

Received 10/14/19

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October 14, 2019

By Hand Delivery

Matthew S. Gilman, MPPA, Program Manager
Certificate of Need Coordinator
OHA – Public Health Division
800 NE Oregon St., Suite 465
Portland, OR 97232

**Re: *Written Testimony by Encompass Health Regarding the Application for CON
By Post Acute Medical, LLC and PAM Squared at Portland, LLC ("PAM")***

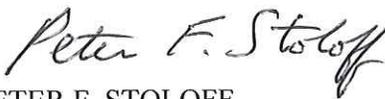
Dear Mr. Gilman:

Encompass Health Rehabilitation Hospital of Oregon ("Encompass") has the following comments on the certificate of need application by PAM 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 that there is a need for at least 91 acute inpatient rehabilitation hospital beds in its service area. Encompass agrees that there is a need for at least 121 acute inpatient rehabilitation beds in the PAM, LLC service area. It is clear to Encompass that there is an overwhelming need for both projects in the region, and that there will still be a need for additional acute inpatient rehabilitation hospital capacity after both projects are implemented.

Accordingly, Encompass supports PAM's calculations which show a need for PAM's proposed facility in PAM's service area.

Sincerely,


PETER F. STOLOFF

PFS:cs

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Oregon's Voice for Long Term Care & Senior Housing

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October 14, 2019

My name is Gwen Dayton, General Counsel and Executive Vice President with the Oregon Health Care Association. OHCA improves the lives of seniors and people with disabilities by promoting quality long term care in Oregon. A nonprofit, OHCA is the largest long term care trade association in Oregon, representing more than 1,000 organizations and 90 percent of long term care providers in the state. Today I speak on behalf of OHCA as well as facilities providing care in the service area; Marquis Companies, Avamere Family of Companies, EmPres Healthcare and Prestige Senior Living. Thank you for the opportunity to offer testimony regarding the Post Acute Medical application to operate a 50-bed inpatient rehabilitation facility (IRF) in Washington County. OHCA and the health care providers I include oppose this application.

Post Acute Medical comes to us from Pennsylvania and this is their first attempt to operate an IRF in Oregon. We believe they will find, and you should recognize, that Oregon is a very different environment and marketplace that does not support the application.

When evaluating health policy, Oregon looks first to the Triple Aim: Better Health, Better Care, Lower Costs. The Post Acute Medical application does not support these goals and is contrary to other Oregon health care policy as well.

Specifically, we assert:

Oregon nursing facilities are different than those found in other states so PAM's analysis of national nursing facilities does not necessarily apply. Unlike other states, our legislature and Department of Human Services have directed that assisted living and residential care facilities provide most of the long term, 24/7 care and services. As stated in ORS 410.020, the state shall "[a]ssure that health and social services be available that [a]llow the older citizen and citizen with a disability to live independently at home or with others as long as the citizen desires without requiring inappropriate or premature institutionalization. In our state, nursing facilities more often provide short stay rehabilitation services. We also know that 95% of admissions to nursing facilities are from acute care hospitals. More than seven in 10 stays lasted 30 days or less, with the median length of stay being only 19 days. (C.A. Mendez-Luck, J. Luck, A.E. Larson, G.B. Dyer, *The State of Nursing Facilities in Oregon, 2018*, at 40. OSU College of Public Health and Human Sciences, 2019)

We also assert:

PAM cannot successfully answer the essential question posed in OAR 333-580-0040: Does the service area population need the proposed project?

A critical factor under the law when answering this question is whether other providers provide the same or substantially the same services to the service population proposed by the applicants. They do. In the counties of Clackamas, Multnomah, and Washington alone, there are 56 nursing facilities that represent 4,554 beds available to the community. The statewide occupancy percentage is between 40% and 84%, so we have room. We know from the most recently available Oregon State University study that approximately 60% of patient diagnoses in Oregon nursing facilities are the same diagnoses as IRFs are allowed by law to care for. (C.A. Mendez-Luck, J. Luck, A.E. Larson, G.B. Dyer, *The State of Nursing Facilities in Oregon, 2018*, at 40. OSU College of Public Health and Human Sciences, 2019) Further, nursing facilities provide extensive therapy services. In 2018, nursing facilities provided physical therapy five or more days for 83% of short stays. That same year, nursing facilities provided occupational therapy for five or more days for 77% of short stays. (*id*) We must note that Oregon has no IRFs in the service area now and patients with therapy needs are being cared for, primarily in nursing facilities.

Pursuant to OAR 333-580-0500, OHA must consider whether the proposed project represents the most effective and least costly alternative to meet population needs. The application does not meet this test either. In addition to providing much the same services, existing nursing facilities in the service area present a more cost effective alternative to an inpatient rehabilitation facility. A national study comparing IRF and nursing facility costs found the following:

IRF patients had the highest post-acute payments. Hip fracture patients who went to IRF cost on average \$6,433 more per episode than those who went to a SNF, and stroke patients cost on average \$10,121 more. . . . Many patients use multiple sites of care. For instance, 54% of hip fracture patients used multiple sites of care, mainly home health care after a SNF or IRF discharge. For hip fracture patients who went to an IRF first, however, Medicare paid \$3,160 on average for SNF care. Similarly, for stroke patients who went to an IRF first, Medicare paid \$4,218 on average for SNF care. (Buntin MB, Colla CH, Deb P, et al. Medicare Spending and Outcomes after Post-Acute Care for Stroke and Hip Fracture. *Med Care*. 2010 September; 48(9): 776–784)

In addition to this analysis, the 2019 MedPAC report indicates that inpatient rehabilitation facilities are overpaid, recommending their Medicare reimbursement be reduced. Similarly, in 2014 MedPAC indicated that average payments to inpatient rehabilitation facilities tend to be higher than paid to nursing facilities, despite fewer patient days/time.

Not only are IRFs more expensive, the Office of Inspector General (OIG) has expressed concern about irregularities in their use of public funds. The OIG audited \$6.75 billion in Medicare payments to IRFs. The subsequent report estimates that 85% of all IRF payments audited by the OIG were found to be unreasonable and unnecessary. (Office of Inspector General-HHS, *Many Inpatient Rehabilitation Facility Stays did not Meet Medicare Coverage and Documentation Requirements*, September, 2018)

Lastly, the proposed facility will disrupt the existing health care marketplace. As noted above, existing nursing facilities currently care for the very therapy patients that might go to applicant's facility if approved. This will threaten the viability of these nursing facilities and thus threaten access to

necessary care in the community. Further, Post Acute Medical indicates in their application that they anticipate accepting a payor mix of only 2% Medicaid, and 5-7% managed care Medicaid. These nominal levels will force area providers to care for much higher levels of low-income patients, both threatening the viability of these providers and limiting available beds for those patients. Also, remember that Oregon, unlike other states that PAM may operate in, is dominated by Medicare managed care. Medicare managed care payers are unlikely to contract with an IRF as costs associated with these sites of care are too high and the patients are being effectively served in nursing facilities now. Without a Medicare managed care contract, the proposed IRF is unlikely to survive. In fact, even as it applies for a new IRF in Oregon, Post Acute Medical has been closing other long term care facilities. In February of this year, the company said it would shut down two specialty hospitals in Corpus Christi, Texas that offer long-term acute care, laying off 220 employees, as questions have also arisen over an application to open an inpatient rehabilitation facility in Indiana. (Indiana Business Journal, *Questions loom over proposed Carmel Rehabilitation Hospital*, May 22, 2019)

We note that the Post Acute Medical is one of two applications for a 50-bed inpatient rehabilitation facility in the same service area. We have described here, and will further describe in additional submissions into the record, why nursing facilities should be counted toward meeting the rehabilitation care needs in the service area and are a more cost effective alternative. We do acknowledge that there may be a subset of therapy patients that are best served in an alternative setting. We do not believe, however, that the service area, Multnomah, Washington and Clackamas counties, can support even the 50 beds Post Acute Medical proposes, and certainly not the proposed total of 100 additional rehabilitation beds.

We urge you to reject the Post Acute Medical proposal.

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

