October 3, 2023

Matt Gilman, MPPA, Oregon Health Authority
Health Care Regulation & Quality Improvement Program
800 NE Oregon Street, Suite 465
Portland, OR 97232
Via email: Matt.S.Gilman@oha.oregon.gov

Dear Mr. Gilman:

On behalf of more than 65,000 workers represented by SEIU Locals 49 and 503, including more than 36,000 in healthcare professions, we write to oppose the Certificate of Need Application submitted by PeaceHealth Riverbend, LLC, to establish an inpatient rehabilitation facility in Springfield, Oregon.

SEIU represents the interests of healthcare workers and their families, as well as the patients our members serve in Oregon. Our members act as both direct healthcare providers and as consumers of healthcare services.

We are concerned that the applicant is unable to meet required Certificate of Need criteria, including, but not limited to:

- Occupancy levels. Historic bed occupancy levels and expected future occupancy levels provided do not meet rehabilitation bed need criteria.

- Adequate staffing. Applicant has had staffing challenges in the past and fails to provide evidence that the additional staff required for the new facility would be available or recruitable. In addition, they do not recognize the impact of new healthcare staffing laws.

- Patient costs. Applicant fails to document how the new facility will impact costs for patients, while projecting double-digit profit margins.

We would also like to express our overall dismay with the applicant's failure to present concrete evidence of their claims and take the Certificate of Need process seriously. For many questions, the applicant either did not answer the required question or answered only in vague statements. The applicant needs to share their analysis more fully to substantiate their statements. The burden of proof lies with the applicant; and we believe, in this case, they have failed to present satisfactory evidence to justify the construction of a new facility.

We sincerely appreciate OHA's dedicated review of this application and general safeguarding of the healthcare needs of all Oregonians. Thank you for your consideration.

Sincerely,

Felisa Hagins, Political Director

October 3, 2023

Comments in Opposition of PeaceHealth Riverbend, LLC's Certificate of Need Application for a New Inpatient Rehabilitation Facility

Submitted by SEIU Local 49 on October 3, 2023

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1. **The applicant fails to substantiate the need for the proposed project, as outlined by the criteria in OAR 333-580-0040 and OAR 333-645-0030.**

Applicant fails to meet the basic criteria developed for calculating the need for rehabilitation services outlined in OAR 333-645-0030 (3).

OAR 333-645-0030 (3)a states that rehabilitation units must have an annualized occupancy rate of at least 85 percent prior to expansion of any bed capacity. The applicants note that the existing ORC's inpatient rehabilitation unit occupancy has been below 85 percent since 2021 due to COVID and staffing, but fail to mention it only achieved 85 percent occupancy in one year out of the previous five provided in the application.[1]

OAR 333-645-0030 (3)a also requires applicants to prove that the unit can maintain a minimal occupancy rate of 75 percent within 18 months of Certificate of Need approval. The applicant fails to address this in their response, though does note in a subsequent section (3b) that they will achieve 75 percent occupancy by year three.[2]

Applicant has not proved that the addition of these beds will address ALOS issues acute care hospitals are currently experiencing.

The applicant asserts that the COVID-19 pandemic illustrated the importance of having these beds for timely discharge from acute care hospitals and provides extensive information on increasing average lengths of stay (ALOS) in these facilities. However, they fail to explain why roughly 15 to 30 percent of their beds sat empty during 2020, 2021 and 2022 while hospitals were desperate for step-down placements.[3]

2. **Applicant fails to demonstrate that opening a new facility is the least costly service, especially in light of newly disclosed plans regarding the current facility, per 333-645-0030(2).**

Proposed project is not only an expansion and relocation, it is a new, independent facility.

According to the application, the proposal "is technically the expansion of an existing rehabilitation unit, but at a new location…"[4] We take issue with this categorization since the current beds operate within a shared service space. Housekeeping, dietary, and all the necessary support services are currently combined across a whole acute care hospital. Yet the "expansion" proposal is to separate and move the rehabilitation unit.

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[1] CNApplicationPeaceHealth (oregon.gov), p 21.
[2] CNApplicationPeaceHealth (oregon.gov), p 21.
[3] CNApplicationPeaceHealth (oregon.gov), p 8.
[4] CNApplicationPeaceHealth (oregon.gov), P 20.

While the separation from an acute care hospital will come with some reduced overhead, the applicant goes into no detail about the services that it will need to provide in a stand-alone facility. Therefore, we are not satisfied with saying this application is "technically the expansion of an existing rehabilitation unit, but at a new location."

Application does not seem to acknowledge PeaceHealth's other plans for its University District (UD) campus.

Moreover, the applicant's response proceeds to explain how, "the existing location of the ORC, within UD, cannot be expanded without significant capital expenditure and disruption to current operations."[5] This explanation was certainly plausible in 2020 when PeaceHealth and LifePoint completed an internal review; however, PeaceHealth's plans for the UD campus have evolved. On August 22, 2023, the health system issued a press release announcing its intentions to close the UD hospital and to close the emergency department and medical floors before the end of 2023.[6]

In order to meet the required criteria, this application needs to be revised to acknowledge and consider the requested closing of the UD hospital. If the emergency department and medical floors close, as PeaceHealth is requesting, how does that impact the feasibility of expanding the ORC in its current location?

3. **The applicant fails to demonstrate how sufficient qualified personnel will be available to support the proposed project, as required by OAR 333-580-0050 (2).**

We believe that the applicant incorrectly assumes that current ORC employees will transfer to the proposed new facility.

Although the applicant already employs some portion of the employees that will be needed to run the new facility, we worry they are not doing enough to retain them. The application states, "All current UD acute rehabilitation personnel will be offered the opportunity to transfer to PeaceHealth IRF."[7]

"Opportunity to transfer" is vague at best and provides no assurances about employees' current compensation or benefit package continuing or improving. The applicant has told the employees' union that they do not know who the employer will be yet at the new facility. Without assurances that their: compensation package will continue (especially with known increases); their benefits will be comparable (including healthcare, paid time off and retirement); and that they will be guaranteed the opportunity to impact working conditions via a collective bargaining agreement going forward, we believe the applicant has failed to demonstrate how sufficient qualified personnel will be available.

Applicant is already struggling to recruit and retain sufficient, qualified personnel at current facilities.

The job posting sites and recruitment tools cited in the application are already in place at UD and yet still, in 2022 "staffing shortages and the high cost of temporary labor constrained" the number of patients the current facility was able to serve.[8] As of August 2023, PeaceHealth had hundreds of job

[5] CNApplicationPeaceHealth (oregon.gov), p 20.
[6] PeaceHealth announces beginning of comprehensive process to close underutilized University District hospital in Eugene | PeaceHealth
[7] CNApplicationPeaceHealth (oregon.gov), p 27.
[8] CNApplicationPeaceHealth (oregon.gov), p 8.

openings in Oregon listed on their website. PeaceHealth also reported that as of June 30, 2023, their contracted workforce was still 138% above pre-pandemic levels, costing the system millions in extra expenses.[9]

Adding to the ineffectiveness of the applicant's current recruitment track record, they are failing to account for workforce realities of the present day.

First, they are failing to account for the impact of Oregon's new healthcare staffing law, HB2697. The built-in ratios mandated by the law will increase competition for healthcare workers across the state, but most immediately for nursing assistants.

Second, they are likely underestimating the annual increases necessary to keep up with current inflation, legal staffing requirements mentioned above, and worker expectations. For example, in year two the adjusted patient days increase by more than 41%,[10] while salaries, wages and benefits increase by half that, less than 19%.[11] Years four and five have only a 2% adjustor for salaries, wages and benefits.[12]

Although doctor and nurse vacancies have been historically hard to fill and remain so, healthcare employers now have the added challenge of recruiting and retaining entry-level healthcare jobs. Healthcare companies increasingly find themselves losing employees to retail and service sector giants offering easier jobs at higher wages.

4. **The applicant fails to disclose the negative impact private equity-ownership has on healthcare consumers and private equity-owned Lifepoint's track record of compromising quality, as required under 333-580-0050(3)(b).**

Research demonstrates that the profit-motivation inherent in private equity investment strategies can compromise patient care.

LifePoint is owned by Apollo Global Management, a multi-billion-dollar private equity firm. SEIU is concerned about the expansion of private-equity-owned companies in Oregon's healthcare landscape, as we seek to protect both the highest quality care and local reinvestment of resources.

A recent study published in the Journal of the American Medical Association cautioned that because private equity firms typically expect greater than 20% annual returns, "these financial incentives may conflict with the need for longer-term investments in practice stability, physician recruitment, quality, and safety."[13] A recent meta-analysis of two decades worth of research bears out concerns about what happens when profits are the primary motivation in healthcare: It found private equity ownership generally results in higher costs and negative impacts on patient care.[14]

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[9] https://emma.msrb.org/P11690767-P11300487-P11731174.pdf, p 7.
[10] CNApplicationPeaceHealth (oregon.gov), Form CN-9, p 80. SEIU calculated the change.
[11] CNApplicationPeaceHealth (oregon.gov), Form CN-5, p 70. SEIU calculated the change.
[12] CNApplicationPeaceHealth (oregon.gov), p 40.
[13] Zhu, Jane, Lynn Hua and Daniel Polsky. "Private Equity Acquisitions of Physician Medical Groups Across Specialties, 2013-2016." *JAMA,* Feb 2018.
[14] PE ownership worsens quality, raises costs, according to BMJ review | Healthcare Dive

LifePoint has a documented track record of compromising quality.

The Private Equity Stakeholder Project recently released a report outlining the various quality and access issues at LifePoint.[15] In June of 2022 regulators found enough patient safety issues with one of LifePoint's hospitals in North Carolina that CMS threatened to terminate its Medicare contract.[16] Regulators found that these deficiencies were serious enough to warrant an "immediate jeopardy" designation – a situation in which a hospital has "placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death."[17]

The North Carolina Department of Justice subsequently opened a separate investigation of the hospital in August 2022.[18] Assistant Attorney General Llogan Walters wrote to LifePoint that the state's DOJ is "extremely concerned about patients' ability to access quality healthcare" at Wilson, noting a decrease in available beds for inpatient care and allegations of chronic understaffing, a decrease in the treatment of low-income patients and the effective denial of care for patients who could not pay for essential treatment.[19] Denying care for patients in need of emergency treatment who do not have the ability to pay would violate the Emergency Medical Treatment and Labor Act (EMTALA). Federal regulators are reportedly reviewing an ongoing investigation into possible EMTALA violations at Wilson.[20]

In 2020, the Wall Street Journal published an in-depth article detailing how LifePoint reduced staffing and services at one of its hospitals in rural Wyoming. The article asserts that Wyoming's Department of Health had to implore LifePoint to ensure adequate staffing after alleged safety incidents involving unsupervised patients and inspection reports that uncovered serious sanitation issues, including unsanitary surgical tools.[21]

Lifepoint has a history of cutting costs, including employee salary and benefits, and financial assistance for needy patients.

The Private Equity Stakeholder Project also noted in a recent report that:

> *Despite the pandemic and the federal relief aid, LifePoint cut operating costs substantially in 2020, slashing salary and benefit costs by $166 million versus the prior year. LifePoint cut supply costs by $54 million in 2020 versus the prior year. LifePoint also cut the charity care it provided by 21% ($7.3 million) in 2020.*[22]

Our concerns regarding cuts to staffing investments are noted above relative to recruitment and retention, but it bears mention that staffing levels have been linked to quality of care.

Moreover, LifePoint's record of cutting charity care should give the surrounding community pause. As part of an acute care hospital currently, the facility is required to provide financial assistance (also called charity care) to patients earning less than 400% FPL; and there is annual reporting of such spending. The

[15] PE_Rural_Health_Jan2023-compressed.pdf (pestakeholder.org)
[16] 2 patient deaths threaten federal funding for Wilson hospital (wral.com)
[17] State Operations Manual (cms.gov)
[18] 8.22 AGO Letter to DLP - DocumentCloud
[19] 8.22 AGO Letter to DLP - DocumentCloud
[20] Duke LifePoint hospital at risk of losing its Medicare contract — again (beckershospitalreview.com)
[21] Brian Speegle, "A City's Only Hospital Cut Services. How Locals Fought Back.," Wall Street Journal, April 11, 2021.
[22] Private Equity Descends on Rural Healthcare (pestakeholder.org) p 12.

reopened facility will no longer be bound by these legal requirements, and we are not aware of the facility making any promises of continued access to financial assistance at the same eligibility levels. Without reporting requirements, the community will have no insight into what does or does not happen at the new facility.

It is critical to understand any potential reduction in access to financial assistance, as more than half of the households in the four counties served by the proposed facility are likely currently eligible for financial assistance from the hospital, including partial or complete forgiveness of their medical bills. In Douglas County alone, 67% of households earned less than $75,000 annually when the cut off for financial assistance was $87,840 for a family of three.[23]

5. **Applicant fails to demonstrate that the best price for the proposal has been sought and selected, as required in OAR 333-580-0050(1)(b).**

Applicant fails to substantiate that they have completed a competitive process or sufficient due diligence on their property development partner, which is critical to lease payment amounts.

Despite the critical role of Capital Growth Medvest (Medvest) in this project and the future of the hospital, little information is provided about the company other than that LifePoint has completed many projects with them. Indeed, on Medvest's website, all of its listed rehabilitation hospital projects have been in partnership with LifePoint.[24]

The applicant provides no evidence of a competitive process or even market competitiveness checks. Given that the lease rate is based on the construction cost, and that Medvest's management fee is a percentage of the construction costs, this deal would seem structured to incentivize something other than the best price.

Building wealth in a nonprofit charitable institution vs. sending money out of state.

We are concerned that the ownership structure of the proposed deal will result in wealth and equity being transferred out of PeaceHealth's nonprofit hands and into an out-of-state company. Critical to the success of the applicant's proposed project is the financing and construction of the building, provided by Medvest. The Alabama-based company will not only be constructing the hospital but will own it.

The ground underneath the building will continue to be owned by PeaceHealth, but the ground lease payments will be paid by the applicant (60% PeaceHealth), not by Medvest. After making 15 years of building lease payments based on the construction cost of the building, plus a percentage fee for Medvest, PeaceHealth will have no equity or ownership stake in the building. They will only have the option to buy the hospital, at market rate, from Medvest.

This transfer of wealth will result in long-term expenses for PeaceHealth rather than the building of equity and wealth. Wealth that, per the mission of the nonprofit, would be reinvested into patient care

[23] Census data for Income in the Past 12 Months. Retrieved August 26, 2023. Note: This uses 2021 inflation-adjusted dollars. The average household size in the United States is 2.54.
[24] https://medvest.com/ accessed August 28, 2023. Some projects are listed with Kindred, which was acquired by LifePoint in 2021.

and better serving the health of the communities that the nonprofit serves. Instead, per the current application, resources will be forever pulled out of the community in the form of lease payments.

6. Applicant fails to adequately address the criteria presented in OAR 333-580-0060(2) related to the proposal's impact on the cost of health care.

<u>High expected profit margins raise questions about how patients will be impacted.</u>

The proposed facility will shift from a hospital-based facility under a nonprofit umbrella, to an independent freestanding facility managed by the for-profit minority partner. The applicant's expected profit margins and industry trends both suggest that the freestanding facility will have dramatically higher profit margins than the current ORC/University District hospital. It is unclear how these margins will be achieved – whether by increased prices for consumers or gained efficiencies that will not be shared with consumers.

It is worth noting that MedPac's 2022 report to Congress highlighted a stark difference in the expected Medicare profit margin for nonprofit inpatient rehabilitation centers compared with for-profits, as well as the wide gulf between margins for freestanding vs. hospital-based facilities. From 2015 even up through the pandemic, hospital-based facilities saw Medicare margins of between .9% and 2.5%, while freestanding facilities were achieving margins about 10 times higher (between 23.5%-26.6%). A similar pattern emerged for nonprofit vs. for-profit operated facilities.[25]

The explanation suggested by MedPac based on the data it reviewed is that for-profit facilities may be prioritizing those with more lucrative Medicare or commercial insurance to achieve such high margins:

> *"Because hospital-based units have, on average, fewer beds and a lower share of Medicare discharges, in 2020, they accounted for only 43 percent of Medicare discharges. In contrast, freestanding IRFs made up just over 25 percent of the IRF supply but in 2020 accounted for 53 percent of Medicare discharges. Similarly, the share of IRFs that are for profit is about 35 percent, but in 2020 they accounted for 53 percent of Medicare discharges. For-profit IRFs are disproportionately freestanding compared with hospital-based ownership."*[26]

While the LLC applicant remains majority owned by a nonprofit, the contract management of the facility is for-profit; and the new facility is clearly following the development pattern of the for-profit, minority partner. Because of the broader industry trends highlighted above, we believe more information is necessary to explain how the applicant plans to generate the profit margins they have outlined in their proposal. While it seems reasonable to expect a negative margin in year one, seeing a 10 percent operating margin in year two and then subsequent 15 percent operating margins in years 3-5 is extraordinarily high.

<u>Applicant fails to answer questions about costs to patients.</u>

The applicant fails to provide sufficient detail in this section by not attempting to describe the "impact of the proposal on overall charges at the institutions and on charges for services affected by the project."

[25] MedPAC March 2022 Report to the Congress; p 323
[26] MedPAC March 2022 Report to the Congress; p 308

They also fail to provide 2(a)(A), which requests an analysis of the proposal's impact on the gross revenues and expenses per inpatient day and adjusted patient day; or 2(a)(B), which relates to the impact on patient charges -- let alone providing data comparing historical and forecasted rates for expenses and patient charges. And finally, the applicant made no attempt to provide 2(b), discussing "both the proposed or actual changes for the proposed service and profitability of the proposed services compared to other similar services in the state (if any)."

If this application is an expansion and relocation of a current operation, as claimed by the applicant, it is especially important to understand how this relocation and change will affect prices charged to patients.