Can I ask, when do you think Steve might arrive? Because we have some people dealing with need and I thought maybe we could shift

--

MS. SELOVER: I'm going to talk to the one who is in direct contact.

MR. GILMAN: Yeah. He will be here as soon as he's able to be here. We do have recordings so we can make sure that he gets both the minutes and the recordings in the case he doesn't get here in time.

MR. STOLOFF: Okay. Thank you. So good afternoon.

MS. O'FALLON: Can you do introductions --

MR. STOLOFF: I will. So good afternoon. My name is Peter Stoloff and I represent Encompass Health Rehabilitation Hospital of Oregon, in the certificate of need application for 50-bed specialty, acute inpatient rehabilitation hospital in Hillsboro. And in addition to my opening remarks, I'd like to introduce Bill Heath, who is a vice president of Encompass in business development. And then to Mr. Heath's right is Joseph Stillo, MD, who is an Encompass vice president of medical services. Dr. Stillo is physiatrist, which is a physical medicine and rehabilitation physician. He has extensive experience with the kinds of acute inpatient rehabilitation hospital services which are

being proposed by Encompass Health. To his right is Edward Stall. Mr. Stall is a nationally-recognized expert on the need for specialty, acute inpatient rehabilitation hospitals. To his right is Rodney Gilchrist, who is a senior project manager for Encompass Health in the design and construction division. And to his right is Carey McCrae, who is Associate General Counsel, who has nationwide responsibility at Encompass for certificates of need and project development.

So I'd like to start out with Bill Heath. Thank you.

MR. HEATH: Can you hear me well enough?

MS. O'FALLON: I think so.

MR. HEATH: Okay. So again, I'm Bill Heath. I'm vice president of business development for Encompass Health. And I want to take a minute to tell you who Encompass Health is. So we're one of the largest providers of post acute care in the country. We are the largest provider of inpatient rehab in the country. As of June 30, we had 131 rehab hospitals around the country. SSince June 30th, we've opened two more, one in Texas and one in Idaho. And before the end of the year, we will be opening two more, another one in Texas in the

Houston market, and one in Southern California.

So as you can see, we're very active in business development and adding new hospitals in markets across the country where we see a need for more inpatient rehab, which is why we're here today. We see a need in Oregon in general, and specifically in the Portland and the three-county area.

So what is inpatient rehab? At a high level, most specifically this is a highly specialized, acute hospital. It's not just a facility where rehab is done. It is an acute hospital level of care. These are complex patients that are being taken care of. It is being done by a team of clinicians. You can see a list here of what those are. A lot of therapy going on there as you can see. This is done under close supervision of a physician with 24-hour nursing care.

So what type much patients are going to inpatient rehab? So I mentioned before, it's a very complex patient. On the left side of the screen you can see a few of those categories. Stroke, brain dysfunction, neurological issues. 90 percent of patients, they have been in an acute care hospital. They are ready to be discharged and are not able to go home. And so they continue to need a hospital

level of care to be able to get back home.

And you see they're elderly. Typically our patients are in their 70s. On the right-hand side it shows you a little bit about how Encompass does. You can see we meet or exceed national benchmarks for quality outcomes.

Okay. Here, leading position and cost effectiveness, there's a lot of information here and I won't spend a whole lot of time, but what I want to show you -- you see on the top line Encompass Health, during this period of measurement, this is publicly available medicare data, we had a 126 hospitals in operation at that time. So in the third -- middle column there you see case mix index. That is a measure of how sick our patients or how complex our patients are. You see at 1.28, higher means more complex. So we're higher than the other freestanding hospitals, or the other hospital-based units across the country. And this is all inpatient rehab providers.

But of note, if you look at the next column, our cost per discharge is actually lower than other providers in the industry. So if you think back to the previous slide, we are meeting an exceeding the national benchmark despite the fact

that we have a higher case mix index and we're doing it at a lower cost.

And then one more thing I wanted to talk about here is it's not just patient care. We're also an advocate in the industry. We work with lots of other associations and this is just one example where we've partnered with the American Stroke Association on their "Together to End Stroke" program. This is a national program to promote stroke awareness and recovery. And I mentioned our hospitals are highly specialized. Across all of our hospitals we have -- most of them have a disease-specific certification from the Joint Commission. 117 of those hospitals have a stroke certification, so that's why this is important to us and the Stroke Association partnership. We will also have a Stroke Association -- I mean, a stroke certification here in this market. But in addition to stroke, there's several other ones that I think Dr. Stillo may talk about in a few minutes, but we hold 289 disease-specific certifications at our hospitals across the country. Dr. Stillo.

DR. STILLO: Thank you everybody. It's my pleasure to address this group today. Thank you so much.

Since my training in physical medicine and rehabilitation at the Rusk Institute of Rehabilitation Medicine at NYU Medical Center years ago, I've had the honor and the privilege of serving the disabled population for over 30 years. I've been with Encompass Health for over 20 years. I should also mention that our chief medical officer who I answer to directly, Dr. Lisa Charbonneau, can say the same about her training as well as her tenure with Encompass Health over the years.

So Dr. Charbonneau and myself, along with the physician advisory board, comprise the medical leadership pf this company. I'm not going to read my slides except to use them as reference material, but I would like to address you in three distinct areas; access, programming, and quality outcome.

So as you can see here, I would point you to the first bullet slide that, you know, we consider the acute care clinicians our partners, the case managers, the therapists, the primary care physicians, the consultants, etcetera, the discharge planners as our partners. Why? Because we want to come together and try to identify the best post acute venue for rehabilitation after a patient has suffered a disabling injury or trauma or a medical

illness. So we try to come together and say what is the best way we can use this individual's Medicare, if it's a medicare patient, etcetera, what's the best way we can put this patient through this system. Why? In order to best achieve the patient and family's goals. Okay.

And part of that is to try to keep the patient from bouncing back into the hospital, both during the course of rehabilitation, as well as after the patient has completed their course of rehabilitation. I can tell you that I and we have been poised to advocate, because this really is an advocacy position that I'm describing. We've been poised to advocate for patients in need of access to rehab services. We try to partner with the regulatory agencies and payers, who sometimes don't seem like we're on the same page in terms of interpreting the medical necessity criteria for admission. So we try to partner with them.

I'll give you an example. A few years ago I was with -- I was on the local coverage determination committee from Cahaba, Alabama. At the time, they were one of the big Medicare administrator contracts, or physical and media, essentially. But we tried to get together, tried to

see what exactly is the inpatient rehabilitation rule saying. Dr. Charbonneau and I were recently in touch with one of our Medicare Advantage or managed Medicare partners. I use the word "partner," again, to try to synchronize our understanding as to the best level post acute venue for a particular patient.

So I think that we really see -- we don't see adversaries, enemies. We feel that everybody can be a partner. Why? Because if we keep the patient first, we really all are partners in a positive manner. I will mention, also, that patients' rehab needs don't vary from state to state. What does vary is perhaps services and accessibility, availability of inpatient rehabilitation and post acute venues. Okay. So that really what does -- can vary from state to state.

I'm not going to read the slide to you unless you really want me to. Okay. I didn't think so. But there is a substantial difference between the inpatient rehabilitation facility or IRF, as we call it, versus the skilled nursing facility world. Okay. We operate on different playing fields, regulatory playing fields, but I can assure you this

is not a game. If we look at the left side of the slide in blue, you'll see the requirements for some inpatient rehabilitation hospitals. Okay.

First of all, we are hospitals, we are designated as acute care hospitals. We have hospital licensure. And with that we are poised to take care of what we call intensity of service. Intensity of services in regard to medical care. Remember, patients -- people come in, they have a disabling illness or injury or trauma, right? So they wind up, let's say, a stroke or spinal cord injury, amputation, brain injury, etcetera. Okay. Other neurological, neuromuscular diseases. Right. Well, that's their rehab diagnosis which needs to be treated and that will have special comorbidities associated with it. Spacticity, loss of sensation, pain, etcetera.

But remember that patients -- people will continue having their comorbid conditions. Diabetes, hypertension, COPD, congestive heart failure, gout, on and on and on. Renal disease, right, chronic kidney disease. All right. So all of those require the level of medical oversight that we have in our hospitals. Indeed, we're demanded to have according to the conditions of participation

and the Medicare rules. Okay. So we have that. And the treatment program, the rehabilitation program first of all is approved by rehabilitation physicians, such as myself. Right. The plan of care is approved. Team -- it's very, very much a team-oriented process. So in terms of rehab intensity services, our patients have to have a minimum of three hours per day, five days a week or 15 hours over seven days of rehabilitation, including physical therapy, occupational therapy, speech therapy, etcetera. Okay.

And we are work together with our very skilled pharmacists and nurses who can be rehabilitation nurses, certified rehabilitation. Why? Because patients can have things associated with their condition. Such as neurogenic bladder, neurogenic bowel, pain issues, wound issues, and on and on and on. So we're very, very much different in terms of what is required. You won't see -- on the right-hand slide, you will not see similar requirements for the skilled nursing facility industry. Okay. It's just not there.

As Mr. Heath was referring to, we -- well, even before I say that, let me just talk about programming. So talk about access a little bit

generally. Let's talk about programming. First of all, in a system the size of our system, 133 hospitals currently, two more by the end of the year, you know we are able to leverage economies of scale. What do I mean by that?

Well, when we want to develop, we can develop and share evidence-based best practice protocols for decision support, for program development. Mr. Heath mentioned that we have 289 disease-specific, Joint Commission certified programs across our company, an average of two to two and a half per hospital. In my former hospital in Toms River New Jersey, we had five. We had stroke, brain injury, cardiac, pulmonary, diabetes. And I think now they have a wound -- so these programs are developed. The advantages that these programs are developed based upon community need. We also have hip fracture, Parkinson's, etcetera.

All right. But one thing that Encompass Health does is support our clinicians in such an outstanding way, in terms of educational programs for further development of their skills and expertise. We fund over 50 research projects within Encompass Health. And the AHA -- American Heart Association, American Stroke Association guidelines

concluded that inpatient rehab facilities are a better rehab option for stroke patients than a skilled nursing facilities. This is the guidelines that came out in 2016.

Yes, we have a lot of technology that I can offer. You we have a whole program of people to evaluate the efficacy and the applicability of all these different technologies that are out there. We have more than this besides the Vector Gait and Bioness and the VitalStim, body weight supported treadmill training, treadmill testing, which we developed on our own, which has great safety features. You know, Bioness, SaeboFlex interactive Metromed, etcetera, etcetera. So we have all the technology that patients could possibly need.

We also have patient-centered technology -- again, busy slide but just a couple things. We do have a proprietary electronic medical record. You should understand that rehabilitation hospitals are not required to participate in electronic medical record program. However, Encompass Health, about 10 years ago, decided to spend $200 million to have our Cerner-based -- Cerner is the company that we use, a Cerner-based electronic medical record. Why? Because now we're able to get in there and leverage

all the data. Last year in 2018 we had 178,000 discharges from our hospitals. Okay. So you can imagine what a spreadsheet might look like. That's a lot of data. But we can manage. Why?

So that we can develop programs such as this. I'll just point to one here which is called the React Program which we partnered with Cerna. This will actually tell us the risk. If you're having rehabilitation in our hospitals -- in one of our hospitals, this React algorithm will run in the background and alert all clinicians that this patient is at risk for bouncing back to the emergency room, to go back to the acute care hospital. Okay. Then we can act on that develop support. We have shared this nationally at the American Medical Rehab Providers Association, so we really want to share this technology and understand that there are ways to triage patients if they wind up at risk.

We're also working on one now for readmissions after patients are -- so this looks busy, but I'll just tell you right now, this is from the Med Pack report to Congress in March of this year, March of 2019. And even though Mr. Heath showed you how Encompass Health fairs against other

rehabilitation hospital benchmarks, according to the Uniform Data System medical rehab data. What this is showing you is how the IRF industry compares to the SNF industry on three different parameters. Two of them are up here. One is in terms of discharge back home, discharge back to the community, that IRFs do that successfully twice as much as skilled nursing facilities. All right.

On the right-hand side it will show that in terms of during the course of -- during the inpatient course, how often do patients go back to the acute care hospital before they are even done with their rehab is four times higher in skilled nursing facilities. Or I should say is four times lower in inpatient rehab hospitals. The graph that is not on this slide is that once patients are discharged either from SNF or from the inpatient rehab hospital, patients wind up going back to the hospital for readmission within 30 days, 30 percent higher when they come from SNFs. Or I should say 30 percent lower when they discharge from IRFs.

So I talked to you briefly about access, about programming, about quality outcome data, and now I'd like to give it over to Mr. Ed Stall. Thank you.

MR. STALL: Thank you. And my task is to talk a little bit, or quickly, about the bed need methodology and those kinds of things. So quickly I'm Edward Stall, a partner with DHG Healthcare. Quickly about DHG Healthcare, we're one of the 10 largest privately-held healthcare advisory practices in the country. We have over 20 advisory professionals spending all day every day advising and learning about healthcare providers and the issues that we're dealing with. We work in all 50 states, several foreign countries. Our expertise is in things like reimbursement, strategy, demand, analytics, clinical alignment, alternative payment models, all of these things that are emerging.

Myself, I have been at this for about 35 years. I founded a small company or part of a small company 35 years ago. That merged into Dixon Hughes 12 years ago. I've built and led practices and strategy and analytics and alternative payments. Planned dozens -- in 35 years you get to do a lot. Planned dozens of hospitals, including rehab hospitals and other specialty hospitals. Many that are open and successful, so we know what works.

I've been an expert witness for state health planning and worked with the state health

planning bed need models. I have significant experience in Medicare data analytics, which is increasingly important, particularly to a service like rehab, which is mostly a Medicare patient base.

So Oregon bed need methodology in a certificate of need, basically we start with this sort of an idea that we've met the standard of the 590, the general bed need. And then regulation 645 comes into play which talks about specialty services. So basically a quick summary of that kind of thing, what we've got to deal with is the rehab need using seven beds per thousands standard. Address specialty rehabilitation, special needs, sizes of populations, rates of historic utilization, accessibility, quality, those kinds of things.

In the next few slides, I hope I'm going to hit many of these for you. They're all in the CON, but I hope I'm going to give you at least a little highlight tour of what those are.

You've heard that Oregon, in general, has a low access to care or beds per thousand of care. This is actually a chart that shows beds per thousand, per hundred thousands by state. What matters here is look to the far right, the little bars in red, one of them is Oregon, which is the

lowest -- the second lowest state. Only Alaska has fewer beds per hundred thousand. This is three-county area is right there in that same -- really low. And our home location of Washington County where we are here has no beds. So a very significant population with no beds.

You see that seven bed her thousand standard, which is the Oregon standard in the health plan. We're going to use that in our bed need methodology, but that isn't even half the ratio of beds per thousand that are in service today in the country. It's a very conservative bed need ratio.

One thing I will point out is the bed need ratio or bed need is per hundred thousand total population. Health care planning has evolved over the years and now focuses on a specific population. And the population for complex rehab is an elderly population. This little pie chart to the right -- to the left shows 72 percent of patients are 65 and older. Medicare also clearly focuses the rehab provider on the complex patient. It's called CMS 13, and it's 60 percent rule. 60 percent of your patients have to come from these conditions. And you saw them in an earlier slide, stroke, brain injury, those kinds of things. But the impact is the

rehab hospital has to serve the elderly and has to serve the complex patient. We don't get paid for things that aren't complex. It's very important to understand that, and that's the need that we're trying to demonstrate.

When I say population segmentation, here's why it matters. We all heard that the age wave on one of those, right, may have been here a little longer, and the age wave drives demand. Here's the population growth of this three-county area that's used in our certificate of need. Notice in Washington County, the 65-and-older population is growing by almost 23 percent. That's in the next five years. And the other two counties in the service area has also grown 22 percent. The impact of this is growth rates of this age group drive demand. Growth rates for this age group will outstrip supply very quickly and we've seen this happen in markets all over the country. So the age wave is coming and the appropriate measures to use is around this 65-and-older population.

The growth rate is not in one place. You know, the age wave happens everywhere. At least here in this market it's happening everywhere. These ZIP Codes shown in red have grown 20 percent

or more. Notice they're not all in Washington County. They're across the metro area. They're across the three-county area, which means all providers. SNFs serving the elderly, rehab providers serving the elderly will be impacted by this group.

So we turn this into a little slightly, maybe more specific measure, which would be patient beds per thousand for the 65-and-older population. Please notice here the same thing happens. Oregon and the three-county area, Washington County would be the lowest in the country. Which simply says is there enough capacity -- enough access to care. U.S. rate of .74 per thousand is almost four times that of the Oregon rate or the service area rate. And it simply says is there an issue with capacity and beds.

Let's put it in a map. Let's talk about this a little more specifically. And this takes that same data and puts in a picture. The dark green are those with high ratios of beds per thousand. The white, you'll see Oregon, is the lowest and that point is also low, over there on the far right. But notice what happens over here in the West, we talk about -- we've heard comments that

we're different. Oregon is different. The West is different. Medicare Advantage impacts all of this. Recent data from CMS, which is September data, they report Medicare Advantage penetration or rates, Oregon was 40 percent, 41.8 percent. California, your neighbor to the south was 40.6 percent. So similar Medicare Advantage rates, but California has twice the number of beds per thousand.

You see Pennsylvania over here on the East. I only point that out because they also have a 40 percent Medicare Advantage rate. Encompass Health has nine hospitals in Pennsylvania and succeeds in these Medicare Advantage markets. So there you go. Medicare Advantage doesn't drive care now. You know what's different is Medicare Advantage requires preapproved. Medicare pays for a patient after the fact. Medicare Advantage you have to go and basically get that patient approved. Encompass has become very good at that for the patients that need that care and they have to tell their value proposition.

There is one other common measurement, and this one I really like because it's not about bed per thousand or how do we stack up. This is how many Medicare patients actually received free

Medicare. Now we're talking about patients. Now we're talking about real people. How many people get the care that they deserve in this market. And the same picture points out the service area, three-county area, the state, all of the above. And the same measure is consistent across the market. This is a map by ZIP Codes. The blue ones are really low. But you'll see Washington County basically one percent versus the state at one, versus the U.S. at almost four. A fourth of the rate. So it's across the market.

Even one other measure which is how existing hospitals discharge their patients. This uses a thing called rehab-appropriate patients. You see on the far right your two providers that have rehab units. They discharge patients at 2.6 to 4 percent. That's higher than most in the market, but it's half of that of the U.S. So again, they're run to serve more.

And finally I want to leave you with a couple of closing thoughts. Don't know if you know this but when you talk about access to care, distance matters. Families don't want to travel long distances to see a patient that's in the hospital or a rehab hospital for 14 days. The

further the distance, the less likely they are to access rehab. So we're finding that putting rehab where the people are really matters. Particularly in these large metro areas.

So Washington County is the second largest county in the country without a rehab bed. Second. That's out of 4,500 or 5,000 counties. Clackamas ninth. So it continues to point to that same thing. Let's bring it home to one final thought which is it matters to the patient. Dr. Stillo has talked about quality and outcomes. Talked about a family member. Talked about a family member that lives here in Hillsboro near the library. It's hard to get to the downtown locations. If that patient has a stroke, do they get access to this high level of care. To the high level of care that Medicare dictate. And then finally there's a value proposition. There's this myth that rehab a very expensive. What you find when you actually study the complex patient -- now this doesn't mean every patient, but the complex patient that acute rehab targets is the costs don't actually go down. I'm not going to go through all the details here, but if you look at what happens here, as patients move from IRF to SNF, readmissions go up for this most complex -- this is cardiac

valve, a really sick patient. Readmission go up. And actually for the very sick population, cost of care can go up. So let me leave it there with you. I'm going to let Peter take us home for the last couple of minutes. I appreciate your time.

MR. STOLOFF: Thank you, Mr. Stillo.

So Encompass filed its certificate of need application on November 2, 2018. And it clearly shows in appendix A in that application, and in the January 7, 2019 response to the screening questions that there is a need for at least 91 specialty, acute inpatient rehabilitation beds in the service area as defined under OHA's rules in OAR 333, division 590-0040 and 0050. And then taking into account the inflow into the service area, which is specifically provided for in OHA rules in 645-0030 A and B, and 590-0450 sub 6, there is a need for more than the 91 acute inpatient beds.

I'm going to speak briefly to the issue of competition. You heard a lot yesterday from the skilled nursing facilities in the area. And I'd like to at least make it clear that the certificate of need process is not intended to eliminate competition or limit access to needed services such a inpatient rehabilitation facilities. The Oregon

Court of Appeals, in fact, held in 1993 in Mercy Medical Center versus Oregon Health Policy that the certificate of need laws do not create an entitlement to a government-sanctioned monopoly.

With respect to the issue of distinction and the line of demarcation in between inpatient rehabilitation facilities and SNFs, and this goes to the question of Dr. Selover yesterday. In fact, the inpatient rehabilitation facilities with respect to exclusionary criteria, there are specific exclusionary criteria. Whereas with skilled nursing facilities, you heard the testimony yesterday and I'll let it speak for itself. But with respect to the inpatient rehabilitation facilities, the exclusionary criteria are that there must be a physician's order. The patient must have an acute medical condition to be distinguished from a chronic or long-term care medical condition, and at least 60 percent of the inpatient population of the inpatient rehabilitation facility requires intensive rehabilitation services for treatment in one or more of the 13 conditions. So that's the line of demarcation there.

I want to point out, also, to the Oregon Health Authority persons here today that the rules

are specific. They clearly establish this line of demarcation in the 645 rules in rehabilitation, which state that the inpatient rehabilitation rules are not intended to apply to beds in long-term care facilities. This is also in OAR 333-590-0010 subsection 1, that defines acute inpatient care as specifically excluding care provided in long-term care facilities.

There's also a number of other rules that OHA has distinguishing this. In fact, the certificate of need rules for skilled nursing facilities in 333-610-001019 provides that SNFs are licensed to provide care for persons who require the availability of an RN 24 hours a day, but do not require the levels of nursing, physician and specialized services available in a hospital. So this goes to the line of demarcation. The Medicare regulations similarly say the same thing in 42 CFR 424.20, which state that SNFs provide skilled nursing care, that as a practical matter, can only be provided in a SNF to be distinguished from an inpatient rehabilitation facility. Thank you.

And in conclusion, based on the testimony of Encompass individuals today and Edward Stall, there is clearly a need for a 50-bed specialty,

inpatient acute rehabilitation hospital in this particular service area as defined by Encompass in its certificate of need application, based on the evidence-based data, which we have provided in the application and appendix A, that I cited earlier, and in accordance with Oregon's certificate of need rules in divisions 590 and 645. Thank you very much.

MS. O'FALLON: Shannon O'Fallon again with the Department of Justice. I have two questions. I think I'll start with Peter, this one's for you. So your last argument, are you basically saying that in looking at bed need, long-term care facility beds sort of shouldn't be counted in the mix of what is available out there; is that what you're saying?

MR. STOLOFF: That's correct because the rules say that. The rules distinguish acute care, and I've cited the rules, but I'll get it in writing in November 4th, distinguish acute care from skilled nursing care. And the rules in 590-0060 say that in determining need under the 590 rules, the general bed need rules, you look at the facility being proposed as against other acute inpatient facilities. SNFs do not provide acute care. They cannot provide acute care. They're not licensed.

They're in a different licensure category. They're not licensed to provide acute care. They provide skilled nursing care. And that's the line of demarcation that's important that we like to make in making sure that OHA at least is cognizant of that position because it's fully evident in the rules.

MS. O'FALLON: All right. Thanks. And then my second question, and I may not sort of be seeing this right, but -- right, so we heard testimony yesterday about -- and I think -- I know most of you were there, right, that Oregon is different. There's more of an emphasis in Oregon -- these aren't my words, like, these are other people's words. I'm paraphrasing. Right, more in0home care, you know, people spending less time in facilities. So I'm trying to figure out when you say, right, we don't have very many beds in Oregon, and therefore, there's need, I mean, can you necessarily make that leap? Or are these patients just being cared for in a different way and not in inpatient facilities?

MR. STOLOFF: Is that for Edward Stall or --

MS. O'FALLON: Yeah. Whoever.

MR. STALL: Yeah. Let me just point us

back to the patients we're talking about here, because Oregon may, in fact, be different on how care is delivered, in-home care, and things like that. These -- look at the 13 CMS patients. These are brain injury patients. They're stroke patients. These are the patients that can't go home. They're very complex. And we're not trying to take care of anybody that just needs a little extra time to recover. We're talking about people that need therapy that cannot function by themselves elsewhere. So this is a very complex patient and that's our specific and specialized population.

MS. O'FALLON: I'm sorry -- I'll talk loudly -- one follow-up. So yesterday I think it was Legacy was saying that their sort of census at the -- is it the RIO facility? Am I saying that right, the RIO facility was 60 percent or something like that. Right. So not full all the time. So how do you explain that again if we have, you know, these low bed numbers?

MR. STALL: Well, I don't know their care or their patterns. I certainly presume that they're very good. What is different that we find about Encompass and its ability to qualify patients, we've talked about that 178,000 records, these clinical

pathways. They're so evidence-based and they have size and scale. So that size and scale let's them negotiate with payers for these pre-approvals. We have great success, for instance, with Kaiser in California.

So these Medicare Advantage plans don't scare Encompass Health away. In fact, they've become a patient advocate to go say why does this patient need it and then the proposition is X. They also go to the hospitals and actually prescreen these patients. When I say the hospitals, they're not an acute hospital so they got to go prescreen patients anywhere they are, doctor's office or otherwise, so they're not getting patients for themselves.

DPUs, let's get a little difference between an IRF and a DPU. DPU is the distinct part unit which is a hospital patient unit. Doing great care, no doubt about that. IRFs, as you saw in that first chart, tend to be larger because they're freestanding. And there's something about that, there's something with size and scale that let's them have depth of therapists, depth of physicians, additional physicians, a wider range of services, those kind of things. So size and depth, a little

bigger can be better in terms of all that you can offer in rehab. The distinct part units, the liaisons or people that will go out and qualify the cases. And then the clinical pathways and just the evidence-based medicine that is allowed to happen.

MS. O'FALLON: Thank you.

MR. GILMAN: If there's no more questions, we can go ahead and get started with our public comment portion. One quick question though is I have Peter, Bill, and Edward, you signed up on the public comment sheet. I'm guessing you meant to sign on the "I'm here" sheet.

MR. STOLOFF: That's correct. I'm not giving public comment.

MR. GILMAN: Okay.

MR. STOLOFF: I made a mistake.

MR. GILMAN: Great. I just wanted to -- so I think based on the amount of time we have left, and we have about 14 folks signed up for public comment, so I think that's about five or six minutes apiece. So let's go with five. And what I'll do is I'll call your name. Lisa will grab them mic. And then if you could do a couple of things for us, let us know your name and what organization or facility you're representing. And then it would also be

extremely helpful if you'd let us know if you're planning to submit written comments too, just so we know to be looking out for that. Yes. Yeah.

MS. SELOVER: And not applicable is also acceptable.

MR. GILMAN: Not applicable is also acceptable, if you're not representing a facility.

Okay. So the first person I have is Marylee Rush.

MS. RUSH: My name is Marylee and I represent Brain Injury Association of Oregon. I'm a nurse and have been for 25 years. I had an accident a few years ago that caused a brain injury and spinal cord injury. I have observed during that time and being active through BIA, two things that have been brought up here. And I just came, so please bear with me, is the scattered effect of getting better at rehab that has occurred. But the scattered effect means the end effect of us getting better has been (inaudible) different types of facilities, different types of results. And in talking to various other people in the health industry that were injured, it would be so nice to have one location knowing -- that's what I was attracted to, what you said -- and having that here

and having it in various departments in the county. But especially for the person that is getting better, that they aren't fragmented all over to different this can help, that can help and so forth. I think it would be a big asset to have you here. Thank you for coming.

MR. GILMAN: Deanna Palm.

MS. PALM: Good afternoon. I'm Deanna Palm, President of the Hillsboro Chamber of Commerce. We represent more than 800 businesses and 50,000 employees in the greater Hillsboro area. I'm here today to speak in favor of the Encompass Health Rehabilitation Hospital of Oregon's application to build an inpatient rehabilitation hospital in Hillsboro to serve our fast-growing Washington County.

As you know, there are presently no acute inpatient rehabilitation hospital services here and although skilled service -- skilled nursing facilities provide rehabilitation care to a great number of patients every year, they do not have the resources nor hospital licensure to provide the intensive inpatient rehabilitation care that numerous research studies have consistently -- sorry about that. That has consistently shown can achieve

significantly better results for patients with certain diagnoses and allow them to return to the community with a higher level of function.

I believe you are also aware that Oregon ranks last behind all states for inpatient rehabilitation beds per thousand population over the age of 65. And also last in all states for the percentage of potentially rehab-appropriate patients referred to an inpatient rehabilitation hospital. So it would seem clear that there is a general need for more of these hospital services in Oregon, especially in our high-population areas.

Our growing population and increasing traffic congestion on Highway 26 means that all services of any kind that are only available in Portland are getting further away time-wise by the year. I would say quicker than that. Intensive inpatient rehabilitation services now only available to us in Portland are no exception and an obstacle to the mostly elderly families in Washington County that need them, who often choose instead local skilled nursing care for their loved ones despite the often less-than-optimal outcomes for those complex conditions.

For all of these reasons, we urge you to

approve the Encompass Health Rehabilitation Hospital of Oregon certificate of need application for Hillsboro and Washington County. We deserve the same level of acute inpatient rehabilitation care here that is readily accessible in other counties and other states. Thank you.

MS. O'FALLON: I assume you'll submit those written comments?

MS. PALM: I will.

MR. GILMAN: Sherry Stock.

MS. STOCK: Hello, I am Sherry Stock, Executive Director of the Brain Injury Alliance of Oregon and neuro gerontologist. I have a son with a severe brain injury so this has been part of my life since he was three months old. And I sustained, four years ago, a spinal court injury so I am coming at it from lots of different angles. So I did submit written testimony, but one of the things I'd like to cover is frequently, especially with younger people with brain injury, what they're diagnosed with is they're diagnosed with mental health issues. So when they're diagnosed with mental health issues, what are they given? They're given medications.

I have one 26-year-old at 19 years old, they said she was schizophrenic. They never did an

X-ray. Never did anything. They just put her on medications. By 22, she was so bad they took her into the ER and they found -- finally did an X-ray. Found that she had a brain tumor the size of lemon. So they did surgery but it was up at OHSU, and she got MRSA in her brain. So she not only then had brain injury from the surgery, but she also then had MRSA and flesh-eating bacteria in her brian.

She took a significant fall at OHSU, knocked unconscious for four days, and so another brain injury. So what has happened to this poor young girl who is now 26 years old? She's locked up in psych hospitals on 13 different medications. And one of the nurses, the day before she quit, told her mother if you don't get her out of here, they're going to kill her with the medications.

So it's not understanding brain injury, that is the that problem we have, brain injury and stroke. But what I see is brain injury at all ages. It's the number one killer in people 65 and over. But also children 0 to 4 learning how to walk fall and hit their head. It's the number one death of children. So understanding that it's brain injury and how to work with brain injury, this is what we desperately need.

And spinal cord injury, when I was in the hospital, I know who to contact because I'm in the business. And what they wanted to do with me is teach me how to transfer from a bed to a wheelchair and how to use my wheelchair and not hurt my fingers. So what I did is I had my husband take me out every day for four or five hours to work with a professional that taught me how to walk, before my working muscle memory and working memory could die, so I could still walk. I might not feel myself from the waist down, but I'm walking.

And that's having the proper facilities for people to go to, which we don't here in Oregon. And not other here in Oregon, by the way, but also Washington. So people would be coming from Washington for this facility as well, so it's just not right here. Thank you.

MR. GILMAN: Gwen Dayton.

MS. DAYTON: Hi, my name is Gwen Dayton, and I'm general counsel for the Oregon Healthcare Association. We represent long-term care facilities across the state, and notably all of the nursing facilities that are in what we believe to be the service area under consideration.

I'm going to submit written testimony and

rather than go through it all with you today, you'll be very grateful I'm sure, what I tend to do is focus my comment on some of what you've heard today. And then also add some additional comments as well. And we also intend to supplement our written testimony submitted today with additional evidence over the course of next 15 business days.

Before I get into some of the things that we've talked about, and some of our unique points, I wanted to put a few just key questions into the record. I don't expect you to answer them today, but I do think they should be considered at least. What actual location is Encompass putting before you for consideration? We know in their original application they had a location that was submitted, but then as of last week, they submitted an amendment that proposed a different location because they hadn't yet received the right approvals for the original location that had been submitted. So which location is under consideration?

And was the application deemed complete last week when there was the amendment? Or was it complete August 21, I think, when it was deemed complete by the state? Because there has been a significant amendment submitted to the application

that changes significantly its request. And what does OHA actually consider to be the service area that we should all be looking at when we assess need? It is OHCA's sense, and we are relying a lot on Mr. Robison's analysis in this, that the service area is the tri-county area, Multnomah, Clackamas and Washington Counties.

What we were surprised to hear Mr. Stoloff say yesterday on the record that he would consider the post medical application and the Encompass application to be subject to different service areas, when they're approximately a little under 20 miles apart depending on which site is actually chosen. We don't understand why they might be in different service areas, or why different service areas might be chosen, based on the state list that applies. So we put those questions into the record.

Moving on from those, I think the core question that has been presented this morning and is the theme, I think really, of the State's consideration of both applications, including Encompass, is to the extent to which nursing facility beds could be considered when assessing the need for rehab beds.

It is not surprising that there are low

stats for the number of rehab beds available in the tri-county area. That's because people are -- all rehab patients, most of them, are being care for in nursing facilities. That's just the reality of it. By the way, a quick example, my own mom is in the hospital for knee replacement surgery. And instead being discharged to home, she was discharged to a nursing facility where she was seen for approximately a week by a nurse practitioner and by a physical therapist. And I was there and she was -- she received assisted care for approximately, I want to say, a week-ish before she was well enough to go home. That's an example of the care we're providing in nursing facilities.

Unlike national -- I saw we had a lot of national data again today, and again, it is important to understand that Oregon is different. The State referenced that a minute ago, I will repeat it now, that our legislature has made a very concentrated and determined decision to focus people into community-based care, like assisted living, before they're considered for nursing facility care. We value independence. We don't want people to be institutionalized before they need to be.

So we have made a concerted effort to

actually limit nursing facility beds in this state, rather than increase them. So we have higher acuity people in assisted living than the rest of the country, and we assuredly have higher acuity, much higher acuity in our nursing facilities than the rest of the nation. And that is reflected in some of the stats that are in the written testimony that I'll submit, and I'll just talk about a few of them today.

We have the second lowest rate in the nation, Arizona is the lowest, of stays over a hundred days. Most of our stays are short stay. Seven out of ten days, I want to make sure that is exactly right, are short stay days. And a short stay, they get five days a week of physical therapy. 82 percent of short stays get five days a week of physical therapy, and 77 percent of that group get occupational therapy services. So we do provide therapy services. And that's why we haven't had an influx of rehab beds into these communities because these patients, by and large, we would never say there's not perhaps a slice of really acute care patients that maybe they're staying in the hospital now. I can't say.

You know, I hear the comments about brain

injury, and I don't want to be disrespectful for that need. There may be some slice of super-ill people for whom a nursing facility would not be appropriate. But everybody else has been served and is being served. Remember, you have to have a physician order to be admitted into a nursing facility. We are not allowed to care for anybody that we cannot care for. We must staff appropriately for the people that we care for. So we staff up for the people that we see. We don't take people we can't care for.

We also are -- Mr. Stall referenced the rules. You also need to consider whether there's a cost-effective alternative to the services being offered. Nursing facilities are that cost-effective alternative. We note that the Med Pak report that was also referenced earlier recommends a reduction in inpatient rehabilitation rates by five percent by unanimous vote. Inpatient rehab facilities are paid more than nursing facilities are for, in our community, arguably the much the same -- much the same care.

We are also significantly concerned that the Office of the Inspector General did an audit of inpatient rehabilitation facilities and found that

84 percent of the payment in the sample size that were made were unnecessary and unreasonable.

MR. GILMAN: Gwen, if you could wrap it up in next 30 seconds.

MS. DAYTON: Yep. One more thing, in just this year, Encompass paid a settlement of $48 million dollars to settle a false claim act. The claim involved allegations that the care wasn't necessary. The claims were inappropriate.

So this is the entity that is proposing to enter our marketplace. They're only going to take three percent Medicaid. So even some of the trauma that you just heard about may not be served by them if they are Medicaid. They're entering into a managed care marketplace that already has contracts to provide care for rehab patients and nursing facility at a lower cost than the IRFs would be proposing. We don't think this will be a successful model and we urge the State to reject the proposal. Thank you. And we will submit additional evidence into the record.

MR. GILMAN: Thank you. Okay. Joe Greenman. And are you going to be teaming up with Pamela?

MR. GREENMAN: I think Ms. Kilmurray also

signed up.

MR. GILMAN: Yes. I didn't know if -- you both went together yesterday, so I was going to ask you if you wanted to go together --

MR. GREENMAN: Can you break us up? We kind of touch on different components.

MR. GILMAN: Okay. So Joe.

MR. GREENMAN: Thanks. Good afternoon, Joe Greenman, outside counsel to Legacy Health System. And I'll talk about the legal components and the rule-based rationale for Legacy's opposition to the Encompass certificate of need application. My colleague, Ms. Kilmurray, will talk about some of the utilization, the clinical issues associated with it.

First and foremost, a broad-brush topic overview. The standard under the certificate of need laws for an applicant is that an applicant will not have -- if it does not have an appropriate relationship with its service area, it will result in unnecessary duplication of services and will have a negative financial impact on other providers. That's the basis for essentially denying the application, and we think that the Encompass application does all of those things. That standard

is articulated in division 580, section 0050.

It's been discussed here, I think most notably by Mr. Stall, that there is a standard of seven beds per 100,000 in population. And, in fact, in division 645, it's not a standard, it's, in fact, a maximum. So that would be the top threshold. So Mr. Stoloff spoke of the service area indicating a need for 91 beds using the 645 rationale, that would be the maximum allocation in the service area, not some sort of standard or need that would indicate the 91 would be indicated. So that's another reason in which we disagree.

You know, when you look at the actual service area, we currently have two IRFs providing services, one with 36 beds, the other with 18. Both have an average occupancy of roughly 60 percent. That has actually been on the decline for a period of time. Those occupancies are dictated, essentially, by the CMS criteria, when you evaluate residents for admission into the inpatient rehab facilities.

Even though it has been noted that there are some demographic issues coming in the next 10, 15 years that might continue to increase the level of need for these services, the mitigating factor on

the need is the declining lengths of stay, that again, are driven by the payer sources, either the FEFR service component of Medicare, and certainly by Medicare Advantage, and where IRFs take Medicaid, the same issues are present as well. So all different payer sources are applying criteria which is having a sustained effect of diminishing lengths of stay. So while the overall admission and discharges might overall start to see an increase, those lengths of say are going to be pushed down on the overall utilization of the service.

In the Encompass application, it's also notable that while they do address the fact that you do need to take account of inpatient need in division 590, they really moved quickly from that issue. And that is because the 590 evaluation component would indicate a maximum of far fewer than 91 beds in the service area. And as a result of that, there's even some discussion about whether the 590 standard is applicable or rational -- a rational methodology to impose upon the application.

We, of course -- the public health division's longstanding practice is that in all cases it does impose the 590 acute care bed evaluation needs standard before moving on to the

subspecialty standard that's found in division 645. And this application is no different in that regard.

There have been some comments today also about the convenience factor of the location here in Hillsboro. While we're sympathetic to the fact that it would be good to have medical services in close proximity to people's homes, the Encompass application did select the tri-county, Clackamas, Washington, Multnomah County as the service area. So the individual Hillsboro-based location has to be factored in with the fact that these Portland services are already available.

In addition to that, if you were to talk about, for instance, Legacy's Rehabilitation Institute of Oregon facility, if they were to apply to you for an expansion of their occupancy right now, there would not sufficient grounds to grant that expansion because under the division 645 rationale, there has to be sustained occupancy of 85 percent. And certainly over the past several years, RIO has not been in the neighborhood approaching 85 percent occupancy. So that would be another reason why the Encompass application is not in order at this time.

So I've got some signals here. We're

happy to note that we will submit written testimony further amplifying some of the points we make and adding some of the ones that time didn't permit to come forward today. And we thank you for providing this forum today.

MR. GILMAN: Thank you. Pamela Kilmurray.

MS. KILMURRAY: Hi. Thank you. I'm Pam Kilmurray. I'm the Director of the Rehab Institute of Oregon at Legacy Good Samaritan, which is also part of Legacy Health. And for those of you who don't know, Legacy Health operates seven hospitals in the Portland metro, northwest Washington and Willamette Valley area, along with 25-plus primary care clinics, and over 90 specialty clinics. Our hospital serves 748 patients a day. And within those hospitals includes Emanuel, which is a Level 1 trauma center, and as well as Randall Children's Hospital. Which Randall Children's Hospital is about 112 patients a day, and Emanuel has about 216 patients patient a day. RIO has 36 beds. It has a interdisciplinary team that includes nursing care, physiatrists that are available 24/7, and stroke certified staff, as well as occupational therapists, rehab therapists. We also have -- what stands us out as different is we have psychologists on our

team that work every day with our patients, as well as an internationally-known corticotherapy program.

We have all state-of-the-art equipment. We are Joint Commission accredited. All of our hospitals are Joint Commission stroke accredited, so we have access to immediate good care for stroke patients. And we are also accredited by the Commission of Accreditation for Rehab Facilities, which is CARF. And you need to be CARF accredited if you want to care for patients in Washington.

The leading diagnosis that we take care of is stroke. 50 percent of our patients is stroke, and the next following is brain injury and TBI, traumatic brain injury.

The other things that I want to call out that's different, we talked about the acuity of patients, I believe it was 1.24. RIO's case mix acuity is 1.44. The region is 1.37, and the nation is 1.38. We have a higher or case mix which suggests that RIO handles a more severe patient population than on average.

In addition our length of stay is 13.6, the region is 14.6, and the nation is 13.9. We have the lowest length stay in the region and the nation. In case I don't get to it, I'm going to say it now:

We also have the highest discharge rate back to the community compared to the region and the nation.

I think what's different, rehab here has changed. I've been with this rehab program for 17 years. And I believe 17 years ago, our length of stay was 26. About a decade ago it was 23, and now our length of stay is 13.6. And that has happened -- we have more admissions than we had a decade ago, so we are seeing more patients. The population is growing, but we have better treatment and we have better technology. So patients are improving and moving back to their community to their home. And I think that's very positive for patients and their care. I think the other important thing with Encompass' operating margin, it's a negative -- it's a negative operating margin until year four. And any over-estimation of patient stays will push negative margin beyond the five year guideline.

We -- and I think -- you can correct me if I'm wrong, but Encompass also estimated to provide 75 percent less Medicaid and charity care than RIO. In RIO 2019 -- fiscal year 2019, the percent of RIO's Medicaid and charity care was 47.85 percent. And the next highest was Medicare and then the rest is commercial payers. And a lot of patients, even

though they have insurance, they don't have an inpatient rehab benefit.

I think what I would like to close on is that RIO serves seven hospitals, all of Legacy's seven hospitals from Southwest Washington Medical Center to Silverton Hospital to east county. We also have the Kaiser contract, and we have for a couple of decades. So all Kaiser patients come to RIO, as well as OHSU, and we get a fair number of referrals right here in Hillsboro from Tuality Hospital.

So if you look at where we draw patients from -- and I hear you about wanting to be close to home, but what I know about healthcare, there is some things that you can't always get close to home, because you can't have that much patient services. What we should have close to home is outpatient rehab services so people don't have to drive.

So I would close and just say that I would -- I would say that if a another rehab center came into town and let's say you were successful in pulling all the patients from rehab, I don't know where our ventilated patients, where our burn patients would go, where those high acuity patients would receive their care.

We are an IRF. We are attached to a hospital, but we are an IRF, and we have our hospital right there to support us. So if we have a patient that has any type of stroke symptoms and we're worried about another stroke, our hospital will come over after help us. So I think that's what sets us aside with our location. Thank you.

MR. GILMAN: Okay. Arden Olson.

MR. OLSON: Hi, my name is Arden Olson. I'm counsel for Post Acute Medical. As you know, from yesterday's proceeding, we're going to submit testimony to show a series of misrepresentations that were made by persons opposed to the proposition for the need for IRF beds in our region. I'm here today simply to refer to Encompass' application that none of those misrepresentations alter PAM's view of there's a very serious need here. So I'll submit this letter, but I just want to read it.

After introducing myself, as you know from reviewing PAM's application, PAM has calculated the need in its service areas is 121 beds. Although Encompass has defined its service area as somewhat differently than PAM, it's more clear to Pam that there's amply need in this region for both projects. Indeed there will still be unmet need after both

facilities build as PAM viewed the evidence.

PAM therefore supports Encompass' assessment that there is a need for the Encompass facility at either the Hawthorn farm site or the at the alternative Andrew (inaudible) site. Thank you for having this hearing and letting me propose -- or submit this information.

MR. GILMAN: Mary Brown.

MS. BROWN: So I think you already have a letter from me. Right? Do you want me to read letter or just make comment?

MR. STENSEN: Mary, I'm going to hand it in to them in just a minute.

MS. BROWN: Oh, okay. Sorry.

MR. GILMAN: We will have the letter. Yeah.

MS. BROWN: Okay. You will have it. Okay. Well, I'll give you the essence of the letter. My husband and I support the certificate of need for a new, freestanding, acute care hospital specializing in rehabilitation in Hillsboro. Dick Stensen -- I worked for Dick Stensen and he asked me to write a letter and I was glad to do it.

On May 31st, Bernie had a stroke and we spent four days in Tuality Hospital after which we

were transferred to Legacy Good Samaritan Rehab Institute of Oregon. He was discharged on June 20th. And I will have to just tell you I'm a registered nurse by profession. I worked for Humana Insurance Company. I've worked for the U.S. Army. I've worked for Community Hospital of Hillsboro, so I've got a wide range of experience. The first thing I would have to say is that if there was anything about the quality of care that we received at RIO, I wouldn't be writing this letter. I think it's all about location, location, location. I will go into that further.

RIO has a stellar reputation and with my background and we're kind if insiders because of my being a medical professional, I would have gone anywhere to go to RIO, wherever they think would have been. And at first I thought they were over at Providence on the east side and I thought, oh, jeez, it's so far away, blah, blah, blah. We're going there anyway if we can. So it was just like, wow, they on the west side and I was really happy about that.

I work for Dick. I've already told you that. And I've already told you about my prior experiences with Humana Hospitals, where I was also

involved in the insurance division as well as being a chief executive officer for nursing and other services.

I know you're getting lots of business-oriented information, so this is all about the patient's experience and that's all it is. So I feel kind of bad because I really like RIO and I really would hate to see anything happen to that. You know, but you're going to make a good decision and I think it will be the right decision for the community.

I do want to point out that I do think that there's lots of people that are in between here and the coast. I can't imagine -- I don't know what other acute rehab facilities are available, but I can't believe that other people that are going to need acute services aren't going to seek them out, regardless of where they live if they've got the means to get there.

Hillsboro is growing by leaps and bounds and that's also half of the silicon forest so it's not getting smaller.

Okay, responses. Reasons to have another acute care facility, location, location, location. I'll just tell you that the commute is brutal. I

know -- I use Google Maps, I still use it I don't go anywhere in Portland anymore without Google Maps. I know every way to get to Legacy Hospital. I know some neighborhoods I would've never seen. I would never want to go back there again. But it took me a different way almost every time we went there. And if I had a 9:00 meeting I had to decide if I was going to try and leave, you know, at 5:30 so I wouldn't have to spend two or three hours in traffic. No, you know, I generally could make it in less than an hour.

So I would will just say that, you know, one of the greatest things we had when were in the hospital, because we were in Tuality Hospital there for four nights, it was, like, where are we going to have to get our rehab. Are we going to have to go someplace we don't want. Because, you know, they want to get you out right away, as soon as they can. Where are they going to send you?

And quite frankly, being an acute care oriented person, I was really not that skilled in understanding the extended care nursing home care and all of that. I can tell you that, you know, my brother had a stroke and he's younger than my husband. He lived in Minnesota. He was in a

skilled nursing unit and I can tell you that the main problem for him is that he didn't get therapy every day. And he was bored and depressed, and now that's Minnesota. It was a rural community. Maybe they didn't have really great services, but Minnesota is a pretty sophisticated medical environment. So, you know, I don't know what was going on there. It's just sort of an observation.

And then the access to our post outpatient care, we have Kaiser insurance, therefore, we had to use their network of services. So when we first got discharged -- by the way, I guess I should back up and say Bernie was a complex patient. He was on cardiac monitoring the entire time that he was in the acute hospital, both hospitals, RIO as well as Tuality. He went home on a cardiac event monitor. They couldn't figure out why he had a stroke. It turned out he had atrial fibrillation, which had been treated in the past, but, you know, I guess it just sneaks in on you what you're not looking.

He also went home with catheter. So we had to use Kaiser facilities for outpatient service and we all over because, like I said, because you go to the first available appointment, not the distance. But eventually all the care is now

provided by west side, with the exception of some complex patient issues, ophthalmology, neuro -- anyway. He's driving again. Before three months we're up, he's driving, but that's not necessarily a good thing, but he is driving.

So in conclusion, we support acute care rehabilitation closer and more accessible to west side patients. I think we -- like I said, I think as insiders we're a little bit more savvy about where you should go and may want to go. A lot people wouldn't have that insider knowledge and understand the importance of it, but we did. Thank you.

MR. GILMAN: John White.

MR. WHITE: Yes, I'm John White and I'm a professor of occupational therapy at Pacific University. And I speak in favor of additional rehabilitation services in Washington County. I've worked as an educator, researcher, and a practitioner over the last 40 years, mostly in the metro area. I've worked at rehabilitation facilities around the country and internationally. And I worked for some very happy years at RIO before it became a part of Legacy. And I've worked for their competition at Emanuel before they became

bonded in Legacy and RIO. And I can attest to the excellence of their services.

And part of why I think it would be good to have an intensive rehab facility in Washington County is because of the kind excellence they're able to provide to a different population, or a more accessible population I should say.

And so in supporting this, I wanted to look at research, convince what was an intuitive feeling about my experiences as to working in rehabilitation intensive and skilled nursing facilities. And that is that the outcomes are better almost across the board in terms of the different types of conditions and certainly for complex rehabilitation patients. That does come at an additional cost. Almost all research studies indicated there was additional cost. And I was not able to find a study that spoke to the long-term outcome cost. I assume there's studies out there that speak to that. I couldn't find them.

But my belief, based on working with a lot of people who had strokes and TBI, in their long-term recovery, that is sometimes 20-year recovery, is that quick intensive intervention makes a difference over the long run in terms quality of

life, in terms of functional ability, and in terms of a caregiver burden for that person. And so my feeling is that -- and again, it's more of an intuitive feeling, but my feeling is that the initial additional cost over skilled nursing in an intensive nursing facility, it paid off over the long term in terms of not having as much rehospitalization and so forth.

Another opportunity that I believe an additional facility would give, certainly healthcare professional students, is additional training opportunities. In terms of our own results of our own graduates from the Pacific University program, when students receive quality clinical education in the area, the chance of them staying in the area to continue practicing is higher. And for the most part, we've had shortages in most of the rehabilitation-related professions that could receive clinical training at a new facility. I know our student love those positions at RIO as opportunities, and I think that they would appreciate additional opportunities at a closer campus.

I think, also, there would be -- again, an intuitive feeling and I didn't hear statistics to

really support this today but Washington County is a more diverse county than Multnomah County as far as I know. And we need healthcare educators that -- or we need healthcare professionals who are able to learn about being more effective care providers of those people across a diverse population. And it seems that that would be true in an additional facility in Washington County.

And finally, one of my roles is working with people who have aphasia, that's a communication disorder related to brain injury -- thank you, I'll wrap it up. And they not only need comprehensive care so that they will have these better outcomes, but their care providers will get better training, and that they'll have additional outpatient services available to them over the often 20-year period that they will live with that condition. So I speak in favor. Thank you.

MR. GILMAN: Tom Hughes.

MR. HUGHES: Hi, I'm Tom Hughes and welcome to Hillsboro, first of all. I am here to speak in favor of this certificate of need for Encompass' hospital. I'm a little hesitant to be here today because the last time I weighed in on an issue about a certificate of need for a medical

facility was in '03, when I was mayor of Hillsboro. And during the process of the discussion, I wound up having a heart attack. So I'm hoping that that was a lightning-strike experience and not something that is cause and effect.

But one of the things that that heart attack taught me, and one of the reasons that I'm here today is that I had to have my stent placed at St. Vincent's. I had no trouble getting there. I had this white thing with a red light on top that took me right straight there. My wife who doesn't drive had a terrible time getting there and getting home, and was pretty much stuck hanging around for as long as I was there. Had that been a prolonged stay, it would have been almost unsupportable. And that was at St. Vincent's, which is relative close as opposed to Emanuel or Good Sam, which are both a little bit harder away. For somebody who doesn't drive, that becomes fairly difficult.

As somebody -- I would speak as somebody not -- I don't speak for the competitors. I don't speak for the healthcare practices in general. I speak mostly as a potential customer. You know, when they went over the list of conditions that they treat for in these hospitals, it was like they had

opened up my medicine chest and looked at all the drugs that I had currently prescribed for all of those kinds of conditions that lead to those kinds of problems.

I'm 76 years old and I think I represent a fair number of the growing population of Washington County, which is growing faster and older than most other parts of the metropolitan area. I think that if things are different in Oregon, we hear that things are different in Oregon on a number of levels. I was surprised to hear it in this discussion. Things are different in Oregon partly because we don't have this facility here. And so skilled nursing facilities have been replacing the treatment that other places people get through these kinds of hospital beds. And as somebody who is a potential customer of those, I would rather be in a facility that gets me out quicker with a higher level of success than the statistics show that the SNFs have on down the road.

So for those reasons, speaking on behalf of the -- I've been used to speaking for this community for eight years as mayor and eight years as president of the metro regional government. So I understand the needs in this part of the region in

particular, but I think that they are general throughout the Portland metropolitan area. So for that I'm speaking in favor. Thank you.

MR. GILMAN: Dick Stensen.

MR. STENSEN: Thank you. My name is Dick Stensen. What I'm here doing is I've been helping gather letters of support for the Encompass project and I'll tell you a little bit about why I did that -- and which includes some of those you have here and others, I think, I'll hand them in.

I was president and CEO of Tuality Healthcare for 22 years, and prior to that I was an associate and then administrator of the Straub Clinic and Hospital in Honolulu for 17 years. Prior to that I was in New Orleans and San Francisco working for healthcare organizations.

While I was in Hawaii, I was appointed to the state health planning and development agency certificate of need panel to review the capital projects, so I have an appreciation for the struggle you have in weighing the benefits across and making the important decisions for the community health services.

I have been impressed with the information about the Encompass project. In fact, I visited an

Encompass hospital when I was at a family gathering in Kansas City, the Mid America Rehabilitation Hospital in Overland Park. And I was very impressed with the quality of service, the intense service provided to patients. And I've been impressed with the organization as far ar everything I've learned about it.

What you have here and you'll see in the packet that I gave you, pages 3 and 4 is a list of all the letters of support that are in there. I would say before I touch on a couple of those for individuals who are not able to be here, that I came to believe this is something we really need in this community. The first time I worked -- I've been living here for the last 27 years. But also to touch on some of the things that Dr. Stillo pointed out that the CMS has noted the difference in outcomes of -- and return to community for both versus SNF. And he also pointed out the American Stroke Association guidelines for patients with stroke, that if they can get to an inpatient rehab facility, they should do rather than a skilled nursing facility. So it's very clear.

Mr. Stall also pointed out, of course, the dearth of beds compared to other states in the

country and our use of those beds. But fourth, and this is some new information for you this afternoon, you will find in my -- I think it's page 6 of that binder I gave you, despite the anxiety of the existing skilled nursing facilities, and I'm very highly aware of the services they provide, an analysis of ten different geographic markets, SNF utilization before and after opening an acute care inpatient rehab facility showed virtually no impact on utilization. And that graph is in there on page 6 take a look at that.

I mentioned my letter includes the names of the one or two dozen individuals who are in support of this project, but I want to touch on three of them briefly and then close my remarks. And those are physiatrists in the community, physical medicine and rehab specialists, board certified. And their specific comments are in the letters that you have there. First I will mention Dr. Bomalaski, to quote, "I am currently responsible for a 17-bed IRF in Eugene which cares for patients with a mix of stroke, traumatic brain injury, spinal cord injury, polytrauma, amputees, and other disabling injuries and diseases. This type of environment maximizes the functional recovery and

chances of returning to home, with greater independence and as compared with other environments, such as skilled nursing facilities. Since moving to Portland in 2018, I have been surprised and disappointed at the lack of inpatient rehab beds available. In comparison to other similar-sized metro areas, Portland lags far behind in providing access to these crucial services."

This is a physiatrist who has worked in several different communities across the country. And wants to stay in this year but wishes he had more resources to work with.

Then from Dr. Ensrud, a physical medicine rehab physician at OHSU, "Oregonians who cannot access acute rehab level services are getting inadequate rehab care that result in excessive disability." I think we've heard that from several different people today. "This does not allow these persons to fully participate in Oregon to the greatest extent of their potential."

And last I will quote Dr. Pagal, who is a resident of Hillsboro, but more importantly is a physiatrist. He is the Medical Director of the VA inpatient rehab facility in Vancouver, just across the river. Quote, "Throughout my years practicing

here, I have concluded that in general Portland should take pride in the high quality of medical services available. However, I have been impressed by the lack of high intensity inpatient rehabilitation in the metropolitan area. The inpatient rehabilitation units in the Portland area do a fine job with the patients they care for." And I think we've heard that today. "These units are all centrally located and the number of beds available for admission are limited. For these reasons, physicians and families routinely choose to place patients who would benefit from high intensity rehabilitation in skilled nursing facilities where only high intensity rehabilitation is available. A new acute inpatient rehabilitation facility on the west side of metropolitan Portland would greatly benefit the residents of Washington County who sustain catastrophic neurological or musculoskeletal injury."

I thank you for hearing my comments. Based on my experience, I think this is long overdue. Thank you.

MR. GILMAN: Bob Terry.

MR. TERRY: Thank you, Dr. Selover and ladies and gentlemen for being here. I encourage

you to approve this great deal for Encompass and our community. I'm a former Washington County Commissioner here and have worked in our county for over 26 years. I sat on our board for 24 years running the -- as chair or co-chair of the budget for this county. I'm also proud to tell you that I support our county and our health and human services division to the -- one of the few accredited -- nationally-accredited health and human services divisions in the state -- or in the country rather. So we are very proud of that and we are still an accredited health and human services.

I have here with me also a letter from our assistant administrator in our health and human services that I want to read, and then I have my own presentation to give to you. First of all, this is to Dr. Selover, and this is from Marie Santell, who as I said is the Assistant Administrator and the Division Manager for our Health and Human Services here in Washington County. "Dear Dr. Selover, Washington County Disability Aging and Veteran Services, DAVS, is supportive of Encompass Health's application to build an inpatient -- inpatient -- very important -- inpatient rehabilitation hospital in Washington County. As a local area agency in

aging, DAVS mission to strive to create -- very small print for my old eyes, I can tell you that. I'm sorry. Options that maintain the quality of life in older adults, veterans, and people with physical disabilities. DAVS serves a diverse population of individuals across urban, suburban, and rural areas in Washington County, Oregon. We believe that it is important for older adults and people with disabilities to have choices when it comes to their healthcare, including their post acute rehabilitation options," as this lady indicated over here. "Rehabilitation hospital can provide better outcomes, lower costs, and help older adults and people with disabilities live independently as possible. I hope that you will consider approving Encompass Health application for an inpatient rehabilitation hospital in Washington County. A regional, freestanding, inpatient rehabilitation hospital will provide the much needed services to older adults and people with disabilities, as well as in the larger community."

I also wanted to make some notes that was talked about transportation in Washington County and getting to downtown Portland or over to Multnomah County in general. I can tell you from firsthand

experience on many occasions, you don't do it very quickly no matter when it is, unless you're out there at 3:00 or 4:00 in the morning. It takes time. And it's not something that somebody needing these types of services that our other facilities do not provide inservice and outpatient as Encompass does, from what I have been able to learn.

And for myself, I am a veteran, as well as being a County Commissioner here, and for my personal endorsement, I have always worked very close to support Washington County Health and Human Services. As a veteran, it is imperative that we provide or have available to our citizens the services that Encompass can provide It is forecast that in a short six to eight years, Washington County will be our largest county in the state of Oregon. It is not practical to be running to Portland or Multnomah County for many of our services, but rather work in conjunction on a local level in support of our community service as we do now.

Washington County has always been a county that was always proud to support itself, support its local services such as Lifeworks and many others here in the local community, both with financial and

with supportive aid. Our walk-in clinic that we just opened is run actually by nonprofit organizations that we support here in the county as part of our county budget. The county has continued to upgrade many of our human resource services in all areas such as supporting Tuality Community Hospital, working with Oregon Health Science University, OHSU, to provide more current services in our community and our county walk-in clinic at Hawthorn Farms.

As I note, I have been on the Tuality Community Hospital Foundation board or at least 17 years. Encompass will make a great needed improvement to medical services not currently readily available to our community. Even though I have not -- in the workup of Encompass, I have not heard any dissent or negative comment as far as the needed services. I think that this would be called hopefully good competition. And I've hear some people here today, I don't agree with them, the services that I know they provide are not the same thing as Encompass and Encompass' type of people do provide, which is needed here locally, not just because of transportation reasons, but because we are the largest county -- will be the largest county

in the state, but we are also the most diverse county both in numbers of people and in the different types of diversity that we have in this county as was stated by Mr. White.

So I personally, as well as this county, encourages you to approve this and do it quickly. Thank you very much. I appreciate your support and your time and hearing us today. Thank you.

MR. GILMAN: All right. That is -- those are all commenters we have signed up and we do have time left if there are additional folks who have not given public comment, they would like to.

MS. STOCK: Sherry Stock again. I had another -- Carol Alleman (ph) that was here, and Carol had to leave. Today is her 80th birthday. Well, no, let me rephrase that. It's her 41st anniversary of being 39. But she -- she has both a traumatic brain injury home and everybody in her home -- it's a five-bedroom home, and everybody has brain and spinal cord injury. And she also has a day program that she works with Pacific University, actually, with students there and professors. So it's great programs that she's got but she only has a five-bedroom home, and she gets eight to ten calls a day for people that are in nursing homes looking

to get into the community to get into a home and to get into her day program. So the problem is there's not enough services here for the people that need them, which is what we're hoping -- what this will be bringing.

MR. GILMAN: Do you know if she's going to be submitting those comments in writing?

MS. STOCK: I can ask her to put that together.

MR. GILMAN: Thank you.

MS. STOCK: Yeah, after today.

MR. GILMAN: Yes.

MR. WHITE: Yes. I failed to cite one systematic review study that concluded that -- kind of emphasizing the point that to the extent IRFs often discharge to SNFs and so as a combination services often serve the community ideally. So again, it's providing the services that they do best. John White.

MR. GILMAN: Okay.

MS. O'FALLON: Can I -- Mr. Hughes, is he still here?

MR. STENSEN: No. He just left.

MS. O'FALLON: Oh, he just left. Do you know if he was representing anybody in particular or

just speaking for himself? Does anybody know?

MR. STENSEN: I think he was speaking for himself. He's retired.

MR. GILMAN: It says retired.

MR. STENSEN: He's a retired mayor of Hillsboro.

MS. O'FALLON: And Mr. Stensen?

MR. STENSEN: Yes.

MS. O'FALLON: Representing yourself or --

MR. STENSEN: I'm retired but I have been assisting Encompass in gathering information.

MS. O'FALLON: Okay. Thanks.

MR. GILMAN: We'll conclude our public meeting. Thank you all for joining us again.

(Whereupon, meeting concluded.)

CERTIFICATE

I, Cheyne Lee, do hereby certify that I reported all proceedings adduced in the foregoing matter and that the foregoing transcript pages constitutes a full, true, and accurate record of said proceedings to the best of my ability.

I further certify that I am neither related to counsel or any part to the proceedings nor have any interest in the outcome of the proceedings.

IN WITNESS HEREOF, I have hereunto set my hand this 28th day of October, 2019.

/S/ Cheyne Lee

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Written Testimony and Letters Supporting Certificate of Need for Encompass Health Rehabilitation Hospital of Oregon, LLC

Presented by:

Richard V. Stenson, FACHE, FACMPE

October 15, 2019

October 15, 2019

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, Oregon 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover,

I was president and CEO of Tuality Healthcare in Hillsboro for 22 years, where I continue to serve on two of its boards. Previously I had been Associate Administrator, and later Administrator, of Straub Clinic & Hospital and Straub Health Plan in Honolulu for 17 years. In my early career I worked in administration at Ochsner Clinic & Hospital in New Orleans and Health Maintenance Inc. in San Francisco. I have masters degrees in health care and business administration and am a Fellow of the American College of Healthcare Executives and the American College of Medical Practice Executives. While working in Hawaii I was appointed by Governor George Ariyoshi to serve as the hospital representative on the State Health Planning and Development Agency's Certificate of Need Review Panel, which had to approve all proposed health care capital projects and costly new service programs covered by CoN. Based on my service on that committee, I have an appreciation for the challenges you face in weighing these decisions of cost versus benefit that are so important to providing quality community health services.

Encompass requested that I work with it regarding its Certificate of Need application for Oregon's first free-standing acute rehabilitation hospital because of my experience in being the CEO of an acute care hospital system in Washington County (Tuality Healthcare), and because I am a resident of the community (Forest Grove), and have a good appreciation for the unmet health care needs in the area. In my work on this Encompass Certificate of Need application, I have been impressed with the company and its executives, and especially the excellent rehabilitation treatment their facilities provide to patients around the country. I have visited an Encompass rehabilitation hospital, the MidAmerica Rehabilitation Hospital in Overland Park, Kansas, and witnessed firsthand the intensive acute rehabilitation hospital treatment which the Encompass hospitals provide. I believe Oregon should approve the proposed Encompass Health Rehabilitation Hospital for Hillsboro because it is a much-needed service that will greatly improve accessibility to acute rehab and patient outcomes, especially for residents of Washington County. Further, I believe the new facility will have a negligible effect on existing skilled nursing rehabilitation services. Below, I will share the letters of over two dozen individuals who also feel this is a needed service in our area.

Before I do, I would like to review some of the most compelling information substantiating the need for this project.

First, with all due respect to the fine care provided by our skilled nursing facilities, we are speaking of two different levels of rehabilitation treatment. This is due in large part to the limited professional staffing and other resources SNFs can provide with the lower reimbursement they are paid by Medicare and other insurers. In short, Medicare and other insurers pay more for this intensive therapeutic care in an acute rehab hospital, with the required higher levels of physician and licensed professional staffing, and other services commensurate with an acute hospital setting. Regrettably, only a very small portion of patients can clinically qualify for IRF admissions. They must have an allowed diagnosis and be able to tolerate and benefit from a minimum of three hours of daily intensive therapy. But when they do clinically qualify for an IRF admission, the outcomes are exceptional. The Encompass slides summarized excerpts from CMS's Medicare Payment Advisory Committee (MedPAC) March 2017 report in which it noted that for similar acute hospital discharge diagnoses of patients requiring inpatient rehabilitation that inpatient rehabilitation hospitals had an average length of stay of 12.7 days versus nursing homes 38.4 days. Further, the IRF patients were discharged back to the community 76% of the time versus the nursing home patients only 40% of the time. It's all about being able to provide intensive therapeutic resources.

Second, to this very point of dramatic differences in outcomes for similar patients treated at IRFs versus SNFs, the American Heart Association-American Stroke Association published Guidelines for Adult Stroke Rehabilitation and Recovery states, "Whenever possible, the American Stroke Association strongly recommends that stroke patients be treated at an inpatient rehabilitation facility rather than a skilled nursing facility". This was included in the Encompass slides.

Third, despite years of research showing the significantly better outcomes for certain rehabilitation diagnoses in IRFs versus SNFs, Oregon is ranked 50th in acute rehab beds with just 0.19 beds per 1,000 population over the age of 65, versus a U.S. high of 1.79 beds (nearly 10 times greater), and U.S. average of 0.74 (nearly four times greater) beds per 1,000 population over age 65. This deficiency in appropriate use of available and accessible IRF beds in Oregon not surprisingly ranks us again last in the country for the percentage of Medicare rehab discharges as a percentage of Medicare acute discharges: barely 1% for Oregon, and slightly less for the tri-county area, versus a national average of 3.83% and high of 9%. We are simply not doing the best we can for our residents needing acute rehabilitation care. These statistics can also be seen in the Encompass slides.

Fourth, despite the understandable anxiety of existing skilled nursing providers, an analysis of 10 different geographic markets' SNF utilization before and after the opening of an acute inpatient rehabilitation hospital found virtually no impact on the SNFs. In fact, they quite often refer patients to each other when appropriate. I have attached this graph as page 6.

Below I list the names of the individuals who are knowledgeable in this field, or have reviewed the data and other information about the benefits of acute inpatient rehabilitation and believe as I do, that we need to move forward with approving more IRF beds. Their letters are also attached here for you to read in detail.

The list of individuals includes physicians specializing in Physical Medicine and Rehabilitation, and other specialties; rehab patients and patient advocacy organizations; elected officials familiar with Oregon's health services and local planning; and community leaders. We have been fortunate to hear from a few of them personally at the public meeting today. The entire list and their letters, in alphabetical order and attached are from:

1. Ann Barr-Gillespie, DPT, PhD, Vice Provost and Executive Dean, Pacific University College of Health Professions, page 7.

2. Martin Nicholas Bomalaski, MD, Board Certified in Physical Medicine & Rehab and Brian Injury Medicine, page 9.

3. Marilyn J. Booth, MD, Board Certified in Family Practice, page 10.

4. Bernie and Mary Brown, stroke patient (Bernie) and former Chief Nursing Officer (Mary) of Tuality Healthcare, page 11.

5. David Buuck, MD, Medical Director, Tuality Orthopedic, Sports, Spine and Rehabilitation Center, Hillsboro Hops Team Physician, page 13.

6. Kevin K. Chui, PT, DPT, PhD, Board Certified Geriatric Clinical Specialist, Board Certified Orthopaedic Clinical Specialist, Certified Exercise Expert for Aging Adults, Fellow of American Academy of Orthopaedic Manual Physical Therapists, Director and Professor, School of Physical Therapy and Athletic Training, Associate Dean for Faculty Affairs, College of Health Professions, Pacific University, page 15.

7. John M. Coletti, MD, FACS, Board Certified Orthopedic Surgeon, page 17.

8. Eric Ensrud, MD, Associate Professor, OHSU Orthopedics and Rehabilitation, Board-certified in Physical Medicine & Rehabilitation/EMG/Neurology/Neuromuscular Medicine, page 18.

9. Timothy J. Gray, II, DO, MBA, Board Certified in Family Practice, page 19.

10. Tom Hughes, former Metro president, former Hillsboro mayor, former chair of the Hillsboro Planning Commission, page 20.

11. Michael Jensen, traumatic brain injury survivor, founder of Happy Heads blog, page 22.

12. Janet LaBar, President & CEO, Greater Portland Inc., page 23.

13. Keith Pagel, MD, Board Certified in Physical Medicine & Rehabilitation, Medical Director of VA Inpatient Rehab facility in Vancouver, Washington, page 24.

14. Deanna Palm, President, Hillsboro Chamber of Commerce, page 25.

15. Jennifer Piper, Dean of Instruction, Portland Community College, page 26. (also signing same letter)
Janeen Hull, Dean of Allied Health, Emergency & Legal Services, PCC
Sheila Meserschmidt, Program Director, Institute for Health Professions, PCC
Karen Sanders, Dean of Health Professions, PCC

16. Heather Reynolds, MSN, RN, Director of Nursing, Portland Community College, page 29.

17. Chuck Riley, Senator, Oregon Senate District 15, page 31.

18. Richard A. Rutt, PhD, PT, Professor Emeritus, Pacific University, page 32.

19. Mjere Simantel, MSW, Program Supervisor, DAVS (Disability, Aging, and Veterans Services); and Director, AAA (Area Agency on Aging), Washington County, page 34.

20. Roger Smith, MD, Board Certified in Internal Medicine, page 35.

21. Adam Soll, MD, Board Certified in Physical Medicine & Rehabilitation, OHSU/Tuality Department of Orthopedics and Rehabilitation, page 36.

22. Sherry Stock, ABD/PhD, MS CBIST, Executive Director – Neuro Gerontologist, Brian Injury Alliance of Oregon, page 37; also testifying from BIAOR, Carol Altman, Traumatic Brain Injury home operator, and BIAOR Treasurer.

23. Bob Terry, former Washington County Commissioner (testimony only)

24. Sheridan Thiringer, DO, Board Certified in Family Practice, page 38.

25. John A. White, Jr., OTR/L, PhD, FAOTA, Professor, School of Occupational Therapy, Pacific University, page 39.

26. Fred Williams, Jr., MD, Board Certified in Neurosurgery, past Chief of Staff, Tuality Community Hospital; past president Oregon Neurosurgical Society; immediate past-President, Oregon Medical Association, page 41.

27. Daniel S. Wright, DC, Spine Care Chiropractic, page 43.

28. Glen Zielinski, DC, DACNB, FACFN, CBIS, Board Certified Chiropractic Neurologist, Certified Brain Injury Specialist, Fellow of the American College of Functional Neurology, page 44.

I would like to close my remarks in support of the Encompass Certificate of Need application with quotes from three of these letters written by physicians specializing in physical medicine and rehabilitation.

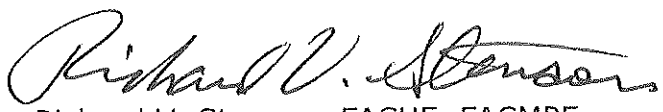
First from Dr. Bomalaski: *"I am currently responsible for a 17 bed IRF (Eugene), which cares for patients with a mix of stroke, traumatic brain injury, spinal chord injury, polytrauma, amputees, and other disabling injuries and diseases...This type of environment maximizes the functional recovery and chances of returning to a home environment with greater independence, as compared to other environments such as skilled nursing facilities...Since moving to Portland in 2018, I've been surprised and disappointed at the lack of inpatient rehab beds available. In comparison to other similar sized metro areas, Portland lags far behind in providing access to this crucial service."*

And from Dr. Ensrud at OHSU: *"Oregonians who cannot access acute rehab level services are getting inadequate rehab care that results in excessive disability. This does not allow these persons to fully participate in Oregon to the greatest extent of their potential."*

And from Dr. Pagel, Medical Director of the VA inpatient rehab facility in Vancouver, Washington: *"Throughout my years practicing here I have concluded that, in general, Portland should take pride in the high quality of medical services available however, I have been impressed by the lack of high intensity inpatient rehabilitation in the metropolitan area. The inpatient rehabilitation units in the Portland area do a fine job with the patients they care for. These units are all centrally located and the number of beds available for admission are limited. For these reasons physicians and families routinely choose to place patients who would benefit from high intensity rehabilitation in Skilled Nursing Facilities where only lower intensity rehabilitation is available. A new acute inpatient rehabilitation facility on the westside of metropolitan Portland would greatly benefit the residents of Washington County who sustain catastrophic neurological or musculoskeletal injury."*

Thank you for taking the time to consider all the community support for a free standing acute inpatient rehabilitation hospital in Hillsboro. In my experience and professional opinion, it is well justified and long overdue.

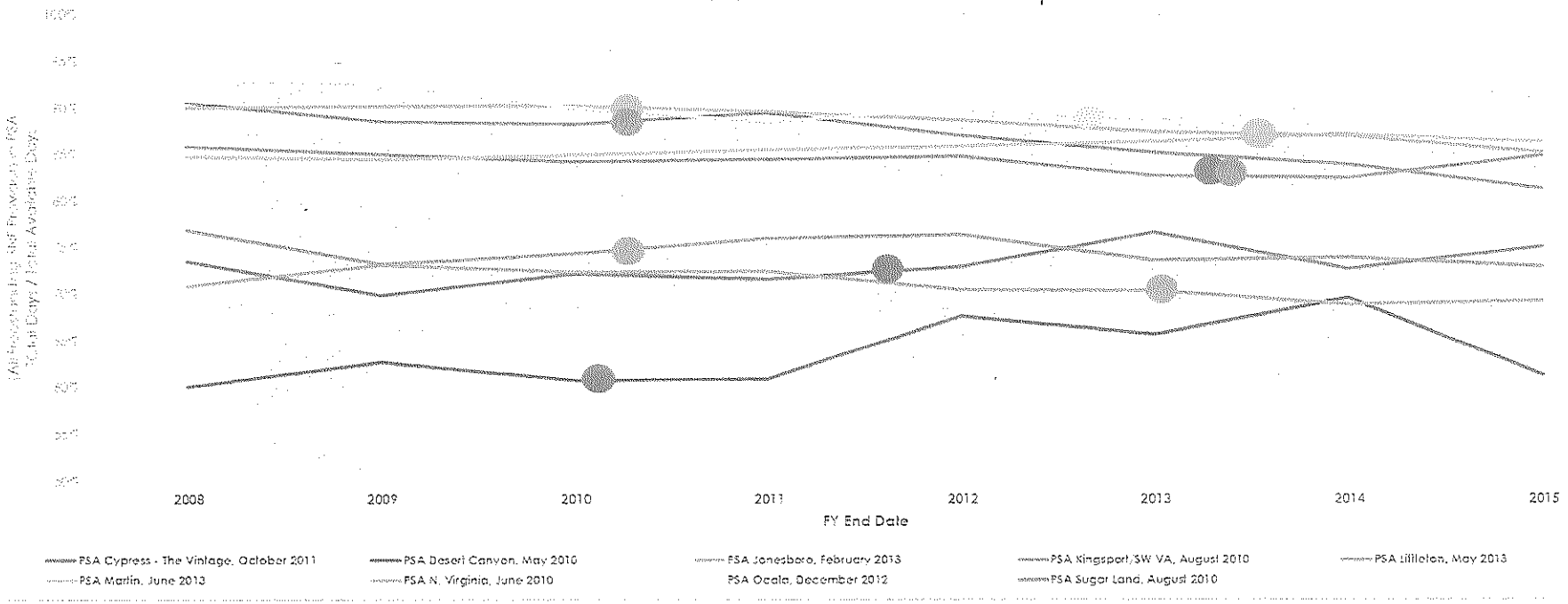
Sincerely,



Richard V. Stenson, FACHE, FACMPE
4872 NW Plum Hill Lane
Forest Grove, Oregon 97116

SNF Utilization in Encompass Health Markets

Before and After EHC IRF Opens



Note: Circle represents when Encompass Health opened hospital.

Pacific University Oregon

June 25, 2018

Dana S. Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

I am writing to express my support for Encompass's (previously known as HealthSouth) Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area. In my role as the Vice Provost and Executive Dean of the College of Health Professions at Pacific University, I am responsible for 14 academic programs in 8 health professions disciplines, including many that are integral to successful inpatient rehabilitation patient outcomes. Our programs in the College of Health Professions include athletic training, audiology, clinical psychology, dental hygiene, health care administration, gerontology, occupational therapy, pharmacy, physical therapy, and physician assistant. In our other four colleges, Pacific University also has graduate and professional programs in business, optometry, public health, social work, speech-language pathology and music therapy. We enroll over 2,000 graduate and professional students annually in these programs, and Pacific is well known for its graduates that are prepared for practice as members of highly collaborative, interprofessional teams.

All our health professions students must complete clinical practical experiences as part of their formal training, and placements in inpatient rehabilitation settings are in short supply in our area. Therefore, our academic programs could benefit from a free-standing inpatient rehabilitation hospital in the Greater Portland area. Such a facility would also provide career opportunities for our graduates in this specialized area of practice. Finally, our academic programs frequently draw upon the knowledge of practicing professionals to teach as adjunct faculty in our academic programs, which provides our students with a rich educational experience and clinicians with the opportunity to stay current in their practice. Again, the close proximity of a full-service inpatient rehabilitation facility to our academic programs would add access to education and practical training that we do not currently have available.

I have contacted colleagues with experience in placing students at Encompass facilities, and they describe a high quality and intensive learning experience that is an excellent opportunity for students. In addition, my review of the company's website indicates that the executive team is

VICE PROVOST & EXECUTIVE DEAN
COLLEGE OF HEALTH PROFESSIONS
190 SE 8th Avenue, Suite 230 | Hillsboro, OR 97123

highly representative of the health professions that comprise the Encompass workforce, including many of the professions represented in our programs.

For these reasons, I hope you will seriously consider the granting of a Certificate of Need to Encompass for an Inpatient Rehabilitation Hospital in the greater Portland area. It would be a welcome addition to the practical clinical preparation of Pacific health professions students, an opportunity for collaboration between our faculty and staff, career opportunities for graduates from our programs, and would provide a much needed service to patients in our area, as such a hospital does not exist in this region.

Sincerely,

Ann E. Barr-Gillespie, DPT, PhD
Vice Provost and Executive Dean
Barr-gillespie@pacificu.ed

9.

August 7, 2019

Dana S Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

My name is Nick Bomalaski, and I'm a physiatrist specializing in acquired brain injury rehabilitation. I am writing to express my support for Encompass Health's Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area. In my role as a physician at the Oregon Rehab Center in Eugene, I am currently responsible for a 17 bed IRF, which cares for patients with a mix of stroke, traumatic brain injury, spinal cord injury, polytrauma, amputees, and other disabling injuries and diseases. My belief in the importance of inpatient rehab has been further shaped by my experiences at the University of Michigan and University of Washington. Inpatient rehab provides a unique opportunity for patients with severe disabilities and often complex medical conditions to receive high intensity therapies and daily supervision from a physician and rehab nursing. This type of environment maximizes functional recovery and chances of returning to a home environment with greater independence, as compared to other environments such as skilled nursing facilities.

Since moving to Portland in 2018, I've been surprised and disappointed at the lack of inpatient rehab beds available. In comparison to other similar sized metro areas, Portland lags far behind in providing access to this crucial service. My intuition turns out to be backed up by statistics showing that Oregon ranks last in the nation in terms of the percentage of potentially IRF eligible patients who are discharged to this level of care (3.0% OR v 5.6% WA v 8.8% ID v 9.9 % nationally). This is unacceptable and should be a point of concern for healthcare providers and community members alike. However, in reaching out to various healthcare/hospital systems in our region, I've found a discouraging lack of interest to remedy this situation. I can't help but wonder where all the patients that would be receiving inpatient rehab in other parts of the country are ending up in the Portland area. My fear is that they are relegated to nursing homes or remaining in hospitals where they are not receiving the level of rehab they need to optimize functional recovery and independence. There is surely a toll to be paid for the overall quality of life of those in our community who are denied access to inpatient rehab.

For these reasons, I hope you can understand the importance and urgency in granting a Certificate of Need to Encompass Health to build Oregon's first free-standing rehab hospital. A project such as this is long overdue, and will bring Oregon closer to fulfilling its responsibilities to its citizens recovering from debilitating diseases and injuries.

Sincerely,

Martin Nicholas Bomalaski MD
Locums Medical Director
Oregon Rehabilitation Center
Board Certified in PM&R and Brain Injury Medicine
bomalamn@gmail.com
(206)422-4496

Hi, Dick,

I am currently in Juneau, AK, 2 weeks into a six week motor home tour of the state and won't be home until early August. I have no access to a real computer or any printer in the meantime.

I do feel that such a facility would be a significant and welcome addition to the currently available rehab options. I've had many patients over the years I suspect would have improved more quickly had such a facility been available. My own father spent time in such a facility in Reno after a hip fracture and I was impressed with the effectiveness of their multidisciplinary approach to rehab.

Please feel free to use this email in support of the project, but it's the best I can do at the moment.

All the best,

Marilyn J Booth, MD (retired)

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August 26, 2019

475 NE Hillwood Drive
Hillsboro Oregon, 97124

Dear Dr. Selover,

We support the Encompass Certificate of Need (CON) for a new, free-standing acute hospital specializing only in rehabilitation to be built in Hillsboro.

Dick Stenson asked that we consider writing a letter supporting this project and are happy to do so in light of our recent and ongoing experience with stroke.

On May 31, 2019 Bernie had a stroke and spent four days in Tuality Hospital after which he was transferred to Legacy Good Samaritan Medical Center, Rehabilitation Institute of Oregon (RIO). He was discharged June 20th.

If excellence, professionalism, and compassion from the RIO staff were the only indicators for considering another inpatient rehabilitation center in the greater Portland metropolitan area we would not be writing in support of an additional facility.

There is no doubt that the people who provide the direct services are the most important component and they are the reason why RIO has a stellar reputation. It is certainly not the facility itself which is difficult to get to and suffers many challenges related to design and the age of the structure.

By way of background we are both retired. Bernie worked for David Evans and Associates (DEA) where he did complex property appraisals and cost analysis for major infrastructure and transportation projects. Prior to that he was managing commercial properties in New Zealand.

Mary worked for Dick at Tuality and was the chief nurse executive before retiring in 2007. Prior to that she held similar positions in Humana Hospitals and was involved in the startup of their insurance division.

We know that you will get lots of business-oriented data so we will focus on what is most important – the patient experience.

But first we want to point out that Hillsboro has over 100,000 residents not including the neighboring cities of Beaverton, Forest Grove, and Cornelius, The unincorporated urban areas are also having increased population growth.

Hillsboro is also the hub of Oregon's silicon forest – high tech and manufacturing and supporting businesses.

Reasons to have another acute care rehabilitation facility.

Location, location, location.
The commute from the westside is brutal. Thanks to Google maps we know every route to and from Portland facilities. Ease of access is the primary reason why we are supporting another acute rehabilitation facility.

Access to acute rehabilitation care.
Once basic survival was established our greatest anxiety was rehabilitation. We talked about RIO being the closest and best place to go but there was no assurance that there would be a bed available when Bernie was to be discharged from Tuality. Thankfully all the physicians and therapy staff at Tuality recommended RIO.

Without offense to skilled nursing facilities (SNF) we had personal experience with the type of services available.

Mary's brother, who lives in Minnesota had a stroke in late January and he was the perfect candidate for acute care rehabilitation. However, he was sent to a SNF rehabilitation unit. Chief among his complaints was how little rehabilitation he actually received over a much longer length of stay. Being bored and discouraged was a problem for him.

Bernie on the other hand had therapy sessions scheduled throughout the workweek and sometimes on weekends. To visit Bernie, one had to be there at mealtimes or participating in the therapy session.

Access to outpatient care
We have Kaiser insurance therefore we receive outpatient care via their network of services.

Initially the commuting was more of the same but in this case to a Kaiser facility that could provide a timely appointment. It didn't take too long before all the outpatient work, with a couple of exceptions for super specialists, was available with time to spare in less than 30 minutes.

In conclusion we support another acute care rehabilitation facility that will serve the needs of patients locally and from outlying areas especially to the west of Hillsboro.

Sincerely,

Bernie Brown, Mary C. Brown

Bernie and Mary Brown

13.

TUALITY HEALTHCARE
An OHSU Partner

OHSU

Orthopedic, Sports, Spine
& Rehabilitation Center

tel 503-844-8219
fax 503-844-8234

1200 NE 48th Ave., Suite 1100
Hillsboro, OR 97124

July 8, 2018

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation and Quality
Public Health Division
800 NE Oregon St.
Portland, Oregon 97232

Re: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover,

I am writing in support for Encompass's proposal for a comprehensive rehabilitation hospital here in Oregon. I have been an orthopaedic surgeon in the greater westside Portland area for the last 24 years. I am currently the medical director for my seven man orthopaedic and physical medicine group. I have been on the staff at Tuality Hospital here in Hillsboro throughout these years. I have had the unfortunate opportunity over the years to see the drop off in quality for rehabilitation services in my area.

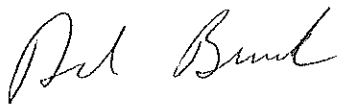
I am on active staff at my hospital which means I have to take emergency room call. This involves taking care of many types of fractures. Specifically, I deal with a lot of hip fractures in the elderly. I also do quite a few knee replacements . Several years ago, we had the luxury of having the ability to transfer our orthopaedic inpatients to the skilled nursing facility within the hospital. That allowed my patients to be seen by the physical therapists at least once, if not twice a day. Once this wing closed, we had to send our patients out to the random local skilled nursing facilities and assisted living facilities in the area. These are not geared for optimal comprehensive rehabilitation and the care has been uneven. For me personally, the rehabilitation is just not as good at these places. In talking to my patients who have been in these facilities, the therapists sometimes do not see them regularly, don't push the patients for maximal progress, sometimes don't come at all. Therapy is critical in my post-op total knee and fracture patients to regain range of motion soon after surgery. They cannot get this back at a later date. The first two weeks are critical for the need

for aggressive, frequent physical therapy.

I feel my patients would do much better if we had a place on the westside of Portland that was a comprehensive, multi-disciplinary facility for these post-surgical patients. Once the surgery is done, I become somewhat of a cheerleader for my patients, encouraging them in the office to work on range of motion and strength. That said, it is the therapists at the facilities that are doing the actual post-op work with the patients that help make the surgery and outcome successful. These patients often come with co-morbitities that would be better treated at a facility with a multi-discipinary approach that would include physical therapy, nutrition evaluation, possible neurologic evaluation and other modalities as needed.

For all of the reasons listed above, I would hope you would grant a Certificate of Need to Encompass for an independent acute comprehensive rehabilitatiion hospital in the greater Portland area. It would provide an upgrade in rehabilitation services in my area that I would definitely use. This type of proposed facility does not exist in my area currently.

Sincerely,



David A. Buuck, MD
Medical Director
Tuality Orthopedic, Sports, Spine and Rehabilitation Center
Hillsboro, Oregon
Hillsboro Hops Team Physician, Arizona Diamondbacks affiliate

15.

Pacific University Oregon

School of Physical Therapy and Athletic Training
222 SE 8th Ave., Hillsboro, OR 97123
Phone: 503-352-7378 Fax: 503-352-7340

10/8/19

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Please consider my support for the Certificate of Need application from Encompass Health Rehabilitation Hospital of Oregon. As the Director of the School of Physical Therapy and Athletic Training, and the Interim Director of the School of Occupational Therapy, I represent the perspective of programs that help to fill the national shortage of health professionals, in particular those that serve patients in need of rehabilitation. In addition, as a resident of Hillsboro, I represent a local voice that recognizes the emerging healthcare needs of our community. Below is a summary of reasons that I offer my enthusiastic support for Encompass Health Rehabilitation Hospital in Hillsboro.

As an administrator at Pacific University, our health professions require full-time clinical education opportunities for our students. These clinical education partnerships serve both parties – the host (Encompass) can use this opportunity to recruit new employees and Pacific can use this opportunity to meet the educational needs of our curriculum and accrediting bodies. In addition, there are numerous opportunities such as research, teaching and continuing education opportunities for Encompass employees, joint program development, and service opportunities, among others. For these reasons we are excited about a new rehabilitation hospital in our community.

As a resident of Hillsboro, I see the population both growing and aging, especially with the addition of ~30,000 residents in "Hillsboro South" in the near future. For current and future residents in Hillsboro and neighboring towns, adding Encompass will increase access to rehabilitation options to those west of Portland. In addition, given the reputation of Encompass, patients will have increased access to a provider with an outstanding reputation for patient care and patient outcomes.

For the reasons noted above, I offer my enthusiastic support for Encompass Health Rehabilitation Hospital in Hillsboro. As an administrator at Pacific University and resident of Hillsboro, adding Encompass to our community will meet many of our educational and healthcare needs. I hope that you will consider granting Encompass a Certificate of Need. Please contact me at your convenience if you require additional information in support of their application.

Respectfully,

Kevin Chui

Kevin K. Chui, PT, DPT, PhD
Board Certified Geriatric Clinical Specialist
Board Certified Orthopaedic Clinical Specialist
Certified Exercise Expert for Aging Adults
Fellow of the American Academy of Orthopaedic Manual Physical Therapists

Director & Professor, School of Physical Therapy and Athletic Training
Associate Dean of Faculty Affairs, College of Health Professions
Pacific University
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The faculty and staff of the College of Health Professions strive to inspire our students to think, care, create and pursue justice in our world.

John M. Coletti, Jr. MD
1651 NE Orenco Station Parkway
illsboro, Oregon 97124

Dana S Selover, MD, MPH
Section Manager, Health Care regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 972342

RE: CON for Encompass Health Rehabilitation Hospital

Dear Dr. Selover

This letter is sent as a voice for support for Encompass's CON as an Inpatient Rehabilitation Hospital in the Portland area. As an Orthopedic Surgeon I have had experience with many patients who have undergone major surgical procedures for both reconstructive and traumatic issues. Many have need of post hospital care for improvement of function. Physical therapy and close follow up for complex medical issues is typically required for return to independent living. Of these many are elderly with multiple medical issues often requiring a lengthy rehabilitation process .

The model of care outlined by Encompass Rehabilitation Hospital brings services in house to include Internists, Physiatrists, Physical Therapists, and even Radiology not typically available where many patients are placed for rehabilitation and thereby shortening length of stay. My experience is such that I find care quite variable in terms of length of stay.

The availability of rehabilitation facilities with such a comprehensive care model is limited in the greater Portland area. I hope you will give serious consideration to Encompass's request for a CON.

Sincerely,

John M. Coletti, MD,FACS

OREGON HEALTH & SCIENCE UNIVERSITY

SCHOOL OF MEDICINE
DEPARTMENT OF ORTHOPAEDICS AND REHABILITATION

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Kathryn Schabel, MD

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James E. Meeker, MD

Hand & Upper Extremity
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Omar Nazir, MD
Robert M. Orfaly, MD

Pediatric Orthopaedics
Matthew F. Halsey, MD
Scott Yang, MD

Physical Medicine/EMG
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Nels L. Carlson, MD
Erik R. Ensrud, MD

Spine
Jayme Hiratzka, MD
Clifford Lin, MD
Paolo Punsalan, MD
Jung U. Yoo, MD

Sports Medicine
Jacqueline Brady, MD
James C. Chesnutt, MD
Dennis C. Crawford, MD, PhD
Andrea S. Herzka, MD

Trauma/Reconstruction
Zachary M. Working, MD

Total Joint
Ryland Kagan, MD

Tumor/Oncology
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Kenneth Gundle, MD
James B. Hayden, MD, PhD

Research Director
Brian Johnstone, PhD

Research
Lynn Marshall, ScD

January 25, 2019

Dana S Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

I am writing to express my support for Encompass's Certificate of Need application to build an inpatient rehabilitation hospital/facility (IRF) in the greater Portland, Oregon area. In my role as Associate Professor of Orthopaedics and Rehabilitation at OHSU, I am responsible for education in rehabilitation medicine for OHSU medical students and orthopedic residents.

Acute level rehabilitation in an IRF, providing three hours of intensive physical/occupational/speech therapies per day, is associated with markedly improved outcomes compared with less intensive subacute nursing facilities (SNF) in many acute disabling illnesses, including lowering the rate of death after a stroke by over 29% in the first two years following the stroke. Oregon has ~1/3 the average US number of per capita acute rehab/IRF beds and subsequently less than 1/3 of Oregon patients are discharged to the IRF level of appropriate and life/function saving rehab therapy. I have somewhat unique extensive experience working in both the acute care setting as a neurologist and the acute rehab setting as a physiatrist, which has resulting in me realizing fully the markedly improved outcomes patients can obtain with acute level rehabilitation after devastating neurologic and orthopedic events. This has been clear in my work in both the Spaulding/Harvard system in Boston and the St. Luke's/Providence system in Spokane.

Oregonians who cannot access acute rehab level services are getting inadequate rehab care that results in excessive disability. This does not allow these persons to fully participate in Oregon to the greatest extent of their potential.

Encompass Health is a well-recognized and respected provider of acute level inpatient rehabilitation throughout the U. S. Their proposed new hospital in Hillsboro would be a great asset for the residents of Portland and wider Oregon, and would be a great step in expanding access to appropriate and effective acute level rehab services.

For the reasons stated above, I hope you will seriously consider the granting of a Certificate of Need to Encompass for a free-standing inpatient rehabilitation hospital to provide greater access to acute level rehabilitation.

Most Sincerely,

Erik Ensrud, M.D.
Associate Professor
OHSU Orthopedics and Rehabilitation
Board-certified in PM&R/EMG/Neurology/Neuromuscular Medicine

19.

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Dana S Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

I am writing to express my support for Encompass's (previously known as HealthSouth) Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area. In my role as Primary Care Physician and Practice Medical Director, I am responsible for primary care to my panel of patients and leadership of a team of physicians, nurse practitioners and physician assistants.

Our current system in Oregon cares for patients needing rehab after hospitalization in skilled nursing facilities. From the 2016 Medicare claims data that I have reviewed, Oregon has the lowest percentage of patients entering inpatient rehab. In my busy family practice I rarely work with patients who were at one of the few inpatient rehab facilities in Portland. When I do I am always impressed at the results and I wish that more of my patients were able to enter one of these facilities. The teams at the skilled nursing facilities are dedicated and work hard but do not have the same level of resources that our patients get from an inpatient rehab facility.

In my care of patients in the outpatient primary care setting we see the benefits of intensive physical, occupational, and speech therapies that results in lower length of stay, improved functionality, returning faster to activities of daily living. CMS data that I have reviewed shows inpatient rehab facilities get lower ED visit usage, shorter time to return home and lower mortality when compared with SNF's.

I fully support the need for a CIPR hospital in this region and urge the Oregon's Public Health Division to approve HealthSouth's CON application. The fact that HealthSouth accepts all insurances, and furthermore will accept unfunded patients as part of their mission, offers the option of CIPR to the people in more rural and less well-to-do counties in the service area who would otherwise have no access to this level of care whatsoever.

Sincerely,

8-7-18

Timothy J Gray II DO, MBA
Medical Director/Family Physician
Mountain View Medical Center

August 29, 2019

Dana S. Selover, MD, MPH
Section Manager, Health Care
Regulation and Quality
Public Health Division
800 NE Oregon St.
Portland, Oregon 97232

Re: CON for Encompass Health
Rehabilitation Hospital of Oregon,
LLC.

Dear Dr. Selover;

I am writing to support Encompass's proposal for a comprehensive rehabilitation hospital here in Oregon. As a former Mayor of Hillsboro and a former President of the regional government (Metro) I have spent many years worrying about the economic and physical health of our region. I am interested, therefore, in the statistics that show that patients who have these types of services available to them are twice as likely to be

successfully returned to the community and, on average, in 1/3 the time as patients who are served by other types of facilities.

As a person over the age of 65, I am clearly in the age group most likely to need these services. I am, therefore, concerned that Oregon ranks last of 6the 50 states for both the percentage potentially rehab appropriate patients discharged to impatient rehabilitation and the number of rehab beds per 1000 population over 65. This proposal would seem to fill an important gap in the health care service delivery system for the state.

For these reasons, I would urge you to grant a Certificate of Need to Encompass for an independent acute comprehensive rehabilitation hospital in the greater Portland Metropolitan area.

SINCERELY,

TOM HUGHES
2722 SE HOLLYHOCK CT
HILLSBORO, OREGON 97123

22.

Happie Heads LLC
9/18/2018

Dear Dr. Selover,

I am writing this letter in support of the building of an Inpatient Rehabilitation Hospital in Portland, OR. I support Encompass's Certificate of Need application to such a facility. As a resident of the west side suburb of Hillsboro, Oregon, and a brain injury survivor, I understand the need of more rehabilitation beds in Hillsboro, and the entire Portland area.

Since I received my brain injury out of state, most of my acute rehab occurred outside of Portland. Although I cannot speak of direct personal experience with the inadequacies with the current rehab opportunities in Portland, I can speak of its impact on the survivors in my community. I run a podcast for brain injury survivors, and run several brain injury support groups in the Portland area, and have seen first hand how Portland's lack of rehab facilities has impacted their recoveries.

One young man I know well was treated in RIO at Legacy's Good Samaritan Hospital for several days after his recovery, and received excellent care. Unfortunately, due to the extent of his injury, a few days was not sufficient to fully prepare him to be discharged. He was sent to a Skilled Nursing Facility (SNF), and his condition slowly worsened due to a lack of resources at the SNF. If he had a longer stay at RIO or another facility equipped to handle his case, he would have recovered more fully and more rapidly. This is just one example of the dearth of appropriate rehab facilities for brain injury survivors in Portland, and I believe an Encompass Inpatient Rehab Hospital would provide support to countless lives.

I can only speak of the brain injury world, but I can say with complete certainty that your granting of a Ceritificate of Need would be a crucial step in providing life altering care for hundreds of brain injury survivors in the greater Portland area, and potential the entirety of the state.

Sincerely,

Michael Jensen
503-804-4841
10697 NW Valley Vista Road Hillsboro, OR. 97124
Founder of Happie Heads LLC

23.

GREATER PORTLAND

[illegible]

August 7, 2018

...E S Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
...blic Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

I am writing to express my support for Encompass Health's (previously known as HealthSouth) certificate of need application to build an inpatient rehabilitation hospital in the Greater Portland area. As President and CEO of Greater Portland Inc, the region's public-private partnership dedicated to bringing jobs and investment to the region, I feel it is critical our region provides high-quality care for its seniors.

As you know, our region's population has grown by hundreds of thousands in the last several years. And as our region's Baby Boomers age, the demand for health care facilities that serve them is growing. According to U.S. Census data, the percentage of Washington County residents age 65 and over has risen from 10 percent in 2010 to 13 percent in 2017.

There is a true need for more rehabilitation facilities in our region, especially for inpatient facilities. While two such facilities currently operate in the market, there are no freestanding inpatient rehabilitation hospitals serving this part of the region. Our region's residents deserve to have a high-quality inpatient facility close to home.

This proposed facility will not just increase the quality of life for our aging neighbors and their families, but boost our economy. In addition to Encompass Health's initial investment for the land and construction of the facility, this project will bring in construction jobs and local tax revenue. Most critically, the proposed hospital will add about 100 high-paying medical jobs upon opening, increasing to about 160 jobs over a five-year period.

This project is a win-win for our region: It will improve quality of life for our senior residents while adding jobs and opportunities for our workforce. For these reasons, I urge you to seriously consider granting a certificate of need to Encompass Health for an inpatient rehabilitation hospital in the Greater Portland area.

Sincerely,

Janet LaBar
President and CEO
Greater Portland Inc

24.

September 25, 2018

Dana S Selover, MD MPH

Section Manager, Health Care Regulation & Quality Improvement

Public Health Division

800 NE Oregon Street

Portland OR, 97232

Re: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

I have been a Physical Medicine and Rehabilitation physician in Oregon for the past 25 years practicing in the Portland metropolitan area. In my role as a senior physician leader I am responsible for a department of 60+ rehabilitation clinicians including physicians, therapists, nurses, etc. I oversee a robust outpatient service, acute inpatient service and 21 bed CARF accredited rehabilitation unit.

Throughout my years practicing here I have concluded that, in general, Portland should take pride in the high quality of medical services available however, I have been impressed by the lack of high intensity inpatient rehabilitation in the metropolitan area. The inpatient rehabilitation units in the Portland area do a fine job with the patients they care for. These units are all centrally located and the number of beds available for admission are limited. For these reasons physicians and families routinely choose to place patients who would benefit from high intensity rehabilitation in Skilled Nursing Facilities where only lower intensity rehabilitation is available. A new acute inpatient rehabilitation facility on the westside of metropolitan Portland would greatly benefit the residents of Washington County who sustain catastrophic neurologic or musculoskeletal injury. It would allow patients to receive high quality rehabilitation close to their families and allow local clinicians to provide continuity of care for their patients.

The rehabilitation literature is clear regarding the benefit of high intensity rehabilitation for select patients. There is limited availability of high intensity rehabilitation available on the westside of Portland. For these reasons, the state of Oregon should consider approving a Certificate of Need for an Inpatient Rehabilitation Hospital in Washington County.

Sincerely,

Keith Pagel, MD

HILLSBORO
CHAMBER

August 26, 2018

Dana S. Selover, MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

The Hillsboro Chamber of Commerce represents more than 800 businesses and 50,000 employees in the Hillsboro area. The Hillsboro Chamber would like to express its support for Emcompass' (previously known as HealthSouth) Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area.

The Hillsboro Chamber is the voice of the business community and as such we know and understand the need for this type of facility in our area. Patients currently must travel long distances for these types of advanced state of the art technologies in acute patient rehabilitation care.

We hope you will seriously consider the granting of the Certificate of Need to Encompass for an Inpatient Rehabilitation Hospital in the greater Portland area. It would provide a much needed service to patients as well as to the larger community, as such as hospital does not exist currently in Oregon.

Thank you for your consideration.

Sincerely,

Deanna Palm
President

26.

Portland Community College

Dana S Selover, MD MPH
Section Manager
Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

We are writing to express our support for Encompass's (previously known as HealthSouth) Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, OR area. In our roles as educational administrators at Portland Community College, we are responsible for supporting instructional learning opportunities for students in on campus and off campus environments. A new rehabilitation hospital in the greater Portland, OR area would provide clinical opportunities for our students pursuing career pathways in many of our Healthcare programs.

Since the 1970's, Portland Community College has played an integral role in training the Portland, OR metropolitan area healthcare workforce. We have 18 healthcare programs and/or certificates representing a range of healthcare training. We spend approximately $7.5 million annually to fund our healthcare programs. We graduate approximately 1000 students that enter the healthcare workforce annually. A new Inpatient Rehabilitation Hospital would provide a clinical location for many of our students to learn and train, some of which may become future employees of Encompass Health. An opportunity that is vital to our students completing their training and certifications in the nation's number one workforce area - healthcare.

An Inpatient Rehabilitation Hospital would provide students a unique and specialized care environment focusing on physical, occupational and speech therapies. Other facilities such as nursing homes do not focus on improved functionality, helping patients return to quality of life activities and restored functionality. Students don't have opportunities to practice skills in facilities that are focused on patient care from a restorative health and wellness perspective.

For these reasons, I hope you will seriously consider the granting of a Certificate of Need to Encompass for an Inpatient Rehabilitation Hospital in the greater Portland area. It would provide a much needed service to patients in the greater Portland, OR area, as such a hospital does not exist in this region.

Sincerely,

Jennifer Piper
Dean of Instruction
Portland Community College
Southeast Campus

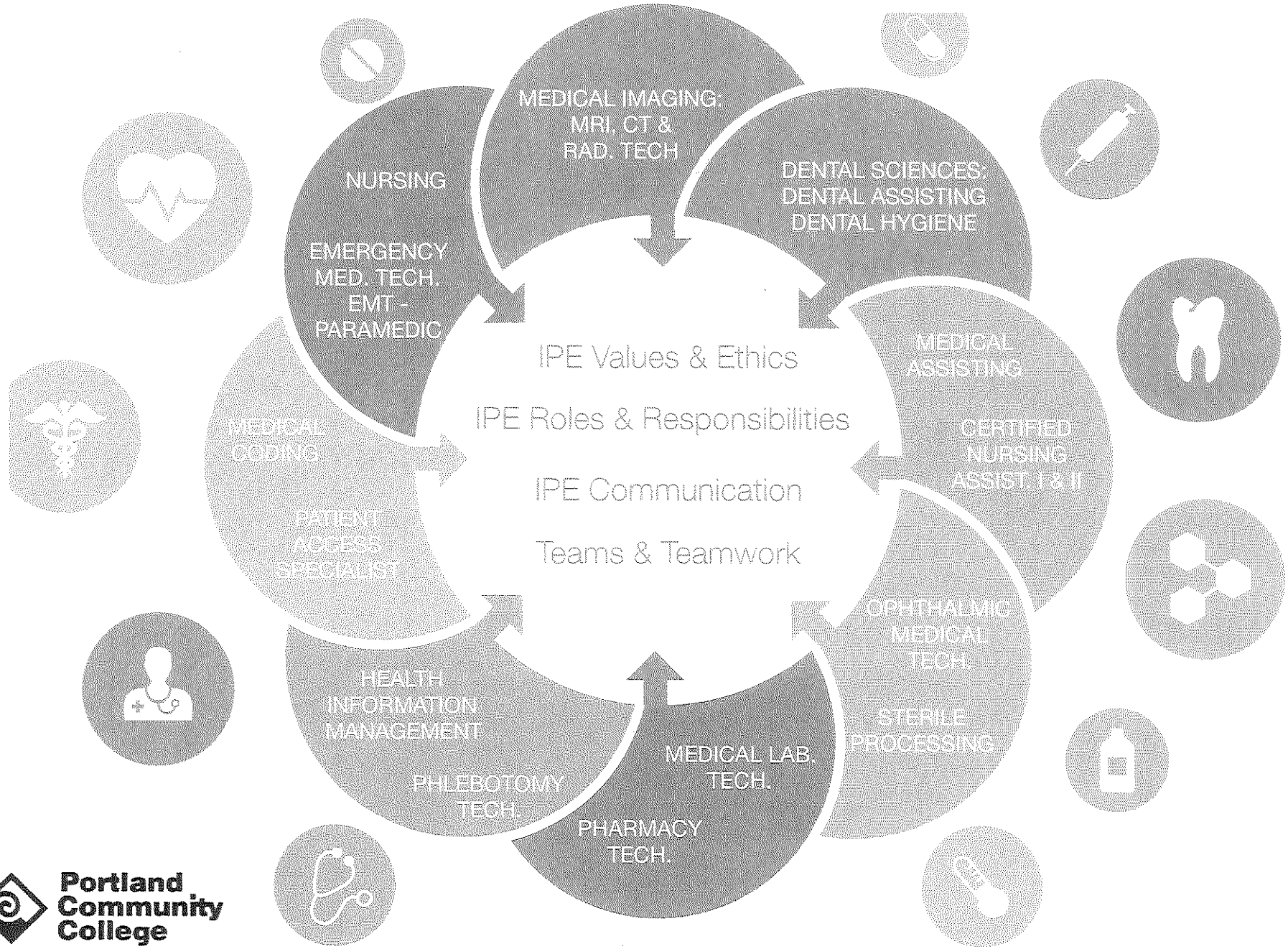
Portland Community College

Janeen Hull
Dean of Allied Health, Emergency & Legal Services
Portland Community College
Cascade Campus

Sheila Meserschmidt
Program Director, Institute for Health Professionals
Portland Community College
Climb Center

Karen Sanders
Dean of Health Professions
Portland Community College
Sylvania Campus

Portland Community College Health Professions Programs



Portland Community College

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August 30, 2019

Dana S Selover, MD MPH
Section Manager, Health Care Regulation &Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover,

I am writing to express my support for Encompass's Certificate of Need application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area. As a nurse, I care deeply about improving the health of our communities. The nursing program at Portland Community College prepares future nurses to meet the evolving health needs of our community. In my role as nurse administrator for this program, I am responsible for providing high-quality instructional learning opportunities for students in on-campus and off-campus environments. A new rehabilitation hospital in the greater Portland, OR area would improve the health of our community by providing high-level rehabilitation care to members of our community and providing clinical opportunities for our students pursuing careers in nursing.

Since the 1970's, Portland Community College has played an integral role in training the Portland, OR metropolitan area nursing workforce. We serve approximately 80 nursing students a year. A new Inpatient Rehabilitation Hospital would provide a clinical location for many of our students to learn and train, some of whom may become future employees of Encompass Health. Clinical opportunities are vital to our students completing their training and joining the nation's largest health care profession – nursing. Clinical placements at an Inpatient Rehabilitation Hospital would provide a unique opportunity to provide specialized nursing care with a healthcare team focused on restorative health and wellness. This type of experience is not currently available to the majority of our students.

As a former coordinator for both the stroke and total joint replacement programs at a large Portland metropolitan area hospital system, I have witnessed the benefits of Inpatient Rehabilitation. I have seen the physical and psychological benefits patents receive from the accelerated recovery care at an inpatient rehabilitation facility provides. Additionally, care at an inpatient rehabilitation facility is recommended by the American Stroke Association.

For the above reasons, I hope you will seriously consider the granting of a Certificate of Need for Encompass for a free-standing Inpatient Rehabilitation Hospital in the greater Portland area.

Such a hospital does not presently exist in this region, and it would provide much needed services to patients and future health care providers and positively impact the health of our community.

Sincerely,

Heather Reynolds, MSN, RN
Director of Nursing
Portland Community College

July 2, 2018

Dana S. Selover, MD, MPH

Section Manager, Health Care Regulation & Quality

Public Health Division

800 NE Oregon Street

Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

First, thank you for the important work you do to assure all Oregonians have quality, cost effective health services available throughout the state.

I am writing to encourage your thoughtful consideration of the Certificate of Need application from Encompass Health to build an inpatient rehabilitation hospital in Washington County.

As you know, there are no inpatient rehabilitation services west of Portland and patients and families often cannot, or prefer not, travel far from home for most things, including health services. This is more so for rehab patients and their spouses who are usually well over the age of 65.

The research I have seen from Encompass Health indicates significantly better outcomes when patients are treated with intensive therapy services and specialists, for a shorter length of stay, in an IRF versus an SNF for similar conditions. Further, Encompass Health assures me they accept all clinically appropriate patients, regardless of insurance coverage, including Medicare, Medicaid, and charity care.

The information I have seen also indicates that Oregon has the lowest use of IRF services in the U.S. for potentially appropriate rehab patients; 3% vs. 9.9% nationally. There would appear to be a correlation between this lower use rate of IRF services in Oregon and the small number of IRF beds available for them in only a handful of our communities.

I believe an inpatient rehabilitation hospital, such as Encompass has proposed for Washington County, would greatly improve the prospects for returning to independent living for patients with these conditions who reside in our westside communities.

Thank you for your consideration.

Sincerely,

Senator Chuck Riley

Senate District 15

32.

503-703-5575 ruttpt@comcast.net 360 SW 192nd Place, Beaverton, Oregon 97006

July 19, 2018

Dana S Selover, MD, MPH
Section Manager Health Care Regulation & Quality
Public Health Division
800 NE Oregon Street
Portland, Oregon 97232

Dear Dr. Selover:

I am writing as former Director of the School of Physical Therapy at Pacific University and private citizen. The School of Physical Therapy located at Pacific's Health Sciences Campus in Hillsboro provided education to 150 (50 in each cohort) students leading to the Doctor of Physical Therapy Degree. In addition to physical therapy Pacific educates students in the areas of occupational therapy, athletic training, pharmacy, physician assistant, clinical psychology, dental hygiene, audiology and health administration.

The primary goal of the School of Physical Therapy is to graduate a well-rounded and highly competent clinician. Students come locally from Oregon, from the Pacific Northwest and from around the country. The program offers an entry-level program that is well balanced in orthopedic, neurologic and general physical therapy with attention to the needs of pediatric patients, geriatric patients and special populations. The Program currently affiliates with approximately 250 clinical sites in 13 states primarily in the Pacific Northwest. Only 2 Oregon sites are inpatient rehabilitation facilities. Facilities offering treatment models of interdisciplinary rehabilitation care would offer exceptional educational experiences to our students. I believe the facility being proposed by Encompass would be such a facility and would be a beneficial clinical site for students of the PT program as well as students from other programs at Pacific.

Early in my career as a physical therapist I was employed by an inpatient rehabilitation facility in Texas. The Institute of Rehabilitation and Research (TIRR) in Houston was and continues to be a free-standing rehabilitation facility focusing on rehabilitation of patients with orthopedic, neurologic and respiratory involvement. My experience there convinced me of the need for facilities focused exclusively on rehabilitation. All the medical, nursing and therapy staff members were experts in rehabilitation with the goal of returning patients to optimal levels of function.

I urge you to approve Encompass Health's application for the approval and construction of a new free-standing inpatient rehabilitation facility in the Portland area. I believe this facility will not only help to meet the rehabilitation needs of patients in Oregon but will prove to be an excellent clinical site for the education of physical therapy students.

Sincerely yours,

Richard A Rutt

Richard A. Rutt, PhD, PT

Professor Emeritus, Pacific University

Former Director of the School of Physical Therapy

35.

Roger G. Smith, MD

34464 SW Firdale Rd

Cornelius, Or 971123

7/9/2018

To Dick Stenson,

You have brought to my attention Encompass' consideration of creating an Inpatient Rehabilitation Hospital in Washington county, Oregon. I am semi retired now and have 50 years history of internal medicine practice in this community, Hillsboro, Oregon. It appears that established hospitals are not eager to undertake this effort. So the IRH would not be trampling on any other heath entity's preserve.

My patients needing rehab have only traditional "nursing homes" to use. These are stuffed full of abandoned demented souls which makes them considered unsuitable for most alert but recovering from injury patients. It would seem therefore like a Win/Win situation for encompass to proceed with building or refurbishing an extant structure for a Rehabilitation Hospital.



Roger G. Smith, MD

36,

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Electrodiagnostic Center

tel 503-844-8310
fax 503-844-8316

1200 NE 48th Ave., Ste. 1100
Hillsboro, OR 97124

Dr Daniel Albrecht, M.D.
Dr Adam Soll, M.D.

August 9th, 2018

To Whom It May Concern:

I am writing this letter to support a proposal I was informed about regarding increasing the quality and accessibility of acute rehabilitation care to the my patients in Hillsboro and Washington County.

I am a board-certified, physiatrist in Hillsboro working closely with neurosurgery and orthopedic surgery in a musculoskeletal/spinal outpatient practice. In the past, we have had to accept limited options in the immediate area for our patients regarding higher level acute rehabilitation care. This has often required sending patients (and their families) into the Portland metropolitan area which can be a burden for family members and suboptimal for the patient's convenience.

I strongly endorse the development of a high quality acute inpatient rehabilitation facility in the Hillsboro/Washington County area which I believe would improve the overall care provided to the local population in need of those services.

Sincerely,

Adam Soll, M.D.

OHSU/Tuality Department of Orthopedics and Rehabilitation

1200 NE 48th Ave.

Hillsboro, OR 97124

Brain Injury Alliance of Oregon, Inc.

September 25, 2018

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover,

I write on behalf of the Brain Injury Alliance of Oregon (BIAOR) in support of Encompass's (previously known as HealthSouth) Certificate of Need Application to build an Inpatient Rehabilitation Hospital in the greater Portland, Oregon area. The goal of the Brain Injury Alliance of Oregon is to contribute to improving the lives of those with brain injury. Through our Neuro Resource Facilitation Information and Referral Helpline we receive over 7500 calls, 10,000 emails, and 1520 customized packets are mailed statewide yearly.

Generally, in Oregon, most individuals with acquired brain injury/spinal cord injury do not get adequate treatment or inpatient rehabilitation in hospitals in Oregon. Severe head injuries can cause serious complications, mainly because the brain can be damaged, sometimes permanently. A severe head injury can be fatal, so a person with this type of injury must be closely monitored in hospital, so that any complications that arise can be dealt with promptly and effectively. If there is a skull fractured during a head injury, there is a greater risk of developing an infection. Skull fractures can occasionally tear the membrane (the thin layer of cells) that surrounds the brain. If this happens, bacteria can enter the wound and cause an infection. Some people who sustain a severe head injury enter a state of impaired consciousness, such as a coma, vegetative state or minimally conscious state. These disorders of consciousness affect wakefulness (the ability to open your eyes and have basic reflexes) and awareness (more complex thoughts and actions, such as following instructions, remembering and communicating). Other issues can include blood clots (deep venous thrombosis), which can cause pulmonary embolism, pressure sores, pneumonia or other infections, and progressive multiple organ failure. It is imperative that people have a rehabilitation facility that they can be transferred to that can provide the 24 hour a day treatment and therapies that they need. In a perfect world, people would have only one injury or problem, but in reality they usually have many: a stroke/brain injury, broken bones, seizure disorders, spinal cord injury, paralysis, chronic pain, especially headache, is a common complication following a TBI and most of these patients are sent home for families to care for them or to unqualified nursing homes, assisted living, residential care and adult foster homes. I believe Encompass will provide these services.

I hope that you will grant the Certificate of Need to Encompass for an Inpatient Rehabilitation Hospital in the greater Portland area. I believe that Encompass Health Rehabilitation Hospital of Oregon would be a much needed and great addition to our community and state.

Sincerely,

Sherry Stock

Sherry Stock, ABD/PhD, MS, CBIST
Executive Director – NeuroGerontologist
Brain Injury Alliance of Oregon

(800)544-5243 biaor@biaoregon.org
Fax: (503)961-8730 www.biaoregon.org
Becki Sparre 503-961-5675

Mailing Address:
PO Box 549
Molalla OR 97038

Sherry Stock, ABD/PhD MS CBIST
Executive Director/Neurogerontologist

BIAOR is a 501(c)(3)
Tax-exempt organization
Tax ID: 93-0900797

Dana S. Selover, MD, MPH

Public Health Division

800 NE Oregon Street

Portland, OR 97232

Subject: Support for construction of a free standing inpatient rehabilitation hospital in Washington County

Dear Dr. Selover,

I have been a medical provider in western Washington County for 53 years. I have provided general anesthesia services at Forest Grove Hospital for many years while practicing primary care including OB services and emergency room duty. I am a retired Navy flight surgeon with service duty in rock pits in the Marine Corp. in Central America and in the U.S. Embassy in England. The last 20 years I worked part time at Tuality Hospital with employed physicians insuring proper coding, chart documentation and medicare compliance. During this time I served 6 years as a member of the Oregon Board of Medical Examiners.

Some of these past activities made me feel very strongly that we must improve our inpatient rehabilitation. At the present time we have no facility to dispense what I understand the proposed facility would provide. Having reviewed several programs that do provide this type of program I think this is on the right track. We must have a facility with a multidisciplinary team led by a full time physiatrist with a single purpose, not a general hospital. We are not able to provide services to this type of patient in the present healthcare system, cost being one of the major reasons.

I am available to spend time and effort to help support your program.

Sheridan Thiringer, DO

PO Box 303

Vernonia, OR 97064

SCHOOL OF OCCUPATIONAL THERAPY
190 SE 8th Avenue
Hillsboro, OR 97123

Phone 503-352-7268
Fax 503-352-7360

Pacific University Oregon

July 18, 2018

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation and Quality Improvement
Public Health Division
800 NE Oregon St.
Portland, OR 97232

Re: Certificate of Need for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dr. Selover,

I recently learned about the effort underway by Encompass (formerly HealthSouth) to establish an Inpatient Rehabilitation Facility (IRF) in the greater Portland area. I am writing to express my strong support for an additional IRF in the area, especially if can be located to better serve the fast-growing population of Washington County. I am writing to support the Certificate of Need being initiated by Encompass in my role as a Professor of occupational therapy at Pacific University, rehabilitation practitioner (practice experience in the rehabilitation units of three of Portland's major rehab centers, including the Rehabilitation Institute of Oregon), an active volunteer with the Aphasia Network, and recent Chair of the Society for the Study of Occupation: USA (SSO:USA) (a research society dedicated to enhancing the theoretical and evidence-based foundation for occupational therapy and other disciplines and improving society).

Particularly through my work annually with approximately 70 survivors of neurological injury or disease as part of the Aphasia Network (a nonprofit committed to improving the lives of those experiencing aphasia), I see how important comprehensive rehabilitation services are to optimizing quality of life. These people with aphasia and their partners have identified the need for initial comprehensive neurorehabilitation services, and especially for effective follow-up through high quality outpatient services. Many of these former patients and family members describe the challenge of traveling long commutes to attend therapy sessions, if and when they are available. An additional Inpatient Rehabilitation Facility (IRF), especially if located in Washington County, would increase opportunities to gain this kind of therapy more frequently and conveniently.

The evidence is clear that therapy outcomes from intensive occupational, physical, speech, and related therapies offered in an IRF are significantly improved for those patients having access to those services (e.g., Buntin et al., 2010; Chan et al., 2013; Duncan et al., 2017; Munin et al., 2006; Nehra et al. 2016; Zhi et al., 2006). These outcomes include fewer re-hospitalizations, higher functional levels, enhanced skills in activities of daily living (ADL), lower caregiver burden, and improved quality of life.

In order to deliver culturally responsive care by therapists that are exposed to range of diverse patients, it is important to have more IRF services available to the growing diversity of the population of Washington County. In addition, having another IRF for clinical education of physiatrists, nurses, and therapists (OT, PT, psychologists, social workers, and SLP) would increase the ability for universities to meet the growing demand for therapy services in the greater Portland area related to a shortage of clinical training placements in the face of a rapidly growing population.

These are just some of the reasons that I support the concept of a new inpatient rehabilitation facility being developed in Washington County and the Certificate of Need applied for by Encompass. I would be happy to share more of the research evidence supporting the value of IRF over less intensive and less comprehensive

rehabilitation programs in a follow-up conversation. There is extensive supporting research available. Not only will patients facing chronic disability benefit from additional IRF services, but the educational opportunities for future rehab professionals provided by such a facility will also help ensure our region is better prepared to meet the growing demand for these therapists.

Sincerely,



John A. White, Jr., OTR/L, PhD, FAOTA
Professor, School of Occupational Therapy
503-352-3622 (office), 503-310-6563 (mobile)
whitejа@pacificu.edu

References

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41.

TUALITY HEALTHCARE
An OHSU Partner
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September 7, 2018

Dana S. Selover, MD, MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

Having practiced neurosurgery in Washington County for 15 years, I have seen many patients who would have benefited from having inpatient rehabilitation treatment in our community. Also, as the president-elect of the Oregon Medical Association, and former Tuality Community Hospital Chief of Staff, I am aware of the disparity of health care services, like IRFs, between communities around the state.

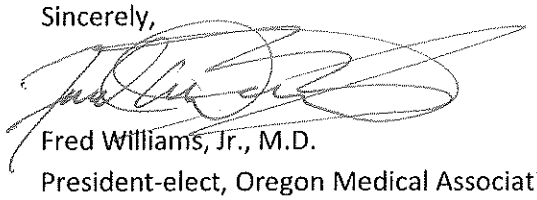
Unfortunately, due to the lack of intensive inpatient rehabilitation services in Washington County, patients may be transferred to two small, busy acute rehab units in Portland hospitals. Many of these patients are in their middle seventies or older and family members often find it more difficult to support their loved ones when they are hospitalized in Portland. Decisions are often made to accept a lower level of rehabilitation such as a subacute nursing facility for the sake of convenience, resulting in a less optimal outcome for the patients.

The state's growing elderly population will only exasperate the IRF shortage problem. I understand that the population over 65 in the Portland area is expected to grow by nearly 50% by 2030, and Washington County alone by 65%. As you may know, nearly two thirds of patients with diagnoses appropriate for IRF treatment will come from this age group.

In addition, younger brain and spine injury patients, who were often gainfully employed and active in their communities, may require acute rehabilitation to get back to their premorbid state. For many, whether they get IRF treatment may make the difference in returning to their homes and employment, or requiring assistance for the rest of their lives due to incomplete recovery of their physical functions.

The families of these patients would also benefit greatly by having IRF closer to home. It is the participation of families which augments the success of these programs.
I hope you will seriously consider the granting of a Certificate of Need to Encompass for an independent, free-standing, 50 bed acute comprehensive rehabilitation hospital in Hillsboro. It would provide a much-needed new service to patients like ours, as well as the larger aging community.

Sincerely,



Fred Williams, Jr., M.D.
President-elect, Oregon Medical Association
Past president, Oregon Neurosurgical Society
Past Chief of Medical Staff, Tuality Community Hospital

43.

SpineCare Chiropractic

Dr. Daniel S. Wright

230 NE 2nd Ave Suite I Hillsboro Oregon 97124
(503) 640-2800 fax (503) 846-9230
spinecarechiro@icloud.com

September 14, 2018

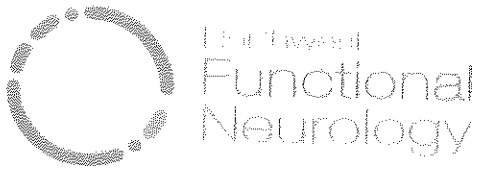
Dana S Selover MD MPH
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland OR 97232

Dear Dr. Selover:

I am writing to you today to demonstrate my support for Encompass Health's Certificate of Need application for an inpatient rehabilitation hospital in the Portland Oregon region. 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. A personal anecdote that I can offer is a patient who sustained a moderate stroke related disability and sought treatment at my chiropractic clinic for rehabilitative services because he felt that the skilled nursing home he was staying at was essentially warehousing him and offering him no rehabilitative options. The relatively happy ending to the story is that he did regain a reasonable level of functional ability with our treatment and was able to take over some aspects of his personal care, including transitioning to in-home care. I believe that if he had been treated in a multidisciplinary inpatient rehabilitative hospital rather than a chiropractic clinic that he would have made significantly more measurable progress. Unfortunately, advanced multidisciplinary rehabilitative care is currently limited in this area even though there is a significant need for this type of service. For these reasons I support the granting of a Certificate of Need for Encompass Health to build a inpatient rehabilitative hospital to serve the greater Portland community. Thank you for your considerations in this matter.

Sincerely,

Daniel S Wright DC



Dana S Selover, MD MPH

Section Manger, Health Care Regulation and Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

October 2, 2018

RE: CON for Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover,

I am writing to express my support for Encompass's Certificate of Need application to construct a sorely-needed inpatient rehabilitation hospital in the greater Portland, Oregon area. I am the owner and Clinic Director of Northwest Functional Neurology. My group supplies outpatient neurological rehabilitation services to patients suffering from the effects of traumatic brain injuries, strokes, movement disorders, neurodevelopmental disorders, and neurodegenerative diseases.

Many of my patients come to me while housed in skilled nursing facilities. The lack of sufficient inpatient rehabilitation beds within this region results in patients that are capable of making great progress through inpatient neurorehabilitation languishing in facilities that lack the tools and providers necessary to maximize their potential recovery. Intervening early in their cases with aggressive rehabilitation leads to far better outcomes, as is solidly supported in the literature. These outcomes are not possible without a multidisciplinary staff of highly trained providers and the investment in technology that allows them to effectively apply their skills.

Early intervention allows rehabilitation to be focused on rebuilding neurological capacity, and significantly increases the possibility of a return to full function. The longer patients must wait to engage in appropriate interventions, the lower the likelihood of a full recovery, and the greater their residual deficit. The consequence of such a delay is often longer stays in skilled nursing facilities, reduced functional capacity, greater demands on family for home care upon

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Facebook: @northwestfunctionalneurology • Twitter: @NWFunctionNeuro • www.NorthwestFunctionalNeurology.com

Northwest Functional Neurology

their release, lost productivity, and ultimately a greater burden on Medicaid and Social Security.

I have attended to numerous patients that have suffered severe traumatic brain injuries and strokes while residing in local skilled nursing facilities. Many of them had been discharged to these facilities for the sole reason that no inpatient rehabilitation beds were locally available. It has been very clear to me that my services and those of other skilled providers would have been far more effectively applied while in a post-acute setting, and that my patients would have reached a far higher level of function with the early intervention that only a comprehensively staffed and equipped inpatient rehabilitation facility could provide.

I strongly urge you to grant the Certificate of Need to Encompass for their Portland Inpatient Rehabilitation Hospital application. Their services are desperately needed in our area.

Sincerely,

Glen Zielinski, DC, DACNB, FACFN, CBIS

Board Certified Chiropractic Neurologist
Fellow, American College of Functional Neurology
Certified Brain Injury Specialist
Assistant Professor of Neurology, Carrick Institute for Clinical Neuroscience
Clinic Director, Northwest Functional Neurology

Exhibit 3

September 15, 2019

Commissioner Bob Terry
Former Washington County Commissioner
PO Box 873
Hillsboro, Or. 97123

503-720-7671

Encompass Health Rehabilitation Hospital

Dear Dr. Selover,

Thank you for your time and consideration on this important addition to Washington County.

First, I would like to read a letter of support from Washington County Assistant Manager to our Health and Human Services Division: Mjere Simantel.

LETTER
Washington County
DAVS Program Supervisor, AAA Director
(Now Ass't Director Washington County
Health and Human Services)

For my personal endorsement: I have always worked very close with and supported Washington County Health and Human Services. As a Veteran, it is imperative that we provide or have available to our citizens the services that and Encompass can provide. It is forecast that in a short 6 to 8 years Washington County will be our States largest County. It

is not practical to be running to Portland or Multnomah County for many of our services., but rather work in conjunction on a local level in support of our Community Services, as we do now. Our County has continued to up grade many of our Human Resource Services in all areas. Such as Support of Tuality Community Hospital and working with Oregon Health Science University - OHSU to provide more and current services and Our County Walk in Clinic at Hawthorn Farms. As a note, I personally have been on the Tuality Community Hospital Foundation Board for 17 years.

Encompass will make a great and needed improvement to Medical Services not currently of immediate available to our Community. Locating these services is more favorable in the Hillsboro area, as it should be noted that roughly 25% of Washington County population lives West of Hillsboro and the largest part of growth and most of future growth will be West of Hillsboro. The first stopping off for Medical facilities From the Coastal Cities West, from Tillamook to Astoria and parts of The Columbia River are the Facilities in the Greater Hillsboro Area. Even though I have not seen other Hospital Services in out right Public Support. I have not heard and decent or negative comment for these needed services. I think that is called hopeful/helpful competition.

Thank you – I look forward to your favorable support.

Commissioner Bob Terry

Exhibit 4 34

WASHINGTON COUNTY
OREGON

September 5, 2018

Dana S. Selover, MD
Section Manager, Health Care Regulation & Quality Improvement
Public Health Division
800 NE Oregon Street
Portland, OR 97232

Re: Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Dr. Selover:

Washington County Disability, Aging and Veteran Services (DAVS) is supportive of Encompass Health's application to build an Inpatient Rehabilitation Hospital in Washington County, OR. As a local Area Agency on Aging (AAA), DAVS' mission is to strive to create options that maintain the quality of life for older adults, veterans and people with physical disabilities.

DAVS' serves a diverse population of individuals across urban, suburban and rural areas in Washington County, Oregon. We believe that it is important for older adults and people with disabilities to have choices when it comes to their health care, including their post-acute rehabilitation options. A freestanding inpatient rehabilitation hospital will potentially provide better outcomes, lower costs and help older adults and people with disabilities to live as independently as possible.

I hope that you will consider approving Encompass Heath's application for an Inpatient Rehabilitation Hospital in Washington County. A regional freestanding inpatient rehabilitation hospital would provide a much needed service to older adults and people with disabilities, as well as to the larger community.

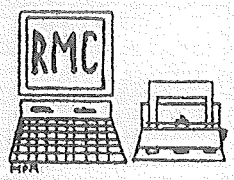
Sincerely,

Mjere Simantel, MSW
DAVS Program Supervisor, AAA Director

Department of Health and Human Services — Disability, Aging and Veteran Services (DAVS)
Mailing Address: 155 N First Avenue, MS-44, Hillsboro, OR 97124-3072
Physical Address: 5240 NE Elam Young Parkway, Suite 300, Hillsboro, OR 97124
Phone: 503-846-3060 • Aging Fax: 503-846-3065 • Veteran Fax: 503-846-3059
www.co.washington.or.us/HHS/DAVS

ADRC
Aging and Disability Resource Connection of OREGON
1-855-673-2372
www.ADRCofOregon.org

Exhibit 5



Business Planning, Strategic Development and Philanthropy
Robert McGuirk, Consultant

June 25, 2018

Cheryl Nester Wolfe, RN
President and Chief Executive Officer
Salem Health
890 Oak Street SE
Salem, OR 97301

Dear Ms. Wolfe:

Thank you for reviewing our request to meet to discuss inpatient rehabilitation services in the Portland area. As you are aware, any new hospital provider in Oregon is required to obtain a certificate of need (CoN) before establishing a new health care facility. That process requires applicants to discuss the plans of existing hospitals within 50 miles of our proposed new facility, take this understanding of the market into account before filing a CoN, and document the outreach effort. We fully understand why you declined to schedule time to discuss the Encompass Health project.

The Encompass Health rehabilitation hospital will be located in Portland over 40 miles from your health system so there is little overlap between the Salem Health market area and the Portland market area for rehabilitation services. Nevertheless, Encompass Health would welcome the opportunity to discuss the proposed project if you would like to discuss this project or have questions about the project in the future. Please contact me if your interests change and I can arrange a phone or in-person conference.

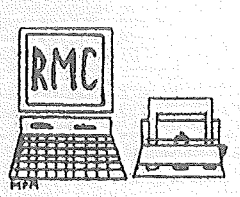
Thank you again for considering the Encompass Health request to meet with you.

Sincerely,

Bob McGuirk, RMC

Cc: Bill Heath, Vice President Business Development
Encompass Health
Ashley Gotlieb, Director Business Development
Encompass Health

1606 NE 60th Ave. • Portland, OR 97213 • Ph: (503) 287-4045
rmconsultingl@qwestoffice.net



June 25, 2018

Business Planning, Strategic Development and Philanthropy
Robert McGuirk, Consultant

Connie Rolf
Director of Rehabilitation Services 890 Oak Street SE
Willamette Valley Medical Center
2700 SE Stratus Ave.
McMinnville, OR 97128

Dear Connie:

Thank you for discussing the history of inpatient rehabilitation services offered through Willamette Valley Medical Center and how it currently manages post acute patients requiring rehabilitation services. Our understanding is that Willamette Valley Medical Center had operated a small, inpatient rehabilitation facility a few years ago but closed that unit because it was no longer financially or economically feasible to continue to operate. Currently, the medical center refers post acute care rehabilitation patients to inpatient rehabilitation programs located outside of your hospital's service area in Salem and Portland or to local skilled nursing facilities.

As we discussed, a new hospital provider in Oregon is required to obtain a certificate of need (CoN) before establishing a new health care facility. That process requires applicants to discuss the plans of existing hospitals within 50 miles of a proposed new facility, take this understanding of the market into account before filing a CoN, and document the outreach effort. The Encompass Health rehabilitation hospital will be in Portland. It will represent another service option for patients referred outside of the service area by your medical center.

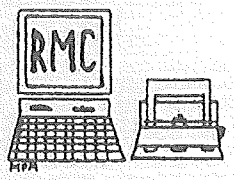
Encompass Health welcomes the opportunity to answer further questions you may have about this development effort in Portland. Thank you again for discussing Yamhill County's post acute care rehabilitation needs.

Sincerely,

Bob McGuirk, RMC

Cc: Bill Heath, Vice President Business Development
Encompass Health
Ashley Gotlieb, Director Business Development
Encompass Health

1606 NE 60th Ave. • Portland, OR 97213 • Ph: (503) 287-4045
rmconsultingl@qwestoffice.net



Business Planning, Strategic Development and Philanthropy
Robert McGuirk, Consultant

September 11, 2018

Mark Enger
Vice President of Network Operations
Oregon Health & Science University
3181 SW Sam Jackson Park Rd.
Portland, OR 97239

Dear Mark:

Thank you for scheduling time for a formal conference presentation with Encompass Health to discuss inpatient rehabilitation services in the Portland area and for being receptive to other requests for information. As we discussed, any new hospital provider in Oregon is required to obtain a certificate of need (CoN) before establishing a new health care facility. That process requires applicants to discuss the plans of existing hospitals relative to a proposed new facility, take this understanding of the market place into account before filing a CoN and document the outreach effort.

In our initial phone discussion, I noted that Manny Berman (retired Tuality Healthcare CEO) referred me to you indicating that OHSU and Tuality Healthcare have an integrated clinical and management structure under direction by OHSU. While Tuality Healthcare maintains separate governance, you are the designated executive managing this new clinical integration as part of OHSU Partners. In our discussion you noted that OHSU evaluated developing an inpatient rehabilitation facility program as part of Tuality Healthcare but determined that there was insufficient demand to develop an inpatient rehabilitation service that would be economically and architecturally feasible.

In this first phone conversation you further noted that OHSU saw no need for inpatient services at University Hospital because OHSU maintained an ongoing relationship with the Legacy Rehabilitation Institute of Oregon and that facility currently has sufficient beds to meet University Hospital's needs. In response to my request for a letter of support for the Encompass Health project, you informed me that the OHSU policy is to neither publicly support or oppose projects through the CoN process and thus, would be unable to provide a letter of support.

1606 NE 60th Ave. • Portland, OR 97213 • Ph: (503) 287-4045
rmconsultingl@qwestoffice.net

Following our conversation, you generously offered to host a conference call with Encompass Health that also included your content expert, Connie Amos, MS, Division Director of OHSU Rehabilitation Services. Encompass Health presented its approach to inpatient rehabilitation and is most appreciative of the frank discussion about the state of rehabilitation services in Portland. After my initial phone conversation and the formal phone conference with Encompass Health, the CoN Program notified me that Post Acute Medical, LLC had filed a letter of intent to develop a 50-bed rehabilitation hospital near the main OHSU campus. Dick Stenson who also represents Encompass Health followed up with you to see if there was a need for a further meeting with Encompass Health. You noted to Dick that the OHSU position relative to rehabilitation services had not changed and that there was no need for an additional meeting.

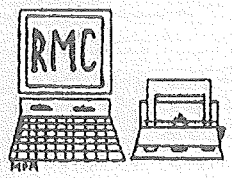
I am very appreciative of your responsiveness to each of our requests. Encompass Health is committed to developing effective relationships with the community of healthcare providers. Please feel free to contact Dick Stenson, Encompass Health representatives or myself if you have any immediate questions or concerns. Your candid input has been invaluable, and I want to keep the channel of communications open with you. To conserve your scarce time, I will periodically follow up with you by e-mail or voice messages as I did prior to the filing of the letter of intent to keep you informed of Encompass Health's efforts in developing rehabilitation services in Oregon.

Thank you again for your assistance.

Sincerely,

Bob McGuirk, RMC

Cc: Bill Heath, Vice President Business Development
Encompass Health
Ashley Gotlieb, Director Business Development
Encompass Health



Business Planning, Strategic Development and Philanthropy
Robert McGuirk, Consultant

September 10, 2018

Victor Jackson
President and Chief Executive Officer
Vibra Specialty Hospital
10300 NE Hancock Street
Portland, OR 97220

Dear Mr. Jackson:

Your executive assistant relayed to me that you did not see a need to discuss the proposed Encompass Health Rehabilitation Hospital of Oregon project. Thank you for reviewing our request to meet to discuss inpatient rehabilitation services in the Portland area. As you are aware, any new hospital provider in Oregon is required to obtain a certificate of need (CoN) before establishing a new health care facility. That process requires applicants to discuss the plans of existing hospitals within 50 miles of our proposed new facility, take this understanding of the market into account before filing a CoN, and document the outreach effort. We fully understand why you declined to schedule time to discuss the Encompass Health project given its distant location from your hospital.

The Encompass Health rehabilitation hospital will be located in Hillsboro, Oregon, 23 miles by road from your hospital to the proposed hospital site. Nevertheless, Encompass Health would welcome the opportunity to discuss the proposed project if you would like to discuss this project or have questions about the project in the future. Please contact me at (503) 287-4045 if your interests change and I can arrange a phone or in-person conference.

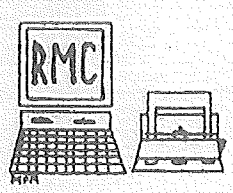
Thank you again for considering the Encompass Health request to meet with you.

Sincerely,

Bob McGuirk, RMC

Cc: Bill Heath, Vice President Business Development
Encompass Health
Ashley Gotlieb, Director Business Development
Encompass Health

1606 NE 60th Ave. • Portland, OR 97213 • Ph: (503) 287-4045
rmconsultingl@qwestoffice.net



Business Planning, Strategic Development and Philanthropy
Robert McGuirk, Consultant

September 11, 2018

Anita Iyenger
Vice President of Strategy and Business Development
Legacy Health System
1919 NW Lovejoy
Portland, OR 97209

Dear Anita:

Thank you for the courtesy of the prior, notification of Legacy Health System's response to the Encompass Health letter of intent to develop a 50-bed inpatient rehabilitation hospital (IRF) in Washington County. As discussed in our extended conversation after the Legacy filing, I noted that Encompass Health would provide a response to express our appreciation of Legacy's openness and to bring closure to the pre-certificate of need (CoN) phase of the project. Encompass Health would welcome future conversations over the course of the CoN process with the goals of improving healthcare for the service area population and to address any concerns that Legacy Health System may have about the impact of the project on Legacy services.

Summary of Meeting and Phone Calls

Encompass Health and Legacy Health System held an introductory conference call early this year involving Jonathan Avery, President and Pam Kilmurray, Director of Rehabilitation Institute of Oregon (RIO) for Legacy Good Samaritan Medical Center. Jonathan's observation was that Legacy RIO had beds available and there was no need. Pam indicated that RIO received many requests for patient admission that were denied eligibility certification by insurers. At Legacy's request, Encompass Health provided additional information on Encompass Health hospital operations.

Upon receipt of additional information, Legacy Health System agreed to meet again on July 3rd to discuss the Encompass Health proposal. Attending that meeting were Jonathan Avery, Pam McMurray, Lewis Low, MD, Chief Medical Officer for Legacy Health System and yourself. There have been two recurring questions in the two meetings and our extended discussion:

1) Why does Encompass Health think that there is bed need when RIO has unfilled beds?

1606 NE 60th Ave. • Portland, OR 97213 • Ph: (503) 287-4045
rmconsultingl@qwestoffice.net

2) Why are national IRF companies interested in developing a Portland hospital every 10 years?

3) Where will the new hospital be located and what will be its characteristics?

Need for Inpatient Rehabilitation Services in the Tri-county Portland Area

The first two questions are interrelated. Currently, RIO has unfilled rehabilitation beds and although not directly expressed, may have concerns about an IRF located in Hillsboro. Regarding bed need, Encompass Health and Legacy share the position that patients who need inpatient rehabilitation services are being denied eligibility by insurers. In short, there is need that has not been converted to patient care.

There is disagreement between us about Need. As you described, Legacy RIO positions itself as a regional specialty service and accepts referrals from hospital and other discharge planners throughout the region for a host of tertiary services. This model depends on having a centralized location. Encompass Health, while intending to offer specialty IRF services after the initial opening period, subscribes to the evidence-based research that location matters and places its IRFs closer to patients in terms of distance and facility design; and provides a variety of outreach services to facilitate patients, families and care-givers selecting the most appropriate services, either IRF or SNF care, that provides the best outcomes for patients.

Regarding why need for rehabilitation beds is assessed every 5 to 10 years, there is an unambiguous answer. The general population has been increasing rapidly especially with the principal, at-risk population, ages 65 and older, which is growing even more rapidly as Portland ages. This has taken place while travel access to central Portland has decreased. In the past decade while there was no additional IRF service developed; this rapid population growth, particularly in Washington County, resulted in the new Kaiser Westside hospital. With the at-risk population expected to grow by 68% in Washington County through 2030, the real issue is what should be the size and scope of services for a new IRF in Washington County.

Operating Characteristics of the Encompass Health Hospital

Encompass Health notes that in our discussions, no representative of Legacy has directly raised issues about adverse impact of our project. Instead, the questions have been about location and the operating characteristics of our new hospital. Encompass Health is mindful of the storied history of RIO and before our meetings directed site studies focusing on Washington County for two reasons: a Hillsboro location addresses the largest service area population with poor access to IRF services and Legacy Health System does not operate a hospital within Washington

County. Also important is that Encompass Health will provide indigent services as described in its charity care policies that are consistent with other Oregon hospitals and Encompass Health will serve Medicaid patients thus assuring that there will be no adverse selection for Legacy RIO or Providence Medical Center.

Our CoN application will document that the Encompass Health hospital site is as far away from Legacy RIO as could be found, while still fully addressing population need. As noted by Bill Heath in our initial conference call, Encompass Health believes that its location and approach to IRF services will result in changing practice patterns including insurer practices that "will raise all boats." Legacy RIO will experience no adverse impact from our project since Legacy RIO is positioned as a regional IRF accepting specialty patients from throughout the State; there is a dramatic increase in the overall tri-county at-risk population; and IRF referral and insurance authorization practices will change

Invitation to Further Collaborative Discussions

As I noted in the introductory paragraph, the entire Encompass Health team expresses its appreciation for the openness and time that your senior management has spent with Encompass Health. As we enter the CoN screening phase of our project, we invite Legacy Health System to meet to discuss ways that our project can best fit in and be an efficient addition to the overall healthcare system. Encompass has made this offer to all the stakeholders in healthcare who have given so much time. If this would be beneficial to Legacy Health System please let me know by phone, e-mail or in writing.

Encompass Health looks forward to serving Oregonians along side Legacy Health System and thanks you personally for sharing your concerns.

Sincerely,

Bob McGuirk, RMC

Cc: Bill Heath, Vice President, Development Office: Encompass Health Corporation
Ashley Gotlieb, Director, Development Office: Encompass Health Corporation
Jonathan Avery, President: Legacy Good Samaritan Medical Center
Lewis L. Low, MD, SnVice President & CMO: Legacy Health System
Pam Kilmurray, Director Legacy Health Rehabilitation Institute of Oregon

Bill Heath
Vice President of Development
9001 Liberty Parkway
Birmingham, AL 35242
205-970-7885
bill.heath@encompasshealth.com

Encompass Health

September 10, 2018

Justin Weatherford
Regional Director of Rehabilitation Services
Providence Health System Oregon
447 NE 47th Ave.
Portland, OR 97213

Re: ***Encompass Health Rehabilitation Hospital of Oregon, LLC***

Filing of Letter of Intent

Dear Justin:

Thank you for scheduling time for a formal conference presentation with Encompass Health to discuss inpatient rehabilitation services in the Portland area; coordinating a meeting of Providence Health System stakeholders and content experts to discuss our program, and a handful of in-person and phone conferences with various members of our team (including your ongoing/timely follow up to our requests for information.)

As we discussed, any new hospital provider in Oregon is required to obtain a certificate of need (CoN) before establishing a new health care facility. That process requires applicants to discuss the plans of existing hospitals relative to a proposed new facility, take this understanding of the market place into account before filing a CoN and document the outreach effort. Although Encompass is disappointed that we were unable to garner a letter of support at this time as CMS continues its efforts toward IRF program change that is creating turbulence and uncertainty about the best future path for IRF providers; we look forward to continuing to find ways to collaborate with your Program in the future.

In our initial March 2018 phone conference discussion, you noted that you were the designated executive for rehabilitation services provided throughout the Providence Oregon Region and requested additional information including: 1) How does the Encompass Health proposal fit into a population health world; 2) How would the service achieve better results than enhanced SNF units for patients (benefits vs. cost) and 3) How would the Encompass Health addition affect Providence business? You were then able to arrange an internal review and subsequently indicated that while there was some support for additional rehabilitation services in the area, Providence Health System would not be able to provide CoN support given the uncertainty

Bill Heath
Vice President of Development
9001 Liberty Parkway
Birmingham, AL 35242
205-970-7885
bill.heath@encompasshealth.com

Encompass Health

surrounding CMS efforts falling generally under "Population Health" as we discussed in our May follow up meeting to the Providence Health System internal review.

As noted, the CoN process requires that hospital applicants discuss the plans of existing hospitals to add bed capacity as well as any ongoing interest in collaborative efforts. You were very helpful in sharing that the Providence Health System Oregon had no formal efforts underway to add to IRF capacity at Providence Portland, although you expressed a potential need to do that and that there were no plans to add IRF capacity at other Providence hospitals in the Portland area.

As part of our mutual efforts toward transparency, Encompass Health did provide notice before filing our Letter of Intent and our consultant followed up with you to answer any questions that you might have about location (Hillsboro) and facility size (50 beds) that we are proposing. Encompass has followed up with provider sources which you recommended, and we are still actively looking at ways to gain Providence Health System support. We believe that our Hillsboro site that is outside of the 30-minute drive time to your IRF program in Northeast Portland shows our efforts to both improve access for IRF services without duplicating services that are provided in other parts of the metropolitan area. Encompass Health welcomes the opportunity to further discuss the proposed project and will periodically contact you directly or through our consultant to see if you have questions or concerns.

Thank you again for your cooperation and assistance.

Sincerely,

Bill Heath
Vice President of Development

Bill Heath
Vice President of Development
9001 Liberty Parkway
Birmingham, AL 35242
205-970-7885
Bill.heath@encompasshealth.com

Encompass Health

October 24, 2018

Pamela Jones
Adventist Medical Center
Regional Director Care Management
10123 SE Market St.
Portland, OR 97216

Dear Pamela:

Thank you for meeting with Encompass Health about the status of rehabilitation services in the greater Portland area. Encompass is very close to filing its CoN application. Your early feedback on behalf of Adventist Health factored into our plans to establish an Inpatient Rehabilitation Hospital in Hillsboro. I note that you indicated that Adventist Health did not at the time have plans to add an IRF service at your facility, although you noted that there is both a shortage of available capacity for Adventist Health System patients and less specialization of services that a freestanding rehabilitation hospital could bring to the Portland metropolitan area.

I appreciate your efforts to facilitate further discussions with David Russell regarding the project as well. Our subsequent meeting with him was very helpful. We will continue to apprise you and David as we progress through the CoN process. Our goal is to gain Adventist Health support for our hospital on a long term basis. I look forward to continuing to work with you as we design our program and proceed in developing the hospital.

Sincerely,

Bill Heath

Gmail

Dick Stenson <richardvstenson@gmail.com>

Thank you!
1 message

Dick Stenson <richardvstenson@gmail.com> Sat, Sep 22, 2018 at 4:37 PM
To: David Russell <russeldm@ah.org>
Bcc: Dick Stenson <richardvstenson@gmail.com>

David,
Thank you for meeting with me Wednesday to discuss the need for more inpatient rehab beds in Oregon and the Metro area. When I spoke to Mark Enger a few months ago he said OHSU's feeling was there wasn't a need and it wasn't something they or their partners planned to do. When I spoke to Lori James-Nielsen at Tuality more recently she said it was a service that the system would probably need to consider at some point in the future, but that it wasn't in the top 10 of program priorities at this time.

Having heard that Pamela Jones in case management at Adventist had shared with Bob McGuirk the local CoN planner, and Bill Heath, of Encompass Health that there is a need as it is very difficult to find IRF placements for patients who would qualify and benefit from these intensive rehab services, I reached out to touch base with you. In meeting yesterday and sharing the Oregon IRF data I was hoping that you would agree that there appears to be a need for more services. Of course, there are many parties who could choose to step up and fill this gap, including yourselves. Our discussions to date with Providence and Legacy, who operate the current services, is that they don't see a need for more services and don't plan to expand what they are doing now.

Based on all the research Encompass has done to validate the need in our community, I was hopeful that Adventist would consider offering this support if this is not something you plan to do in the near future. But I also understand that you need to consider the greater OHSU partners' system's thinking on this. I would hope that if there is not a willingness to publicly support the Encompass CoN application based on the demonstrated need, and otherwise current lower priority in the community to provide these services now, that you would at least not oppose the application.

Please let me know if you need additional information. Encompass executives would be happy meet in person or by phone to answer more questions.

Warm regards,

Dick
P.S. It was great to catch up on all our mutual friends over the years.

Gmail

Dick Stenson <richardvstenson@gmail.com>

Follow-up to August 2nd Meeting at Cambia

1 message

Dick Stenson <richardvstenson@gmail.com> Wed, Sep 19, 2018 at 10:59 AM
To: "Sause, Steven" <Steven.Sause@regence.com>, "Mar, Steven" <Steven.Mar@regence.com>
Cc: Bill Heath <Bill.Heath@encompasshealth.com>, "Ashley Gotlieb Director, Business Development" <ashley.gotlieb@encompasshealth.com>
Bcc: Dick Stenson <richardvstenson@gmail.com>, Bob McGuirk <rmconsulting1@qwestoffice.net>

Steven Sause, Director of Provider Contracting, Cambia-Regence

Steven Mar, Senior Provider Contracting Executive, Cambia-Regence

Re: Encompass Health Rehabilitation Hospital of Oregon, LLC

Dear Steven and Steven,

I want to take the opportunity to update you on the proposed Encompass Health IRF specialty hospital we discussed in your offices on August 2nd. Since then the property has been secured, (9.14 acres on Belknap Ct. in Hillsboro), and a Letter of Intent has been filed (on August 16th) with the Oregon Certificate of Need program office in Portland. We expect the full application to be completed and filed with the state in a few weeks.

I'd like to thank you again for taking the time to meet with me, and by phone Bill Heath and Ashley Gotlieb in the Encompass corporate development office, to review the state of IRF care in Oregon in general, and the Metro area specifically. Regrettably, despite the well documented improved outcomes for treating numerous physical injuries in IRFs vs. SNFs, e.g. traumatic brain injuries, stroke, amputations, and spinal cord injuries, Oregon has the lowest utilization of IRF services in the country and, not surprisingly, the fewest IRF beds per population.

Once approved and built, Encompass Health looks forward to working with Cambia-Regence in providing IRF services to your clinically appropriate members of all ages. As we also discussed, Encompass is working with insurers using various alternative payment models in other states and would be happy to entertain discussion of similar quality incentivized models for Oregon.

We will keep you apprised as the project moves through the state and local government planning and approval processes.

Please let me know if you have any questions.

Thank you for your interest in this important new service for our community.

Dick Stenson

Gmail **Dick Stenson <richardvstenson@gmail.com>**

Thank you for the meeting

1 message

Dick Stenson <richardvstenson@gmail.com> Sat, Jun 16, 2018 at 2:27 PM
To: "Dreyfuss, Stephanie C" <stephanie.dreyfuss@providence.org>
Cc: MaryLynn Swartz <marylynn.swartz@healthsouth.com>
Bcc: Bill Heath <Bill.Heath@encompasshealth.com>, Ashley Gotlieb <ashley.gotlieb@encompasshealth.com>, Bob McGuirk <rmconsulting1@qwestoffice.net>, Dick Stenson <richardvstenson@gmail.com>

Hi Stephanie,

I want to thank you again for taking time to have breakfast with Mary Lynn Swartz and me to discuss the Encompass proposal to build a new inpatient rehabilitation hospital in our area. As you can see from the information we shared with you, the experience in other communities has shown an inpatient rehabilitation hospital enables more patients to return to the community, and more quickly, after major injuries or surgeries that respond to intensive rehabilitation services. And certainly Providence has seen this with the patients it treats in it's inpatient unit at Providence Portland.

As we explained, to build a new hospital in Oregon, even a specialty hospital, requires state approval or Certificate of Need (CON). Part of the CON process is the gathering of community input about the potential or expected benefit of the new hospital. We are requesting that you share this information with Dr. Gluckman and ask if he would allow you to provide a letter of general support for more inpatient rehabilitation beds in the community as there is a need, and we understand the Providence unit is at capacity, with no plans to expand. I have attached a general outline of a support letter that touches on aspects of the project that would be helpful to us. Obviously any letter should be based on Providence's experiences with these types of patients and services.

I have also attached an updated set of slides specifically for Providence. Please see the added pages on Oregon's apparent underutilization of inpatient rehabilitation services (page 7), and ways Encompass Health is actively engaged in alternative payment models in other markets (page 9). This one should be of particular interest to you and the Health Plan.

If Providence Health Plan is able to provide a letter of support, might we have it in the next week or two? And may I come and pick it up? We want to be sure all our support letters are included with our application and not mislaid in the state's bureaucracy.

Please let me know if you have any questions or need additional information.

I will call next week to check back with you.

Thank you for your interest and help.

Sincerely,

Dick

---

2 attachments

Encompass sample general letter of support.docx
14K

Encompass Health Materials for Providence Health Plan.pdf
1934K

Exhibit 6

BEFORE THE OREGON HEALTH AUTHORITY

In the Matter of the	)	No.: CON Application #679
	)	
Certificate of Need Application ("CON") #679 by	)	AFFIDAVIT OF CAREY B. McRAE
	)	
Encompass Health Corporation.	)	

State of Alabama)
)
County of Jefferson)

BEFORE ME, the undersigned Notary, Mia K. Haynes, on this 31st day of October, 2019, personally appeard Carey B. McRae, known to me to be a credible person and of lawful age, who being by me first duly sworn, on his oath, deposes and says:

1. I, Carey B. McRae, am Associate General Counsel, State and Regulatory Compliance, of Encompass Health Corporation ("Encompass"). In this capacity, I have responsibility for the Encompass CON application #679 for a 50 bed inpatient rehabilitation hospital in Hillsboro, Oregon.

2. My other responsibilities include nationwide oversight over certificate of need applications of Encompass. I also have responsibility for Encompass' state and federal regulatory compliance.

3. In the September 20, 2019 requests by the petitioners, including without limitation the Oregon Health Care Association (collectively, "the SNFs"), for a stay and for reconsideration, references were made to a settlement between Encompass and the U.S. Department of Justice. In addition, in an October 15, 2019 letter, a representative of Oregon Health Care Association made reference to the DOJ settlement. The references were based on a DOJ press release. The actual facts regarding the settlement are in the paragraphs which follow.

4. The Department of Justice opened its investigation in 2012. Ultimately, the investigation concerned 6 qui tam suits brought by individual relator plaintiffs, which were consolidated in the Middle District of Florida. The DOJ issued subpoenas to 24 hospitals as part of its early investigation in 2013 and 2014. Most of the hospitals that received subpoenas were never required to produce documents or were further investigated by the DOJ.

5. DOJ asserted claims based on a post-treatment audit of 37 patient charts with extrapolated results. Encompass disputed the review. The investigation lasted seven years, and involved voluminous documents and over 30 depositions. It produced no evidence of falsity or fraud. Nevertheless, DOJ maintained that physicians at our hospitals misdiagnosed particular myopathies to manipulate compliance with the 60% rule. The physicians at our hospitals do not work for Encompass and do not take direction from Encompass. Their diagnoses and determinations of medical necessity are independent. In every instance, the physicians stood by their diagnoses and their judgment on medical necessity.

6. CMS never challenged Encompass' coding and never denied claims based on DOJ's interpretation. Through a FOIA request, Encompass confirmed that DOJ had discussed its theory with CMS as early as 2012. With full knowledge of DOJ's interpretation, CMS never changed its position on Encompass' coding practices and never denied Encompass' claims. In 2017 CMS declined to revise the IRF payment rule to remove the code at issue and thereby reflect DOJ's interpretation. In 2017 CMS proposed a rule that would adopt DOJ's interpretation. That is when we filed our FOIA request, to determine DOJ's role in encouraging CMS to revise its rule retroactively to fit DOJ's litigation theory. We commented against the proposed revision and CMS withdrew it, issued the new rule without DOJ's proposed interpretation and confirmed that any misuse of the subject code should be a matter of regulatory audit and review, not False Claims Act litigation.

7. Thereafter, the District Court in Florida, after extending DOJ's intervention period by over seven years, denied further extensions. DOJ declined to intervene. Accordingly, Encompass was faced with a renewal of litigation by six plaintiffs that would potentially extend to all 130+ hospitals. The Encompass board of directors determined that a settlement of $48 million was in the best interest of shareholders given the external cost of litigation and the substantial burden on internal resources from extended litigation. The settlement and release covers medical necessity, coding and coverage concerns for all hospitals from 2006 through the date of settlement.

8. In addition, this settlement confirms our past and current coding practices. Encompass expressly denied all wrong doing. Encompass did not enter into a Corporate Integrity Agreement (CIA). In addition to relieving Encompass of substantial reporting and oversight obligations, the absence of a CIA confirms the government is not requiring Encompass to change any of its practices. Although the government does not provide "exoneration" in such cases, by action CMS has ratified Encompass' use of the codes and DOJ and OIG have acknowledged Encompass has done nothing that requires correction.

Carey B. McRae
Associate General Counsel
State Regulatory & Compliance
Encompass Health
9001 Liberty Parkway
Birmingham, AL 35242

SUBSCRIBED AND SWORN TO before me this 31st day of October, 2019.

Notary Seal:

Mia K. Haynes

Notary Public for Alabama

Mia K. Haynes

[typed name of Notary]

My commission expires: 5/9/23



LEGACY GOOD SAMARITAN HOSPITAL
1015 NW 22ND AVENUE
PORTLAND, OR 97210

MULTNOMAH BACK

WORKSHEET: S300001
PROVIDER: 380017
FY BEGIN: 04-01-2018
FY END: 03-31-2019
STATUS: As Submitted
FORMAT: 2552-10

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

LINE	TITLE	Worksheet A line No (00100)	Number of Beds (00200)	Bed Days Available (00300)	Days/Visits/Trips Title XVIII (00500)	Days/Visits/Trips Total Title XIX (00700)	Days/Visits/Trips Total All Patients (00800)	FTEs Total Interns & Residents (00900)	FTEs Employees on Payroll (01000)	Discharges Title XVII (01300)	Discharges Title XIX (01400)	Discharges Total All Patients (01500)
001001	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30	136	49,640	9,833	2,425	33,955			2,241	1,933	9,684
002000	HMO				9,833	7,253				1,993		
004000	HMO IRF Subprovider				2,408	692						
006700	Total Adults and Peds. (exclude observation beds) (see instructions)		136	49,640	9,833	2,425	33,955					
008300	Intensive Care Unit	31	28	10,220	1,133		4,050					
009300	Coronary Care Unit	32										
010400	Burn Intensive Care Unit	33										
011100	Surgical Intensive Care Unit	34										
012000	Other Special Care	35										
013500	Nursery	43				418	3,196					
014000	Total (see instructions)		164	59,860	10,965	2,843	40,161	44.51	1,191.5	2,241	1,933	9,684
016300	Subprovider - IPF	40										
017000	Subprovider - IRF	41	36	13,140	1,624	1,185	9,041		38.83	134	128	700
018500	Subprovider - Other	42										
019000	Skilled Nursing Facility	44										
020000	Nursing Facility	45										
021000	Other Long Term Care	46										
022000	Home Health Agency	101										
022500	ASC (Distinct Part)	115										
023000	Hospice (Distinct Part)	116										
024100	ADULTS & PEDIATRICS *	30										
025000	CMHC	99										
025100	*	99.1										
026000	RHC/FQHC (specify)	98										
026250	FEDERALLY QUALIFIED HEALTH CENTER *	89										
027000	Total (sum of lines 14-26)		389					44.51	1,230.33			
028500	Observation Bed Days					493	2,415					
031200	Labor & delivery days (see instructions)		23	8,395		74	421					
032001							207					

Exhibit 7

LEGACY GOOD SAMARITAN HOSPITAL 1015 NW 22ND AVENUE PORTLAND, OR 97210 MULTNOMAH BACK	WORKSHEET: PROVIDER: FY BEGIN: FY END: STATUS: FORMAT:	S300001 380017 04-01-2017 03-31-2018 As Submitted 2552-10	CMS CENTERS for MEDICARE & MEDICAID SERVICES

LINE	TITLE	Worksheet A line No (00100)	Number of Beds (00200)	Bed Days Available (00300)	Days/Visits/Trips Title XVIII (00500)	Days/Visits/Trips Total Title XIX (00700)	Days/Visits/Trips Total All Patients (00800)	FTEs Total Interns & Residents (00900)	FTEs Employees on Payroll (01000)	Discharges Title XVII (01300)	Discharges Title XIX (01400)	Discharges Total All Patients (01500)
(01000)	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30	136	49,640	9,792	2,041	33,972			2,218	1,994	9,935
(00200)	HMO				10,717	6,708				2,147		
(00400)	HMO IRF Subprovider				2,502	720						
(00700)	Total Adults and Peds. (exclude observation beds) (see instructions)		136	49,640	9,792	2,041	33,972					
(00800)	Intensive Care Unit	31	28	10,220	1,351		4,599					
(00900)	Coronary Care Unit	32										
(01000)	Burn Intensive Care Unit	33										
(01100)	Surgical Intensive Care Unit	34										
(01200)	Other Special Care	35										
(01300)	Nursery	43				488	2,332					
(01400)	Total (see instructions)		164	59,860	11,143	2,529	40,903	43.27	1,228.23	2,218	1,994	9,935
(01600)	Subprovider - IPF	40										
(01700)	Subprovider - IRF	41	36	13,140	1,771	1,066	8,627		39.33	140	135	699
(01800)	Subprovider - Other	42										
(01900)	Skilled Nursing Facility	44										
(02000)	Nursing Facility	45										
(02100)	Other Long Term Care	46										
(02200)	Home Health Agency	101										
(02300)	ASC (Distinct Part)	115										
(02400)	Hospice (Distinct Part)	116										
(02410)	ADULTS & PEDIATRICS *	30										
(02500)	CMHC	99										
(02510)	*	99.1										
(02600)	RHC/FQHC (specify)	88										
(02625)	FEDERALLY QUALIFIED HEALTH CENTER *	89										
(02700)	Total (sum of lines 14-26)		200					43.27	1,267.56			
(02800)	Observation Bed Days					446	2,035					
(02900)	Labor & delivery days (see instructions)		23	8,395		93	500					
(03201)							248					

BED UTILIZATION DATA

PUBLICLY AVAILABLE DATA, UNRESTRICTED USE

FACILITY INFORMATION	
PROVIDER	380017
NAME	LEGACY GOOD SAMARITAN HOSPITAL
ADDRESS	1015 NW 22ND AVENUE
CITY	PORTLAND
STATE	OR
ZIP	97210
CONTROL	Voluntary Nonprofit, Other
SERVICE	General Short Term
SYSTEM	LEGACY HEALTH
DATE_CERTIFIED	07/01/1966
MULTI_CAMPUS	N

CMS

ALL DATA AS REPORTED ON
CMS COST REPORTS
SCHEDULES S200000 AND S300000

MEDICARE | MEDICAID | OTHER

REPORT ID: **653351** REPORT FORMAT: **2552-10** REPORT YEAR: **2018** REPORT STATUS: **As Submitted** FY BEGIN DATE: **04-01-2018** FY END DATE: **03-31-2019** PERIOD DAYS: **365**

TYPE	BEDS	BED DAYS AVAILABLE	MEDICARE DAYS	MEDICAID DAYS	ALL DAYS	FTES	MEDICARE DISCHGS	MEDICAID DISCHGS	ALL DISCHGS	PAYOR MIX DAYS / ALL DAYS	ADC	ALOS	BEDS UTILIZED
ACUTE	136	49640	9833	2425	33955		2241	1933	9684	28.9% 7.1% 63.9%	93	4	68.4%
REHAB	36	13140	1824	1185	9041	38.83	134	128	700	20.2% 13.1% 66.7%	25	13	68.8%

RAW SCHEDULES S2 S3 FOR REFERENCE/DEBUGGING

REPORT ID: **632272** REPORT FORMAT: **2552-10** REPORT YEAR: **2017** REPORT STATUS: **As Submitted** FY BEGIN DATE: **04-01-2017** FY END DATE: **03-31-2018** PERIOD DAYS: **365**

TYPE	BEDS	BED DAYS AVAILABLE	MEDICARE DAYS	MEDICAID DAYS	ALL DAYS	FTES	MEDICARE DISCHGS	MEDICAID DISCHGS	ALL DISCHGS	PAYOR MIX DAYS / ALL DAYS	ADC	ALOS	BEDS UTILIZED
ACUTE	136	49640	9792	2041	33972		2218	1994	9935	28.8% 6.0% 65.2%	93	3	68.4%
REHAB	36	13140	1771	1066	8627	39.33	140	135	699	20.5% 12.4% 67.1%	24	12	65.7%

RAW SCHEDULES S2 S3 FOR REFERENCE/DEBUGGING

PROVIDENCE PORTLAND MEDICAL CENTER
4805 NE GLISAN
PORTLAND, OR 97213

MULTNOMAH | BACK

WORKSHEET: S300001
PROVIDER: 380061
FY BEGIN: 01-01-2018
FY END: 12-31-2018
STATUS: As Submitted
FORMAT: 2552-10

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

LINE	TITLE	Worksheet A line No (00100)	Number of Beds (00200)	Bed Days Available (00300)	Days/Visits/Trips Title XVIII (00600)	Days/Visits/Trips Total Title XIX (00700)	Days/Visits/Trips Total All Patients (00800)	FTEs Total Interns & Residents (00900)	FTEs Employees on Payroll (01000)	Discharges Title XVII (01300)	Discharges Title XIX (01400)	Discharges Total All Patients (01500)
(00100)	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30	289	105,485	19,483	3,941	81,819			3,774	858	18,403
(00200)	HMO				25,504	22,016				4,574	3,504	
(00300)	HMO IPF Subprovider				20						421	
(00400)	HMO IRF Subprovider				1,249	510					30	
(00700)	Total Adults and Peds. (exclude observation beds) (see instructions)		289	105,485	19,483	3,941	81,819					
(00800)	Intensive Care Unit	31	36	13,140	1,829	375	7,404					
(00900)	Coronary Care Unit	32										
(01000)	Burn Intensive Care Unit	33										
(01100)	Surgical Intensive Care Unit	34										
(01200)	Other Special Care	35	17	5,386		442	3,365					
(01300)	Nursery	43				982	5,352					
(01400)	Total (see instructions)		342	124,011	21,312	5,740	97,940	33.3	2,614.63	3,774	858	18,403
(01600)	Subprovider - IPF	40	31	11,861	2,238	786	9,893		71	135	90	948
(01700)	Subprovider - IRF	41	18	6,570	1,221	255	5,208		28	107	19	399
(01800)	Subprovider - Other	42										
(01900)	Skilled Nursing Facility	44										
(02000)	Nursing Facility	45										

Exhibit 8

PROVIDENCE PORTLAND MEDICAL CENTER
4805 NE GLISAN
PORTLAND, OR 97213

MULTNOMAH BACK

WORKSHEET: S300001
PROVIDER: 380061
FY BEGIN: 01-01-2018
FY END: 12-31-2018
STATUS: As Submitted
FORMAT: 2552-10

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

LINE	TITLE	Worksheet A line No (00100)	Number of Beds (00200)	Bed Days Available (00300)	Days/Visits/Trips Title XVIII (00600)	Days/Visits/Trips Total Title XIX (00700)	Days/Visits/Trips Total All Patients (00800)	FTEs Total Interns & Residents (00900)	FTEs Employees on Payroll (01000)	Discharges Title XVII (01300)	Discharges Title XIX (01400)	Discharges Total All Patients (01500)
(00100)	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30	289	105,485	19,483	3,941	81,819			3,774	858	18,403
(00200)	HMO				25,504	22,016				4,574	3,504	
(00300)	HMO IPF Subprovider				20						421	
(00400)	HMO IRF Subprovider				1,249	510					30	
(00700)	Total Adults and Peds. (exclude observation beds) (see instructions)		289	105,485	19,483	3,941	81,819					
(00800)	Intensive Care Unit	31	36	13,140	1,829	375	7,404					
(00900)	Coronary Care Unit	32										
(01000)	Burn Intensive Care Unit	33										
(01100)	Surgical Intensive Care Unit	34										
(01200)	Other Special Care	35	17	5,386		441	3,365					
(01300)	Nursery	43				982	5,352					
(01400)	Total (see instructions)		342	124,011	21,312	5,740	97,940	33.3	2,814.63	3,774	858	18,403
(01500)	Subprovider - IPF	40	31	11,861	2,238	786	9,693		71	135	90	948
(01700)	Subprovider - IRF	41	18	6,570	1,221	255	5,208		28	107	19	399
(01800)	Subprovider - Other	42										
(01900)	Skilled Nursing Facility	44										
(02000)	Nursing Facility	45										

Table						
Required 2019 OAR 333-590-0050 (8) Bed Capacity for Legacy RIO and Providence Portland IRF at Current Average Daily Census with Insurance Barriers						
	Available Total Beds	Daily Census	Estimate of Standard Deviation	>10 miles from alternate facility multiplier	Required Beds	Bed Need (-)
Legacy Sood Samaritan RIOI	36	25	6.2	2.88	42.86	-6.86
Providence Portland IRF	18	14	4.7	2.88	27.71	-9.71

Exhibit 9

Table						
Required 2019 OAR 333-590-0050 (8) Bed Capacity for Legacy RIO and Providence Portland IRF at Current Average Daily Census						
	Available Total Beds	Daily Census	Estimate of Standard Deviation	< 10 miles from alternate facility multiplier	Required Beds	Bed Need (-)
Legacy Sood Samaritan RIOI	36	25	6.2	2.33	39.45	-3.45
Providence Portland IRF	18	14	4.7	2.33	25.14	-7.14

OHCA
OREGON HEALTH
CARE ASSOCIATION

11-04-2019 RCVD

Oregon's Voice for Long Term Care & Senior Housing

11740 SW 68th Parkway Ste. 250
Portland, OR 97223
Office: (503) 726-5260
Fax: (503) 726-5259
www.ohca.com

Statement in opposition to Encompass application

Oregon Health Authority must deny the Encompass application for a 50-bed inpatient rehabilitation facility (IRF) because the applicant has not met the required burden of proof required to justify such a facility under the Oregon certificate of need laws. General criteria for reviewing this project are provided in OAR chapter 333, division 580. The specific need methodology and standards for demonstration of need for acute inpatient beds and facilities are found in OAR chapter 333, division 590. The specific need methodology and standards for demonstration of need for inpatient rehabilitation beds are found in OAR chapter 333, division 645. Encompass has not met the requirements in these rules.

Further, the Encompass proposal does not support Oregon's Triple Aim; better health, better care, lower cost.

Need for the proposed facility; OAR 333-580-0040; OAR 333-590-0050; 333-645-0030

1. Does the service area population need the proposed project? **No**, applicant has not met its burden to identify the past, present and future bed-need within the proposed service area.

- Encompass asserts a service area of Multnomah, Washington and Clackamas counties. OHCA does not disagree with this assertion.

- Encompass has not met the standards for both a general acute care bed need and for specific inpatient rehabilitation bed need.

- The CN rules do not differentiate between types of inpatient beds when assessing need. All proposed new inpatient facilities are required to demonstrate a need for general acute care beds. Applicant has not attempted to show a need for additional general acute care beds, but rather has attempted to show there is not a need for more inpatient rehabilitation beds in an acute care setting.

- Applicant may assert that inpatient rehabilitation beds are sufficiently different from general inpatient acute care beds that the need cannot be met through acute care beds and so they need not be measured. That argument denies the current existence of rehabilitation beds in two area acute care hospitals, Legacy Health System and Providence St. Vincent.

- The CN rules demonstrate a strong preference for use of existing beds over construction of new beds. OAR 333-645-0030; OAR 333-580-0050; 333-590-0060

- Existing acute care inpatient rehabilitation facilities are meeting the need for rehabilitation beds:

  - Several area hospitals offer inpatient rehabilitation beds. The existence of, location and experience at these facilities demonstrates lack of current actual need.

    - Legacy Health System operates an inpatient rehabilitation facility in Multnomah County, less than 20 miles from either of the Encompass proposed sites. Testimony at the October 15 hearing indicates this facility offers 36 beds and those beds are only 60% occupied. This occupancy level has been consistent over time. If Encompass's need calculation were correct, the Legacy beds would be filled beyond 60%.
    - In addition to the Legacy facility, Providence Health System operates a rehabilitation unit at their Providence Portland site, offering 18 beds. This facility is This facility is just 20 miles from the Encompass Hawthorn Farm site and similarly situated from the Amberglen site.
    - These area hospitals may increase their inpatient rehabilitation beds without going through certificate of need process if there is actual need for additional rehabilitation beds. OAR 333-550-0010

- Applicant's need demonstration further fails because area referral sources do not assert a need for new rehabilitation beds and likely would not discharge their patients there:

  - Rehabilitation patients typically are discharged to nursing facilities or to existing acute care rehabilitation units from area hospitals. No hospitals in the service area or other referral sources such as payors testified that they need additional sites to which to refer, including hospitals in Washington County; Kaiser Westside Medical Center, Tuality Community Hospital and Providence St. Vincent.

  - In its application, Encompass indicates it interviewed area hospitals and none indicated they intended to offer additional inpatient rehabilitation capacity or provide space to other providers to add additional capacity. Encompass appears to use this information to argue that any increasing future need will not be met by other providers. This information also demonstrates, however, that no area providers see a need either now or in the future.

    - We understand that Kaiser Westside Medical Center, one of the largest hospitals in the service area, has a contract with another existing

inpatient rehabilitation unit to care for its discharged patients so likely would not discharge to Encompass.
- Providence St. Vincent likely will not discharge to Encompass as it operates its own inpatient rehabilitation unit.
- Legacy Health System similarly will utilize its own inpatient rehabilitation unit.

- Medicare Managed Care plans are unlikely to contract with IRFs because similar services are currently available in area nursing facilities at lower cost. See AGERIGHT Care Management Solutions submitted testimony.

- Applicant may assert that their showing of future need, based changing demographics, requires construction of beds now to meet that later surge need. This argument fails because:

  - There is no sufficient current need or Medicare payment source, as demonstrated in this document and submitted testimony, to maintain a viable IRF now so future need is not relevant.

  - OAR 333-645-0030(2) provides that priority is to be given to expansion of existing facilities over building of new beds.

    - The potential surge need can be met with existing licensed bed capacity in area nursing facilities, or these facilities generally could expand their licensed capacity without going through the certificate of need process (OAR 333-550-0010; note some limitations in law).
    - Area hospitals also may increase their inpatient rehabilitation beds without going through certificate of need process. OAR 333-550-0010

2. Has applicant affirmatively demonstrated that there is not a more efficient, cost effective alternative to the proposed facility?

No, applicant has not demonstrated this key factor. Without a need for general acute care beds, applicant must now apply the rules specific to inpatient rehabilitation facilities. These rules require applicants to evaluate need in a manner *consistent, where applicable*, with the methods and principles established in OAR 333-590-0030 to 333-590-0060, (OAR 333-645-0030(4)), and demonstrate that their proposed services are the least costly of any reasonable alternatives (OAR 333-645-020(1)). These key words, emphasized, indicate that applicant is not required to strictly adhere to the acute care bed need analysis expressed in OAR 333-590. Rather, a rational approach is required that promotes the principle expressed in the specialty inpatient rehabilitation rules, that rehabilitation units should provide the least restrictive and most cost-effective setting possible to meet patient needs. This approach also honors the goals

of the certificate of need program, to promote effective, lower cost health care through encouraging less expensive, more accessible alternatives to care. See, analysis supporting Newco decision #675. Applicants must demonstrate that their proposed services are the least costly of any reasonable alternatives. (OAR 333-645-020(1))

OHA further states in its analysis supporting the Newco decision #675 that, under OAR 333-590-0060, applicant is required to evaluate the use of non-inpatient alternatives for its proposal when general inpatient need is not shown under OAR 333-590-0050 or OAR 333-590-0060.

Encompass rejects area nursing facilities as an effective alternative. It is incorrect in this assessment and cannot demonstrate there is actual need for inpatient rehabilitation beds in the service area:

- This approach is directly contrary to the rational approach directed by both the rules and OHA interpretation

- Based on the state's nursing facility data, there are 56 nursing facilities with 4,541 licensed beds that are able to offer therapy services in the tri-county area. The average occupancy across the three counties is 71%.

- Similar to the psychiatric hospital at issue in the Newco decision, CN#675, alternatives to specialty inpatient rehab beds are available as nursing facilities have increasingly moved to caring for higher acuity, short stay patients in response to state direction. See, OHCA and Marquis submitted testimony and discussion herein.

- Encompass provides largely national data when asserting that Oregon nursing facilities should not be considered as an alternative. For the reasons expressed in this document and other submitted testimony, that data does not present an accurate picture.

- Oregon nursing facilities care for higher acuity patients than nationally, including many patients with the same diagnoses as served in IRFs.

    - The state allows nursing facilities to care for these patients, defining a nursing facility as an establishment with permanent facilities, including inpatient beds, that provides medical services..." (OAR 411-085-0005).

    - Nursing facilities function in much the same way as an IRF in that virtually all admissions come from hospital discharges. See, OHCA hearing testimony; nursing facility submitted testimony, Mendez-Luck, Luck, Mahakalanda, Govier, *The State of Nursing Facilities in Oregon, State Fiscal Year 2018,* Oregon State University, College of Public Health and Human Sciences, 2019.

- Nursing facilities do care for rehabilitation patients. See submitted testimony by nursing facilities in the service area, *The State of Nursing Facilities in Oregon, State Fiscal Year 2018,* citing significant percentages of IRF diagnoses cared for in nursing facilities currently.

- Nursing facilities provide extensive therapy services. See, Dr. Kolonic's testimony.

- CMS and MedPAC also believe patients currently cared for in IRFs can also receive similar therapy care in a nursing facility:
  - In the FY 2020 SNF PPS Final Rule 84 FR 38746, CMS standardized the definition of group therapy services between SNFs and IRFs as follows: "...in an effort to support CMS' cross-setting initiatives under the IMPACT Act and Meaningful Measures Initiative, we looked at ways to align the definition of group therapy used under the SNF PPS more closely with the definitions used within the...IRF PPS, as this type of standardization would reduce administrative burden on providers by utilizing the same or similar definitions across settings...we stated that *given the greater degree of similarity between the IRF and SNF settings in terms of the intensity of therapy and patient acuity,* we believe that the IRF PPS definition would be more appropriate in the SNF setting." (emphasis added)

  - MedPAC, in its 2016 report, stated in an endnote on page 103, "In an analysis of 22 conditions frequently treated by IRFs and SNFs, beneficiaries had similar risk profiles (or the lower cost SNF patients had higher risk profiles)...the Post-Acute Care-Payment Reform Demonstration conducted by CMS found considerable overlap in the patients treated...."

  - Based upon IMPACT Act requirements, CMS has applied the same functional outcomes quality measures to SNF as had been applied to IRFs to permit comparison of outcomes across settings.

- Nursing facilities in the service area offer significantly more available beds than Encompass indicates in its application will be necessary, now and in the future. See the number of nursing facilities, beds and occupancy cited above.

- We note that OHA, through analysis by Mr. Robison, calculates an assumed need of 126 beds. This evaluation is based on area hospital discharges. As indicated, nursing facilities receive virtually all admissions through area hospital discharges. As there has been no testimony, either written or oral, that rehabilitation patients are not being cared for in the service area (other than limited evidence of need for treatment of brain trauma patients) it is safe to assume these patients are discharged to existing hospital-based IRFs and nursing facilities for care.

- Nursing facilities are a more cost-effective provider of rehabilitation services in the service area.

  - Using Marquis facilities as an example (see their submission), the average cost from all payors of a nursing facility stay is approximately $13,000 compared to more than $20,000 as cited in the Encompass application. While nursing facility length of stay may

be slightly longer than in an IRF, the difference does not negate the gap in cost.

- As cited in the previously submitted OHCA testimony, the 2019 MedPac report indicates unanimous support for reducing IRF reimbursement as the current reimbursement is excessive.

- Encompass cites the *2017 Long-term Services and Supports State Scorecard* calculation projection that by addressing avoidable nursing home care costs, another $48 million could be available for other needed services, such as home and community-based services. This statement is reflective of the policy direction in Oregon that older, vulnerable citizens can be cared for in facilities such as assisted living and residential care and supports why nursing facilities now care for more acute patients. Further, any savings from moving patients away from nursing facilities would not go to pay for inpatient rehabilitation services. Those funds are managed by the Department of Human Services, not the Oregon Health Authority where IRFs would be regulated and paid.

- Nursing facilities provide quality services.

  - Notably, OAR 333-580-0050(1)(C) references "adequate quality" in the context of whether there is a reasonable alternative to the proposed facility. While OHCA asserts that nursing facilities services are of very good quality, that is not the standard they must meet to qualify as an alternative provider. Encompass cites no data indicating the care provided by nursing facilities in the service area is of inadequate quality.

  - Nursing facilities are heavily regulated in both state and federal law. These regulations impose significant care and oversight requirements on providers. See, ORS chapter 441, OAR chapter 411, divisions 70-90; 45 CFR 483, including new and extensive federal nursing facility requirements of participation that require, among many other things, facility-based quality plans that measure and support quality of care.

  - Nursing facilities are subject to a five-star rating which measures, among other factors, information on 15 different physical and clinical measures for nursing facility resident quality of care. Almost 80% of nursing facilities in the tri-county region maintain a rating of 3-stars or better. (Consonus Copilot Report, October 30, 2019)

    - Medicaid payors typically contract with facilities with a 3 or higher rating.

  - Data cited by Encompass for the proposition that IRFs provide better quality care, such as fewer emergency room and hospital readmissions ("Assessment of Outcomes in Rehabilitation Care in Rehabilitation Facilities and after Discharge"), is national data with no specific reference to Oregon. Oregon data submitted by providers in the service area, such as successful return to community rates and hospital readmission rates,

indicate strong outcomes.

- Encompass cites an American Heart Association/American Stroke Association study for the proposition that an IRF is the evidence-based choice over nursing facilities. Again, this study did not consider Oregon nursing facilities and their uniquely high level of services. For example, it states as a distinguishing factor that IRFs offer at least three hours of rehabilitation a day from various therapists; see, the Marquis testimony that it averages 2.5 hours of therapy 5 days a week for its ultra-high rehab patients. It further states that nurses are continuously available in an IRF; they must be continuously available in a nursing facility pursuant to our staffing laws. They note that a doctor typically visits daily; nursing facilities have medical directors, one of which you heard from at the Oct. 15 hearing.

- Nursing facilities provide much more convenient access to therapy care than would either of the Encompass sites.

  - Nursing facilities are scattered throughout the service area, providing easy access to care for patients as well as their families. See, submitted map showing dispersion of nursing facilities throughout the service area.

Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project; OAR 333-580-0050(2)?

1. Has Encompass demonstrated, as required, that there will be sufficient numbers of caregiving personnel to support the proposal? **No.**

   - Encompass does not acknowledge or address the ongoing, severe staffing shortage that exists in Oregon generally, and certainly in the tri-county area. See the Marquis data and narrative for evidence of unfilled staff positions. Staffing challenges are a result of a grossly inadequate supply of caregiving staff in the area. There is no evidence this shortage will ease in the near future.

2. Has Encompass demonstrated that it has adequate land available to support the project? **No.**

   - The original Encompass application cited a "Hawthorn Farm" location as the proposed location. Since submittal of the application, however, Encompass has made clear pursuant to an amendment to the application that they do not have the necessary permissions from the Port of Portland to use the land.

   - Encompass, in its amendment, proposes a new site, the "Amberglen" site. No where in the amendment does Encompass demonstrate what its rights are to the land. Does Encompass own the land? Do they just have an option on it? Without this information, Encompass has not met the requirements in the law.

Applicant has not considered the health care marketplace it hopes to occupy and will disrupt that marketplace.

1. OAR 333-580-0060 requires applicants to answer the question: Will the impact of the proposal on the cost of health care be acceptable? **Encompass cannot answer this question with a "yes."**

    - As discussed earlier in this document, the average cost of care for an IRF is much higher than for a nursing facility.

    - When insurers are forced to pay higher costs to providers, the cost to patients, through copays and coinsurance, commensurately increases.

2. Will the proposed IRF thrive in the marketplace it proposes? **No.**

    - Encompass proposes to accept less than 10% Medicare managed care. That is not sustainable. Oregon generally is a very high Medicare managed care state, and the tri-county area average 57% Medicare managed care. (see, AGERIGHT testimony)

    - Given the high cost of care, and available successful alternatives, Medicare managed care plans are unlikely to contract with an IRF. (See, AGERIGHT)

    - Similarly, the local CCOs are unlikely to contract with Encompass because:

        - They are a higher cost Medicaid provider than other available providers in the area; and
        - They will only take limited numbers of patients.

    - Applicant likely intends to limit its patients to Medicare fee for service and private pay patients. Given the saturation of managed care, finding sufficient patients to fill its beds is unlikely.

3. Will applicant support Oregon's triple aim? **No.**

    - Encompass proposes taking less than 5% Medicaid and thus will not contribute to providing better care to Oregon's low-income population.

    - Encompass proposes to provide rehabilitation care at a much higher cost than provided to other rehabilitation providers in the marketplace (nursing facilities).

    - By limiting its patients to fee for service and private pay, Encompass will push low income patients and lower Medicare managed care reimbursement to area nursing facilities, causing those facilities to be less viable. Not only will this cause essential community providers to leave, it will cause access problems for vulnerable citizens in this area.

4. Will applicant promote fewer health care options in the service area? **Yes.**

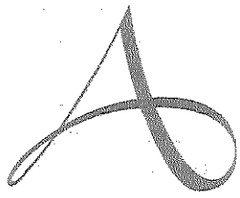
    - As noted above, Encompass will pull away the higher reimbursement patients from existing community providers, likely leading to closure of those other community providers.

        - Encompass submitted a graph titled "SNF Utilization in Encompass Health Markets" to assert that area nursing facilities will not be affected by entry of IRFs into the market. This graph reflects national markets, not Oregon. As discussed in this document, the Oregon market is very different due in large part to the high acuity patients cared for by nursing facilities here and the levels of therapy care provided.
        - Note the already high percentage of Medicaid served in area nursing facilities. They cannot succeed with even higher numbers.

For all these reasons, and those expressed in prior submissions and by other opponents, OHCA urges the Oregon Health Authority to deny the Encompass application.

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11-04-2019 RCVD



PART OF THE AVAMERE FAMILY
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November 4, 2019

Avamere Family of Companies

Statement in opposition to the Encompass application:

My name is Lawrence Lopardo and I am Chief Legal Officer for each company within the Avamere Family of Companies. Within this family of companies are a number of skilled nursing facilities in the Multnomah, Clackamas and Washington county area (the "Tri-County Area"). I am writing to strongly urge the Oregon Health Authority (the "OHA") to deny the inpatient rehabilitation facility application submitted by Encompass. Attached to this letter is data that details the demographics of the patients serviced by the Avamere skilled nursing facilities in the Tri-County Area, which data supports the argument that the Encompass application should be denied. Thank you for the opportunity to present this data and to present our argument that there is no need for additional rehabilitation beds in the Tri-County Area.

Oregon's certificate of need administrative rules require that when evaluating an application for a certificate of need for additional acute beds in an area, there must be an assessment of the existing acute care beds in the area and whether there is a need for more acute beds in the service area. In its October 15 hearing, Encompass testified that the OHA may only consider other acute care beds when assessing need under the certificate of need administrative rules. Encompass failed to make an argument that there is a need for more acute beds in the Tri-County Area. Encompass' argument boils down to a claim that there is currently a need for specialty rehabilitation beds and this need must be measured only against rehabilitation offered in acute care beds. This argument completely ignores the legal requirement that Encompass demonstrate that there is not currently available a satisfactory alternative in the marketplace.

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We strongly disagree with Encompass' argument that there is a current need for additional beds in the Tri-County Area. OAR 333-645-0030 provides the baseline requirement that the total need for inpatient rehabilitation services shall not exceed seven beds in 100,000 general population. Encompass calculates that this approach yields a net bed need in the Tri-County Area of 91 beds in 2028. Avamere facilities currently have approximately 610 licensed nursing facility beds in the Tri-County Area that average just under 85% occupancy. The excess occupancy of Avamere facility beds indicates a lack of need for additional beds.

We also know that the seven bed per 100,000 population is just the beginning of the analysis. When no acute bed need is demonstrated, applicants must look to the specific rules for inpatient rehabilitation facilities; OAR 333- 645. These rules require applicants to evaluate need in a manner consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060 (OAR 333-645-0030(4) and demonstrate that their proposed services are the least costly of any reasonable alternatives(OAR 333-645-020(1)). Notably, OAR 333-645-0030 does not require strict adherence to the rules for demonstrating acute care bed need but rather just a rational application of those rules. As such, area nursing facility beds must be considered as a reasonable alternative to the proposed IRF beds. The data accompanying this memorandum demonstrate that the currently existing beds in the Tri-County Area, including the facilities within the Avamere Family of Companies, already meet the rehabilitation bed needs for the Tri-County Area.

We believe that the data that accompanies this letter will support our arguments and speak for itself. However, please allow us to call attention to a number of key findings revealed by our data:

- Avamere skilled nursing facility beds serve patients with the same diagnoses served in inpatient rehabilitation facilities. The attached data shows that between 21% to 32% of the short stay patients of Avamere facilities have the same primary diagnoses as those in the 13 required diagnosis categories inpatient rehabilitation facilities are subject to, and we can accept more.
- The "successful return to community" rates for short stay patients at Avamere facilities are quite high, ranging from 64% all the way up to 80%.
- Avamere facilities offer a much lower cost provider for the same services. Encompass indicates it will accept a very low percentage of Medicaid patients. The majority of Avamere facilities in the Tri County Area average over 50%. Avamere Crestview of Portland averages almost 73% Medicaid patients.
- Encompass has indicated that it will accept less than 8% of Medicare Advantage patients. Avamere facilities have an average of 68% Medicare Advantage for its short stay days. Encompass will generally rely on the higher cost Medicare fee for service or private pay to fund its services. We also know from other testimony submitted that MedPac considers inpatient rehabilitation facilities to be overpaid.
- Encompass will disrupt an already stressed labor market. While Avamere facilities expend significant efforts and resources in recruiting and retaining our essential caregivers, Avamere facilities in the Tri-County Area had 113 unfilled staff positions as of September 30, 2019. This struggle of finding a sufficient number of qualified caregivers is not specific to Avamere but is the norm across the industry in the Tri-County Area. There is no reason to expect that Encompass will not face the same recruiting challenge.

The data accompanying this letter support the rejection of the Encompass application. The reality in the Tri-County area is that there is no need for more acute beds as there are already sufficient

beds, and the existing beds are more cost-efficient than the proposed Encompass beds. The services that inpatient rehabilitation facilities traditionally provide are already being met in the Tri-County Area. The needs that would be met by such additional IRF beds are already being met by the existing combination of inpatient rehabilitation hospital units (Legacy Rehabilitation Institute of Oregon and Providence Portland Medical Center) and skilled nursing facilities, with capacity left over. As such, the Oregon Health Authority must deny the application submitted by Encompass.

Submitted,

DocuSigned by:

A447694061E9442...

Lawrence Lopardo
Chief Legal Officer

Data Info for IRF C O N Opposition

Avamere Companies - Tri-County Are SNF's only

Date Range	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*Sept 2018 - Aug 2019 (1 Year)*	*Sept 2018 - Aug 2019 (1 Year)*	*2018 publicly reported rate*	*Oct 2018 - Sept 2019 (1 Year)*
Source	Co-Pilot ??? "Patient Dx Data"	*SNF Scorecard (KRA Data)*	*SNF Scorecard (PCC In and Out Data)*	*SNF Scorecard (PCC In and Out Data)*	*SNF Scorecard (PCC In and Out Data)*	*Abaqis*	*Abaqis*	*Medicare.gov*	*Abaqis*
			LOS for Short-Stay Episodes			Readmission Rates			
Facility	Short-stay Episode % of Residents with identical Primary Dioagnosis Code as the 13 IRF codes	Occupancy Rate (Using Available Beds)	MCR	MCR Adv	Combined	In Facility (Raw rate - All Payors)	In Facility (Risk Adjusted Rate - All Payors)	30-day CMS	Successful Return to Community Rates
Avamere Rehabilitation of Clackamas	32.00%	80.20%	18.4	15.2	16.5	9.80%	8.90%	21.20%	80.00%
Avamere Rehabilitation of Oregon City	24.00%	91.30%	18.7	15.7	16.7	14.70%	11.20%	17.60%	77.00%
Avamere Rehabilitation of King City	28.00%	72.90%	21.2	16.4	18.3	12.10%	9.00%	16.70%	74.00%
Avamere Rehabilitation of Beaverton	29.00%	83.70%	16.8	12.5	13.2	17.60%	14.00%	22.10%	72.00%
Avamere Rehabilitation of Hillsboro	30.00%	86.70%	21.4	14.8	16.3	16.40%	12.70%	27.90%	78.00%
Avamere Crestview of Portland	21.00%	77.40%	21.4	15.3	17.8	21.20%	19.60%	20.10%	64.00%
The Pearl at Kruse Way	27.00%	92.20%	18.8	17.6	18.1	15.10%	12.70%	26.30%	80.00%
Laurelhurst Village	25.00%	89.90%	17.4	14.4	15.1	20.50%	19.00%	23.20%	71.00%
Total		84.90%	19.2	14.8	16.1				

Oct 2018 - Sept 2019 (1 Year)	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*Oct 2018 - Sept 2019 (1 Year)*	*As of 9/30/2019 Open Positions Report. Includes all Nursing and Non-Nursing open positions.*	*As of Sept 2019*
IN and Out/ PCC	*IN and Out/ PCC*	*KRA Automated (PCC) (Medicaid Census / Total Census)*	*KRA Automated (PCC)*		*UltiPro*

Sources

Hospital 3	% of Referrals/Admissions from Hospital	Medicaid Occupancy % to Total Occupancy	Medicare Advantage Days to total Short Stay days	# of unfilled open staff positions as of 9-30-19	Total Employees
Providence Willamette Falls Hospital	97.22%	58.73%	57.99%	12	56
Legacy Meridian Park Hospital	95.84%	63.11%	68.26%	7	77
OHSU	87.74%	59.73%	57.61%	12	70
Kaiser Sunnyside Medical Center	96.60%	55.35%	84.55%	12	108
Providence St Vincent Medical Center	96.12%	38.58%	73.82%	5	106
Providence St Vincent Medical Center	95.61%	72.70%	56.65%	20	105
OHSU	96.11%	4.40%	57.10%	25	120
Legacy Emanuel Medical Center	95.21%	58.07%	73.23%	20	191
	95.38%		68.09%	113	833

11-04-2019 RCVD

MARQUIS
COMPANIES

November 4, 2019

Marquis Companies

On behalf of Marquis Companies, thank you for the opportunity to submit the attached data describing the patients our nursing facilities care for in the Multnomah, Clackamas and Washington county area. This data strongly supports our assertion that there is no need for additional rehabilitation beds in this area.

Encompass indicated in its testimony during the October 15 hearing that OHA may only consider other acute care beds when assessing need under the certificate of need administrative rules. It does not argue, and indeed cannot do so successfully, that there is the need for more acute care beds in the service area. It argues instead that there is a need for specialty rehabilitation beds and this need must be measured only against rehabilitation offered in acute care beds. In making this argument, it ignores the requirement in law that it must also demonstrate that there is not another acceptable alternative already available in the marketplace.

OAR 333-645-0030 provides the baseline requirement that the total need for inpatient rehabilitation services shall not exceed seven beds in 100,000 general population. Encompass calculates that this approach yields a net bed need in the tri-county area of 73 beds in 2017 and 91 beds in 2028. Marquis has 755 licensed nursing facility beds in the service area. Of these, we average 80% occupancy

OAR 333-580-0050 requires applicants to demonstrate that the proposed project represents the most effective and least costly alternative, considering all appropriate and adequate ways of meeting the identified needs. See also, OAR 333-590-0060. The data accompanying this memorandum demonstrate that the Marquis facilities alone meet the rehabilitation bed need for the service area.

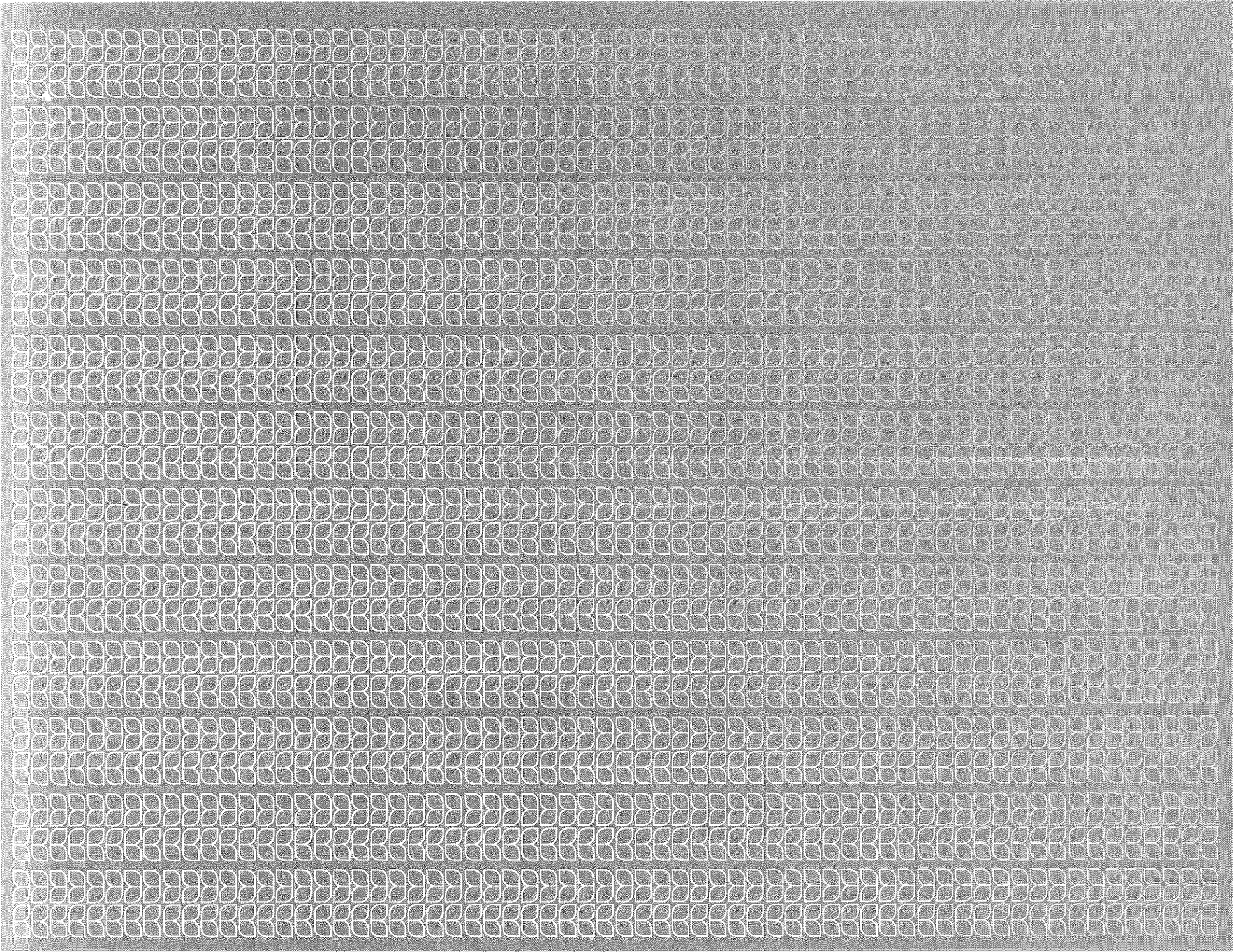
We welcome your review of all the data we submit, but will highlight a few key numbers and their implications:

Our nursing facility beds serve patients with the same diagnoses served in inpatient rehabilitation facilities. See the attached data showing that an average of 37% of our short stay patients have the same primary diagnoses as those in the 13 required diagnosis categories inpatient rehabilitation facilities are subject to, with one facility serving as high as 49%.We believe that if we actually did a careful study of all diagnosis, (IRF -vs- SNF) the similar diagnosis codes would exceed 60%.

We provide therapy services to these patients every day. In Dr. Kolonic's written testimony we demonstrate that we average 2.4 hours for a five-day therapy week for residents in the "ultra-high" rehabilitation category. The large majority of our Marquis facility rehab days are in this ultra-high category. She described the good work we do every day with these patients.

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marquiscompanies.com

ph. 971.206.5100
fx. 971.206.5201



Reflecting this good work, our successful "return to community" rates for short stay patients are quite high, averaging 65%, and our hospital readmission rates are commensurately low.

Marquis is a much lower cost provider for the same services. Our average cost per short-stay episode is approximately $13,000, as compared to over $20,000 per episode in the Encompass application. Encompass indicates it will accept a very low percentage of Medicaid patients; Marquis facilities in the service area average almost 50%. We will care for these patients; Encompass will not. Similarly, Encompass indicates it will accept less than 8% of Medicare Advantage patients; In contrast, Marquis has an average of 56% Medicare Advantage for its short stay days. Encompass will generally rely on the higher cost Medicare fee for service or private pay to fund its services. We also know from other testimony submitted that MedPac considers inpatient rehabilitation facilities to be overpaid.

In addition to ignoring a successful existing resource, Encompass will disrupt an already stressed labor market. We work hard every day to recruit and retain our essential caregivers, but our data nonetheless shows a significant number of unfilled positions. This is not because we are not dedicated to full staffing but rather that there simply are not the caregivers in the marketplace to hire. Encompass will face the same challenge.

We have presented data that strongly supports rejection of the Encompass application. In addition, we believe the Oregon "difference," unrecognized by Encompass in its application, requires Oregon Health Authority to deny the application. Specifically, the tri-county marketplace is different than nearly every other market in the country with regard to "need" for IRF services for the following reasons:

High penetration of Medicare Advantage coverage for the over 65 population in the tri-county area– 57% coupled with Medicare Advantage payors clearly not being interested in contracting with IRF's. This removes a material portion of the potential payor market for this IRF that is not seen in other markets where IRF's drive occupancy.

In Oregon, we have no actual need for IRFs because, pursuant to unique state direction, nursing facilities care for these patients. Oregon has a long history of supporting active community-based care options for seniors that has led to significantly lower occupancies in Oregon nursing facilities. We currently have the lowest nursing facility occupancy in the country (The State of Nursing Facilities in Oregon, 2017, OSU College of Public Health and Human Sciences, 2018) This has led to nursing facility operators gravitating to provide more extensive therapy / post-acute short stay episode services to seniors in an effort to remain economically viable. It is not surprising that Oregon has a very low inpatient rehabilitation facility referral rate. Approval of the Encompass application, or any IRF application, would be in direct contradiction to Oregon's policy direction.

Consistent with this policy direction, nursing facilities in the tri-county area care for a high percentage of the IRF diagnosis episodes and achieve much more impressive outcomes.

Due to our impressive skilled nursing facility outcomes (hospital readmission rates, return to community success, etc.) the economic cost add of providing IRF services is more tangibly higher than in other markets. Length of stay may be shorter in an IRF, but the daily cost is significantly higher which leads to an overall episode cost of a greater magnitude in an IRF.

The services that IRF's traditionally provide are already being met in the tri-county area. The combination of the existing inpatient rehabilitation hospital units (Legacy Rehabilitation Institute of

Oregon) and skilled nursing facilities, are more than meeting the needs. While there may be some extraordinary events / conditions that occur, where a higher level of service need is necessary, these cases are limited and will not drive a market demand level needed to warrant a specialty facility.

Submitted,

Steve Fogg, CFO

Data Info for IRF C O N Opposition

Marquis Companies - Tri-County Area SNF's only

			LOS for Short-Stay Episodes			Readmission Rates			Primary Referral/Admmission Sources							
Facility	Short-stay Episode % of Residents with identical Primary Dioagnosis Code as the 13 IRF codes	Occupancy Rate	MCR	MCR Adv	Combined	In Facility	30-day CMS	Successful Return to Community Rates	Hospital 1	Hospital 2	Hospital 3	% of Referrals/Admissions from Hospital	Medicaid Occupancy % to Total Occupancy	Medicare Advantage Days to total Short Stay days	# of unfilled open staff positions as of 9-30-19	Total Employees
Marquis Oregon City, Oregon City	38.57%	57.84%	22.92	22.41	22.52	11.51%	20.47%	55.40%	Providence Willamette Falls	Providence Milwaukie		90.78%	62.79%	66.85%	3	101
Marquis Hope Village, Canby	32.63%	92.00%	28.36	21.20	22.99	7.19%	14.16%	64.89%	Legacy Meridian Park	Providence Willamette Falls		95.63%	42.49%	54.39%	14	65
Marquis Wilsonville, Wilsonville	33.61%	84.00%	23.40	20.71	21.84	9.79%	17.08%	67.00%	Legacy Meridian Park	OHSU		93.42%	42.87%	62.68%	7	70
Marquis Centennial, Portland	37.18%	95.00%	24.96	23.03	23.67	14.02%	17.34%	57.33%	Providence Portland	Legacy Mt Hood	Legacy Good Sam.	96.36%	57.73%	67.25%	2	120
Marquis Mt Tabor, Portland	32.40%	72.50%	21.74	14.64	16.52	16.25%	20.21%	69.50%	Providence Portland	Legacy Emanuel	Legacy Good Sam.	94.99%	60.77%	66.97%	29	165
Marquis Mill Park, Portland	37.07%	92.59%	26.25	21.09	24.49	9.05%	12.88%	67.40%	Providence Portland	Adventist Health	OHSU	98.38%	9.38%	23.25%	5	120
Marquis Piedmont, Portland	38.72%	90.00%	21.27	17.50	18.96	10.77%	18.04%	56.00%	Legacy Emanuel	Legacy Good Sam	Providence Portland	88.85%	63.62%	47.85%	22	100
Marquis Vermont Hills, Portland	36.82%	76.71%	21.64	22.65	22.16	13.67%	17.54%	70.56%	Providence St. Vincents	OHSU	Legacy Good Sam.	94.87%	49.17%	46.12%	5	89
Marquis Tualatin, Tualatin	49.36%	88.89%	24.61	19.29	21.42	11.02%	18.93%	62.90%	Legacy Meridian Park	Providence St. Vincents	OHSU	96.04%	24.02%	46.91%	19	85
Marquis Forest Grove, Forest Grove	35.26%	80.95%	20.81	14.89	18.05	11.55%	16.10%	61.56%	Tuality Community Hosp.	Providence St. Vincents	OHSU	90.42%	57.90%	52.72%	5	80
Total	37.16%	80.73%	23.83	19.01	20.99	11.48%	17.28%	64.93%				93.98%	49.25%	56.32%	111	995

AGERIGHT
CARE MANAGEMENT SOLUTIONS

11-04-2019 RCVD

November 4, 2019

AgeRight Care Management Solutions

I am Lisa Hynes, Vice President of AgeRight Care Management Solutions. I am submitting this testimony on behalf of Marquis Advantage, Inc. dba: Ageright Advantage Health Plan. We provide Medicare Advantage insurance coverage for nearly 500 people receiving care in long-term care facilities in the State of Oregon, with the large majority of those residing in the Multnomah, Clackamas and Washington county service area.

We understand Oregon Health Authority has received two applications to open inpatient rehabilitation facilities in this area, Encompass and Post Acute Medical. 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. We have no such facilities in Oregon now but, based on the reimbursement experienced nationally, we would be asked to agree to much higher rates than we currently pay to nursing facilities. Why would a managed care plan move our members to a new, higher cost, provider type when we have sufficient nursing facility beds available to serve our members and these nursing facilities provide rehabilitative care that fully meets and exceeds the quality standards our members have? 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.

We also know that inpatient rehabilitation facilities were recently criticized by the Office of Inspector General for engaging in significant levels of inappropriate billing and misrepresentation of services. This criticism is reflected in recent substantial settlements by both applicants for allegations of much the same behavior the OIG has noted. We have not experienced such fraudulent behavior in Oregon nursing facilities and, particularly in light of the disincentives discussed above, we would be very surprised if any Medicare Advantage plan would not find it challenging to engage with providers who present a known risk of illegal conduct.

AGERIGHT

CARE MANAGEMENT SOLUTIONS

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 members or the Portland Tri-County health care marketplace.

In summary, we believe approval of either or both of the applications to open inpatient rehabilitation facilities in this area would not provide any additional access to rehabilitation services for Medicare Managed Care members and would disrupt the marketplace for existing providers. Thank you for considering my testimony

Respectfully Submitted,

Lisa Hynes

Vice President, AgeRight Advantage Health Plan

11-04-2019 RCVD

EmpRes
HEALTHCARE MANAGEMENT
100% Employee Owned

EmpRes Healthcare Management, LLC

4601 NE 77th Avenue, Ste 300, Vancouver, WA 98662 • Ph. 360-892-6628 • Fax 360-882-5793

November 4, 2019

On behalf of the EmpRes Hillsboro Health and Rehabilitation Center and Portland Health and Rehabilitation, EmpRes Healthcare Management, LLC expresses its appreciation for the opportunity to submit this response to the Certificate of Need application submitted by Encompass. We assert that there is no need for additional rehabilitation beds in the Multnomah, Clackamas and Washington County area.

Encompass indicated during its testimony during the October 15 hearing that OHA may only consider other acute care beds when assessing need under the certificate of need administrative rules. It does not argue, and indeed cannot do so successfully, that there is the need for more acute care beds in the service area. It argues instead that there is a need for specialty rehabilitation beds and this need must be measured only against rehabilitation offered in acute care beds. In making this argument, it ignores the requirement in law that it must also demonstrate that there is not another acceptable alternative already available in the marketplace.

OAR 333-645-0030 provides the baseline bed per population requirement that the total need for inpatient rehabilitation services shall not exceed seven beds in 100,000 general population. Encompass calculates that this approach yields a current net bed need in the tri-county area of 73 beds, with 91 beds needed in 2028, and a need for 49 beds in Washington County. EmpRes and several other Skilled Nursing companies have significant operations in the service area, including Marquis, Avamere and Prestige. In total, there are 56 nursing facilities which offer 4554 beds to the community with an average occupancy rate of 73% in Multnomah County, 72% in Washington County and 69% in Clackamas County.

As is the case with other local nursing facilities, the EmpRes nursing facilities operating in the service area care for a high percentage of patients with the same diagnoses served by inpatient rehabilitation facilities ("IRFs") and provide very favorable outcomes.

The median short stay patient successful return to community rate for the EmpRes facilities operating in the service area is 61.3% and the median hospital readmission rate is only 18.6%. Although these rates may be a marginally less favorable than those of IRFs nationally, it is important to take into account that the EmpRes nursing facilities and other local nursing facilities provide these services at a much lower cost than what IRF are able to charge and these numbers include challenging diagnoses in addition to the 13 IRF diagnoses.

We accept a much higher percentage of Medicaid than what Encompass proposes (3%). This is an unreasonable expectation based on the demographics in the service area. In contrast, our Medicaid percentage is 85%. Similarly, we have very high levels of Medicare managed care than Encompass proposes; we average 6%. As we all know, Medicaid and Medicare managed care pay much lower rates than fee for service and private pay. Simply put, IRFs receive too much reimbursement for providing services that we provide for less. As confirmed through other testimony submitted, MedPac reported to congress that IRFs are overpaid and recommended that IRF Medicare reimbursements be reduced significantly.

It also cannot be understated how the introduction of additional IRFs in the service area will disrupt the health care marketplace. The labor market for nurses and other care providers is already at crisis level. 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. The IRFs will face the same challenges and will put further strain on the already stressed labor market.

Further, access by populations relying on Medicaid and Medicare Advantage programs as a payor source for nursing services will be compromised by the introduction of new IRFs in the service area. As noted, the proposed IRF will serve very few Medicaid patients or Medicare Advantage patients, all of which reimburse for services at a much lower rate. As is the case with other nursing facilities in the service area, the majority of patients served EmpRes nursing facilities have Medicaid or Medicare Advantage plans as their primary source of payment. If the Medicare fee for service and private pay patients go elsewhere for services, this will threaten the viability of EmpRes and other nursing facilities in the service area, all of which typically operate much below capacity.

Accordingly, we urge the OHA to reject the Encompass proposal.

Sincerely,



Misty Thomas
Vice President - Clinical

11-04-2019 RCVD

AHCA® AMERICAN HEALTH CARE ASSOCIATION
NCAL® NATIONAL CENTER FOR ASSISTED LIVING

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October 30, 2019

To The Oregon Health Authority:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents nearly 14,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. Each day, our members provide essential housing and health care services to residents in nearly 1.07 million skilled nursing facility (SNF) beds and more than 255,000 assisted living beds.

With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

We are writing this brief letter to dispel myths about the quality of rehabilitation care provided in SNFs as compared to Inpatient Rehabilitation Facilities (IRFs) well as the impact on SNF admission patterns and care now that the Centers for Medicare and Medicaid Services (CMS) has converted from the Medicare Part A SNF Prospective Payment System (PPS) Resource Utilization Groups, Version 4 (RUG-IV) payment model to the Patient Driven Payment Model (PDPM), effective October 1, 2019.

First and foremost, per CMS, PDPM represents a change in the payment classification model, not the SNF benefit. As stated in the FY 2020 SNF PPS Final Rule, "*PDPM... improves the overall accuracy and appropriateness of SNF payments by classifying patients into payment groups based on specific, data-driven patient characteristics*" (84 FR 38734). PDPM does not disincentivize SNFs from admitting beneficiaries with intensive therapy needs, but more accurately allocates payments based on their therapy needs by separating the single blended therapy component under RUG-IV into the three separate Physical Therapy, Occupational Therapy, and Speech-Language Pathology case-mix adjusted components under PDPM. For example, SNF PPS therapy component payments for beneficiaries with clinical characteristics typically requiring intensive therapy services from all three therapy disciplines, such as after suffering a stroke and presenting with hemiplegia and swallowing and speech disorders will receive more adequate payments under PDPM than under RUG-IV.

Additionally, Chapter 8, Section 30 of the Medicare Benefit Policy Manual (Pub. 100-02) has not been updated since January 2014 and continues to state that to be covered, the services provided to a SNF resident must be "*...reasonable and necessary for the treatment of a patient's illness or injury, that is, are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.*" Additionally, CMS has indicated that, in addition to current SNF Quality Reporting Program (QRP) and Value-Based Payment (VBP) penalties that could apply to substandard care, CMS will also be monitoring SNF therapy utilization and quality outcomes measures closely as PDPM is implemented.

Secondly, CMS continues the process of implementing the IMPACT Act of 2014 requirements to standardize regulations, assessments, and quality measurement across post-acute settings including SNFs and IRFs. For example, in the FY 2020 SNF PPS Final Rule 84 FR 38746, CMS standardized the definition of group therapy services between SNFs and IRFs as follows: *"...in an effort to support CMS' cross-setting initiatives under the IMPACT Act and Meaningful Measures Initiative, we looked at ways to align the definition of group therapy used under the SNF PPS more closely with the definitions used within the...IRF PPS, as this type of standardization would reduce administrative burden on providers by utilizing the same or similar definitions across settings...we stated that given the greater degree of similarity between the IRF and SNF settings in terms of the intensity of therapy and patient acuity, we believe that the IRF PPS definition would be more appropriate in the SNF setting."*

Additionally, it is important to note that in previous rulemaking, based upon IMPACT Act requirements, CMS has applied the same functional outcomes quality measures to SNF as had been applied to IRFs to permit comparison of outcomes across settings. The specific measures, listed in Table 12 of the FY 2020 SNF PPS Final Rule (84 FR 38755) are as follows:

- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634)
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
- Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).

Third, it must be noted that as part of the IMPACT Act Congress asked the Medicare Payment Advisory Commission (MedPAC) and CMS for guidance on the establishment of a unified prospective payment system (U-PAC) and develop a prototype design to standardize payments across all post-acute settings by 2023. In its June 2016 Report to Congress, MedPAC stated *"Despite the overlap in patients, Medicare continues to pay considerably different rates for similar patients depending on the setting"* (page 63). Additionally MedPAC stated in an endnote on page 103, *"In an analysis of 22 conditions frequently treated by IRFs and SNFs, beneficiaries had similar risk profiles (or the lower cost SNF patients had higher risk profiles)...the Post-Acute Care-Payment Reform Demonstration conducted by CMS found considerable overlap in the patients treated..."*

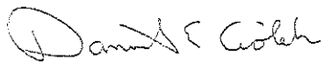
In general, the above three points all indicate that there is a great degree of similarity in the types of patients that receive rehabilitation services between SNFs and IRFs, that the patient assessment data and outcomes measures that each setting must adhere to are in alignment, and that the Congress, MedPAC and CMS recognize the similarities and that efforts are being made to standardize the payment models across post-acute settings. In addition, the introduction of the PDPM payment model in SNF in no way creates an environment where SNFs would seek fewer admissions for beneficiaries requiring rehabilitation services or that the quality of rehabilitation services will decrease because: 1) the payment model is more adequately aligned with patient care needs, 2) SNF benefit policies and skilled care requirements have not changed, 3) SNFs are subject to payment adjustment and other penalties if quality declines, and 4) CMS is closely monitoring the PDPM implementation process.

Finally, with respect to the key geographic locations most impacted by the SNF and IRF discussion in Oregon, the following table reflects that Medicare Part A is not the primary payor for SNF services in Clakamas, Multnomah, and Washington counties, but instead, Medicare Advantage Organizations (MAOs) are the primary payor for Medicare services. It is important to note that MAOs establish their own payment pricing models with each provider, which may or may not be similar to PDPM. However, SNF MAO providers remain subject to requirements to provide skilled care and provide quality outcomes to Medicare beneficiaries, and in many cases, cannot participate in MAOs unless their Medicare SNF 5-Star Quality Ratings are also at least 3 stars or better.

County Name	Medicare Eligible	MA Enrolled	Uptake
Clackamas	93,796	52,824	56.32%
Multnomah	141,090	76,441	54.18%
Washington	98,592	52,755	53.51%

In summary, we believe that any efforts to imply that SNFs are unwilling or unable to continue to provide quality rehabilitation services to patients in Oregon because of the implementation of the Medicare SNF PPS PDPM payment model on October 1, 2019 is unsupported by the evidence. We would be happy to provide additional supporting evidence or respond to any additional questions you may have.

Respectfully,



Daniel E Ciolek, PT, MS, PMP
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American Health Care Association
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Washington, DC 20005
dciolek@ahca.org

Reference Links:

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020.
https://www.federalregister.gov/documents/2019/08/07/2019-16485/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

Medicare Benefit Policy Manual, Chapter 8
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf

Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. Chapter 3: Mandated Report: Developing a unified payment system for post-acute care. June 2016.
http://www.medpac.gov/docs/default-source/reports/chapter-3-mandated-report-developing-a-unified-payment-system-for-post-acute-care-june-2016-report-.pdf?sfvrsn=0

Centers for Medicare & Medicaid Services. Medicare Advantage/Part D Contract and Enrollment Data. October 2019.
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html

11-04-2019 RCVD

Inpatient Rehabilitation Facilities and Nursing Facilities: Overlapping Care and Services

Inpatient Rehabilitation Facility Requirements (2019 MedPAC Report)	Nursing Facility Requirements
Admission: Must have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program.	**Admission**: May only admit residents if they can meet needs. Must perform both a baseline assessment of new resident and comprehensive person-centered assessment after the resident's needs are fully known.
Staffing: Must ensure that the patient receives close medical supervision and provides—through qualified personnel—rehabilitation nursing, physical therapy, occupational therapy, and, as needed, speech–language pathology and psychological (including neuropsychological) services, social services, and orthotic and prosthetic services.	**Staffing**: Must ensure that staffing meets acuity, range of diagnosis, and care needs of residents. (OAR 411-086-0110; 42 CFR 483.35) Nursing facilities routinely employ physical therapists, occupational therapists and other providers that are necessary to meet resident needs.
Medical director: Must have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs.	**Medical director**: Must have a physician medical director that assists the facility to assure that adequate medical care is provided. (OAR 411-086-0220)
Interdisciplinary team: Use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment.	**Interdisciplinary team**: Comprehensive care plan must be prepared by interdisciplinary team that includes at least an attending physician, RN, nurse aide, food/nutrition staff, and other staff as determined by resident need. (42 CFR 483.21) Nursing facilities employ broad spectrum of providers, including but not limited to social workers, activity directors, physical and occupational therapists, dieticians, RNs, and CNAs as necessary to meet resident care needs.
Must have a plan of treatment for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	Must prepare preliminary care plan and comprehensive person-centered care plan upon resident admission. Plan must include therapy and rehab needs. Comprehensive care plans must be prepared by interdisciplinary team. Care plans must be updated at least quarterly or upon a change in resident condition. (42 CFR 483.21; OAR 411-086-0040; -086-0060)
Meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.4.	Medicare covers skilled therapy services provided by skilled nursing facilities based on beneficiary's need for skilled care (Jimmo v. Sebelius settlement agreement, 2013). Significant percentages of nursing facility residents in the service area have one of the diagnoses specified by CMS.4.

11-04-2019 RCVD

Portland Area Skilled Nursing Facilities

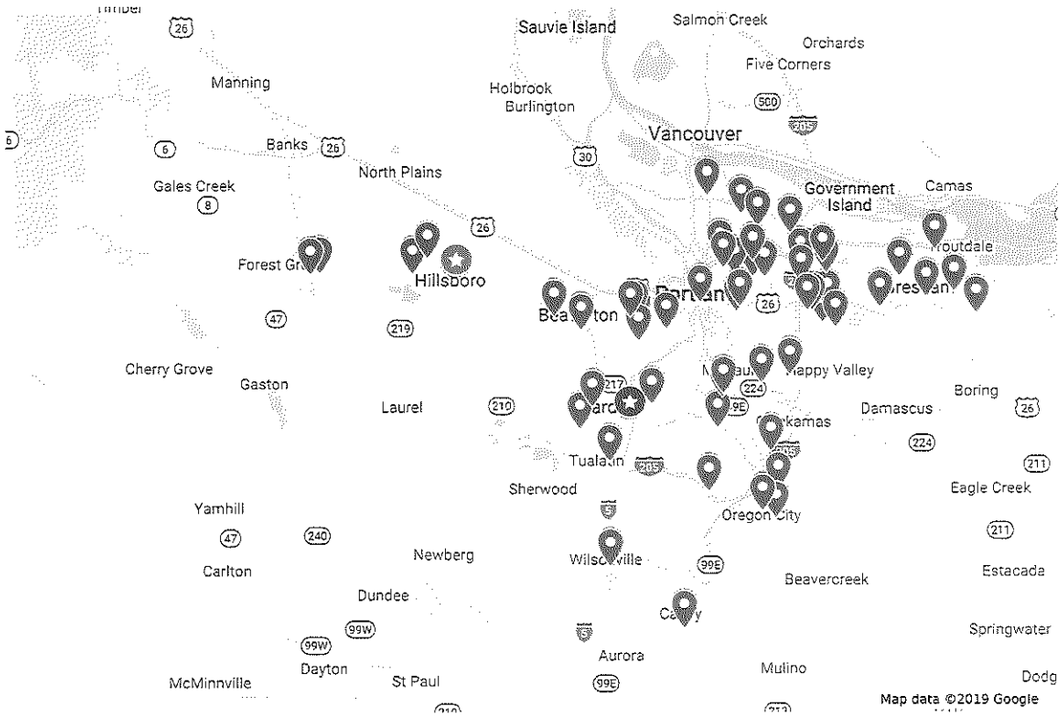
Skilled Nursing Facilities (Existing)

57 SNFs within Washington, Multnomah, and Clackamas Counties.

Inpatient Rehabilitation Facilities (Proposed)

Post Acute Medical

Encompass Health



MARCH 2019

REPORT TO THE CONGRESS

Medicare Payment Policy

MEDPAC Medicare Payment Advisory Commission

RECOMMENDATION

10 For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

(Additionally, the Commission reiterates its March 2016 recommendations on the inpatient rehabilitation facility prospective payment system. See text box, p. 261.)

CHAPTER 10

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2017, Medicare spent $7.9 billion on IRF care provided to fee-for-service (FFS) beneficiaries in about 1,180 IRFs nationwide. About 340,000 beneficiaries had around 380,000 IRF stays. On average, the Medicare FFS program accounted for 58 percent of IRF discharges.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs are positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and of IRFs' marginal profit under Medicare's IRF prospective payment system suggest that access remains adequate.

- *Capacity and supply of providers*—After declining for several years, the number of IRFs increased in 2014 and continued to grow through 2016, reaching 1,188 facilities nationwide. In 2017, however, the number of IRFs declined slightly, to 1,178 facilities. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number

In this chapter

- Are Medicare payments adequate in 2019?
- How should Medicare payments change in 2020?

of freestanding and for-profit IRFs has increased. In 2017, the average IRF occupancy rate remained at 65 percent, indicating that capacity is more than adequate to meet demand for IRF services.

- *Volume of services*—From 2016 to 2017, the number of Medicare FFS cases declined 2.7 percent, falling to about 380,000 cases after having experienced small annual growth every year since 2010.
- *Marginal profit*—The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 19.4 percent for hospital-based IRFs and 38.8 percent for freestanding IRFs—a very positive indicator of patient access.

Quality of care—The Commission tracks three broad categories of IRF quality indicators: risk-adjusted facility-level change in patients' functional and cognitive status during the IRF stay, rates of discharge to the community and to skilled nursing facilities, and rates of readmission to an acute care hospital. Most measures were steady or improved between 2012 and 2017.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for almost half of freestanding IRFs in 2017 and about a quarter of all Medicare IRF discharges, also has good access to capital. This assessment is reflected in the chain's continued expansion. We were not able to determine the ability of other freestanding facilities to raise capital. IRFs' access to capital in large part depends on their total (all-payer) profitability, and in 2017, total margins for freestanding IRFs were 10.4 percent. Data on all-payer profitability are not available for hospital-based units, but we can examine the all-payer margins of hospitals with IRF units, which, in 2017, had an aggregate all-payer margin across all lines of business of 7.0 percent.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has grown steadily since 2009. In the three-year period between 2015 and 2017, the aggregate IRF Medicare margin remained above 13 percent and in 2017 stood at 13.8 percent. Also in 2017, Medicare margins in freestanding IRFs were 25.5 percent, down slightly from their peak in 2015 of 26.7 percent. In 2017, hospital-based IRF margins were comparatively low at 1.5 percent, but one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. Lower margins in hospital-based IRFs were driven largely by higher unit costs. In addition, there are notable differences in hospital-based and freestanding IRFs' mix of cases, which may indicate differences in profitability across case types. Finally, while

not definitive, evidence indicates that IRFs' assessments of patients' motor and cognitive function are not reliably consistent across providers. To the extent that hospital-based IRFs routinely assess their patients as less disabled than do their freestanding counterparts, their payments—and margins—will be systematically lower.

Growth in IRFs' costs historically has been low. From 2009 to 2015, the cumulative growth in cost per discharge was 8.4 percent, well below the 13.5 percent increase in the market basket for IRFs over the period. In 2016, per case cost growth (3.6 percent in aggregate) exceeded payment growth (2.9 percent in aggregate) for the first time since 2008. In 2017, however, per case payments again grew faster than costs (3.4 percent compared with 2.8 percent), resulting in an aggregate IRF margin of 13.8 percent. In 2018 to 2019, we anticipate costs in IRFs will grow faster than payments since updates in those years were constrained to 1.0 percent and 1.35 percent, respectively. For 2019, we project an aggregate Medicare margin of 11.6 percent.

This year, the Commission for the first time examined the financial performance of relatively efficient IRFs. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 18 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower costs. Freestanding and for-profit facilities were more likely to be in the relatively efficient group.

On the basis of these factors, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2020. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity. ■

11-04-2019 RCVD

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE

Friday, June 28, 2019

Encompass Health Agrees to Pay $48 Million to Resolve False Claims Act Allegations Relating to its Inpatient Rehabilitation Facilities

Encompass Health Corporation (formerly known as HealthSouth Corporation), the nation's largest operator of inpatient rehabilitation facilities (IRFs), has agreed to pay $48 million to resolve allegations that some of its IRFs provided inaccurate information to Medicare to maintain their status as an IRF and to earn a higher rate of reimbursement, and that some admissions to its IRFs were not medically necessary.

"This settlement demonstrates our commitment to ensuring that those who participate in federal healthcare programs follow the rules," said Assistant Attorney General Jody Hunt for the Department of Justice's Civil Division. "Medicare and Medicaid providers who seek to profit inappropriately at the expense of taxpayers will be held accountable."

Medicare and Medicaid use information about patients' diagnoses to determine whether a facility is properly classified as an IRF, and to determine the level of reimbursement the facility is awarded for specific patients. The government alleged that beginning in 2007, in order to insure compliance with Medicare's rules regarding classification as an IRF, and to increase Medicare reimbursement, some Encompass IRFs falsely diagnosed patients with what they referred to as "disuse myopathy" when there was no clinical evidence for this diagnosis. Additionally, Encompass IRFs allegedly admitted patients who were not eligible for admission to an IRF because they were too sick or disabled to participate in or benefit from intensive inpatient therapy.

"This important civil settlement concludes a lengthy, comprehensive investigation that brought to light a nationwide scheme that the government contends was intended to defraud our fragile public health programs," said U.S. Attorney Maria Chapa Lopez. "In doing so, we confirm our commitment to civil health care fraud enforcement as a key component of the mission of our office."

The settlements resolve allegations raised in three lawsuits filed by Dr. Emese Simon M.D., a former contract physician employed at an Encompass inpatient rehabilitation facility in Sarasota, Florida; Melissa Higgins the former Director of Therapy Operations at Encompass's inpatient rehabilitation facility in Arlington, Texas; and Dr. Darius Clarke M.D. the former Medical Director at Encompass's inpatient rehabilitation facility in Richmond, Virginia, and his company, Restorative Health & Wellness P.L.L.C. The lawsuits were filed under the *qui tam,* or whistleblower, provisions of the False Claims Act, which permit private individuals to sue on behalf of the government for false claims and to share in any recovery. Here, the whistleblowers collective share of the settlement will be $12.4 million.

The settlement was the result of a coordinated effort by the Civil Division of the Department of Justice, the Unite States Attorney's Office for the Middle District of Florida, and the U.S. Department of Health and Human Services Office of Inspector General.

11-04-2019 RCVD

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MANY INPATIENT REHABILITATION FACILITY STAYS DID NOT MEET MEDICARE COVERAGE AND DOCUMENTATION REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Daniel R. Levinson
Inspector General

September 2018
A-01-15-00500

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: September 2018
Report No. A-01-15-00500

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements

Why OIG Did This Review

Our prior reviews have found that some hospitals did not comply with Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs). The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for IRFs increased, ranging from 9 percent in 2012 to a high of 62 percent in 2016.

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for fee-for-service (FFS) claims for services provided in 2013.

How OIG Did This Review

Our audit covered $6.75 billion in Medicare payments to 1,139 IRFs nation-wide for 370,872 IRF stays. We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling almost $11.3 million in payments to 164 IRFs for calendar year 2013, the most recent claims data available at the time the audit started. We used an independent medical review contractor to determine whether the medical records for the sampled IRF stays met coverage requirements. In addition, we determined whether the medical records complied with Federal documentation requirements.

What OIG Found

IRFs complied with all Medicare coverage and documentation requirements specified for reasonable and necessary care for 45 of the 220 sampled stays. However, for 175 of the sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare's requirements. These errors occurred because many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prepayment review for IRF admissions; CMS's extensive educational efforts and postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide $5.7 billion for care to beneficiaries that was not reasonable and necessary.

What OIG Recommends and CMS's Comments

We recommend that CMS (1) educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to develop best practices to improve internal controls; (2) increase oversight activities for IRFs, such as postpayment medical review; (3) work with the Office of Medicare Hearings and Appeals to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented at ALJ hearings; and (4) reevaluate the IRF payment system, which could include a demonstration project requiring preauthorization for Medicare Part A FFS IRF stays modeled on Medicare Advantage practices, a study of the relationship between IRF PPS payments and costs and take any necessary steps to more closely align them, and a consideration of the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform. In their written comments to our draft, CMS concurred with our recommendations, described actions that it planned to take to address them, and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while preventing improper payments.

The full report can be found at https://oig.hhs.gov/oas/reports/region1/11500500.asp.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review of Medicare coverage and documentation requirements for inpatient rehabilitation facilities (IRFs) expands on our prior reviews of an individual hospital-based IRF and recent hospital compliance reviews that included a limited number of IRF claims. (Appendix B contains a list of prior Office of Inspector General (OIG) reports.)

Our prior reviews found that some hospitals did not comply with Medicare coverage and documentation requirements for IRFs. The Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program found that the error rate for Medicare payments to IRFs increased from 9 percent in 2012 to 62 percent in 2016.[1] According to the Medicare Payment Advisory Commission (MedPAC)—a nonpartisan, legislative branch agency that provides the U.S. Congress with Medicare Program analysis and policy advice—in 2013 Medicare spent $6.8 billion on fee-for-service (FFS) IRF care provided in about 1,160 facilities.[2] In recent years, Medicare FFS has paid for the majority of the services IRFs provide.[3]

OBJECTIVE

Our objective was to determine whether IRFs complied with Medicare coverage and documentation requirements for FFS claims for services provided in calendar year (CY) 2013.

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[1] CMS, *Medicare Fee-for-Service, Improper Payments Report* and *Appendices*, 2012 through 2016. CERT published a payment report and an appendix for each year. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html. Accessed March 8, 2018. CERT reported an IRF error rate of 17.2 percent for 2013, the year we reviewed in this report.

[2] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015. Available at http://www.medpac.gov/docs/default-source/reports/chapter-10-inpatient-rehabilitation-facility-services-march-2015-report-.pdf?sfvrsn=0. Accessed May 9, 2017.

[3] For example, MedPAC stated, "On average, Medicare fee-for-service accounts for about 61 percent of IRFs' discharges." See MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 239, March 2015 (2013). See also MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 9, p. 237, March 2016 (60 percent, 2014), and MedPAC, *Report to the Congress: Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 257, March 2017 (60 percent, 2015).

BACKGROUND

Inpatient Rehabilitation Facilities

Inpatient rehabilitation hospitals and rehabilitation units of acute-care hospitals, collectively known as IRFs, provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, because of the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (the *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 1, § 110).

Inpatient Rehabilitation Facility Prospective Payment System

The Social Security Act (the Act) established a Medicare prospective payment system (PPS) for IRFs (§ 1886(j)). CMS implemented the payment system for cost-reporting periods beginning on or after January 1, 2002. Under the PPS, CMS established a Federal prospective payment rate, based on clinical characteristics and resource needs, for each of 92 intensive rehabilitation subcategories called case-mix groups (CMGs).[4]

Under the PPS, IRFs are reimbursed at a rate generally 2.5 times greater than the acute inpatient prospective payment system (IPPS) rate. In exchange, Medicare requires IRFs to provide intensive rehabilitation to higher severity patients.[5] MedPAC has recommended IRF payment reform based on a closer alignment of cost with payment.[6]

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[4] Medicare Learning Network (MLN), *Inpatient Rehabilitation Facility Prospective Payment System*, ICN 006847, Jan. 2017. According to the MLN:

> Federal rates are adjusted to reflect patient case-mix, which is the relative resource intensity typically associated with each patient's clinical condition as identified through the patient assessment process. Cases are grouped into Rehabilitation Impairment Categories, according to the primary condition for which the patient was admitted to the IRF. Cases are further grouped into case-mix groups which group similar cases according to their functional motor, cognitive scores, and age. Finally, cases are grouped into one of four tiers within each CMG, according to patient's comorbidities (conditions that are secondary to the principal diagnosis or reason for the inpatient stay).

[5] B. Gage, L. Smith, et al., *Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities,* Report to Congress, September 2009, p. 13. Prepared for CMS by RTI International, RTI Project Number 0211995.

[6] Among several other recommendations, MedPAC recommended for fiscal year (FY) 2018 a payment rate reduction of 5 percent, "coupled with an expansion of the high-cost outlier pool, as previously recommended by MedPAC, to redistribute payments within IRF PPS and reduce the impact of potential misalignments between IRF payments and costs." (MedPAC, *Report to* Congress: *Medicare Payment Policy*, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," chapter 10, p. 259, March 2017). See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

During our audit period, CMS contracted with Medicare administrative contractors (MACs) to process and pay Medicare FFS claims and perform other services, including medical reviews for selected claims. CMS also contracted with (1) Recovery Audit Contractors (RACs) to identify and correct Medicare FFS improper payments and (2) the Supplemental Medical Review/Specialty Contractor (SMRC) to perform and provide support for a variety of tasks to lower the improper payment rates and increase the efficiencies of the medical review functions of Medicare and Medicaid.

Reasonable and Necessary Care

No Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

Effective for discharges on or after January 1, 2010, all coverage[7] and documentation[8] requirements must be met for IRF care to be considered by Medicare as reasonable and necessary under the Act (42 CFR §§ 412.622(a)(3), (4), and (5) and 74 Fed. Reg. 39762, 39788 (Aug. 7, 2009)).[9] If the claim is deemed not reasonable and necessary, the entire payment will be in error.

For discharges starting in 2010, CMS updated IRF requirements to reflect best practices in medicine that enhance the quality of care for patients.[10] These requirements address the unique responsibility[11] of the rehabilitation physician to closely supervise and coordinate a medical and functional rehabilitation course of care for the patient and to clearly and comprehensively document these decisions and processes in the medical records.[12]

As of 2010, CMS no longer considers trial admissions (IRF admissions of 3 to 10 days to allow the physician to determine whether the patient would benefit from IRF treatment) to be reasonable

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[7] 42 CFR § 412.622(a)(3), as interpreted in the Medicare Benefit Policy Manual (the Manual), Pub. No. 100-02, chapter 1, §§ 110.2, 110.3.

[8] 42 CFR §§ 412.622(a)(4) and (5), as interpreted in the Manual, chapter 1, §§ 110.1, 110.2.4, 110.2.5.

[9] "All requirements must be met" as interpreted by the Manual, chapter 1, § 110. These requirements apply equally to all Medicare patients regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.29 (b)(2) and used by Medicare for classifying a hospital or unit of a hospital as an IRF.

[10] 74 Fed. Reg. 39762, 39790 (Aug. 7, 2009).

[11] 74 Fed. Reg. 39796 (Aug. 7, 2009).

[12] CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, p. 4. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

and necessary. A rehabilitation physician must review and approve the need for care only after a comprehensive preadmission screening within the previous 48 hours has been documented.[13, 14] CMS stated that the purpose of the coverage requirements is to clarify that patients who do not require, cannot participate in, or cannot benefit from the intensive rehabilitation therapy program offered in an IRF should be referred to another setting. Additionally, CMS stated that the purpose of the documentation requirements is to provide clear, up-to-date instructions for determining and documenting the medical necessity of the IRF admission.[15]

Oversight of Inpatient Rehabilitation Facility Compliance

CMS aims to improve the quality and coordination of care for Medicare beneficiaries and to reduce improper payments. This work includes corrective action for Medicare compliance and the testing of new care and reimbursement models. Examples are:

- educational outreach programs and publications for IRF stakeholders,[16]

[13] For the purposes of this report, "rehabilitation physician" is the IRF physician, with specialized training and experience in rehabilitation, in charge of the patient during the inpatient rehabilitation stay, as opposed to ancillary physicians, such as cardiologists, neurologists, internal medicine specialists, and others who assist the rehabilitation physician at the IRF.

[14] The Manual, Pub. No. 100-02, chapter 1, § 110.1.1.

[15] CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, pp. 4–5. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed March 8, 2018.

[16] CMS's Medicare compliance education for IRFs includes detailed transcripts of IRF national provider training sessions, which have been consistently posted on the CMS website since late 2009. These transcripts give providers access to specific and comprehensive Medicare requirement clarifications. The transcripts for November 12, 2009, and May 31, 2012, are available at the IRF coverage web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed on March 5, 2018.

CMS provides access to regulatory updates in the IRF payment system and educational materials, such as MLN publications. For example, (1) Inpatient Rehabilitation Therapy Services: Complying With Documentation Requirements, MLN ICN 905643, July 2012; (2) Inpatient Rehabilitation Facility Prospective Payment System, MLN ICN 006847, Jan. 2017; (3) Inpatient Rehabilitation Facility (IRF) Medical Review Changes, SE 17036, Dec. 11, 2017; (4) Provider Compliance Tips for Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units, ICN 909406, Feb. 2018; and (5) "MLN Connects"—Centers for Medicare & Medicaid Services IRF PPS: New IRF-Patient Assessment Instrument (PAI) Items Effective October 1, 2015, National Provider Call, Jan. 15, 2015; and Centers for Medicare & Medicaid Services IRF-PAI Therapy Information Data Collection, National Provider Call, Jan. 12, 2017. In addition, MACs provide access to educational materials on their websites.

CMS also administers the Program for Evaluating Payment Patterns Electronic Report (PEPPER) resources, which provides provider-specific Medicare data statistics for discharges and services vulnerable to improper payments. The PEPPER reports, which can be downloaded by each IRF, compare an IRF to other IRFs in three comparison groups: Nation, MAC jurisdiction, and State. These comparisons enable an IRF to determine if it differs from other IRFs.

- innovative demonstration projects such as the Comprehensive Care for Joint Replacement Model,[17] and

- postpayment reviews.

For example, the goal of the CERT A/B MAC Outreach & Education Task Force for Error-Free Medicare Claims is to give providers educational opportunities aimed at reducing the Part A and Part B error rates.[18] This task force has specifically targeted education outreach about IRF Medicare compliance by continuing to offer web-based training to explain IRF Medicare regulations that have been in effect since 2010. Additional CMS educational outreach programs include open-door compliance forums for other types of providers and consumers.[19]

In addition to CMS's educational and outreach efforts for the IRF community and CERT's improper payment evaluations, several RACs and MACs performed postpayment reviews from 2013 through 2017. These reviews tested medical necessity, CMG coding, and compliance with documentation requirements and identified overpayments of $18.5 million. In 2016, CMS also directed the SMRC to perform IRF postpayment medical review.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $6.75 billion in Medicare payments to 1,139 IRFs for 370,872 IRF stays in CY 2013.[20] We selected for review a stratified random sample of 220 IRF claims (IRF stays) totaling $11,277,251 for stays at 164 IRFs. We used an independent medical review contractor

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[17] This model program for joint replacement care at acute-care hospitals began in April 2016 and tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute-care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery (80 Fed. Reg.73274 (Nov. 24, 2015); 82 Fed. Reg. 180 (Jan. 3, 2017)). Regulations, notices, and fact sheets are available at https://innovation.cms.gov/initiatives/cjr. Last accessed on March 5, 2018.

[18] CMS designed The CERT A/B Task Force to assist Medicare FFS contractors in strengthening customer service to improve provider experience. It is composed of volunteers from MACs who reimburse for services in Medicare Part A (hospital insurance) and Part B (medical insurance).

[19] CMS sponsors regularly scheduled "Open Door Forums," providing an opportunity for conversation between CMS and the stakeholder community on a variety of topics. During 2016 and 2017, CMS presented a series of open-door forums, "The IMPACT ACT and Improving Care Coordination," for IRFs and other post-acute-care providers and solicited feedback pertaining to the Improving Medicare Post-Acute Care Transformation Act of 2014, P.L. No. 113-185, Oct. 6, 2014. This legislation requires the Secretary of Health and Human Services to submit a report to Congress, expected in 2022, that will include recommendations and a technical prototype for a post-acute-care PPS. Available at https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts.html. Last accessed on March 5, 2018. See Appendix G, MedPAC Recommendations for Reform of Inpatient Rehabilitation Facility and Post-Acute-Care Payments, in this report.

[20] CY 2013 IRF claims data were the most recent data available at the start of the audit.

to determine whether sampled IRF stays met coverage requirements. In addition, we determined whether the IRFs complied with Medicare documentation requirements. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains sample results and estimates, and Appendix E contains deficiencies in documentation for the IRFs associated with our sampled claims.

FINDINGS

IRFs complied with Medicare coverage and documentation requirements for 45 of the 220 sampled stays. However, for the remaining 175 sampled stays, corresponding to 135 IRFs, medical record documentation did not support that IRF care was reasonable and necessary in accordance with Medicare coverage and documentation requirements. Specifically, 146 stays did not meet both coverage and documentation requirements, and 29 stays met coverage requirements but did not meet documentation requirements.

These errors occurred because of a number of contributing factors: Many IRFs did not have adequate internal controls to prevent inappropriate admissions; Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions; CMS's extensive educational efforts and recent postpayment reviews were unable to control an increasing improper payment rate reported by CERT since our 2013 audit period; administrative law judge (ALJ) hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and the IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

On the basis of our sample results, we estimated that Medicare paid IRFs nation-wide $5.7 billion (84 percent of the dollars covered by our audit) in 2013 for care to beneficiaries that was not reasonable and necessary.

Information about the 45 stays that complied with Medicare coverage and documentation requirements could be informative to CMS as it works with providers to reduce noncompliance. (See Appendix F.)

MEDICARE COVERAGE REQUIREMENTS

The coverage requirements (42 CFR § 412.622(a)(3)) specify that, at the time of admission, the IRF must have a reasonable expectation that the patient meets all of the following requirements:[21]

- needs the multiple active and ongoing therapies of an acute inpatient rehabilitation interdisciplinary program, one of which must be physical or occupational therapy;
- requires supervision by a rehabilitation physician to assess the patient, both medically and functionally, and modify the course of treatment as needed to maximize the benefit from the rehabilitation process; and
- is sufficiently stable to be able to actively participate and benefit from an intensive rehabilitation therapy program and demonstrate measurable improvement that is of practical value to the patient in improving functional capacity or adaptation to impairments.

MEDICARE DOCUMENTATION REQUIREMENTS

The Medicare IRF requirements (42 CFR §§ 412.622(a)(4) and (5)) specify that the patient's medical record at the IRF must include the following types of documentation with all required elements:[22]

- comprehensive preadmission screening;
- a postadmission rehabilitation physician evaluation;
- an individualized overall plan of care developed and documented by a rehabilitation physician; and
- a demonstration that the patient requires an interdisciplinary approach to care, with weekly interdisciplinary team meetings led by a rehabilitation physician.

[21] The Manual, Pub. No. 100-02, chapter 1, "Medical Necessity Criteria," §§ 110.2–110.2.5, 110.3.

[22] We identify the required component elements of these types of documentation in Appendix E, Details of the Inpatient Rehabilitation Facility Documentation Deficiencies Found in the Sample.

MOST SAMPLED STAYS WERE NOT REASONABLE AND NECESSARY

For 175 of the 220 sampled claims, the IRFs did not meet all coverage and documentation requirements. Medicare paid 135 IRFs $8,325,940 for these stays.[23] Neither coverage nor documentation requirements were met for 146 of the 175 stays.

The other 29 of the 175 stays generally met coverage requirements but did not meet all of the documentation requirements.[24] We will provide CMS with a list of the 135 IRFs with sampled stays that did not meet coverage or documentation requirements separately for further review.

Coverage Requirements Not Met

Of the 175 stays, 146 did not meet the coverage requirements. Specifically, the medical records for the stays did not reflect that the patients had the medical needs and functional rehabilitation goals that require the complexity and intensity of inpatient rehabilitation. Medical reviewers determined that, for these IRF stays, appropriate care would have required only individual therapy interventions rather than an intense interdisciplinary program with rehabilitation physician supervision. In some of these stays, the therapy would be expected to consist of general exercises and regular activities, such as walking or exercises to improve tolerance for sitting. In other stays, nonskilled caregivers would have been able to provide needed assistance with only intermittent skilled therapy oversight.

For all of these stays, the high level of physician supervision that accompanies acute intensive rehabilitation therapy services would not have been required. These patients did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In some stays, the patients were unable to participate in an intensive therapy program regardless of medical and rehabilitation needs.

We found that stays that did not meet coverage requirements were predominantly, but not exclusively, related to the following:

- generalized weakness, overall fatigue, and impaired mobility for which appropriate therapy would be regular activities, such as walking, use of a wheelchair, or just general exercises (56 stays);

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[23] When they receive Medicare contractor denials, IRFs are eligible to bill Part B inpatient services if the service (1) was denied under Part A because the inpatient admission was not reasonable and necessary *and* (2) is not by definition solely an outpatient service that would not be provided to an inpatient (42 CFR § 414.5). There are time limits for rebilling: rebilling will be rejected as untimely when the bill is filed later than 1 CY after the date of the service (42 CFR §§ 414.5(c) and 424.44(a)).

[24] Of these 29 stays, 22 had more than 1 documentation deficiency and 7 had a single documentation deficiency. By documentation deficiency, we mean that an element of required documentation was missing. Based on these 29 stays, we estimated that $571 million of the total estimated $5.7 billion was paid for stays that might have qualified as reasonable and necessary if documentation requirements had been met.

- simple fractures, single extremity deficits, simple or minor trauma, elective or emergency single joint or other orthopedic repair without postoperative complications, or no new and acute significant impairing event or condition (48 stays);

- miscellaneous conditions without complications or other new impairing events to include other orthopedic, central nervous system, cardiac, and pulmonary conditions (25 stays); or

- inability to participate in intense rehabilitation and demonstrate measurable improvement of practical value to the patient (17 stays).

Examples of Information Contained in the Medical Records for Stays That Were Not Reasonable and Necessary

Example 1: According to the medical review contractor, the patient had his right hip partially replaced after a fall, and there were no significant postoperative complications. At the time of IRF admission, he was able to tolerate bearing weight, perform transfers from sitting to standing and from a bed to a chair with minimal assistance, and walk 40 feet with minimal assistance. There was no expected need to modify the patient's treatment to maximize the patient's capacity to benefit from rehabilitation. The patient did not require a physician's supervision at an acute rehabilitation level of care, interdisciplinary rehabilitation, or the intensity of acute-level rehabilitation. In addition, the documentation did not include all the required elements for the individualized, overall plan of care and the interdisciplinary team meetings.

Example 2: According to the medical review contractor, the patient had been treated during a 2-week, acute-care hospital stay for pneumonia caused by a fungal infection and then had acute kidney failure. Before that admission, she had been functionally independent. After the acute-care hospital stay, she was admitted to an IRF. The IRF preadmission screen identified that the patient had generalized weakness and impaired mobility and was suffering from malnutrition and anemia. At admission, the patient was (1) walking 100 feet without an assistive device, (2) performing activities of daily living with minor assistance, and (3) able to respond cognitively at a high level of complexity. The patient was limited by fatigue. The admitting IRF provider found the patient to be in stable condition and did not identify any further functional defects on the postadmission evaluation. She did not require interdisciplinary rehabilitation or the intensity of an acute-level rehabilitation program. In addition, the documentation did not include all the required elements for the individualized overall plan of care.

Documentation Requirements Not Met

The medical record documentation for 175 stays did not contain all of the information required by CMS. Of these stays, medical records for 147 had more than 1 documentation deficiency, and medical records for 28 had 1 documentation deficiency. Twenty of the 147 stays were missing 1 or more elements of all 4 types of required documentation. As a result of these documentation deficiencies, we were unable to determine that IRF care for those 175 stays was reasonable and necessary. For many of the stays, we were unable to determine that a rehabilitation physician had:

- reviewed and concurred with the findings of the preadmission screenings that took place within 48 hours before the IRF admission;
- conducted a postadmission evaluation that identified any relevant changes that might have occurred since the preadmission screening;
- prepared an overall and individualized plan of care; and
- participated in weekly team meetings and concurred with the results, findings, and decisions made at the meetings.

Appendix E contains details of the deficiencies in IRF documentation associated with the sample items.

CAUSES OF NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

A number of factors might have contributed to the admission practices that resulted in IRFs being reimbursed for patients who did not need the complexity and intensity of inpatient rehabilitation. These factors included the following:

- IRFs' internal controls failed to prevent inappropriate admissions, and IRFs lacked monitoring procedures for Medicare documentation compliance. We concluded this solely on the basis of our review of the medical records and the high error rate.
- Medicare Part A FFS lacked a prior authorization review process for IRF admissions that could reduce inappropriate admissions. By instituting an FFS prior authorization

process, similar to the process used by Medicare Advantage plans, CMS may be able to improve IRF provider compliance.[25]

- Although Medicare contractors have performed yearly postpayment reviews since 2013, these reviews, together with CMS's extensive educational and outreach efforts, were insufficient to control the rising and significant increase in the IRF improper payment rate. CERT reported increasing error rates for Medicare payments to IRFs: 9 percent in 2012, 17.2 percent in 2013, 20.7 percent in 2014, 45.5 percent in 2015, and 62.4 percent in 2016.

- ALJ hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted. Previous OIG work[26] has shown that (1) for 56 percent of FY 2010 appeals, ALJs reversed prior-level decisions by the CMS Qualified Independent Contractors (QICs) and decided fully in favor of appellants; (2) differences between ALJ and QIC decisions were due to varying interpretations of Medicare policies, in their degree of specialization and the use of clinical experts; (3) these differences may provide appellants an incentive to appeal to the ALJ level where they are likely to receive favorable decisions; and (4) 44 percent of FY 2010 ALJ decisions was fully favorable to appellants when CMS participated, but 60 percent of ALJ decisions (based on all provider appeals including IRFs) was fully favorable when CMS did not participate. Based on CMS data for 2014 through 2017 IRF appeals, the overturn rate with CMS contractor participation was 39 to 53 percent and 55 to 73 percent when CMS contractors did not participate.[27] An official we interviewed

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[25] Medicare Advantage healthcare coverage plans are offered by private companies approved by Medicare to receive reimbursement for services. Some Medicare Advantage plans require the IRF to obtain prior authorization for IRF admissions from the Medicare Advantage plan (a party external to the IRF itself). IRF stays covered by these plans generally follow Medicare FFS coverage and documentation requirements. In addition to requiring an IRF to request prior authorization, some Medicare Advantage plans may require further evaluation for patients with certain conditions. Evaluation criteria may include an assessment of whether the care needed could be safely provided in a less restrictive clinical setting. Some plans also require additional review of medical records after the authorization to increase a length of stay beyond initially approved limits.

[26] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals* (OEI-02-10-00340), November 2012. As noted in that report on pages 19 and 20, we acknowledge that CMS may have strategic considerations "about which contractors are in the best position to represent CMS and which appeals most warrant CMS participation in ALJ hearings, such as Part A hospital appeals or those from frequent flyers."

[27] The Office of Medicare Hearings and Appeals administers the ALJ hearing program for provider appeals about individual claims for Medicare coverage and payment for items and services furnished to beneficiaries. The ALJs decide appeals at the third level of the Medicare appeals system; the first level is adjudicated by the CMS Medicare Administrative Contractors and the second by CMS QICs. These data include appeal decisions at the QIC and AJL levels, and CMS contractor participation, in this case, includes paper or testimony presentation by MAC, QIC, or RAC contractors.

at a for-profit facility belonging to a large national IRF corporation stated that the organization expected to have any denials overturned at the ALJ level of appeal.

- The IRF payment system did not align costs with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately. (See Appendix G.)

ESTIMATE OF MEDICARE PAYMENTS MADE FOR CARE THAT WAS NOT REASONABLE AND NECESSARY

On the basis of our sample results, we estimated that for the audit period Medicare paid IRFs nation-wide $5.7 billion for stays that did not meet the coverage and documentation requirements for care to be considered reasonable and necessary.

RECOMMENDATIONS

We recommend that CMS:

- educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls;

- increase oversight activities for IRFs, such as postpayment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements;

- work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented; and

- reevaluate the IRF payment system, which could include:

    - conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices,

    - studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them, and

    - considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute-care PPS system.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft, CMS concurred with our recommendations and reiterated its commitment to providing Medicare beneficiaries with high-quality healthcare while protecting taxpayer dollars by preventing improper payments. CMS also provided us written technical comments that we addressed.

In addition to its many educational efforts, CMS stated that it has approved the MACs to review IRF providers under its Targeted Probe and Educate program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. These actions, together with actions taken in response to our recommendations, may significantly reduce the number and amount of improper payments to IRFs.

CMS's comments, excluding its technical comments, are included in their entirety as Appendix H.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our nation-wide review covered 370,872 IRF claims from 1,139 IRFs totaling $6,751,375,988 in payments for services that were provided from January 2013 through December 2013.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the facilities that were associated with our sampled claims. Instead, we obtained a general understanding of controls related to admission decisions and documentation requirement compliance at facilities associated with a subsample of our claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our data collection from September 2015 through December 2016. CY 2013 IRF claims data were the most recent data available at the start of the audit.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed with CMS officials the 2010 revisions to the Medicare regulations for documenting IRF care;
- extracted from CMS's NCH file paid IRF claims data;
- identified a sampling frame of 370,872 IRF claims from 1,139 IRFs totaling $6,751,375,988 in payments for services provided from January 2013 through December 2013;
- selected a stratified random sample of 220 claims for our review, for which Medicare paid $11,277,251 to the associated 164 IRFs (Appendix C);
- reviewed data from CMS's Common Working File for the 220 sampled claims to validate claim information extracted from the NCH file and determine whether any of the selected claims had been canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by the 164 IRFs associated with our sampled claims;

- used an independent medical review contractor to determine whether the documentation for the 220 sampled claims met medical necessity requirements;

- discussed a subsample of the billed claims with certain IRF clinical and billing representatives to determine the underlying causes of noncompliance with Medicare requirements and the internal control procedures needed to foster compliance;

- used our sample results to estimate the total improper payments in our sampling frame (Appendix D); and

- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
Norwalk Hospital Did Not Comply with Medicare Inpatient Rehabilitation Facility Documentation Requirements (A-01-11-00531)[28]	February 2013
Medicare Compliance Review of University of Minnesota Medical Center for 2012 and 2013 (A-05-14-00050)	January 2016
Medicare Compliance Review of Hennepin County Medical Center for 2012 and 2013 (A-05-14-00048)	February 2016
Medicare Compliance Review of New York-Presbyterian Hospital for 2011 and 2012 (A-02-13-01027)	August 2016
Medicare Compliance Review of Abbott Northwestern Hospital for 2013 and 2014 (A-05-15-00043)	December 2016
Medicare Compliance Review of North Shore University Health System for 2013 and 2014 (A-05-15-00044)	December 2016
Medicare Compliance Review of Mount Sinai Hospital for 2012 and 2013 (A-02-14-01019)	April 2017

[28] Unlike this review, the other reviews include only a limited number of claims from the rehabilitation units of the acute-care hospital.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare FFS claims for services that IRFs provided to beneficiaries in CY 2013.

SAMPLING FRAME

We extracted from the NCH file Medicare inpatient claims for IRF services that were provided to beneficiaries in CY 2013. We created a database of these 442,259 claims, which had $6,866,084,932 in total payments. We analyzed the claims data and removed claims that met one or more of the following criteria:

- claims in which the claim payment was less than or equal to $2,500;
- claims submitted by providers that are under investigation by OIG's Office of Investigations; and
- claims already under review by other entities, including those claims marked as being under review by other entities.

The resulting sampling frame consisted of 370,872 IRF claims with payments totaling $6,751,375,988.

SAMPLE UNIT

The sample unit was an IRF claim.

SAMPLE DESIGN

We used a stratified random sample as follows to review Medicare Part A payments made to nation-wide IRFs for services provided January 1, 2013, through December 31, 2013. To accomplish this, we separated the sample units into four strata as follows:

Stratum	Stratum Bounds	Number of Frame Units	Sample Size	Dollar Value of Frame Units
1	≥ $2,500 and < $15,857	156,756	50	1,870,356,189
2	≥ $15,857 and < $25,397	162,715	50	3,222,316,883
3	≥ $25,397 and < $97,891	51,331	50	1,650,539,578
4 (100% Review)	≥ $97,891	70	70	8,163,338
Total		**370,872**	**220**	**$6,751,375,988**

SAMPLE SIZE

We selected 50 claims each from strata 1, 2, and 3 and selected all 70 claims from stratum 4. Our total sample size was 220 IRF claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the claims in strata 1, 2, and 3. After generating 50 random numbers for each stratum, we selected the 150 corresponding claims for review. We reviewed every claim in stratum 4 (70 in total).

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to nation-wide IRFs during the audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS

Table 1: Overall Sample Details and Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims for Care Not Reasonable and Necessary	Value of Claims for Care Not Reasonable and Necessary
1	156,756	$1,870,356,189	50	$582,320	46	$531,520
2	162,715	$3,222,316,883	50	$982,171	46	$909,879
3	51,331	$1,650,539,578	50	$1,549,421	33	$993,221
4	70	$8,163,338	70	$8,163,339	50	$5,891,320
Total	**370,872**	**$6,751,375,988**	**220**	**$11,277,251**	**175**	**$8,325,940**

Table 2: Overall Estimates
(Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Value of Improper Payments
Point Estimate	$5,652,951,081
Lower Limit	$5,322,701,315
Upper Limit	$5,983,200,848

APPENDIX E: DETAILS OF THE INPATIENT REHABILITATION FACILITY DOCUMENTATION DEFICIENCIES FOUND IN THE SAMPLE

One or more of the four types of required rehabilitation physician documentation did not include all required elements of each of these documentation types:

- a comprehensive preadmission screening (101 stays);
- a postadmission rehabilitation physician evaluation (62 stays);
- an individualized overall plan of care developed and documented by a rehabilitation physician (166 stays); and
- a demonstration that the patient requires an interdisciplinary approach to care, as evidenced by weekly interdisciplinary team meetings led by a rehabilitation physician (106 stays).

DEFICIENT DOCUMENTATION OF PREADMISSION SCREENING

At the time of admission, a patient's medical record at the IRF must contain documentation of a comprehensive preadmission screening performed within the 48 hours immediately preceding the IRF admission. A comprehensive and accurate preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care.[29] The medical record must also include evidence of the rehabilitation physician's review and concurrence with the findings of the completed preadmission screening and before the IRF admission. The screening should include a detailed clinical review of the patient's condition and medical history; serve as the

[29] CMS continued: "As we are placing more weight on the rehabilitation physician's decision to admit the patient to the IRF, we believe that it is important to require that the rehabilitation physician document the reasoning behind the decision. We realize that this level of detail may exceed what some IRFs may have included in the past, but we believe that it will benefit both IRFs and Medicare contractors who are reviewing IRF claims to have the rationale for the reasoning behind the admission recorded in each patient's medical record" (74 Fed. Reg. 39791 (Aug.7, 2009)). CMS also stated: "The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not how the process is organized" (The Manual, chapter 1, § 110.1.1).

basis for the initial determination of whether the patient meets the requirements for an IRF admission; and be used to inform a rehabilitation physician, who reviews and documents concurrence with the findings and results of the screening (42 CFR § 412.622(a)(4)).[30]

For 101 stays, IRF medical records did not include documentation of (1) a rehabilitation physician review and concurrence with the findings of the completed preadmission screening and before the IRF admission (or evidence of preadmission screening actually being performed within the 48 hours immediately preceding the IRF admission) (84 stays), (2) a comprehensive medical and functional assessment (33 stays), and (3) any preadmission screening (7 stays).

The documentation for 84 stays did not include proof that a rehabilitation physician reviewed and concurred with preadmission findings. The approval statements and signatures of rehabilitation physicians were absent, untimely, or illegible, and the names of the rehabilitation physicians were not identified elsewhere in the medical charts. Therefore, we were unable to determine that a rehabilitation physician had reviewed and concurred with the findings of the preadmission screenings taking place within 48 hours before the IRF admission.

The medical records for 33 of the 84 stays did not support IRF admissions because the preadmission screening did not detail the conditions causing the need for intensive rehabilitation, the patient's prior and current level of function, and the risk of clinical complications. Medical records for seven other stays did not include any preadmission screening documentation.

For an additional 10 stays, the IRFs provided documentation of history and physical examinations, progress notes, and consultations from the immediately preceding acute-hospital stay instead of preadmission screening documentation. However, this substitute documentation was not comprehensive, did not include most required clinical information, and did not support that a rehabilitation physician had approved the IRF admission.

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[30]According to the Manual, chapter 1, § 110.1.1, IRFs must support the IRF admission by retaining in the patient's medical record the results of a preadmission screening that was conducted within the 48 hours immediately preceding the admission:

> The preadmission documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e. physical therapy, occupational therapy, speech therapy-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

DEFICIENT DOCUMENTATION OF THE REHABILITATION PHYSICIAN'S POSTADMISSION EVALUATION

The patient's medical record at the IRF must include documentation of a rehabilitation physician's postadmission evaluation that meets all of the following requirements: (1) completed within 24 hours of the patient's admission to the IRF, (2) includes a documented history and physical exam, (3) documents the patient's status on admission to the IRF, (4) includes a comparison of observed medical and functional status with the information noted in the preadmission screening documentation, and (5) serves as the basis for the development of the overall individualized plan of care (42 CFR § 412.622(a)(4)).[31]

Although medical records for most stays included documentation of a history and physical exam performed within the first 24 hours after admission, for 62 of the IRF stays the medical records did not include documentation showing that the rehabilitation physicians' postadmission evaluations met all of the requirements. Specifically: (1) documentation of postadmission evaluations did not include a medical and functional status comparison with the information noted in the preadmission screening documentation and (2) the postadmission rehabilitation physicians' evaluations were not completed within 24 hours after admission as required.

For eight of the 62 stays, physician extenders[32] documented the history and physical examination, but the documentation did not include evidence that a rehabilitation physician documented a visit with the patient, the patient's status on admission to the IRF, a comparison with the information noted in the preadmission screening documentation, and a basis for the development of the overall individualized plan of care within the 24 hours after the IRF admission.

DEFICIENT DOCUMENTATION OF INDIVIDUALIZED, OVERALL PLAN OF CARE

The patient's medical record for the IRF stay must contain an individualized overall plan of care that is developed by the rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission (42 CFR § 412.622(a)(4)).

It is the sole responsibility of a rehabilitation physician to combine information that is required in the overall plan of care, including an estimated length of stay, and to document it in the patient's IRF medical record. The overall plan of care must detail the patient's medical

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[31] As interpreted by the Manual, chapter 1, §110.1.2.

[32] Rehabilitation "physician extenders" in this case include nurse practitioners, physician assistants, and physicians other than rehabilitation physicians (CMS, *National Provider Training Call Transcript, Inpatient Rehabilitation Facility Prospective Payment System*, "Physician Extenders," p. 16, May 31, 2012).

prognosis, anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.[33]

For 166 IRF stays, rehabilitation physicians did not document an individualized overall plan of care that met all of the requirements. For the 146 IRF stays not meeting the coverage requirements, medical reviewers could not identify individualized, overall plans of care supporting the medical necessity of the admission. The requirements for the documentation of individualized, overall plans of care were also not met for 20 of the 29 stays that generally met coverage requirements at admission but did not meet all documentation requirements.

For 104 stays, rehabilitation physicians documented only general and brief plans of care, not individualized and detailed plans that included medical prognoses, anticipated interventions, functional outcomes, estimated lengths of stay, and discharge destinations. For these stays, the rehabilitation physicians did not coordinate medical and functional courses of care for the patients, which could have identified and linked medical management to functional interventions and goals and to the complex conditions that require intervention by a rehabilitation physician. For 27 stays, treatment plans were developed and documented by therapists and nurses, not rehabilitation physicians as required, and were intended to be individualized, overall plans of care. These treatment plans did not contain decision making by rehabilitation physicians for a coordinated medical and functional rehabilitation course of care for the patient.

DEFICIENT DOCUMENTATION OF INTERDISCIPLINARY TEAM MEETINGS

For an IRF claim to be considered reasonable and necessary, the patient must require an interdisciplinary team approach to care, as evidenced by documentation retained in the patient's medical record. That documentation should contain summaries of interdisciplinary team meetings whose purpose is to foster communication among disciplines to establish, prioritize, and achieve treatment goals.[34] These summaries must (1) include the names and professional designations of the participants and (2) the results, findings, and decisions made at the team meetings and the rehabilitation physician's concurrence with those decisions (42 CFR § 412.622(a)(5)).[35] In addition, the team meeting must (1) be led by a rehabilitation physician; (2) consist of a registered nurse, social worker, or case manager and a licensed or certified therapist from each therapy discipline involved in treating the patient; and (3) occur at least once a week throughout the stay to implement appropriate treatment services and review progress toward goals.

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[33] As interpreted by the Manual, chapter 1, § 110.1.3.

[34] CMS also stated: "Though we agree that informal communications among the disciplines on a daily basis are beneficial for the patient, we believe that it is important to require that all treating disciplines meet formally at least once per week to maximize the patient's potential for meeting the treatment goals." (74 Fed. Reg. 39795 (August 7, 2009)).

[35] As interpreted by the Manual, chapter 1, § 110.2.5.

For 106 IRF stays, medical record documentation was not compliant with the requirements for weekly interdisciplinary team meetings. The documentation was missing key elements that are intended to demonstrate a collaborative, interdisciplinary approach to care. Specifically, documentation retained in the patients' medical records of interdisciplinary team meetings did not provide enough detail to identify one or more of the following key elements:

- the results, findings, and decisions made at the meetings (74 stays);
- the names and professional designations of the participants (70 stays); and
- the concurrence of the rehabilitation physician with the results, findings, and decisions (50 stays).

Although therapists, nurses, and case management specialists may have individually documented weekly notes about the patient's medical and functional status, those notes were not documented as final decisions made by the interdisciplinary team at a weekly team meeting. The notes also did not clearly identify the rehabilitation physician's concurrence and participation in a meeting.

Documentation for some team meetings included only check boxes as patient status indicators. For other meetings, rehabilitation physicians briefly documented that team meetings took place and what was discussed. For all these stays, this documentation did not show a clear communication among disciplines for a coordination of care through an interdisciplinary team approach.

APPENDIX F: SAMPLED STAYS THAT WERE REASONABLE AND NECESSARY

The IRFs in our review complied with all Medicare coverage and documentation requirements for 45 of the 220 sampled stays. The medical records for these stays supported that IRF care was reasonable and necessary in accordance with Medicare's coverage and documentation requirements. Even though patients with other types of conditions may be suitable candidates for IRF care, these 45 stays were predominantly related to patient needs resulting from injuries and other impairments related to the head and spinal cord.[36]

The preadmission screening documentation for these patients demonstrated that the patients had (1) complex nursing, medical management, and rehabilitation needs, requiring an interdisciplinary team approach to care supervised by a rehabilitation physician during an inpatient stay and (2) the ability to make measurable improvement that is of practical value to them according to predefined goals.

TWO EXAMPLES OF INFORMATION CONTAINED IN THE MEDICAL RECORDS FOR STAYS THAT WERE REASONABLE AND NECESSARY

The records for both these examples had the appropriate documentation elements required for the preadmission screening; a postadmission rehabilitation physician evaluation; an individualized, overall plan of care; and an interdisciplinary team approach to care. The documentation presented a detailed description of the patient's required needs for acute inpatient rehabilitation.

Example 1: According to the medical review contractor, the patient, who had previously been independent, had had multiple strokes. He had a significant blood circulation disorder in his left lower leg and had undergone emergency procedures to remove blood clots. When admitted for rehabilitation, the patient was at high risk of losing that leg. He was able to follow simple commands and perform transfers only with maximal assistance. He required complex pain management and skilled physical therapy, occupational therapy, and speech therapy services, as well as a high level of medical oversight and nursing care in the treatment of his medical conditions. He was medically stable and able to participate in and benefit from acute-level rehabilitation. With this therapy, it was anticipated that the patient would obtain measurable improvement that was of practical value to him.

[36] CMS National Provider Training Call Transcript, "Revised Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements," Nov. 12, 2009, p. 7. A patient meeting all of the coverage criteria for admission to an IRF, as supported by required medical record documentation, could be a candidate for IRF care. Available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html. Last accessed June 2017.

Example 2: According to the medical review contractor, the patient, who had previously been independent, injured his spinal cord in a fall. He depended on a ventilator and had bowel and bladder problems, with secondary complications of pneumonia and sepsis. He was able to participate in treatments that included weaning him off the ventilator, physical therapy, and occupational therapy for preventing further secondary complications and for improving mobility. He required speech therapy for swallowing and communication. His therapy goals were to obtain measureable improvement of practical value in recovering from infection, achieving bowel and bladder independence, progressing in the ability to swallow and communicate, developing tolerance for sitting in a wheelchair, and attaining mobility with the use of adaptive equipment. He had both medical needs and rehabilitation goals that required the complexity of acute-level rehabilitation and the specialty care of a spinal cord injury unit. A home discharge had been planned.

PROVIDER INTERNAL CONTROLS

We discussed internal control procedures with staff at several of the IRFs in our sample and determined that the IRFs that demonstrated compliance with Medicare coverage and documentation requirements had established strict admissions and quality control monitoring policies and procedures for Medicare coverage and documentation compliance. These IRFs had strengthened their controls as a result of the establishment of the 2010 Medicare requirements.

AN EXAMPLE OF ONE PROVIDER'S INTERNAL CONTROL PROCESS

We visited an IRF unit of an acute-care hospital that created internal controls in 2010 to comply with IRF coverage and documentation requirements that CMS revised in 2009.

The IRF described its preadmission screening process, which begins soon after it receives the order for the IRF admission. The IRF obtains all applicable medical records from the referring facility. The admission liaison nurse and rehabilitation physician review these records before the patient's admission and document their preadmission screening analysis and admission decision. If the order is for a patient in the acute-care hospital unit of the same facility, the admission nurse liaison and the rehabilitation physician also visit the patient, perform a physical examination, and document their findings. This admission team also visits outside facilities to perform preadmission screening for patients being referred to the team's IRF. Clinicians at this IRF stated that the appropriateness of the IRF admission depends on the completeness and accuracy of the preadmission screening they perform.

The IRF also designed its electronic medical record system to prompt the user to enter documentation required by Medicare and their facility. An electronic message prompts the rehabilitation physician and other users to enter scheduled documentation if it has not been properly completed in a timely manner. The physician director of the rehabilitation unit said these prompts include a reminder to the rehabilitation physician in charge of the patient to document an individualized, overall plan of care almost immediately after the patient's admission. Additional prompts require rehabilitation physicians to document weekly team meetings with a detailed description of patient status and to explain the need for continued inpatient rehabilitation.[37]

[37] In addition, this rehabilitation physician director said he makes it his practice to seek out information at national professional society meetings to determine whether the IRF is providing a high quality of care in comparison to other facilities. He and his fellow physical medicine and rehabilitation physicians make daily visits to the patients, although many rehabilitation physicians at other facilities visit only the minimum number of three times per week as required by Medicare.

APPENDIX G: MedPAC RECOMMENDATIONS FOR REFORM OF INPATIENT REHABILITATION FACILITY AND POST-ACUTE-CARE PAYMENTS

INPATIENT REHABILITATION FACILITY PAYMENTS

MedPAC has made recommendations that could reduce Medicare spending on IRF stays. The Commission reported the following in 2017:

- Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, while Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent.

- IRFs may differ in their assessment and coding of patients' motor and cognitive function. Although aggregate payments may be more than sufficient, payments for some IRFs may be too low relative to the costs incurred in treating their patients, while the payments for other IRFs may be too high.

- There are differences in freestanding and hospital-based IRFs' mix of cases, with some case types being more profitable than others, resulting in higher margins for facilities that admit larger shares of the cases.[38]

Since 2009, as IRF profit margins have been greater than 10 percent for most of the last 10 years,[39] MedPAC has recommended reform in a 0-percent update to IRF payments and concluded, "In the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase. Thus payments have continued to rise."[40, 41]

POST-ACUTE-CARE PAYMENTS

IRFs provide one post-acute-care setting for Medicare beneficiaries. Other settings, each with a separate payment system, include home health agencies, skilled nursing facilities, and long-term-care hospitals. According to MedPAC, there is a variation in the supply and use of post-acute-care providers across the country and a substantial overlap in types of patients treated

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[38] MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 258.

[39] MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 7, "Post-Acute Care: The Congress and CMS Must Act To Implement Recommended Changes to PAC Payments," March 2017, p. 190.

[40] MedPAC, *Report to Congress: Medicare Payment Policy*, chapter 10, "Inpatient Rehabilitation Facility Services: Assessing Payment Adequacy and Updating Payments," March 2017, p. 259.

[41] Individual market baskets for Medicare payment systems, such as the IRF PPS, are inflation-adjusted price indices that are developed to measure the price changes over time for each type of provider.

across these four settings, while Medicare continues to pay significantly different rates for similar patients depending on the setting.[42, 43]

MedPAC has stated that an unnecessarily high level of spending—post-acute-care Medicare margins being greater than 10 percent for most of the last 10 years—has been high relative to the cost of treating beneficiaries. In response to the initial mandate of the Improving Medicare Post-Acute Care Transformation Act of 2014, MedPAC has recommended features of a unified post-acute-care payment system based on patient characteristics rather than setting, a closer alignment of costs and payments, more equitable payments across different kinds of patients, and outcomes-based quality measures.

MedPAC estimates that this system would redistribute payments among types of stays (from physical rehabilitation to medically complex care) and from higher cost settings and providers to lower cost settings and providers. Under this system, MedPAC says that (1) profitability should be more uniform across different types of stays or patients; (2) providers should therefore have less financial incentive to admit certain types of patients over others; and (3) payment would no longer be based in part on the number of services furnished, so providers would have less financial incentive to provide unnecessary services.[44]

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[42] MedPAC, *Report to Congress: Mandated Report,* chapter 3, "Developing a Unified Payment System for Post-Acute Care," June 2016, pp. 57, 63.

[43] B. Gage, M. Morley, et al., The Post-Acute Care Payment Reform Demonstration, final report, "12.5 Next Steps," volume 4, March 2012, p. 251. Authorized by section 5008 of the Deficit Reduction Act of 2005, P.L. No. 109-171, and prepared for CMS by RTI International (RTI project number 0209853.005.001).

[44] MedPAC, *Report to Congress*: chapter 3, "Developing a Unified Payment System for Post-Acute Care," June 2016, p. 59.

APPENDIX H: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: AUG 16 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (A-01-15-00500)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars by preventing improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. CMS is constantly looking for ways to improve this process; for example, in February 2018 CMS updated the Medicare Program Integrity Manual and provided guidance to Medicare contractors to clarify instructions for conducting medical review of inpatient rehabilitation facility claims. Specifically, it clarified the process for assessing intensity of services in relation to the inpatient rehabilitation facility benefit which will help ensure consistent interpretation of the policy.

Additionally, CMS has taken action to prevent improper Medicare payments by educating health care providers on proper billing for inpatient rehabilitation services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. For example, the Medicare Administrative Contractors conducted outreach and education events, both one-on-one and seminar-structured events, with inpatient rehabilitation facilities on issues such as Medicare coverage rules, billing instructions, and certification requirements. CMS also maintains a provider resource mailbox specifically for inpatient rehabilitation facilities, through which we provide responses to a wide range of questions related to proper billing and other issues. Further, CMS has approved the Medicare Administrative Contractors to perform reviews of inpatient rehabilitation providers under its Targeted Probe and Educate Program. This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. Finally, CMS developed standardized denial reason statements for contractors to promote uniformity and help with provider understanding of billing issues and future compliance.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop, and share compliance best practices that may lead to improved internal controls.

CMS Response

CMS concurs with this recommendation. CMS will continue to educate providers regarding Medicare coverage and documentation requirements for inpatient rehabilitation facilities. Additionally, CMS will explore ways to identify and share compliance requirements so providers can develop or improve internal controls.

OIG Recommendation

The OIG recommends that CMS increase oversight activities of IRFs, such as post payment medical review, to determine compliance with coverage and documentation requirements, including a review of a subsample of the 135 IRFs in this review that had 1 or more sampled stays that did not comply with Medicare requirements.

CMS Response

CMS concurs with this recommendation. CMS will instruct a Medicare review contractor to review a sample of the inpatient rehabilitation facilities identified in the OIG's audit to determine compliance with coverage and documentation requirements. Based on the findings of the sample review, CMS will determine the appropriate follow up course of action.

OIG Recommendation

The OIG recommends that CMS work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented.

CMS Response

CMS concurs with this recommendation. CMS will work with the Office of Medicare Hearings and Appeals, to the extent possible, to explore opportunities for improvement, such as policy education or contractor participation at hearings, so that Medicare coverage and documentation requirements for inpatient rehabilitation facilities are fairly represented and interpreted during Administrative Law Judge hearings.

OIG Recommendation

The OIG recommends that CMS reevaluate the IRF payment system, which could include conducting a demonstration project requiring preauthorization for Part A IRF stays modeled on Medicare Advantage practices, studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make changes necessary to more closely align them, and considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation services payment reform, which may be a component of a unified postacute care PPS system.

CMS Response

CMS concurs with this recommendation. CMS continuously evaluates the inpatient rehabilitation facility payment system on an annual basis and has recently issued the Fiscal Year 2019 Inpatient

Rehabilitation Facilities Prospective Payment System final rule, which updates Medicare policies and payment rates for fiscal year 2019. These changes, specifically the changes to the documentation requirements, may potentially decrease the number of improper payments. CMS will take the OIG's suggestions into account when determining appropriate next steps.

11-04-2019 RCVD

The State of Nursing Facilities in Oregon, State Fiscal Year 2018

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April 2019



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The State of Nursing Facilities in Oregon, 2018

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www.seiu503.org

We are grateful to Alexandra Kaiser for her assistance in preparing this report.

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Formatted: English (United States)

Commented [MAE1]: You mention OHA Health Analytics later. Do you want to include them here?

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Executive Summary

Nursing facilities are an integral component of Oregon's long term services and supports continuum, serving residents who need high-level skilled care on a short term or long term basis. This report presents the most recent federal and state data for all licensed nursing facilities that operated in Oregon during State Fiscal Year (SFY) 2018.

Licensed Capacity and Occupancy. There were 11,102 licensed beds in Oregon's 136 nursing facilities in SFY 2018. The number of beds has decreased gradually since 2000, and the decline accelerated somewhat beginning in SFY 2015. ~~Nevertheless,~~ Currently, Oregon has the second lowest nursing facility occupancy rate among all 50 states and the District of Columbia, reflecting the state's ongoing commitment to community-based long-term care options, such as assisted living, adult foster care, residential care, and memory care. The total number of resident days per year in Oregon nursing facilities has remained stable at approximately 3 million since 2002. Nursing facilities are concentrated in urban areas, and seven counties had no freestanding nursing facilities.

Admissions, Discharges, and Reentries. There were 40,786 admissions to Oregon nursing facilities in SFY 2018, a 45% increase from 2012. Approximately 1 in 4 admissions was a reentry by a person who had been discharged from the nursing facility less than 30 days before. Slightly more than 95% of admissions were from acute care hospitals. During SFY 2018, Oregon nursing facilities statewide had 39,888 discharges, an increase of 23% from 2012. The large majority of discharges (71%) were to community settings, including home as well as community-based long-term care facilities. Of the 26% of discharges that were to acute care hospitals, more than 9 in 10 returned to a nursing facility within 30 days.

Residents. Nearly 47,000 individuals resided in an Oregon nursing facility for at least one day during SFY 2018. Most nursing facility residents (57%) were female, and more than 80% were 65 years of age or older. The nursing facility population is less racially and ethnically diverse than the general Oregon population.

Length of Stay. The average length of stay for residents discharged from Oregon nursing facilities in SFY 2018 was 49 days, but the median length was only 19 days. More than 7 in 10 stays lasted 30 days or less. This reflects the fact that most residents of Oregon nursing facilities are there to receive post-acute care or rehabilitation care after discharge from a hospital. Linkage to hospital discharge data showed that 59% of nursing facility stays were by residents who had been hospitalized for medical conditions, such as infections or pulmonary problems, while 33% had been hospitalized for surgical procedures such as joint replacement.

Acuity of Residents. Most Oregon nursing facility residents required a great deal of assistance with the six basic activities of daily living (ADLs), that is, bed mobility, transferring, eating, dressing, toileting, and bathing. Forty-five percent of short nursing facility stays involved dependence on five or more ADLs, as did 60% of long stays. In addition, 92% of all nursing facility stays involved at least one chronic medical condition, such as hypertension, hyperlipidemia, and diabetes. Sixty-two percent of all nursing facility stays involved at least one

Commented [MAE2]: There is a lot of focus on individuals with dementia, and I would like to see something related to dementia included here.

Commented [DW3]: Does Oregon have the lowest rate of occupancy or the second lowest rate of occupancy? Other parts of this report state that Oregon has the lowest rate. Which one is it: lowest or second lowest?

Commented [LK4]: Why is 2012 used as the benchmark year?

Commented [DW5]: Importantly, this explanatory trend is mentioned in the executive summary

Commented [MAE6]: Can this term be defined? We talk a lot about mobility, but bed mobility is slightly different. Could we differentiate?

acute medical condition, such as anemia or urinary tract infections, and 43% of all stays involved behavioral health conditions such as depression or anxiety.

Payers. Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during SFY 2018. Traditional (fee-for-service) Medicare paid for 14% of days in 2018, while Medicare Advantage managed care plans paid for 10% of days. Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of resident days.

Quality Measures. Oregon nursing facilities performed as well or better than the national average on 11 of 23 specific quality measures defined by the Centers for Medicare and Medicaid Services (CMS). Additionally, long-stay nursing facility residents in Oregon were less likely than the national average to receive antipsychotic, antianxiety, or hypnotic medications. Some measures for which Oregon nursing facilities did not perform as well as the national average included seasonal flu and pneumococcal vaccines, worsened ability to move independently, and self-reported moderate to severe pain for nursing facility long-stay residents, and having an outpatient emergency department visit and self-reported moderate to severe pain for short-stay residents.

Commented [MAE7]: Some items in this list have qualifiers (e.g., worsened ability) and others do not. I think it would be helpful to make it consistent one way or another, so it is clear to a reader not familiar with the measures.

Commented [DW8]: This is also a product of post-acute care and rehabilitation compared to other states where nursing facilities continue to play a larger role in housing than post-acute skilled rehab.

Would be good to add an explanatory sentence about the connection between pain and post-acute and rehabilitative care.

Commented [LK9]: Agree. Oregon's pain QM has historically been high for the short term stay residents. It is an area that should be examined further for improvement but much of it is due to the post acute episode.

Commented [MAE10]: I think this would be fine.

Background

This is the fifth annual report on Oregon nursing facilities funded by the Oregon legislature and prepared by Oregon State University in collaboration with the Oregon Department of Human Services (DHS), LeadingAge Oregon, the Oregon Health Care Association, SEIU, and the Oregon Health Authority's Office of Health Analytics. These new annual reports replace those published between 1998 and 2009 by the Office for Oregon Health Policy and Research (OHPR), in collaboration with the Seniors and People with Disabilities Division[1] of the Department of Human Services. The data in those prior reports were based on annual surveys of the state's nursing facilities and are included in this report as trend data.

Commented [MAE11]: Wondered if you wanted to include them on the cover page...

The purpose of this annual report is to paint a portrait of ~~Oregon's~~ the 136 Oregon nursing facilities that were in operation in the 2018 state fiscal year to assist in local and statewide planning and policy-making efforts in long-term care services.

In this report, we use data from the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set (MDS) 3.0 and Nursing Home Compare 3.0, Oregon hospital discharge data, and Oregon provider tax cost and revenue reports. We examine an array of characteristics of the state's nursing facilities, including licensed capacity, bed availability, occupancy, admissions, discharges, readmissions, resident characteristics, length of stay, acuity, payer sources, and quality metrics.

Introduction

Oregon continues to be a bellwether for reform and innovation in long-term services and supports (LTSS) in the United States. LTSS refers to an array of medical, social, and support services for individuals who, for an extended period of time, are dependent on others for assistance. The focus of this report is on nursing facilities, which are an important part of LTSS in Oregon. Nursing facilities provide 24-hour medical care and monitoring for people who need it due to a disability or have been discharged from the hospital but are not yet able to return to the community. Thus, nursing facilities serve two different populations—individuals with post-acute care needs, which are characterized by short stays (≤ 90 days), and individuals with ongoing and indefinite needs, which are characterized by longer or indefinite stays (>90 days). ~~While~~ nNursing facilities are the most clinically intensive setting in Oregon's long-term care continuum, and they are critical for both short-stay and long-stay individuals with a high need for skilled care. The services offered in nursing facilities are often comprehensive, and include medical treatment;, physical, speech and occupational therapy;, assistance with ~~the~~ Activities of Daily Living;[2] case management;, and social services. Nursing facilities will continue to be an

Commented [MAE12]: The Katz Scale refers to mobility in general, which is why I think it important to differentiate between that and bed mobility.

[1] Now called the Aging and People with Disabilities Program. Prior to 1998, the Office of Health Policy also conducted surveys of nursing facilities.

[2] ~~The~~ Activities of Daily Living (ADLs; Katz et al., 1963) measure the functional impairment of individuals (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). ADLs commonly refer to assistance with bathing, eating, dressing, mobility, transferring, grooming, and toileting.

important part of the state's array of LTSS because of the four percent projected annual growth of the 65 and older population through 2050 (Office of Economic Analysis, 2013).

Research Highlights

Commented [MAE13]: On all of the data points in this section that mention a national stat, we should use the word Oregon to clarify which stats are Oregon's and which are national. It is confusing in some spots, and I want this to be accessible to readers who don't know too much about our systems or settings.

This report provides a comprehensive and current look at the state's 136 certified nursing facilities in State Fiscal Year 2018 (SFY), which covers the period of July 1, 2017 to June 30, 2018.[3]

Nursing facilities serve long-term care residents with the most acute care needs, such as those receiving post-acute care after being hospitalized. The state's nursing facility population reflects ~~its~~ the state's continued efforts to direct as many individuals as possible into community-based long-term care options, including assisted living, residential care, and adult foster care.

Commented [DW14]: This is a notable point

There were 11,102 licensed beds in Oregon nursing facilities in SFY 2018 (Exhibit 1.0). The number of facilities per county ranged widely, from zero ~~none~~ in seven counties to 34 in Multnomah County, for an average of 4 facilities per county statewide.

In 2018, 46,931 individuals required services in an Oregon nursing facility for at least one day, representing a 1% decrease from SFY 2017, and the first year since 2012 that a decrease has been observed. Compared to national averages, the residents of Oregon nursing facilities were more likely to be under age 85 and non-Hispanic white, but less likely to be female.

Other notable findings in this report are highlighted below.

Exhibit 1.0. Characteristics of Oregon Nursing Facilities, OR Fiscal Years, 2018

Characteristic	
Total number of facilities	136
Total number of licensed beds	11,102
Average licensed capacity per facility	82
Minimum number of licensed beds	5
Maximum number of licensed beds	214
Average number of facilities per county	4

Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

Facilities

- The number of facilities ranged widely across counties, with an average of 4 per county.
- Over two-thirds of all facilities (67%) were small- to medium-sized facilities with fewer than 100 beds, accounting for more than half (55%) of all beds statewide.

Licensed Capacity & Bed Availability

- The total number of licensed beds has declined consistently (15.4%) over the past 18 years, to 11,102 in 2018. This decline accelerated beginning in 2015, which may in part be due to

[3] Unless otherwise noted, all references to 2017 refer to the State Fiscal Year.

Oregon House Bill 2216 that reimburseds ~~quality~~ nursing facilities for voluntarily reducing bed capacity.

- The average number of licensed beds was 82, compared to the national average of 109 in 2014.
- The number of licensed beds per~~by~~ facility ranged from five to 214.
- The number of licensed beds per 1,000 population 75 years and older increased by 1% from 40 in 2017 to 41 in 2018. However, there has been a relatively consistent decline (32%) in the number of licensed beds per 1,000 population 75 years and older in the last 19 years.
- 80% of licensed beds statewide were staffed and ready for use (i.e., set-up), however, the percentage of set-up beds ranged widely across the state, from a low of 58% in Umatilla County to a high of 100% in Curry, Douglas, Grant, Lincoln, and Malheur Counties.

Commented [LK15]: This should be past tense.

Commented [MAE16]: agree

Commented [LK17]: Quality should be deleted.

Commented [MAE18]: agree

Commented [DW19]: Is quality the basis for the bed capacity reduction deal?

Commented [MAE20]: I don't believe so.

Commented [MAE21]: It seems odd to me that we are comparing a national average from 2014 to our state average in SFY 2017. Are there any more recent national numbers or estimates?

Occupancy

- Average occupancy rates decreased from 72% in 2000 to 67% in 2017 and 2018, a 1% increase from 2016. Oregon continues to have the lowest occupancy rate in the nation.
- Across counties, average occupancy rates ranged from 40% to 84%.
- Oregon nursing facilities with ~~less~~ fewer than 50 beds had an average occupancy rate between 4 to 7 percentage points higher than larger facilities of any other size. Facilities with 100 to 149 beds had the lowest average occupancy rate (64%) compared to facilities of other sizes.
- Between 2010 and 2018, the number of resident days has remained relatively stable; however, there was a 0.4% decrease in resident days from 2017 to 2018.
- Facilities with 50-99 beds accounted for the greatest share of resident days (48%) among all facilities.
- Multnomah, Clackamas, Lane, and Washington Counties had the highest numbers of total resident days, accounting for 26, 11, 10, and 9% of all resident days statewide, respectively.

Commented [DW22]: Is Oregon first or second?

Admissions, Discharges and Reentries[4]

- 95% of all admissions came from acute care hospitals.
- Facilities with less than 50 beds had the lowest average numbers of admissions and discharges (139 and 143, respectively), whereas facilities with 150+ beds had the highest average numbers of admissions and discharges (442 and 457, respectively).
- 26% of all discharges were to an acute care hospital; 93% of these discharges to hospitals subsequently reentered a nursing facility within a 30-day period.
- 71% of all discharges returned to the community.

Commented [LK23]: Another telling data point.

Commented [MAE24]:

Commented [MAE25]: Does this include community-based long term care settings or just non-facility settings?

[4] An admission refers to an entry into a nursing facility by an individual for the very first time or for the first time after having been discharged from the facility at least 30 days before. A reentry occurs when an individual returns to a facility from which he or she was discharged less than 30 days before. A discharge refers to an individual being released from a nursing facility whether they re-enter or not.

Residents

- The state's nursing facility population was younger than national estimates, with 81% of nursing facility residents being age 65 or older, compared to 85% of residents nationwide.
- 43% of residents were male compared to 33% of U.S. nursing facility residents.
- Racial/ethnic minority individuals were under-represented in Oregon nursing facilities compared to the Oregon general population and to nursing facilities nationally.
- Racial/ethnic minority residents were younger compared to the state's general nursing facility population.

Length of Stay

- 73% of Oregon nursing facility stays lasted 30 days or less.
- 92% of all nursing facility stays were less than or equal to 90 days, referred to as a "short stay."
- Short- and mid-length stays—meaning stays for less than a full year—averaged 30 days compared to 916 days (or approximately 2.5 years) for long-stays.
- Average lengths of stay were highest for the younger residents (18 to 24 years) at 98 days.
- The median length of stay in Oregon facilities was 19 days.
- 59% of nursing facility stays linked to hospital discharges were for residents who had been hospitalized for medical conditions, such as infections or pulmonary problems, while 33% had been hospitalized for surgical procedures.
- The overall average nursing facility length of stay was 24 days for stays linked to hospital discharges, with a median of 18 days.

Acuity of Residents

- Average ADLs of nursing facility residents decreased 6.7% from 3.74 in 2012 to 3.48 in 2018.
- 48% of stays involved residents who were somewhat or completely dependent on five ADLs, compared to 23% of all nursing facility residents in the U.S.
- 45%, 60%, and 64% of short-, mid-, and long-stays, respectively, involved dependence on five or more ADLs.
- Stays of residents under 18 years of age had higher levels of complete dependence than stays of other age groups for all ADLs except bed mobility.
- Bathing was the most common ADL need for all stays (72%), followed by toileting (70%) and bed mobility (69%).
- 62% of stays involved at least one acute medical condition, with anemia, cancer, and urinary tract infections being the most common individual diagnoses.
- 92% of stays involved at least one chronic medical condition, with seven in 10 having hypertension, more than four in 10 having hyperlipidemia, and more than three in 10 having diabetes.
- Physical therapy was provided five or more days per week for 83% of short stays.
- Occupational therapy was provided five or more days per week for 77% of short stays.

Payers

- Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during 2018, a proportion that has remained relatively stable since 2010.
- Medicaid paid for 61, 57, and 73% of resident days in urban areas, large rural cities/towns, and small/isolated rural towns, respectively.
- Medicare Fee-For-Service paid for 14% of Oregon nursing facility resident days in 2018. Medicare Advantage managed care plans paid for 10% of days.
- Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of all resident days.

Quality Measures

- Oregon nursing facilities performed the same or better than the national average on 11 of 23 CMS-defined quality measures.
- Oregon facilities' average performance on individual quality measures in 2018 was similar to 2017 and 2016.
- For long-stay residents, average rates of pneumococcal pneumonia vaccination decreased in Oregon facilities compared with 2017, and seasonal flu vaccination in Oregon facilities stayed the same compared with 2017, remaining somewhat lower than the average for all nursing facilities nationwide.
- For short-stay residents, average rates of vaccination for pneumococcal pneumonia and seasonal flu in Oregon facilities stayed the same compared with 2017, but were lower than the average for all nursing facilities nationwide.
- Reported rates of pain were higher among both short- and long-stay residents in Oregon facilities than nationwide, which may reflect the higher acuity of nursing facility residents in Oregon, particularly residents receiving post-acute care after hospitalization for surgery such as joint replacement, which may increase their need for pain control.
- Like 2017, short- and long-stay nursing facility residents in Oregon were less likely than the national average to receive antipsychotic, antianxiety, or hypnotic medications. In addition, fewer long-stay residents reported having depressive symptoms compared with the average rates for all nursing facilities nationwide.
- Rates of several negative outcomes among long stay residents (for example, ~~losing too much weight~~excessive/unsafe weight loss, ~~high-risk patients with~~development of pressure ulcers, presence of urinary tract infections, or occurrence of falls with major injury) were somewhat higher in Oregon than the national average.
- Short stay residents in Oregon nursing facilities were more likely than the national average to visit a hospital emergency department, but less likely to be re-hospitalized after entering the nursing facility.

Commented [MAE26]: What are actual numbers? How far below are we?

Commented [MAE27]: What are actual numbers? How far below are we?

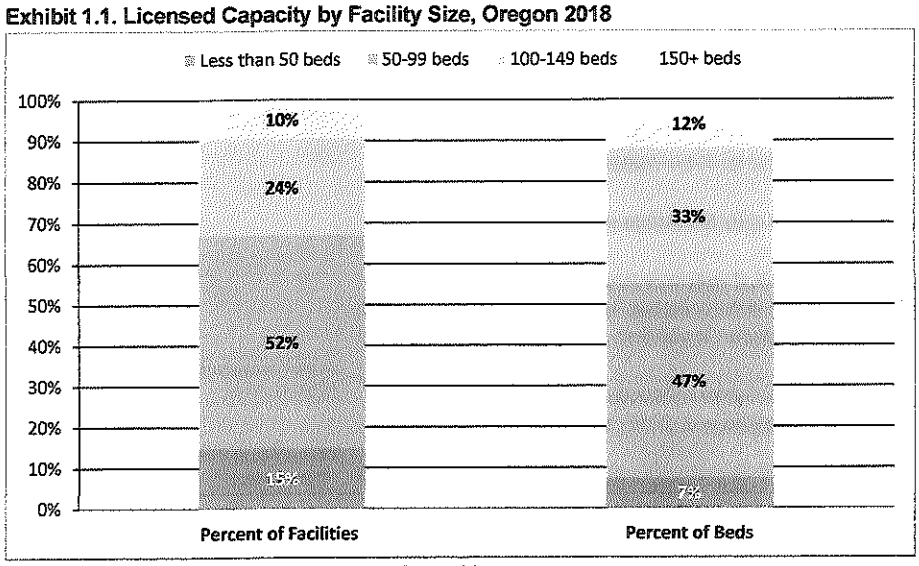
Commented [DW28]: A note about this should be included in the summary of

Commented [MAE29]: I'm fine with this. It will also be a good point to bring up in the policy/trend document.

Section 1. Licensed Capacity

Oregon had 136 nursing facilities in SFY 2018, with a total of 11,102 licensed beds (Exhibit 1.1). Sixty-seven percent of all facilities had fewer than 100 beds, accounting for more than half (55%) of all beds statewide. The average number of licensed beds was 82, compared to 108 nationally in 2016, the most recent data available (Harrington & Carrillo, 2018).

Exhibit 1.1. Licensed Capacity by Facility Size, Oregon 2018



Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

The total number of nursing facilities in Oregon (n=136) was similar to the total number in 2016 and 2017 (n=137). Two nursing facilities changed ownership at the beginning of or during SFY 2018. One facility closed, and no facilities opened during SFY 2018.

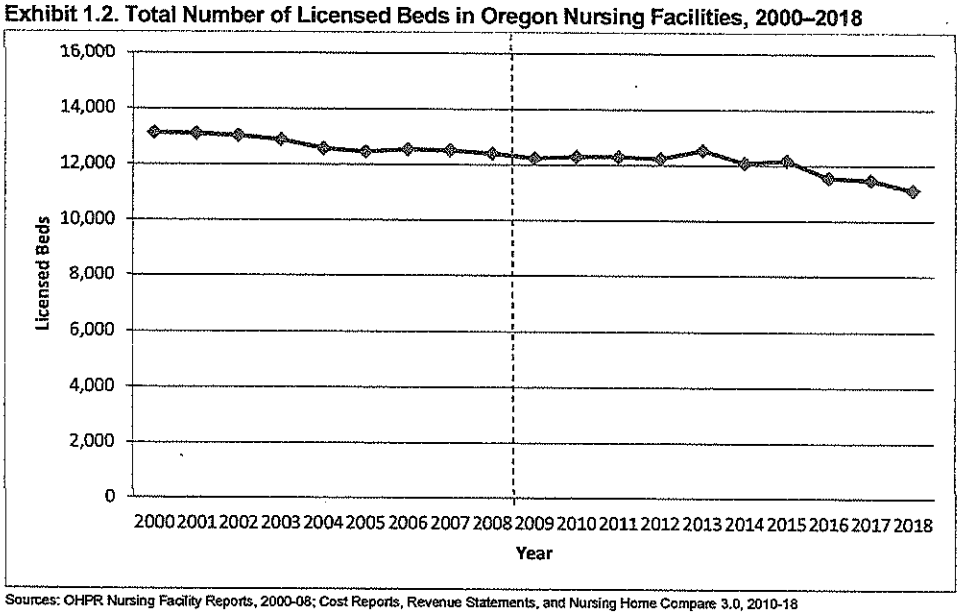
The total number of licensed nursing facility beds in Oregon declined 15.4% over the last 19 years, from 13,127 in 2000 to 11,102 in 2018 (Exhibit 1.2). The total number of licensed beds in 2018 declined slightly (3%) from 2017. The dashed vertical line between 2000-08 and 2009-18 signifies a change in the methodology used to obtain the data reported in this exhibit and in Exhibit 1.3 (page 10). Thus, the trends for these two time periods may not be completely comparable.[5]

[5] Data for the 2000-08 period are based on information used by the state for facility licensing. The trend for 2009-18 come from state and federal data collected as part of the reporting requirements for nursing facility certification and payment.

One contributor to the decrease in licensed beds was reductions in licensed beds at existing facilities. During 2017, one facility reduced its number of licensed beds, while two facilities increased their number of licensed beds.

The long-term decrease in licensed bed-capacity contrasts with the national trend, which has remained relatively stable since 2004 (American Health Care Association, 2015). Oregon has the third lowest number of nursing facility residents per 1,000 population 65 years and older in the United States (Reinhard et al., 2014), providing further evidence of the state's commitment to non-institutionalized long-term care.

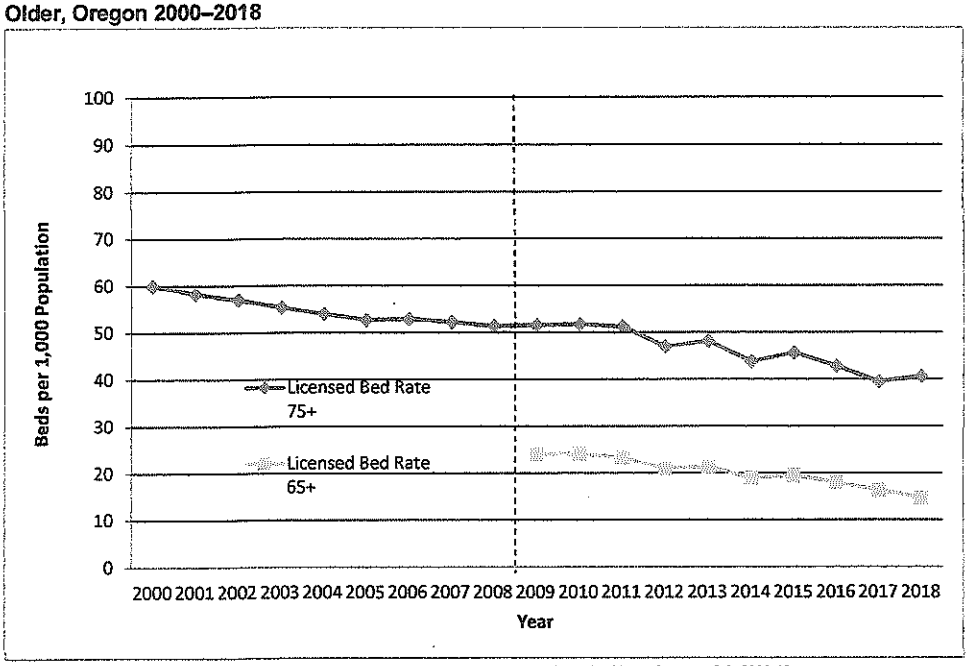
Exhibit 1.2. Total Number of Licensed Beds in Oregon Nursing Facilities, 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08; Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2010-18

The number of licensed beds per 1,000 population has declined steadily for the 75 years and older population since 2000 (60 vs. 41; Exhibit 1.3) and for the 65 years and older population since 2009 (24 vs 15; Exhibit 1.3). The 32% decrease over the past 19 years in licensed beds per 1,000 population 75 years and older reflects the overall reduction in licensed capacity and the growth in the state's older population during this same time period. Over the last 10 years, the decrease in the number of licensed beds per 1,000 was smaller for the population 75 years and older (21%) than for the population 65 years and older (39%). This reflects faster population growth among individuals in the oldest age categories, consistent with national demographic trends in the U.S. population.

Exhibit 1.3. Licensed Bed Rate per 1,000 Population 75 Years and Older and 65 Years and Older, Oregon 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08; Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2009-18

Section 2. Bed Availability

In 2018, there were 41 licensed beds per 1,000 population 75 years and older in Oregon (Appendix, Table A). This rate varied widely across the state's 36 counties. Seven counties—Baker, Gilliam, Harney, Morrow, Sherman, Wallowa, and Wheeler—had no nursing facilities and thus no beds. Among counties that had nursing facilities, the number of licensed beds per 1,000 population 75 years and older ranged from a low of 12 in Lincoln County to a high of 155 in Wasco County (Appendix, Table A).

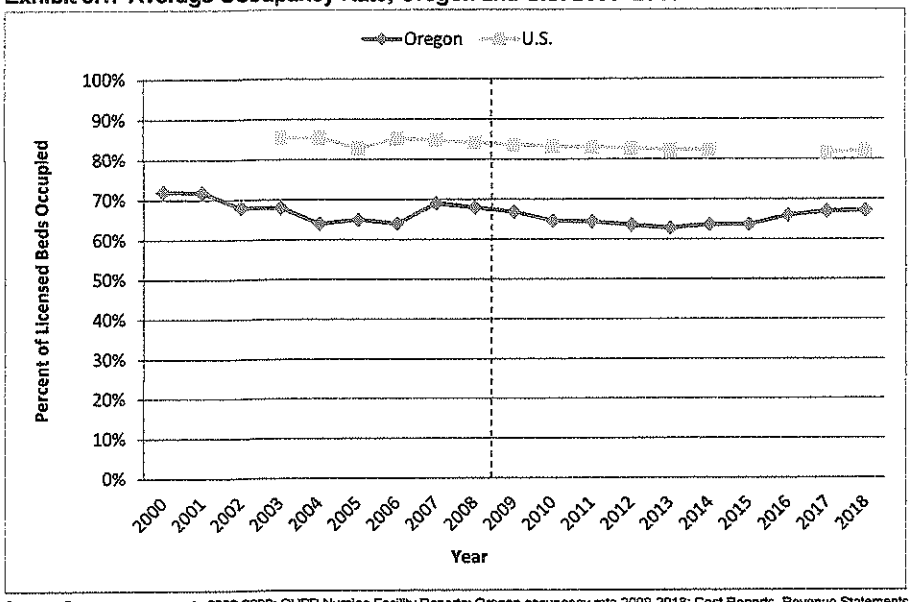
Statewide, 82% of licensed beds were staffed and available for use, what we refer to as "set-up." However, the proportion of licensed beds that were "set-up" varied widely across the state. For example, Umatilla County had the lowest percentage of licensed beds that were set-up (58%), followed by Hood River (60%). Five counties had 100% of licensed beds that were set-up: Curry, Douglas, Grant, Lincoln, and Malheur There was a more than fifteen-fold difference in the number of set-up beds per 1,000 adults 75 and older across Oregon, from a low of eight in Jefferson County to a high of 124 in Wasco County (Appendix, Table A).

Section 3. Occupancy

The average occupancy rate[6] statewide decreased from 72% in 2000 to 67% in 2018 (Exhibit 3.1). The average occupancy rate remained relatively stable between 2016 (66%) and 2018 (67%). The dashed line between the 2000-09 and 2010-18 periods signifies a change in the methodology used to obtain the data reported in this exhibit. Thus, the trends for these two time periods may not be completely comparable.[7]

Nonetheless, in 2016, the most recent data available on state rankings, Oregon's average nursing facility occupancy rate ranked as the second lowest in the nation, greater only than Utah (The Henry J. Kaiser Family Foundation, 2018).

Exhibit 3.1. Average Occupancy Rate, Oregon and U.S. 2000–2018



Sources: Oregon occupancy rate 2000-2008: OHPR Nursing Facility Reports; Oregon occupancy rate 2009-2018: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0; National occupancy rate: 2003-2016: The Henry J. Kaiser Family Foundation; National occupancy rate 2017-2018: National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing Data Report, 2017 & 2018.

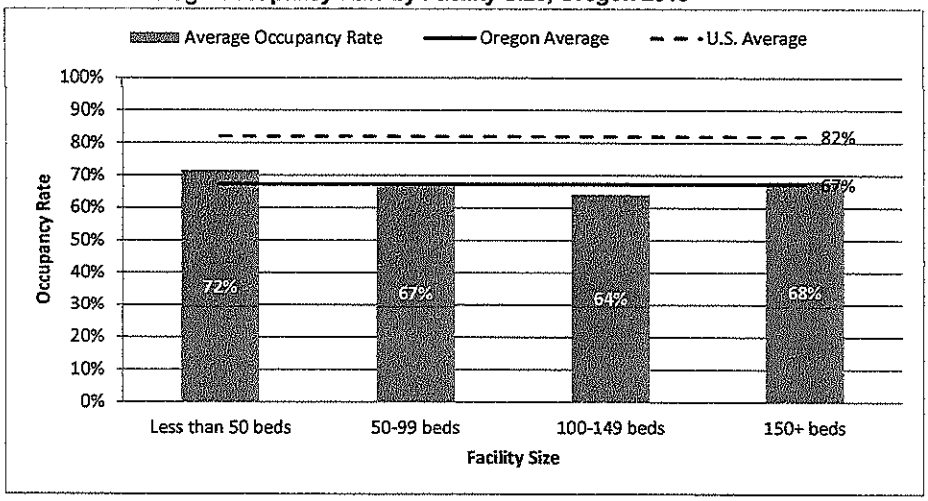
In SFY 2018, the average statewide occupancy rate of 67% (Exhibit 3.2) was 15 percentage points lower than the national average (82%) in 2018 (the most current data available for

[6] A facility's occupancy rate is the total number of resident days reported by that facility during the state fiscal year divided by the total number of bed days available at that facility during the same fiscal year. Occupancy rates are adjusted for facility openings and closings during the state fiscal year.

[7] Data for the 2000-08 period were collected from annual surveys of the state's nursing facilities, and year-by-year fluctuations reflect variation in responses rates to the survey. Data for 2009 and later years come from state and federal reporting for nursing facility certification and payment, which are not affected by response rates.

national average occupancy rates) (National Investment Center for Seniors Housing & Care, 2017). Smaller nursing facilities with less than 50 beds had a higher average occupancy rate (72%) than facilities of any other size whereas facilities with 100 to 149 beds had the lowest occupancy rate (64%). The occupancy rate for facilities with 150 or more beds increased by seven percentage points from 2017 to 2018 but the rates for other-sized facilities were similar to those in 2017.

Exhibit 3.2. Average Occupancy Rate by Facility Size, Oregon 2018



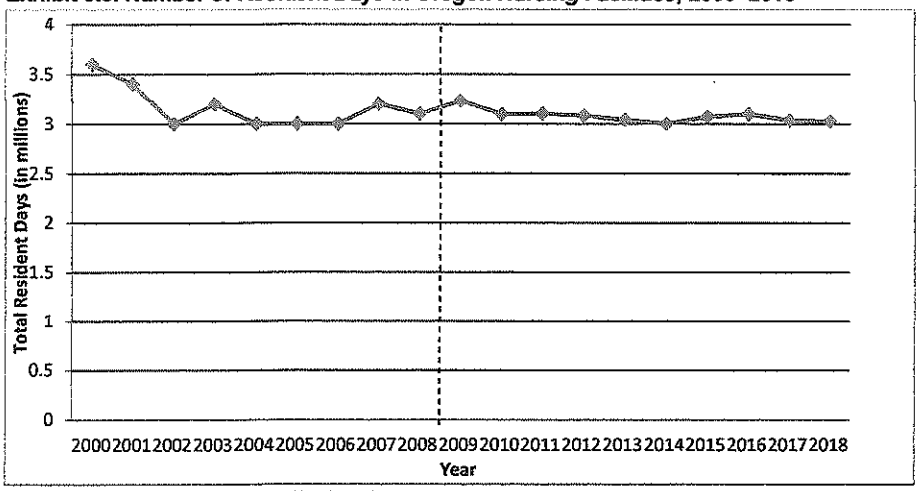
Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0,; National Investment Center for Seniors Housing & Care (NIC), Skilled Nursing Data Report, 2018.

Average occupancy rates also varied across the state's 36 counties (Appendix, Table A). Jefferson (84%), Klamath (77%), Linn (75%), Jackson (73%), Multnomah (73%), Lincoln (73%), Washington (72%), Douglas (72%), Marion (69%), Crook (69%), and Clackamas (69%) counties had occupancy rates higher than the statewide average of 67%. Twelve counties had rates under 60%, with Clatsop County having the lowest occupancy rate (40%) of all counties statewide.

Exhibit 3.3 shows the total number of resident days for Oregon nursing facilities, which declined between 2000 and 2008, from 3.6 million to 3.1 million. The number of resident days decreased by 6.4% in the last 10 years, from 3.23 million in 2009 to 3.02 million in 2018.

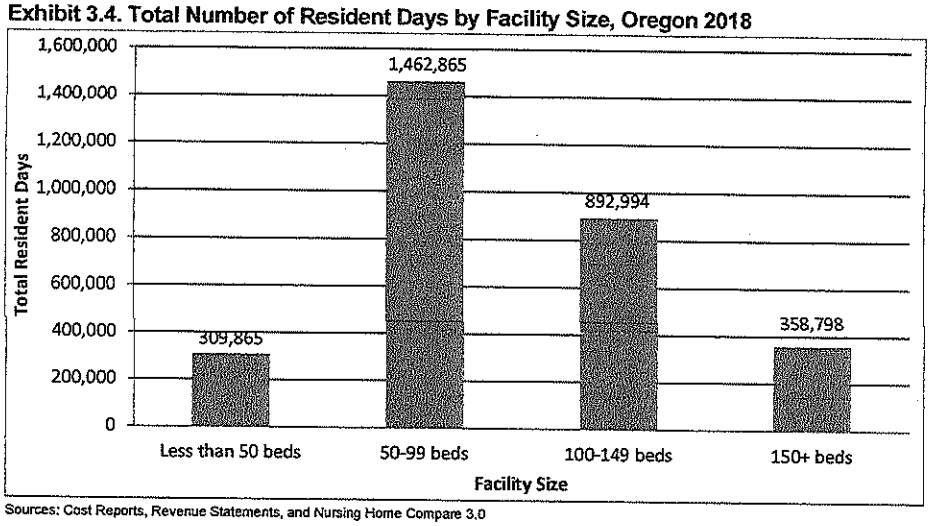
Facilities with 50-99 beds accounted for the greatest share of resident days (48%) among all facilities in 2018 (Exhibit 3.4). In contrast, the smallest- and largest-sized facilities had the fewest numbers of resident days, representing 10% and 12% of all resident days statewide, respectively. This overall pattern is consistent with 2016 and 2017 data although the proportion of resident days by facility size changed somewhat since 2017. Resident days decreased for facilities with less than 50 beds, 50-99 beds, and 150+ beds, with facilities with less than 50 beds having the largest decrease from 2017 (1.4%). On the other hand, resident days increased for facilities with 100-149 beds, representing a 4.6% increase from 2017.

Exhibit 3.3. Number of Resident Days in Oregon Nursing Facilities, 2000–2018



Sources: OHPR Nursing Facility Reports, 2000-08 (adjusted for annual survey response rates); Cost Reports, Revenue Statements, and Nursing Home Compare 3.0, 2009-18

Exhibit 3.4. Total Number of Resident Days by Facility Size, Oregon 2018

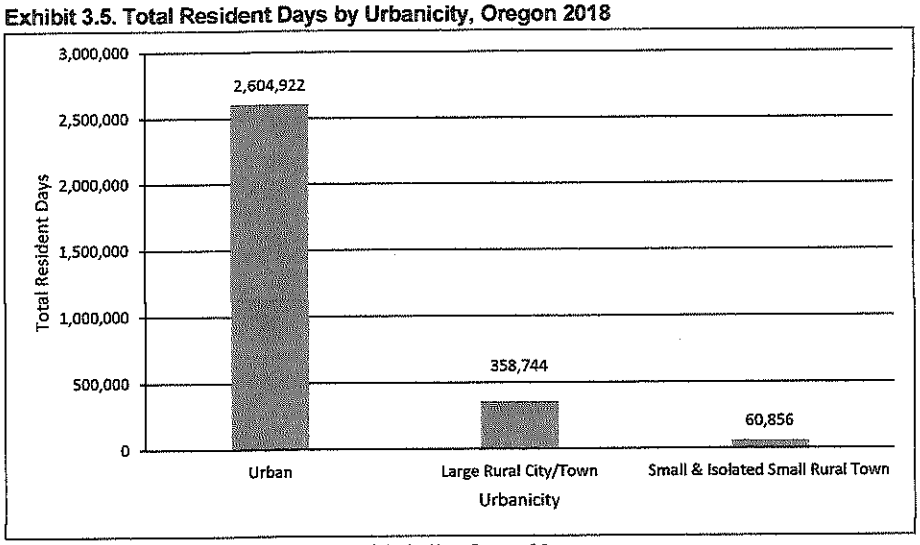


Sources: Cost Reports, Revenue Statements, and Nursing Home Compare 3.0

The total number of resident days in 2018 also varied by county (Appendix, Table A). Consistent with 2017 numbers, Multnomah, Clackamas, Lane, and Washington Counties had the highest numbers of total resident days, accounting for 26, 11, 10, and 9% of all resident days statewide, respectively.

Exhibit 3.5 shows resident days by Rural-Urban Commuting Area (RUCA) categories that we refer to as "urbanicity." RUCA categories are defined by U.S. Census tracts, where "urban" refers to an area with a population ≥50,000, "large rural city/town" refers to an area with a population from 10,000-49,999, and "small and isolated small rural town" refers to a population size of 2,500-9,999 (Rural Health Research Center, n.d.).[8] As expected, 86% of all resident days were in urban areas (Exhibit 3.5), compared to 12% and 2% in large rural towns and small rural towns, respectively.

Exhibit 3.5. Total Resident Days by Urbanicity, Oregon 2018



Sources: Cost Reports, Revenue Statements, RUCA 2.0, and Nursing Home Compare 3.0

[8] See Technical Notes for more detailed information on these definitions.

Section 4. Admissions, Discharges, and Reentries

Methodology

An admission refers to an entry into a nursing facility by an individual. There are two categories of admissions, according to CMS Minimum Data Set (MDS) definitions:

- An entry is when an individual enters a facility for the very first time, or for the first time after having been discharged from the facility at least 30 days before.
- A reentry is when an individual returns to a facility from which he or she was discharged less than 30 days before.

A discharge refers to when a person leaves a nursing facility to return to the community, to be admitted to a hospital, or to go to other destinations. A nursing facility stay is a period of continuous residence in a nursing facility, beginning with an admission and ending with a discharge.

For this report we first identified discharges in the MDS, and then identified the admission date that corresponded to each discharge; the nursing facility stay was constructed as the period from admission to discharge.[9] We also identified reentries directly, using dates of discharge from and reentry to the same facility within 30 days. We excluded from our analyses nursing facility stays for which the MDS does not include a discharge date. See the Technical Notes for further details.

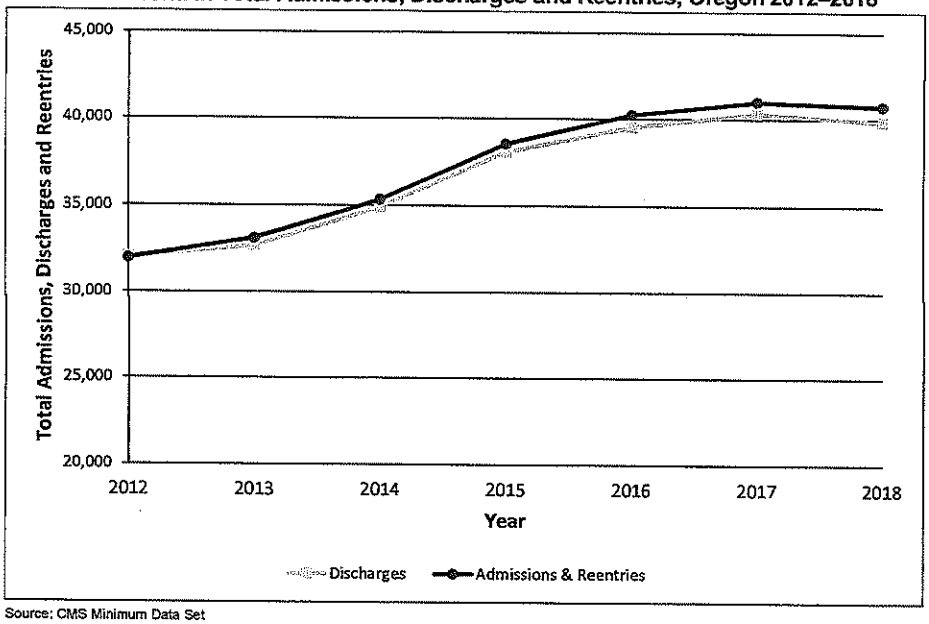
The total number of nursing facility admissions in SFY 2018 included in this report is 40,786[10] (all admissions with a discharge date in MDS), which is within 6% of the total number of Oregon nursing facility admissions derived from detailed annual cost reports submitted to the Centers of Medicare and Medicaid Services by nursing facilities (Hansen Hunter & Co., 2019).

As shown in Exhibit 4.1, admissions and reentries and discharges increased overall from 2012 to 2018 (22.8%, 24.5%, and 45.2%, respectively). The numbers of admissions and reentries increased steadily from 2012 (31,954) to 2017 (41,029), and decreased slightly to 40,786 in 2018, suggesting a leveling off in recent years. Similarly, discharges increased from 32,048 in 2012 to 40,332 in 2017, and then decreased slightly to 39,888 in 2018. The percent increases in admissions, discharges, and reentries

[9] As described in the Technical Notes, we began using the current approach for identifying stays in the 2015 report. For persons still residing in a nursing facility on the date the MDS dataset was created for Oregon State University, March 15, 2019, we constructed a stay that began on the admission date and ended on December 4, 2018.

[10] There were a total of 41,684 nursing facility admissions in Oregon before excluding 898 admissions without a discharge date in MDS.

Exhibit 4.1. Trend in Total Admissions, Discharges and Reentries, Oregon 2012–2018

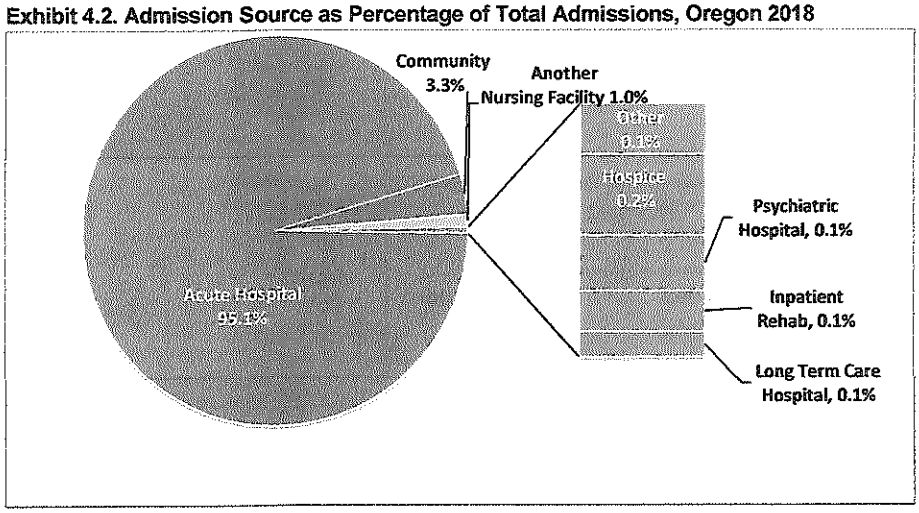


Source: CMS Minimum Data Set

Admissions

In SFY 2018, nursing facilities statewide had 40,786 admissions, based on MDS data. Of these, 9,973 (24.5%) were reentries. Exhibit 4.2 displays the admission source as a percentage of total admissions. Acute hospitals accounted for the highest percentage at 95.1%. Community admission sources contributed 3.3% while another nursing home accounted for 1.0% of total admissions. This pattern has been consistent since 2012 (See Appendix Table B).

Exhibit 4.2. Admission Source as Percentage of Total Admissions, Oregon 2018

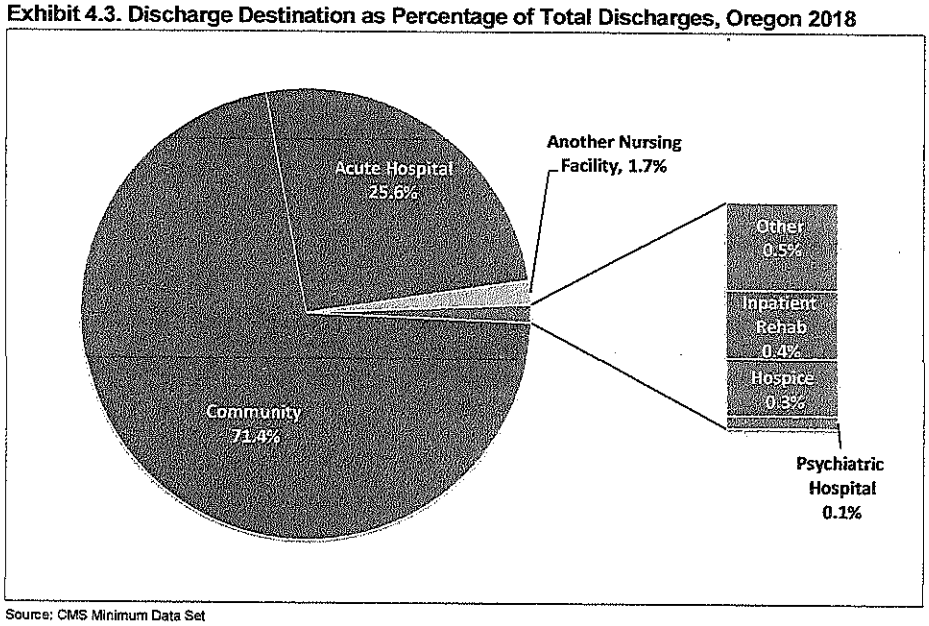


Source: CMS Minimum Data Set

Discharges

In 2018, nursing facilities statewide had 39,888 discharges, based on MDS data. Exhibit 4.3 presents discharge destination as a percentage of total discharges. The majority of individuals who discharged from nursing facilities returned to the community (71.4%), which includes other long-term care settings such as assisted living, residential care, and adult foster care. Slightly more than 1 in 4 discharges from nursing facilities (25.6%) were to acute care hospitals. A small proportion of residents (1.7%) were transferred to another nursing facility or other facility (0.5%), which included long-term care hospitals or facilities not otherwise specified. Inpatient rehabilitation, hospice, and psychiatric hospitals represented less than one percent of all discharges. The distribution of discharge destinations has been very similar since 2012, except that the proportion of discharges to the community has increased slightly, and the proportion to hospital has decreased slightly (see Appendix Table C).

Exhibit 4.3. Discharge Destination as Percentage of Total Discharges, Oregon 2018

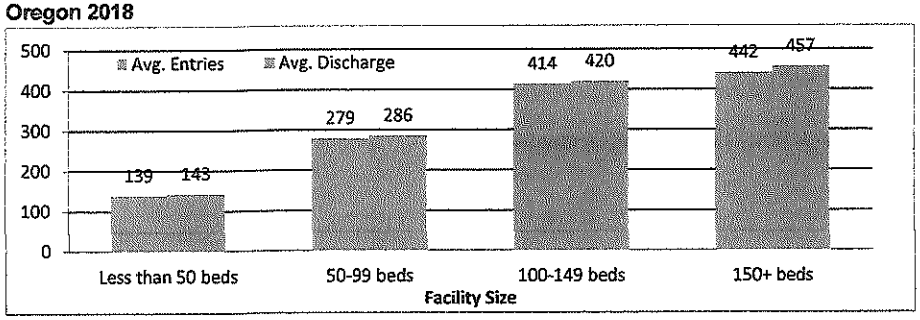


Source: CMS Minimum Data Set

Admissions and Discharges by Facility

Statewide, the average number of admissions per facility was 293 in SFY 2018, and the average number of discharges was 300. Exhibit 4.4 shows that the average numbers of admissions and discharges increased with the size of facility. Facilities with less than 50 beds had the lowest average numbers of admissions and discharges (139 and 143, respectively) and facilities with 150+ beds had the highest average numbers of admissions and discharges (442 and 457, respectively).

Exhibit 4.4. Average Numbers of Admissions and Discharges by Facility Size, Oregon 2018



Source: CMS Minimum Data Set

Reentries to Nursing Facilities after Discharge to Acute Hospitals

As mentioned earlier in this section, some individuals return to nursing facilities within 30 days of being discharged. This event, defined as a reentry,[11] may occur as part of a treatment plan or as a result of a new or unexpected health problem. In State Fiscal Year 2018, approximately one in four nursing facility admissions was a reentry, for a total of 9,973 reentries statewide. Ninety-five percent of these reentries (9,444; Exhibit 4.5) were from an acute hospital. Other reentries came from the community (3%), and other places (2%; data not shown).

Commented [DW30]: This (see footnote) is an important clarifying statement

Exhibit 4.5 shows the numbers of discharges to acute care hospitals, the number of those discharges followed by reentries to nursing facilities, and the percent reentering within 30 days. Of the 10,173 nursing facility discharges to acute care hospitals, 93% reentered the same nursing facility within a 30-day period. Reentry rates varied only modestly by facility size. Facilities with 150+ beds had the highest reentry rate (96%), and facilities with less than 50 beds or 100 to 149 beds had the lowest reentry rates (91%). Some reentries in SFY 2018 were for discharges that occurred in SF 2017.

[11] In this report we use the term "reentry" to a nursing facility to avoid confusion with "readmission" to an acute hospital.

Exhibit 4.5. Discharges to and Reentries from Acute Hospitals by Facility Size, Oregon 2018

	Number of Discharges to Acute Hospitals	Number of Reentries from Acute Hospitals within 30 Days	Percent Reentering within 30 days
<50 Beds	777	704	91%
50 - 99 Beds	5,191	4,864	94%
100 - 149 Beds	3,309	3,016	91%
150+ Beds	896	860	96%
Total	**10,173**	**9,444**	**93%**

Source: CMS Minimum Data Set

Commented [LK31]: It would be interesting to see this broken out by urban and rural areas.

Commented [MAE32]: I agree – maybe for next year if not possible for this year.

Although directly comparable national data on reentries were not available at the time of this report, it is important to note that residents of Oregon nursing facilities were much less likely to be hospitalized than were nursing facility residents in other states. Compared to other states, Oregon has the sixth-lowest rate of hospitalization[12] among its long-stay nursing facility residents (Reinhard et al., 2017) and the third lowest hospitalization rate among its Medicare-paid nursing facility residents (Levinson, 2013).

[12] This rate includes new hospitalizations and re-hospitalizations.

Section 5. Residents

Exhibit 5.1 shows the composition of Oregon's nursing facility population by age group, which remained relatively stable from SFY 2017. In 2018, the state's nursing facility population was younger on average (77 years) than national estimates, with 81% of nursing facility residents being age 65 or older, compared to 85% of residents nationwide (Centers for Medicare & Medicaid Services, 2013).

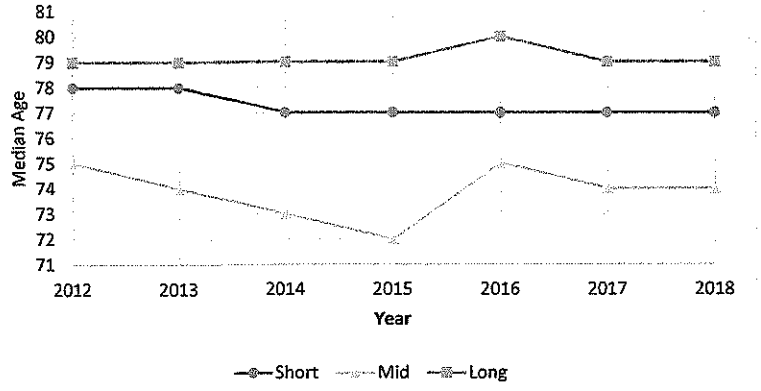
Exhibit 5.1. Distribution of Oregon Nursing Facility Residents by Age, 2018

Age Group	Percent
Under 18	0.2%
18 - 24	0.2%
25 - 44	1.8%
45 - 64	16.9%
65 - 74	24.4%
75 - 84	28.7%
85 and over	27.8%
Total	**100.0%**

Source: CMS Minimum Data Set

Exhibit 5.2 shows the trend in resident median age by length of stay. The overall trend indicates that resident median age for long-stays is older than that for mid- and short-stays. This trend has remained consistent between 2012 and 2018, with some fluctuations occurring year-to year.

Exhibit 5.2. Trend in Resident Median Age for Short-, Mid-, and Long-Stays, Oregon 2012--2018



Source: CMS Minimum Data Set

Exhibit 5.3 displays the distribution of Oregon's nursing facility population by marital status. Most of the residents were married (38.4%) or widowed (31.2%). The remaining residents were divorced (15.7%), never married (13.5%) or separated (1.3%).

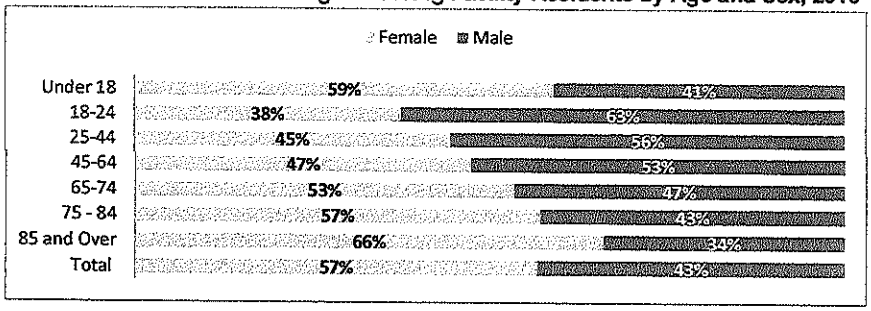
Exhibit 5.3. Distribution of Oregon Nursing Facility Residents by Marital Status, 2018

Marital Status	Percent
Never Married	13.5
Married	38.4
Widowed	31.2
Separated	1.3
Divorced	15.7
Total	100

Source: CMS Minimum Data Set

Exhibit 5.4 shows the composition of Oregon's nursing facility population by age and sex. In 2018, the majority (57%) of all residents were women, which was lower than the national average of 67% (Centers for Medicare & Medicaid Services, 2013). The proportion of female residents increased with age, with 66% of residents in the oldest age category being female.

Exhibit 5.4. Distribution of Oregon Nursing Facility Residents by Age and Sex, 2018



Source: CMS Minimum Data Set

Exhibits 5.5 and 5.6 show the distribution of race/ethnicity for all nursing facility residents and for residents 65 years and older, compared to their counterparts in the general Oregon population. In 2018, the majority of nursing facility residents were non-Hispanic white (83.5%), followed by African American (1.8%) and Hispanic (1.5%). In comparison, the state's general population in 2017, the most recent data available, was 76.5% non-Hispanic white, 12.7% Hispanic, 4.1% Asian American, and 1.8% African American or Black. The racial/ethnic composition of Oregon's nursing facility population also differed from that of the U.S. nursing facility population in 2012, where 78%, 13.9%, and 5% of all U.S. nursing facility residents were non-Hispanic white, African American, and Hispanic, respectively (Centers for Medicare & Medicaid Services, 2013). The slightly higher proportion of non-Hispanic white residents in the 65+ age category indicates that racial/ethnic minority residents were younger compared to the general nursing facility population.

Exhibit 5.5. Oregon Nursing Facility Residents and General Population by Race/Ethnicity, 2018

Race/Ethnicity	All Nursing Facility Residents	All Oregon Residents
White, Not Hispanic	83.5%	76.5%
American Indian/Alaska Native, Not Hispanic	0.6%	4.5%*
Asian American, Not Hispanic	1.1%	4.1%
African American or Black, Not Hispanic	1.8%	1.8%
Native Hawaiian/Pacific Islander, Not Hispanic	0.1%	0.4%
Hispanic of any race	1.5%	12.7%
More than 1 race, Not Hispanic	0.3%	3.6%
Unknown	11.2%	**
Total	**100.0%**	**N/A**

Source: CMS Minimum Data Set; U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
* This category includes American Indian/Alaska Native alone or in combination with one or more races, not Hispanic.
** The American Community Survey does not provide estimates for the Oregon population in these racial/ethnic groups.

Exhibit 5.6. Oregon Nursing Facility Residents and General 65+ Population by Race/Ethnicity, 2018

Race / Ethnicity	Nursing Facility Residents 65+	Oregon Residents 65+
White, Not Hispanic	84.3%	93.5%
American Indian/Alaska Native, Not Hispanic	0.4%	2.2%*
Asian American, Not Hispanic	1.1%	2.7%
African American or Black, Not Hispanic	1.4%	0.9%
Native Hawaiian/Pacific Islander, Not Hispanic	0.1%	0.1%
Hispanic of any race	1.2%	3.0%
More than 1 race, Not Hispanic	0.3%	1.5%
Unknown	11.3%	**
Total	**100%**	**N/A**

Sources: CMS Minimum Data Set; U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates
* This category includes American Indian/Alaska Native alone or in combination with one or more races, not Hispanic.
** The American Community Survey does not provide estimates for the Oregon population in these racial/ethnic groups.

The distribution of race/ethnicity was similar by sex, with non-Hispanic whites comprising the majority of all male and female nursing facility residents (data not shown). However, the composition of men and women varied within racial/ethnic categories. The ratio of males to females was roughly equal for non-Hispanic African American or Black and Native Hawaiian/Pacific Islander, and for Hispanic residents. However, there were more males than females for Native American/Alaska Native (1.3:1), and fewer males than females for non-Hispanic White (0.7:1) and Asian (0.6:1) residents.

Section 6. Length of Stay

Nursing facilities provide 24-hour medical care and monitoring for individuals who need it due to a ~~disability~~medical condition or illness, or for those who have been discharged from the hospital but are not yet able to return to the community; either their own home or a licensed community based care setting. Nursing facilities thus serve individuals with post-acute care needs and those with ongoing needs. The length of a nursing facility stay reflects whether services are needed on a temporary or an indefinite basis. Individuals who enter nursing facilities and remain for 100 or more days are far less likely to return to the community than are those who have shorter stays (Reinhard et al., 2014).

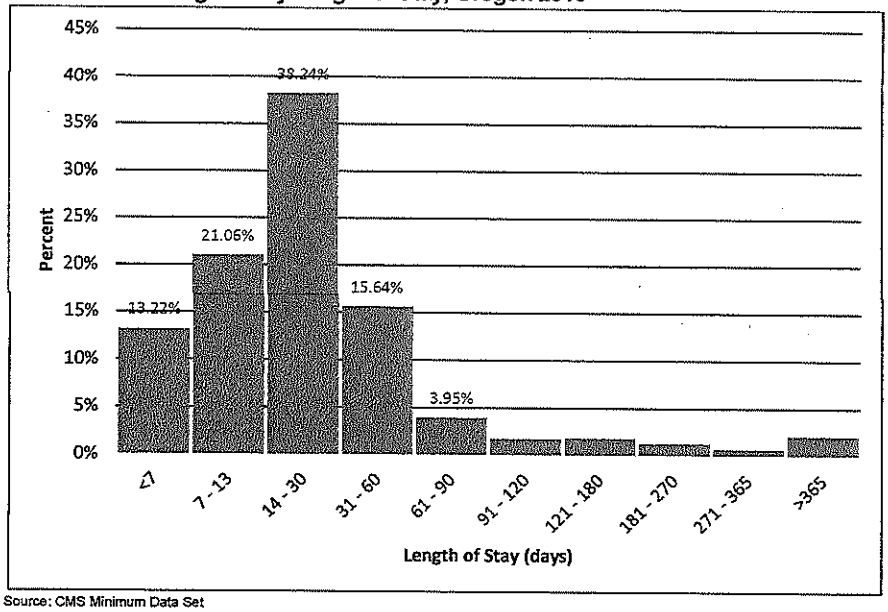
In this report, we define short-term nursing facility stays as less than or equal to 90 days, mid-length stays as 91 to 365 days, and long stays as more than one year. An individual may have more than one nursing facility stay during the fiscal year. To ensure that length of stay data are directly comparable across years, we report length of stay results only for nursing facility stays that had a discharge during the report year.[13] The Technical Notes at the end of this report provide further detail on how length of stay was calculated for this report.

Long stays averaged 916 days (or approximately 2.5 years), compared to short- and mid-length stays that averaged 30 days (data not shown).

Exhibit 6.1 shows the distribution of length of stay for Oregon's nursing facility population. In 2018, 92% of all nursing facility stays were short, while 6% and 2% were mid-length and long, respectively. More than one in three (38%) stays lasted between 14 and 30 days.

[13] In other words, persons who are residents in a nursing facility at the end of the state fiscal year (30 June 2018 for this report) are not included in length of stay results. This approach differs from the 2014 and 2015 reports, in which length of stay was calculated for all residents who spent at least 1 day in a nursing facility during the report year. However, the distributions of length of stay results changed little as a result of the new approach.

Exhibit 6.1. Nursing Facility Length of Stay, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 6.1 also shows that 73% of Oregon nursing facility stays lasted 30 days or less. This reflects the dominant role of post-acute care in nursing facility utilization in Oregon. The percentage of new nursing facility stays in Oregon that lasted 100 days or longer is lower than in any other state except Arizona (Reinhard et al., 2017). The greater utilization of nursing facilities for short stays is likely due to the utilization of home and community-based services and assisted living for ongoing long-term care (American Health Care Association, 2013).

Commented [DW33]: Would be good to also include that 92% of all stays lasted less than 90 days.

"Exhibit 6.1 also shows that 73% of Oregon nursing facility stays lasted 30 days or less and 92% of all stays lasted less than 90 days."

Commented [MAE34]: Fine with me

Exhibit 6.2 shows the average and median lengths of stay in SFY 2018. The median length of stay—that is, the number of days for which half of stays were longer and half were shorter—provides further detail about the utilization of nursing facility care in Oregon. Although the overall average length of stay was 49 days, the median length of stay was 19 days because a relatively small proportion of residents with very long lengths of stay inflated the average.

Exhibit 6.2 also presents average and median lengths of stay by age group. Average length of stay was highest for the 18 to 24 age group. The median length of stay was 20 days or less for all age groups, but the average length of stay was approximately 2 to 7 times longer than the median length of stay within the same age category.

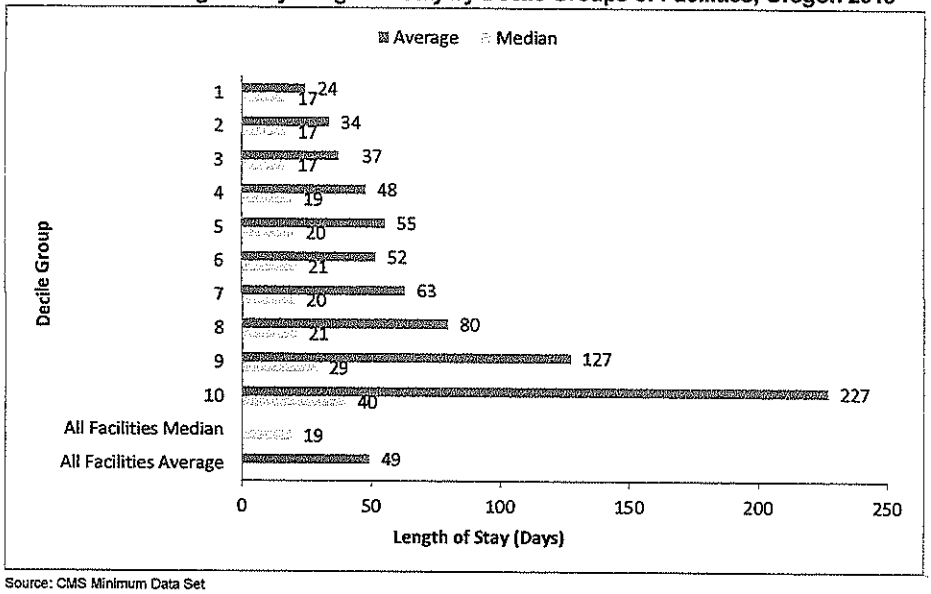
Exhibit 6.2. Nursing Facility Length of Stay (Days) by Age, Oregon 2018

Age Group	Average Length of Stay	Median Length of Stay
Under 18	18	9
18-24	98	15
25-44	46	17
45-64	53	18
65-74	48	18
75-84	45	19
85 and Over	52	20
Total	**49**	**19**

Source: CMS Minimum Data Set

Length of stay also varied across facilities. To characterize this variation, we ranked nursing facilities in order of average length of stay, then divided the facilities into 10 equal-sized groups based on average length of stay (Exhibit 6.3). Each group represents 13 to 14 facilities. Average length of stay increased from 24 days in group one, to 227 days in group 10. However, the median length of stay was 29 days or less for facilities in all of the first nine groups, reflecting the preponderance of short stays in Oregon nursing facilities. Group 10 had much higher average and median lengths of stay compared to all other groups of nursing facilities. This is consistent with the fact that many facilities in group 10 serve residents with extensive, ongoing care needs including pediatric, enhanced care, and non-dementia behavioral health care needs.

Exhibit 6.3. Nursing Facility Length of Stay by Decile Groups of Facilities, Oregon 2018

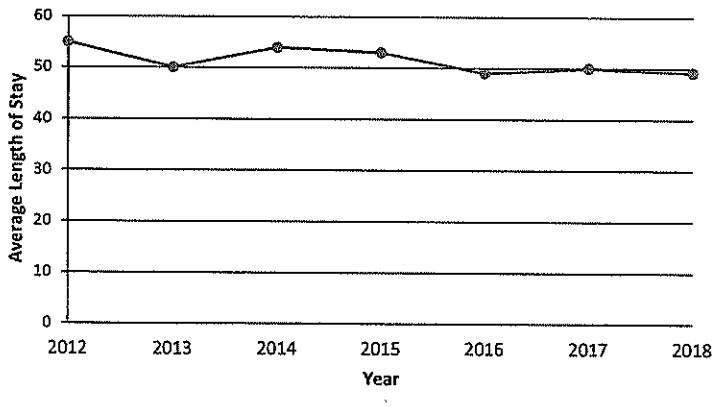


Source: CMS Minimum Data Set

Commented [DW35]: This is a great chart!

Exhibit 6.4 shows the trend in average length of stay for nursing home residents in Oregon from 2012 to 2018. The average length of stay declined from 55 days in 2012 to 49 days in 2018, indicating a 10.5% decrease during this time period.

Exhibit 6.4. Trend in Average Length of Stay, Oregon 2012–2018



Source: CMS Minimum Data Set

Commented [DW36]: What about a chart trending the median length of stay over the past six years too? Or perhaps a combined chart?

Hospitalizations Linked to Nursing Facility Stays

Although more than nine in 10 entries or reentries to nursing facilities were from hospitals, MDS data does not provide information about why these residents were hospitalized. Because nursing facility care often focuses on helping residents recover from conditions for which they were hospitalized, such information is helpful in understanding the mix of clinical needs among nursing facility residents.

We therefore linked MDS data to Oregon hospital discharge data records in a two-step linkage process involving Oregon State University, the Oregon Department of Human Services, and the Oregon Health Authority's Office of Health Analytics. First, hospital discharge records were matched to the MDS by name and date of birth. Second, specific hospital discharge dates were matched to nursing facility entry or reentry dates for individual nursing facility residents in the MDS. *[HDD results forthcoming]*

[HDD results forthcoming]

[HDD results forthcoming]

Exhibit 6.5. Nursing Facility Length of Stay (Days) by Hospital MS-DRG, Oregon 2018

Category of Hospital MS-DRG	Percent of Hospital Discharges	Average Length of Nursing Facility Stay
Orthopedic		
Infectious		
Cardiology & Cardiac Surgery		
Other		
Pulmonary		
Trauma		
Neurology & Neurosurgery		
Stroke & TIA		
Gastroenterology		
Vascular		
Endocrine		
General Surgery		
Renal Failure		
Urology		
Ventilator		
All Discharges		

Sources: CMS Minimum Data Set and Oregon Hospital Discharge Records
Note: Results are shown for nursing facility stays where resident entered from a hospital within SFY 2018 and where MDS data can be linked to hospital discharge data.

Section 7. Acuity of Residents

Acuity Measurements

Acuity commonly refers to an individual's requirements for nursing care. Individuals ~~that~~ who enter a nursing facility are assessed to identify the level of care needed during their stay. For example, many post-acute care patients are discharged from acute care hospitals after surgery or treatment for acute medical conditions, and temporarily require skilled rehabilitation or nursing care that cannot be provided effectively at home or in community-based facilities. Such individuals comprise a significant portion of short-stay nursing facility residents.

Nursing facilities use acuity information to plan personnel resources, manage costs, and measure quality. There are many measures of acuity. In this section, we report data about several of those indicators, including: Activities of Daily Living (ADLs), reasons for hospitalization, diagnoses among residents, and therapies received by residents.

Most data in this section are based on facilities' assessments of their residents as reported in the MDS. Beginning with the SFY 2016 report, we changed methodology to capture assessments for calculating Activities of Daily Living (ADL), diagnoses and treatments. Assessments coded as an entry, reentry or annual assessment were identified first. For any stay that did not have one of these coded assessments, the first assessment of the stay was identified and used instead. This approach allows us to use information from all enrollees in SFY 2018 and to characterize acuity among short and mid-length stays at the time residents entered the nursing facility, and among long-stay residents at the time of their annual reassessment. Residents who had more than one stay during SFY 2018 may be counted more than once in the ADL, diagnoses, or treatment measures presented in this section. See the Technical Notes for further details.

Activities of Daily Living

ADLs measure the extent to which care recipients cannot perform self-care tasks (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963). ADLs are used to characterize individuals' levels of caregiving need (National Center for Health Statistics, 2015) , whether on a temporary or indefinite basis. Once admitted to a nursing facility, residents are assessed for their level of dependence for each ADL, ranging from independence in performing the activity to complete dependence on staff. In this report, we focus on bed mobility, transferring, eating, dressing, toileting, and bathing ADLs.

Commented [MAE37]: Again, the Katz et al scale measures mobility, but this refers to bed mobility, which may be confusing.

Exhibit 7.1 displays the trend in average number of ADLs with which individuals needed help during their stays from 2012 to 2018. The average number of ADLs individuals needed help with during resident stays has declined by nearly 7%, from 3.74 in 2012 to 3.48 in 2018.

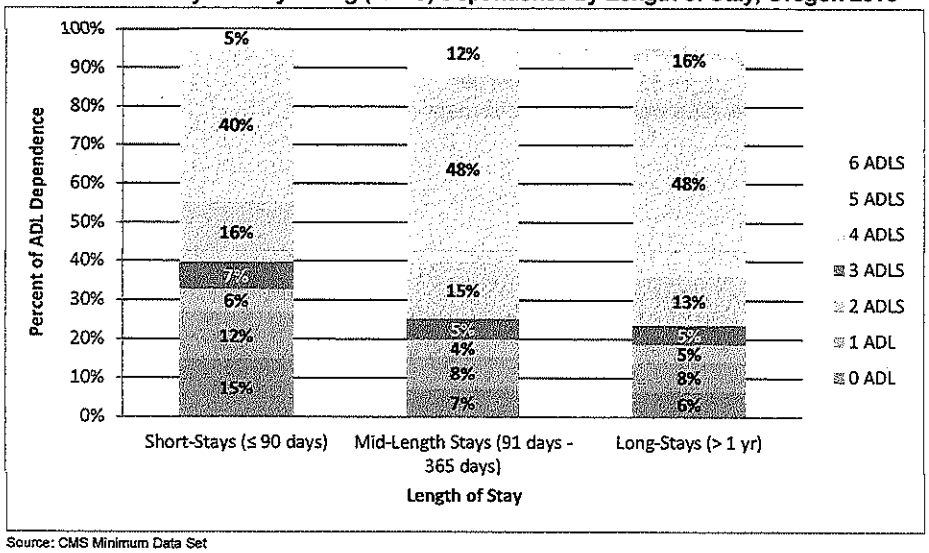
Exhibit 7.1. Trend in Average Number of Activities of Daily Living for which Help Was Needed, Oregon 2012–2018



Source: CMS Minimum Data Set

In 2018, stays with dependence on five ADLs represented the greatest proportion of short-stays (40%), mid-stays (48%) and long-stays (48%; Exhibit 7.2). These percentages are approximately twice as high than for all nursing facility residents in the U.S (23%; Centers for Medicare & Medicaid Services, 2014). Forty-five percent of short stays, 60% mid-length stays, and 64% of long stays involved dependence on five or more ADLs.

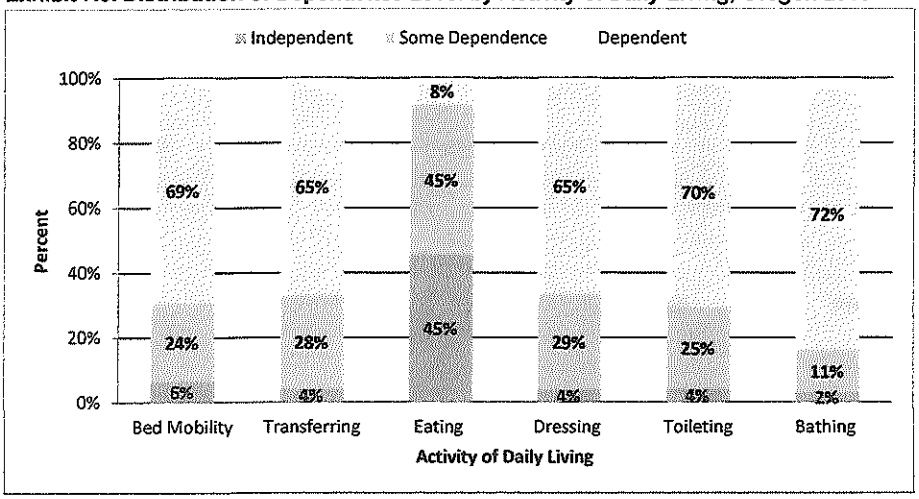
Exhibit 7.2. Activity of Daily Living (ADLs) Dependence by Length of Stay, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 7.3 presents the distribution of dependence level of six individual ADLs. Complete dependence on staff was reported for at least 65% of all stays, except for eating.

Exhibit 7.3. Distribution of Dependence Level by Activity of Daily Living, Oregon 2018



Source: CMS Minimum Data Set

Exhibit 7.4 provides more detail on ADL dependence. Toileting was the most common ADL need for all stays in 2018. Compared with other lengths of stay, long stays had the highest proportions of complete dependence in five of six ADLs. Mid-length stays had the highest proportions of complete dependence for bed mobility (76%). For all ADLs other than bed mobility, stays of individuals under 18 years of age had the highest levels of complete dependence compared with other age groups, followed by individuals 85 years and over (all ADLs except eating). The rates of complete dependence for all ADLs were similar by sex (data not shown).

Exhibit 7.4. Complete Dependence for ADLs by Length of Stay and Age, Oregon 2018

	Bed Mobility	Transferring	Eating	Dressing	Toileting	Bathing
Length of Stay						
Short stay	67%	63%	7%	62%	67%	70%
Mid-length stay	77%	72%	15%	78%	8%	81%
Long stay	76%	73%	19%	80%	82%	86%
Age Group						
Under 18	63%	92%	91%	90%	91%	99%
18-24	62%	63%	46%	68%	67%	74%
25-44	47%	45%	13%	45%	50%	56%
45-64	53%	50%	8%	50%	55%	62%
65-74	65%	61%	7%	61%	66%	70%
75-84	73%	39%	8%	69%	74%	75%
85 and Over	79%	76%	9%	77%	80%	79%
Total Complete Dependence	**69%**	**65%**	**8%**	**65%**	**70%**	**72%**

Source: CMS Minimum Data Set

Clinical Conditions Among Nursing Facility Residents

The number and severity of clinical conditions impact the type and intensity of services received by a nursing facility resident. The MDS provides information about whether a resident had each of 56 specific diagnoses within seven days prior to his or her assessment. We grouped these diagnoses into several major categories, and tabulated whether each stay had one or more diagnoses in each category. Residents who had more than one stay during SFY 2018 may be counted more than once in the diagnoses measures presented in this report.

Exhibit 7.5 presents the prevalence of each diagnosis category and the most common individual diagnoses. Six in 10 nursing facility stays (62.2%) involved at least one acute medical condition, with anemia, cancer, and urinary tract infections being the most common individual diagnoses. Nearly all stays (91.6%) involved at least one chronic medical condition, with seven in 10 involving hypertension, more than four in 10 involving hyperlipidemia, and over three in 10 involving diabetes. Approximately three in ten stays involved a cardiac rhythm disorder and/or arthritis. Approximately one quarter of stays involved heart failure, end stage renal disease (ESRD), and/or ulcer or reflux disease. Approximately one in five stays involved coronary artery disease and/or asthma or chronic obstructive pulmonary disease (COPD). One in nine stays involved osteoporosis, benign prostatic hyperplasia, and/or degenerative disease of the eye.

More than one in 10 stays involved a hip fracture, and nearly one in seven another type of fracture. Approximately, one in seven stays involved neurologic conditions such as seizure disorders or Parkinson's disease. Over four in 10 stays involved one or more behavioral health conditions, with nearly four in ten involving depression and one in five involving anxiety. Approximately one in five stays involved dementia.[14] Severely disabling conditions such as full or partial paralysis or traumatic brain injury were present in six percent of stays.

Commented [DW38]: These are comments for footnote 14:

It is important this explanation for the low reported prevalence of Alzheimer's disease and other dementias is included within the report.

You may want to add a sentence noting how it compares to the national percent of nursing home residents with a diagnosis of dementia, which is 47.8% (or nearly half)

Source: National Center for Health Care Statistics, 2016. https://www.cdc.gov/nchs/fastats/alzheimers.htm

Commented [MAE39]: I would like to see more about dementia in the report in general, but I want to be careful that we don't report percentages of diagnoses without explaining that there are a lot of people in all of our settings who have undiagnosed dementia – or at least ADL needs related to cognitive impairment. I believe we could provide the number of Medicaid consumers currently living in NF settings whose assessment indicates needs related to cognition, if that is something that would be helpful.

Commented [MAE40]: I'm also confused about the footnote. It sounds like vascular or multi-infarct dementia is something different than dementia related to stroke. My understanding has always been that these two are the same – infarcts are small strokes and vascular dementia is dementia related to stroke.

[14] The MDS diagnosis category of "Alzheimer's Disease" shown in Exhibit 7.5 may underestimate the prevalence of Alzheimer's dementia in nursing facility residents. MDS assessments require that a diagnosis be -confirmed by a physician within the past 60 days and have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, treatment, monitoring, or mortality risk within the 7 days before the assessment. Diagnoses for which prior physician documentation is not available or that are not being specifically treated may therefore not be captured on an MDS assessment. MDS also provides another possible category of "Non-Alzheimer's Dementia" described as "e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases."

Exhibit 7.5. Percent of Nursing Facility Stays with Specific MDS Diagnoses by Category, Oregon 2018

Category Specific MDS Diagnosis	Percent of Stays	Category Specific MDS Diagnosis	Percent of Stays
Acute Medical	**62.2**	**Chronic Medical Cont'd**	
Anemia	24.3	Benign Prostatic Hyperplasia	11.1
Cancer	11.6	Cataracts, Glaucoma, Macular Deg.	9.9
UTI	11.0	Peripheral Artery Disease	6.8
TIA or Stroke	10.1	**Fractures**	**23.1**
Respiratory Failure	8.9	Other Fracture	14.2
Pneumonia	7.8	Hip Fracture	10.3
Septicemia	7.3	**Neurologic**	**14.4**
Malnutrition	**6.9**	Seizure/Epilepsy	5.8
Hyponatremia	6.4	Parkinson's Disease	3.8
DVT	4.6	Neurogenic Bladder	3.1
Chronic Medical	**91.6**	**Behavioral**	**42.8**
Hypertension	72.2	Depression	35.9
Hyperlipidemia	45.3	Anxiety	17.4
Diabetes	34.7	**Dementia**	**18.6**
Atrial Fibrillation	31.0	Non-Alzheimer's	16.8
Arthritis	27.2	Alzheimer's	3.4
Heart Failure	25.0	**Paralysis & TBI**	**6.0**
ESRD	24.7	Hemi/Para/Quadriplegia	4.7
Ulcer or Reflux Disease	23.6	Traumatic Brain Injury (TBI)	1.1
Thyroid Disorder	23.2	**Severe & Persistent Mental Illness (SPMI)**	**14.6**
Coronary Artery Disease	20.1	Schizophrenia	7.9
Asthma, COPD...	19.8	Manic Depression	5.1
Osteoporosis	11.6	**None of the Above**	**0.8**

Source: CMS Minimum Data Set

Notes Percent indicates stays with one or more specific MDS diagnoses in that category. Because diagnoses are not mutually exclusive, percentages add up to more than 100%. Diagnoses that occur in less than 2.5% of stays are not shown individually, but are included in the category. See Technical Notes for a list of all diagnoses. Data in this table are based on 32,609 stays that have a diagnosis-coded entry, reentry, or annual assessment.

As shown in Exhibit 7.6, the prevalence of some diagnoses varied by length of stay. Acute medical conditions were somewhat more common in mid-length stays, but the prevalence of chronic medical conditions was high regardless of length of stay. All short stays involved residents with a chronic medical condition. Fractures were much more common in short stays. However, the prevalence of other categories of diagnoses, including neurologic conditions, behavioral health conditions, dementia, and paralysis were markedly higher among residents with longer lengths of stay compared with residents with short lengths of stay. The prevalence of some diagnoses also varied by resident age (data not shown). Residents age 75 and older were more likely than younger residents to have had fractures, chronic medical conditions, and/or dementia, but less likely to have suffered from neurologic or behavioral conditions, paralysis, or SPMI.

Exhibit 7.6. Distribution of MDS Diagnosis Categories by Length of Stay, Oregon 2018

Diagnosis Category	Percent of Stays with One or More Diagnoses in Category		
	Short Stay	Mid Stay	Long Stay
Acute Medical	62%	64%	58%
Chronic Medical	100%	91%	92%
Fractures	25%	15%	14%
Neurologic	12%	24%	25%
Behavioral	40%	53%	53%
Dementia	15%	28%	38%
Paralysis & TBI	0%	14%	16%
SPMI	15%	13%	15%
None of the Above	0%	0%	1%
Total Stays	**25,382**	**3,968**	**3,259**

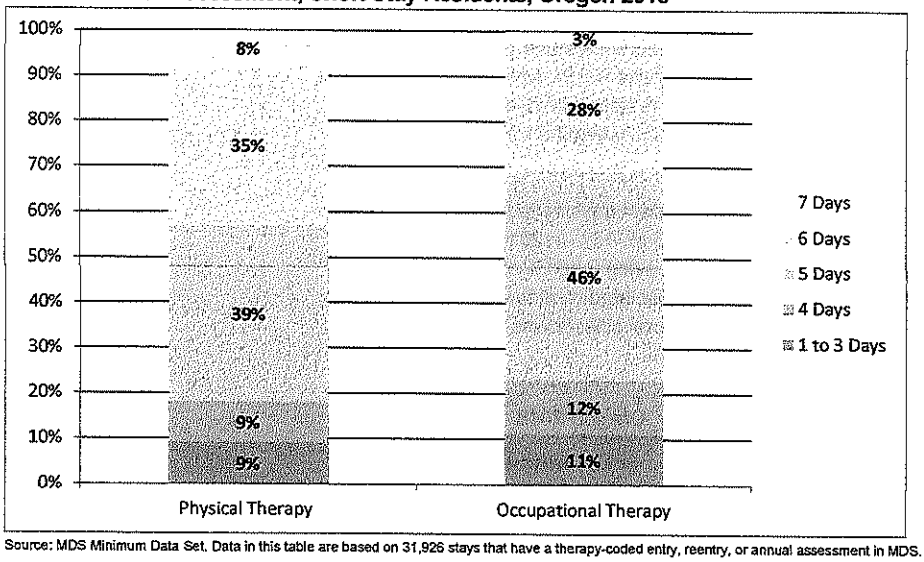
Source: CMS Minimum Data Set. Data in this table are based on 32,609 stays that have a diagnosis-coded entry, reentry, or annual assessment.

Treatments Provided to Nursing Facility Residents

MDS captures information about select types of treatments provided to nursing facility residents. We measured the number of stays for which specific types of treatment were provided within 7 days prior to the assessment.

As shown in Exhibit 7.7, nearly all short-stays involved physical and occupational therapy in the period following an admission or entry to a nursing facility. For more than eight in 10 short stays, physical therapy was provided five or more days per week. Occupational therapy was provided five or more days per week during nearly eight in 10 short stays.

Exhibit 7.7. Distribution of Number of Days of Physical and Occupational Therapy within 1 Week Prior to Assessment, Short Stay Residents, Oregon 2018



Source: MDS Minimum Data Set. Data in this table are based on 31,926 stays that have a therapy-coded entry, reentry, or annual assessment in MDS.

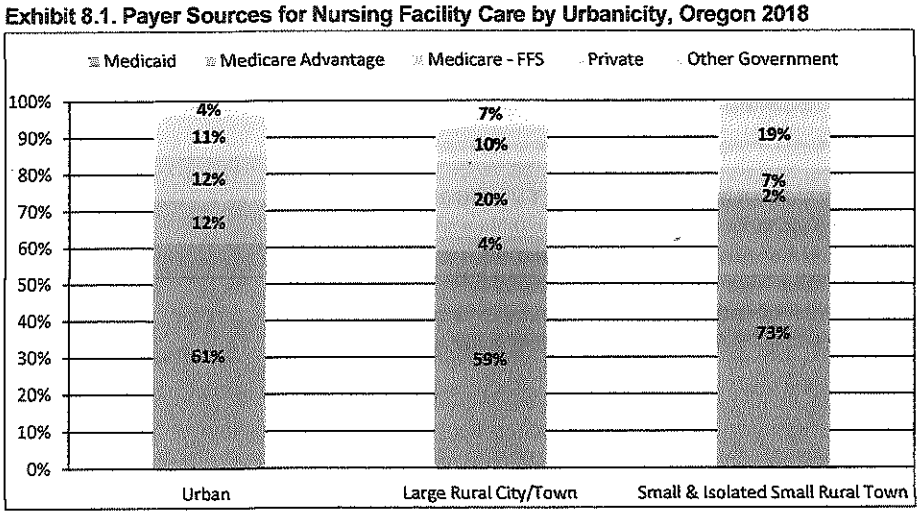
Additionally, oxygen was administered during 18.3% of nursing facility stays in SFY 2018 (data not shown). BiPAP treatment (to prevent breathing stoppages during sleep for residents with sleep apnea) was provided for 5.8% of stays (data not shown). Dialysis, which indicates the presence of renal failure, was needed for 3.1% of stays (data not shown). The rate of BiPAP and dialysis treatments was roughly twice as common among short stays compared to long stays. Oxygen treatment was administered during nearly 20% of short and mid-length stays, but only 12% of long stays.

Section 8. Payers

Medicaid was the primary payer for 61% of resident days in Oregon nursing facilities during 2018. Private payers (including commercial insurers, long-term care insurance plans, and self-pay residents) paid for 12% of all resident days. Medicare Fee-For-Service (FFS), which covers up to 100 days of skilled nursing facility care per year, paid for 14% of resident days, and Medicare Advantage plans[15] paid for 10%. Other government payers (including the Veterans Administration) paid for the remaining 4% of resident days in 2018.

Exhibit 8.1 breaks down payer sources for Oregon nursing facility resident days by facility location, using the same urbanicity categories described for Exhibit 3.5 (p. 18). In 2018, Medicaid was the predominant payer in urban as well as rural areas, paying for 61% of resident days in urban areas, 57% in large rural cities/towns and 73% in small/isolated rural towns. The proportion of days paid by Medicare FFS was highest (20%) in large rural cities/towns, and the private pay proportion was highest (19%) in small/isolated rural towns.

Exhibit 8.1. Payer Sources for Nursing Facility Care by Urbanicity, Oregon 2018



Source: Cost Reports and Revenue Statements

Medicare Advantage, the managed care option for Medicare beneficiaries, is an important payer in the Oregon health care market. At 44% of eligible beneficiaries, Oregon has the third highest rate of Medicare Advantage enrollment among states (Gold, Jacobson, Damico, & Neuman,

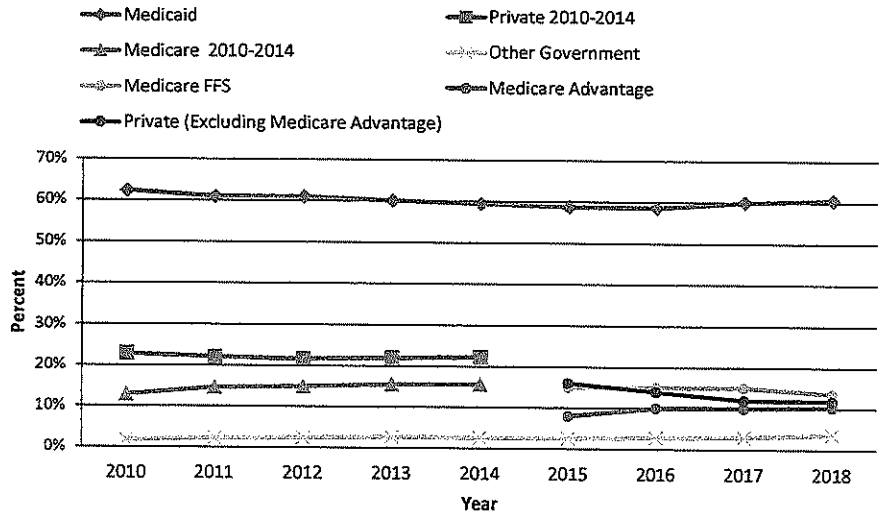
[15] This is the third year that we can report the proportion of resident days paid for by Medicare Advantage, based on enhanced DHS data collection. Prior to 2015, Medicare Advantage days were mostly included in the private payer category.

2014). The lower proportion of Medicare Advantage payment in rural areas likely reflects the lower Medicare Advantage enrollment rates in Oregon's rural areas.

Exhibit 8.2 shows the trend in payer sources in Oregon nursing facilities. Beginning in 2015, nursing facilities were required to separately report resident days paid for by Medicare Advantage, Medicare FFS, and private pay. Because of this methodological change, we show data 2015 and forward separately from pre-2015 data. We further note that data reported for Medicare and private payers for 2015-2018 are not directly comparable to those of prior years. Additionally, the possibility of under-reporting of Medicare Advantage resident days continues to exist. As nursing facilities gain more experience with the new reporting categories, the proportion of Medicare Advantage versus private payer days may change further in future years.

The share of nursing facility resident days paid for by Medicaid declined slightly between 2010 and 2018 (62% vs. 61%). The apparent sharp decline in the proportion of days paid by private payers in 2015 through 2018 reflects both the improved measurement of Medicare Advantage payments, as well as a slight increase in the proportion of days paid for by Medicaid. The proportion of days paid for by Medicare Fee-For-Service remained stable from 2015 to 2017, and declined slightly in 2018 (14%).

Exhibit 8.2. Payer Sources for Nursing Facility Care, Oregon 2010–2018



Sources: Cost Reports and Revenue Statements
Note: For years 2010 through 2014, "Medicare" includes Medicare FFS only.

Section 9. Quality Measures

CMS provides data on a wide range of nursing facility quality measures. These measures are derived from MDS 3.0 assessments and made available from Nursing Home Compare.

Quality measures are calculated separately for short-stay and long-stay residents. In this section, a short stay is defined as lasting 100 or fewer days; a long stay is one that lasts more than 100 days.[16] In SFY 2018, more than 9 in 10 stays in Oregon were short stays.

Below we present the average performance level of Oregon nursing facilities on each quality measure, as well as the national average. In order to describe the variation in performance across facilities within our state, we also divide Oregon facilities into four equal groups—or quartiles—for each measure, and present the average performance within each group.[17] There was wide variation between facilities in the best and lowest performing groups for almost every measure presented below.

Exhibit 9.1 presents 6 measures for which a higher percentage represents better performance. For long-stay residents, average rates of pneumococcal pneumonia vaccination decreased in Oregon facilities compared with 2017, whereas seasonal flu vaccination in Oregon facilities stayed the same. Vaccination rates for short- and long-stay residents were slightly lower than the averages for all nursing facilities nationwide. Average rates of vaccination for pneumococcal pneumonia and seasonal flu among short stay-residents stayed the same compared with 2017, and were slightly lower than the average for all nursing facilities nationwide. Similar to 2017, in 2018 the proportion of short stay residents whose functional status improved was higher in Oregon than the national average. The proportion of short stay residents discharged to the community was also higher in Oregon than the national average in 2017 and 2018.

Exhibit 9.1. Vaccination Rates, Functional Status, and Discharge Destination by Length of Stay and Specific Nursing Facility Groups, Oregon and U.S. 2018

	All Oregon Facilities	Best	Second	Third	Fourth	All U.S. Nursing Facilities
Long stay						
Seasonal flu vaccine	92%	99%	96%	92%	82%	95%
Pneumococcal pneumonia vaccine	91%	100%	97%	93%	75%	94%
Short stay						
Seasonal flu vaccine	79%	93%	86%	78%	61%	82%
Pneumococcal pneumonia vaccine	80%	96%	89%	81%	55%	83%
Improved functional status	71%	84%	75%	70%	56%	68%
Discharged to community	63%	71%	66%	62%	54%	54%

Source: Nursing Home Compare

[16] This CMS definition is slightly different from the definition of short stay (90 days or less) used in other sections of this report. Most stays reported as "mid-length" (91 to 365 days) in other sections of this report are included in the long stay category for these quality measures.

[17] The total number of facilities for which a given measure is reported ranged from 119 to 133 facilities, and so the number of facilities in each quartile group also varies somewhat across measures.

Exhibits 9.2 and 9.3 present 17 measures for which a lower percentage represents better performance. Long-stay measures are shown in Exhibit 9.2, and short stay measures in Exhibit 9.3. Overall, Oregon nursing facilities performed the same or better than the national average on 9 of these 17 quality measures.

The higher overall average rates of reported pain in Oregon facilities than nationwide, for both long stay and short stay residents, may reflect the higher acuity of nursing facility residents in Oregon compared with other states. In particular, a high proportion of Oregon Nursing facility residents are receiving post-acute care after hospitalization for surgery such as joint replacement, and therefore may have significant need for pain control. Reported rates of pain varied widely across facilities, which may reflect variations in the acuity of residents across facilities. Relative to 2017, in 2018, rates of self-reported moderate to severe pain increased for both long-stay and short stay residents.

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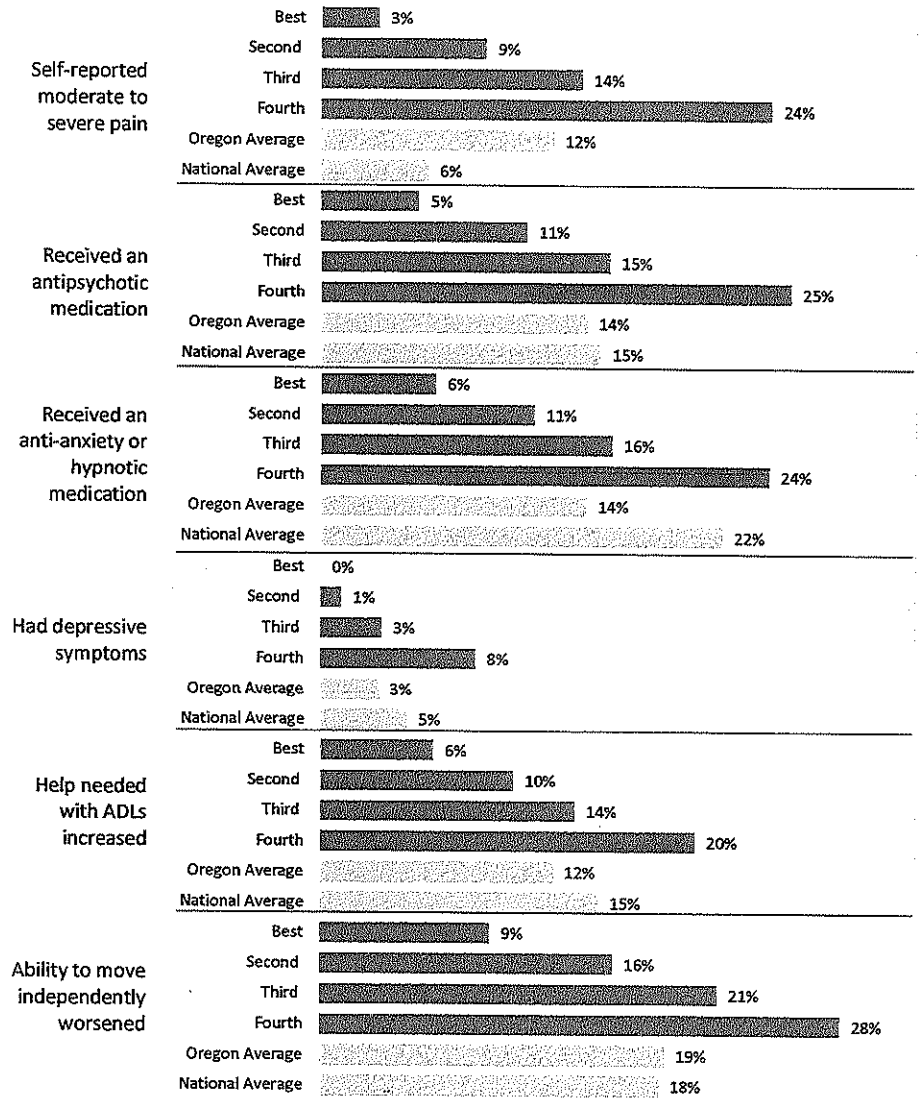
Fourteen percent of long stay residents newly received an antipsychotic medication compared with two percent of short stays.[18] These rates are lower than or the same as the national average; the rate for long-stay residents is lower than in 2017 and 2016, however the rate for short stay residents is higher than in 2017. Use of antipsychotic medications among long-stay residents has been the target of a national quality improvement initiative since 2011, and has declined steadily in Oregon nursing facilities over that time period (Centers for Medicare & Medicaid Services, 2016). Long stay residents in Oregon were also far less likely than the national average to receive an antianxiety or hypnotic medication in both 2017 and 2018.

Rates of several negative outcomes among long stay residents (for example, losing too much weight, high-risk patients with pressure ulcers, urinary tract infections, or falls with major injury) were similar to the national average, and performance in 2018 was similar to that in 2017 and 2016. The same pattern was observed for pressure ulcers among short stay residents. In 2017 and 2018, short stays in Oregon facilities were more likely than short stays nationwide to have an outpatient emergency department visit; yet, short stays in Oregon were less likely than short stays nationwide to be rehospitalized after entering the nursing facility; these measures were not available in 2016.

Commented [MAE42]: See comment related to qualifiers in summary portion of document.

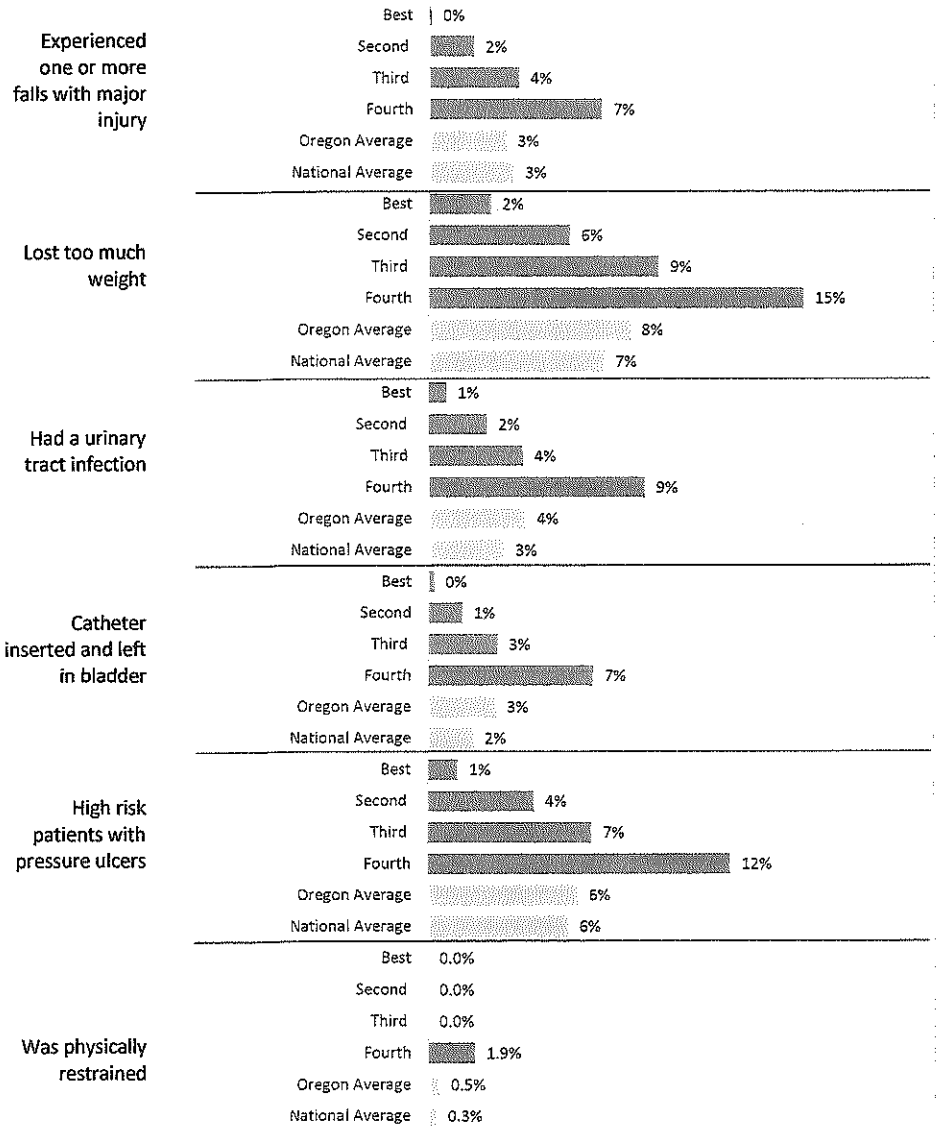
[18] This measure excludes residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome.

Exhibit 9.2. Quality Measures of Long Stays by Nursing Facility Groups, Oregon and U.S. 2018



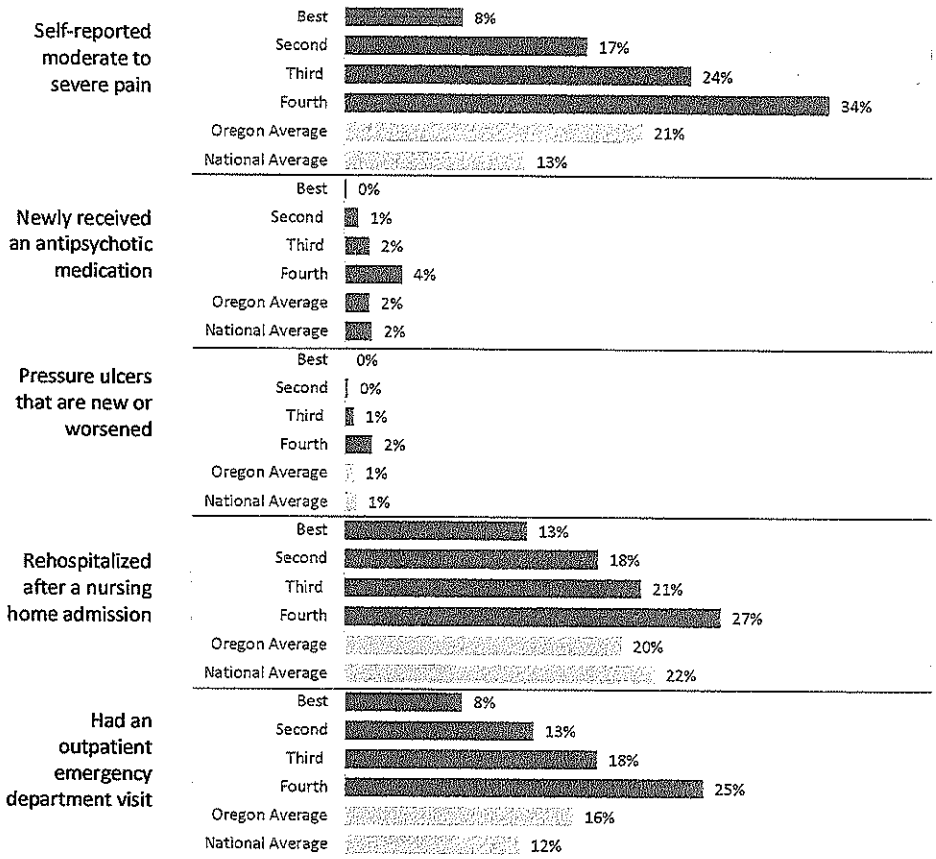
Source: Nursing Home Compare

Exhibit 9.2. Quality Measures of Long Stays by Nursing Facility Groups, Oregon and U.S. 2018



Source: Nursing Home Compare

Exhibit 9.3. Quality Measures of Short Stays by Nursing Facility Groups, Oregon and U.S. 2018



Source: Nursing Home Compare

Appendix

Table A. Number of Licensed Beds and Set-Up Beds per 1,000 Population 75 years and Older, Occupancy Rate, and Resident Days by County, Oregon 2018

County	Licensed Beds per 1000 75+	Set-Up Beds per 1000 75+	% Beds That Are Set-Up	Occupancy Rate	Resident Days
Benton	37	30	82%	64%	42,476
Clackamas	29	23	80%	69%	321,675
Clatsop	25	23	96%	40%	10,319
Columbia	40	37	92%	52%	22,636
Coos	50	37	74%	49%	78,133
Crook	22	18	82%	69%	11,097
Curry	20	20	100%	59%	12,618
Deschutes	38	31	84%	64%	50,344
Douglas	23	23	100%	72%	66,087
Grant	46	46	100%	48%	7,025
Hood River	97	58	60%	42%	20,054
Jackson	21	20	95%	73%	150,332
Jefferson	13	8	65%	84%	28,036
Josephine	47	43	92%	60%	92,303
Klamath	17	17	99%	77%	26,674
Lake	66	42	64%	47%	8,136
Lane	41	35	85%	67%	296,300
Lincoln	12	12	100%	73%	13,780
Linn	49	48	98%	75%	131,861
Malheur	16	16	100%	59%	7,115
Marion	42	36	86%	69%	274,748
Multnomah	71	60	85%	73%	796,618
Polk	33	28	86%	62%	47,858
Tillamook	21	19	92%	53%	9,582
Umatilla	60	35	58%	54%	46,882
Union	36	28	78%	47%	13,154
Wasco	155	124	80%	61%	76,762
Washington	33	29	89%	72%	281,037
Yamhill	54	42	77%	59%	80,880
Oregon	1213	990	82%	67%	3,024,522

Sources: Cost Reports and PSU Population Estimates for June 30, 2017. American Community Survey estimates for 2017
Note; Baker, Gilliam, Harney, Morrow, Sherman, Wallowa, and Wheeler counties not shown because they have no nursing facilities.

Table B. Admission Source as Percentage of Total Admissions, Oregon 2012 – 2018

	2012 Percent	2013 Percent	2014 Percent	2015 Percent	2016 Percent	2017 Percent	2018 Percent
Acute Hospital	93.81	93.21	93.23	93.35	94.09	94.72	95.13
Community	4.51	4.69	4.29	4.15	3.82	3.38	3.33
Another NF	1.05	1.34	1.44	1.56	1.41	1.23	1.04
Other	0.18	0.22	0.41	0.43	0.19	0.17	0.10
Hospice	0.19	0.18	0.22	0.17	0.19	0.21	0.16
Psych Hospital	0.14	0.15	0.19	0.14	0.09	0.11	0.11
Inpatient Rehab	0.11	0.14	0.11	0.13	0.09	0.08	0.08
LTCH	0.01	0.07	0.11	0.08	0.13	0.10	0.05
ID/DD	0.01	0.00	0.00	0.00	0.00	0.00	0.00
Died	0.00	0.00	0.02	0.00	0.00	0.00	0.00
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: CMS Minimum Data Set

Commented [DW43]: This table provides trends year over year is helpful for visualizing the changes over the past six years

Commented [MAE44]: I agree – this is nice!

Table C. Discharge Destination as Percentage of Total Discharges, Oregon 2012 - 2018

Destination	2012 Percent	2013 Percent	2014 Percent	2015 Percent	2016 Percent	2017 Percent	2018 Percent
Community	67.96	69.25	68.72	68.28	70.59	71.07	71.39
Acute Hospital	28.50	26.47	26.50	26.74	25.19	25.47	25.59
Another NF	1.88	2.13	2.37	2.48	2.12	1.91	1.72
Other	0.58	0.96	1.44	1.55	1.16	0.71	0.50
Inpatient Rehab	0.48	0.60	0.53	0.49	0.49	0.40	0.38
Hospice	0.24	0.29	0.26	0.30	0.32	0.32	0.32
Psych Hospital	0.14	0.13	0.11	0.09	0.07	0.08	0.07
LTCH	0.01	0.03	0.03	0.04	0.04	0.03	0.03
ID/DD	0.01	0.02	0.02	0.03	0.02	0.01	0.02
Died	0.20	0.12	0.02	0.00	0.00	0.00	0.00
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: CMS Minimum Data Set

Commented [DW45]: Same comment as on Table B – very helpful

Technical Notes *Pending Revision*

Data Sources and Analyses

This report is based on analyses of data from multiple sources, including:

- Annual Cost Reports and Revenue Statements provided to the Department of Human Services (DHS) by all Oregon nursing facilities
- Assessments of nursing facility residents as reported in the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS)
- Facility-specific data on nursing facility characteristics and performance from the CMS Nursing Home Compare (NHC) datasets
- Hospital Discharge Data (HDD) for persons discharging from a hospital to an Oregon nursing facility or persons entering a hospital from an Oregon nursing facility

Each of these data sources is described briefly below. Also described are important assumptions or methods used in data analyses whose results are presented in this report.

DHS Cost Reports and Revenue Statements

Each Oregon nursing facility that contracts with DHS to receive Medicaid reimbursement must submit an annual Cost Report that contains data including numbers of beds, resident days, costs, and revenues. DHS uses data from these reports to establish and update Medicaid payment rates.

Each facility that does not contract with Medicaid must submit an annual Revenue Statement, which contains similar information but not data on licensed or setup beds or costs. For these facilities, numbers of licensed beds were obtained from Nursing Home Compare data (see below); numbers of setup beds were estimated based on other facilities of similar size.

The reporting period for Cost Reports and Revenue Statements is the State Fiscal Year (SFY), which begins July 1st and ends June 30th. This report focuses on SFY 2017, which ended June 30th, 2017, but also includes data for SFYs 2009 through 2016. If a facility changed ownership during a year, resident days from partial-year cost reports from the different owners were combined for that facility.

Occupancy rates for each facility were calculated using resident days and number of available bed days from Cost Reports and Revenue Statements. Occupancy rates were adjusted for facilities that increased or decreased the number of licensed beds available during the SFY or were only open for part of the year. If information about when the change in licensed beds occurred was not available, the average of beginning and end of year bed numbers was used. As Revenue Statements do not contain information about the number of licensed beds in a facility, this was obtained from Nursing Home Compare July 2016 and June 2017 (see below). Facilities in operation for less than 2 months of a SFY were excluded from that year. If a data

element, such as number of beds or resident days was missing for a facility for one year, we estimated it based on data from prior and/or subsequent years' reports. If a Cost Report facility did not report set-up beds numbers, they were imputed based on the set-up bed to licensed-bed ratio of other like-sized facilities.

Many sections of the Cost Reports and Revenue Statements provide details by payer and by payment category within payer. We used these detailed data to exclude Assisted Living and Residential Care resident days from our analyses of occupancy rates and of payer sources.

Population data used to calculate nursing facility bed availability rates were obtained from Portland State University's annual population estimates. The numbers of licensed and set-up beds at the beginning of each fiscal year were divided by population estimates for the beginning of that year.

MDS Assessments

CMS mandates that the Minimum Data Set (MDS) assessment questionnaire be completed for all nursing facility residents within 7 days of entry (admission). This assessment includes a wide range of data, including admission source, discharge destination, demographics, ADLs, diagnoses, treatments received, and quality measures. This report is based on Version 3.0 of the MDS questionnaire.

Nursing facility residents are assessed at entry and at discharge. Reassessments are to be performed if there is a significant change in a resident's health status, or quarterly if a resident's stay exceeds 3 months. If the resident is discharged within 7 days, only one assessment need be performed.

MDS data files were provided to Oregon State University (OSU) by DHS. These data files included assessments reported to DHS through December 5, 2017, which permitted analyses of nursing facility stays that extended past the end of SFY 2017. The data received by OSU were de-identified, so that resident names or other unique identifiers were removed. DHS provided a unique random ID number for each person, so that multiple assessments per person could be linked together. Duplicate assessments were removed from the de-identified dataset prior to analyses. OSU created a crosswalk between MDS facility identifiers and DHS report identifiers so that MDS results could be disaggregated by county or facility size.

This report is based only on assessments of residents for whom discharge dates were available in the MDS data. Residents with an uncertain discharge status (that is, no assessment within 150 days of the December 5, 2017 date when the dataset was created) were excluded from analyses. Residents of facilities with unknown or missing facility identification numbers were also excluded from analyses.

This report employs a systematic approach for capturing and counting entries, reentries, discharges, and stays in the MDS data. Entries and reentries into a nursing facility data are captured based on the date of discharge,[19] because while only the final assessment of a stay

[19] This methodology was first implemented for the SFY 2015 report.

includes a discharge date, all assessments include the date of entry. Therefore, for any discharge assessment, the entrance date associated with that assessment is also used to define the beginning and end of that stay.[20] Residents still enrolled at the time the MDS dataset was created for OSU, December 5, 2017, were assigned this date as their discharge date for the purpose of counting entries and reentries.

Reentries are counted based on the MDS definition of a reentry: if a person is discharged from a nursing facility and then reenters the same facility within 30 days, it is a reentry.[21]

Nursing facility length of stay (LOS) was calculated from the resident's entry or reentry date and discharge date. If a resident was discharged from a nursing facility and subsequently re-entered that facility within 30 days, this was treated as two separate stays.[22] To accurately present trends trend based on multiple years of MDS data, LOS in Section 6 is reported based only on stays that had a discharge in the reported SFY.[23]

Demographic data presented in Section 5 were derived from the discharge assessment. Individuals who had more than one stay during the fiscal were counted only once in exhibits that present demographic data.

The Activities of Daily Living (ADL), diagnoses, and treatment data presented in Section 7 are based on the first assessment of each resident who was enrolled in SFY 2017.[24] This approach allows us to use information from all stays in SFY 2017. It thereby characterizes acuity among short and mid-length stays at those time residents entered the nursing facility, and among long-stay residents at the time of their annual reassessment. However, a resident who had more than one entry or reentry in SFY 2017 may have been counted more than once in these analyses.[25]

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[20] For the 2014 report, any entry or reentry that was coded in MDS as being an entry assessment, or the very first assessment for a resident if no coded entry assessment existed for that resident, was counted as the beginning of a stay. Discharge dates were then filled in to align with those entry or reentry dates. However, this method was determined to undercount total stays because it did not capture all discharges.
[21] The 2014 report counted as reentries only assessments coded as such in MDS.
[22] For the 2014 report, if a resident was discharged from and subsequently re-entered a nursing facility within 30 days, this was counted as one stay. However, the LOS in the 2014 report was calculated from the last entry date (even if it was a re-entry) to the final discharge date.
[23] In the 2014 and 2015 reports, LOS calculations also included residents who remained in the facility through December 5, with their LOS truncated as of that date. However, this method did not produce LOS results that were fully comparable across years.
[24] In the 2015 report, only assessments that were coded as entry, reentry or annual assessments in SFY 2015 were used to capture this information. The 2014 report captured ADLs using the last assessment of a person's first stay in that fiscal year.
[25] In the 2014 report, an individual could have only one ADL score.

Nursing Home Compare (NHC) data

The NHC system reports data collected by CMS during periodic surveys of nursing facilities, which must happen at least every 15 months. Because Oregon facilities that only submit Revenue Statements do not include information on the number of licensed or set up beds, NHC data on licensed beds were used instead. July 2016 NHC data were utilized to fill in beginning of SFY licensed bed numbers for these facilities, and June 2017 data were used to fill in end of SFY licensed bed numbers. These NHC data are for each facility's survey date closest to the relevant SFY.

NHC also reports the percentage of each facility's residents who meet each of several quality measures for each calendar quarter. Quality measure definitions can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V10.pdf

Section 9 of this report presents MDS-based quality measures for the weighted four-quarter average of Oregon SFY 2017,[26] derived from the December 2017 report from NHC. Long and short stay measures had differing quarter lengths: long stay measures were calculated from four three-month quarters, and short stay measures from four six-month quarters. The end of each six-month quarter coincided with the end of the calendar quarter. This definition of short stay quarters means that our reported short stay quality measures for SFY 2017rely on some data from the last three months of SFY 201.

Three new MDS-based quality measures were recently added to NHC and therefore included in the 2017 report:

- Long-stay residents who received an antianxiety or hypnotic medication
- Long-stay residents whose ability to move independently worsened
- Short-stay residents who made improvements in function

In addition, three new "claims-based" short stay measures were also recently added to NHC and appear in the 2017 report:

- Short-stay residents who hospitalized after admissions
- Short-stay residents who had an outpatient emergency department visit
- Short-stay residents who were successfully discharged back into the community

These measures are called "claims-based" because the measures calculated form MDS data are risk adjusted based on data reported to CMS from hospitals. This risk adjustment introduces a time lag into the NHC reporting, and so the data for these measures describe the 4-quarters that make up Oregon SFY 2016. Definitions for the claims-based measures can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/New-Measures-Technical-Specifications-DRAFT-04-05-16-.pdf

[26] This is a change from the three-quarter average used in the SFY 2016 report.

Facilities that reported a measure for less than 20 short-stay residents or 30 long-stay residents during SFY 2017 are excluded from analyses for that measure. This report presents the average of values for all facilities for which NHC reports data for that measure.

Hospital Discharge Data (HDD)

Hospital Discharge Data (HDD) collected by the Oregon Association of Hospitals and Health Systems (OAHHS) capture diagnosis, payer, and demographic information on individuals who spend time in an inpatient hospital in Oregon. HDD data were linked to MDS in a 2-step process. First, using LinkKing software, OHA probabilistically matched persons who, per MDS, had entered or discharged from a nursing facility in SFY 2014 though SFY 2017 to persons who, per the HDD, were discharged from a hospital during calendar years 2013 through 2017. Matching was based on first name, last name, middle initial, date of birth, and sex. Second, we aligned these matched hospital discharges and nursing facility admissions by date; an alignment margin of plus or minus two days was used. At the end of these steps, 31,748 of the 41,029 nursing facility admissions in SFY 2017 were linked to hospital discharges. For 1,640 of the unlinked nursing facility admissions, MDS indicated that the resident had not entered from a hospital; these admissions were excluded from the denominator in calculating the linkage rate. Overall, therefore, we achieved an 82.9% linkage rate between HDD and MDS for SFY 2017. This compares to 83.4% and 80.5% linkage rates in SFY 2016 and 2015, respectively.

Rural Urban Commuting Areas (RUCAs)

Rurality was measured using the Rural-Urban Community Areas-B (RUCA-B) classification. RUCAs utilize distance to a city center and commuting flows to classify rurality and have been found to be very sensitive to demographic changes[27]. To create the analytic file that assigned a rurality to each facility, Census tracts were matched to facility ZIP codes in our data using a ZIP-Tract crosswalk file from the US Census bureau. Because some ZIP codes map onto more than one Census tract and some Census tracts map onto more than one ZIP code, ZIP codes that fell into more than one Census tract were assigned to the largest area grouping.

Commented [DW46]: A comment for footnote 27:

University of Washington School of Medicine. *RUCA Data: Travel Distance and Time, Remote, Isolated, and Frontier.* Available at: http://depts.washington.edu/uwruca/ . Accessed September 1, 2016.

The citation states it was accessed on September 1, 2016. Might want to update the accessed date to 2019.

The Census tract-based RUCA Version 2 codes are based on: a) 2000 Census work commuting information, and b) Census Bureau-defined Urbanized Areas and Urban Clusters.

RUCA-B classifications are as follows:

"Urban": An area with population ≥50,000 or town of any size with high primary commuting flow (30-49%) to an Urban Core (UC) and/or ≥30% secondary flow to an Urban Area (UA)

"Large Rural City/Town": An area with population of from 10,000-49,999 with ≥10% primary commuting flow to an UC and/or <29% secondary commuting flow to an UA.

"Small and Isolated Small Rural Town": A city/town core with a population size of 2,500-9,999 with ≥10% primary commuting flow to a small UC and/or with 10-29% secondary commuting flow to a UA or a town with a population core <2,500 with primary commuting flow to a tract outside a UA or UC and/or with ≥10% secondary commuting flow to a UC or 10-29% secondary commuting flow to a UA.

RUCA Definitions:

"Urban Clusters": cities/towns of from 2,500 to 49,999 populations

"Urban Area": cities of 50,000 and greater population

"Primary Flow": the primary commuting destination; assigned by the first digit

"Secondary Flow": second largest share of commuting flow; assigned by the second digit

[27] Larson, EH., Hart, LG., Rural Health workforces methods and analysis. In: Larson, EH., Johnson, KE., Norris, TE., Lishner, DM., Rosenblatt, RA., & Hart, LG. eds. *State of the Health Workforce in Rural American: State Profiles and Comparisons.* Seattle, WA: WWAMI Rural Health Research Center, University of Washington; 2003: 15-22.
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Definitions Used in This Report

Admission: This occurs when a person enters a NF and is admitted as a resident. An admission may be:

- An entry into a nursing facility (if the resident has never been admitted to the specified facility before, or if the resident was in the specified facility previously and was discharged and not did not return within 30 days of the discharge); or
- A reentry, which occurs when an individual is discharged from a nursing facility and then returns to the same facility within 30 days of that discharge.

Discharge: A discharge occurs when an individual is released from a nursing facility whether they re-enter or not. This does not include a leave of absence or hospital observational stays of less than 24 hours unless the individual was admitted to the hospital.

Final discharge: A final discharge occurs when an individual is released from the nursing facility and does not return to the same facility within 30 days of that discharge date

Discharge followed by a reentry within 30 days: This occurs when an individual is released from a nursing facility and returns to the same facility within 30 days of the discharge date.

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