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CERTIFIED MAIL
RETURN RECEIPT REQUESTED

March 13, 2020

Carey McRae
Encompass Health Corporation
9001 Liberty Parkway
Birmingham, AL 35242

Re: Proposed Decision: Encompass Health Rehabilitation Hospital of Oregon, LLC #679

Dear Mr. McRae:

The Oregon Health Authority (OHA), Public Health Division, Certificate of Need Program is tasked with reviewing and making decisions on certificate of need (CN) applications. ORS 442.315(4).

On November 2, 2018, Encompass Health Rehabilitation Hospital of Oregon, LLC (Encompass) filed a CN application with the required fee for a 50-bed freestanding inpatient rehabilitation hospital to be located at NE Belknap Court in Hillsboro, Oregon. The application was determined to be complete on July 23, 2019 and review began on July 24, 2019. On October 4, 2019, the applicant submitted an amendment to its application, adding an alternate site. The amendment was received within 45 days of the application being declared complete. OAR 333-570-0050(2). A proposed recommendation was issued on January 10, 2020. Following the release of the proposed recommendation, an informal hearing was requested by the Oregon Health Care Association (OHCA), an affected party, and was held on February 10, 2020. Following the adjournment of the informal hearing, the record was held open for 15 calendar days, in accordance with CN rules. On February 25, OHA notified affected parties and Encompass that it was extending the open record date until March 2.

The CN rules envision that a project will have one proposed location. While the alternate site is located approximately three miles from the original site and within the same service area, there are no CN rules that specifically permit an applicant to have more than one proposed location and no rules to guide OHA in how to conduct a review based on more than one location. It is OHA's position that the rules implicitly require that an applicant have only one proposed location. Because Encompass has specified that the NE Belknap Court location is its preferred location, OHA's review is limited to that location. A public meeting was held on October 15, 2019.

The CN process is governed by a number of rules adopted by OHA under ORS 442.315(2), found at Oregon Administrative Rules (OAR) 333, Divisions 545 through 670. The burden of proof for justifying the need and viability of the proposal rests with the applicant, Encompass. OAR 333-580-0000(8). In order for a CN to be granted, OHA must find that Encompass satisfies 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 (Demonstrations of Need for Acute Inpatient Beds and Facilities) and applicable service-specific methodologies and standards in Division 645 (Demonstration of Need for Rehabilitation Services).

OHA makes findings and bases its decision on the extent to which the applicant demonstrates that the applicable 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 333-580-0030(2).

PROPOSED DECISION

OHA proposes to approve the Encompass application. OHA finds that Encompass has met its burden of proof for justifying the need for a 50-bed inpatient rehabilitation facility. The proposed decision is based on the application and accompanying documents, the agency record, including information submitted by interested parties, affected parties, and staff analysis.

Proposed Findings and Analysis

As stated above, in order to grant a CN application, the applicant must submit facts

and documentation that support a finding that the criteria for a CN have been met. Only applicable criteria in the CN rules are addressed.

I. APPLICABLE REVIEW CRITERIA

A. Need: OAR 333-580-0040, OAR 333-590-0050, and OAR 333-645

This section combines the "need" criteria described in OAR 333-580-0040, OAR 333-590-0050, and OAR 333-645.

1. Criterion: Does the service area population need the proposed project? OAR 333-580-0040(1).

OHA Findings: **Yes, the service area population needs the 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 rehabilitation beds within the service area. Applications for inpatient rehabilitation facilities (IRFs) are required to address the criterion above through the specified methodologies of OAR 333-645[1] and OAR 333-590-0030 to 333-590-0060.

a. Service Area

The applicant has proposed siting a new, freestanding IRF in Washington County, Oregon. In summary, OHA finds there is a sufficient population-based unmet need for inpatient rehabilitation services among discharges from general inpatient hospitals in Northwest Oregon to support the proposed facility. From its proposed site it is expected that the proposed facility will serve a combination of local and regional inpatients. IRFs draw their patient population from the discharges of other inpatient facilities. In turn, Portland metropolitan and surrounding area hospitals draw their general inpatient population rom a wider swath of Oregon. Therefore, OHA has determined that the appropriate population base and service area for IRFs should be based on discharges from the inpatient facilities within the region, though not statewide. Under OAR 333-590-0030, such a regional service area is represented by a Health Service Area. OHA has

[1] The definitions in OAR 333-645-0010 are incorporated by reference.

determined Health Service Area 1, as defined in OAR 333-545-0000(15)(a), is the appropriate service area for the proposed facility as it encompasses the larger geographical unit from which the facility may reasonably be expected to draw from based on the above analysis. *See also* OAR 333-580-0040 and 333-645-0030(1)(a).

b. Bed Need Calculation

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

There are two crucial components in the CN rules for assessing IRF bed need. The first component is that total need shall not exceed seven beds per 100,000 general population. OAR 333-645-0030(1). This means that the applicant and OHA must determine the total number of IRF beds currently available, and that will be available if the proposed project is approved, against the service area population. If the total bed need calculated is more than seven bed per 100,000, the application cannot be approved. If the total bed need calculated is less than seven beds per 100,000, the review can proceed. This rule does not mean that extra beds must be approved when the available total is less than seven beds per 100,000. Rather, it indicates that extra beds *may* be needed, and allows review of the application to continue. The applicant has demonstrated to OHA that if this project is approved there will not be more than seven IRF beds per 100,000 general population in Health Service Area 1.

The second component is the instruction at OAR 333-645-0030(4) to assess bed need in a manner "*consistent, where applicable, with the methods and principles established in OAR 333-590-0030 to 333-590-0060."* The rule makes it

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

The applicant has identified a net need in 2023 for 82 rehabilitation beds and a net need bed need in 2028 of 91 rehabilitation beds[2] in its proposed service area.

Additionally, in its application, the applicant highlighted the fact that the senior population in the service area (and in Oregon) is increasing. Senior populations are at a higher risk for stroke, and therefore, have a greater need for stroke, brain injury, and related neurological issues care. Oregon's senior population is growing at a rate that outpaces the rest of the country, and seniors outside of the state are choosing Oregon as a retirement destination. Oregon Department of Human Services (DHS) estimates that by the end of 2020, Oregon will be home to approximately 500,000 people between the ages of 65 and 74 and that across the last decade there has been a 35 percent increase in the number of people between the ages of 75 and 84[3].

There is no historical CN precedent for the determining need for inpatient rehabilitation beds. Therefore, OHA used a combination of patient-level discharge data provided by the OHA's Health Policy and Analytics Division as well as information from peer-reviewed literature addressing the use of IRFs in the treatment of specific conditions. This literature indicates strong support for the use of IRFs, versus a skilled nursing facility (SNF) for the treatment of stroke, brain

[2] Encompass application. Page 39.
[3] https://www.oregon.gov/DHS/SENIORS-DISABILITIES/LTC/LTC30/LTC30ServiceSubDocs/Oregon%E2%80%99s%20Demographic%20Trends%20and%20Review.pdf

injury, and other neurologically related conditions[4].

To conduct its analysis OHA reviewed hospital discharge data for the five-year period of 2013 to 2017 for all licensed Oregon hospitals, including diagnosis related group (DRG) identifiers. OHA filtered out hospitals based on their geographical location, so only hospitals within the previously defined Health Service Area 1 remained. Sixteen hospitals fall within the geographical boundaries of Health Service Area 1. The discharges from these hospitals were analyzed, counting only DRGs related to stroke, brain injury, and other neurological conditions. The specific DRGs included in this calculation were: 61-66, 68-74, and 82-90. Data available from Healthcare Cost and Utilization Project (HCUP) support the selection of these stroke DRGs. Of the top ten conditions and procedures with discharges to a post-acute care (PAC) facility, 32.6 percent of stroke patients (DRGs 61-66) were discharged to an IRF and 40 percent were discharged to a skilled nursing facility[5].

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

- Total number of days as an inpatient, assuming an average length of stay (ALOS) of 12.7 days = 333,794.[6]
- Total bed need, assuming 100 percent occupancy and an ALOS of 12.7 = Average of 183 beds per year.

In order to ensure the availability of an IRF bed 95 percent of the time across the year, the 183 beds per year was adjusted. This adjustment resulted in an identified a need for 208 IRF beds. To account for current capacity, OHA subtracted all 57 inpatient rehabilitation beds at existing hospital-based facilities. This resulted in an identified need for 151 IRF beds. This number was further reduced, based on literature review that stated most, but not all, stroke, brain injury, and other related neurological condition diagnosed patients who would not qualify for nor benefit from IRF placement.[7] Therefore, the calculated need has

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952961/;https://www.medicareadvocacy.org/inpatient-rehabilitation-facilities-and-skilled-nursing-facilities-vive-la-difference/

[5] Tian, W. Healthcare Cost and Utilization Project. Statistical Brief #205. Page 9.

[6] ALOS cited by applicant.

[7] Deutsch A, Granger CV, Heinemann AW, et al. *Stroke.* 2006; 37:1477–1482; Langhorne P, Duncan P. *Stroke*. 2001; 32: 268 –274; Winstein CJ, Stein J, Arena R, Bates B, Cherney LR, Cramer SC, Deruyter F, Eng JJ, Fisher B, Harvey RL, Lang CE. *Stroke*. 2016 Jun;47(6): e98-169; Foley N, McClure JA, Meyer M, Salter K, Bureau Y,

been reduced by an additional 25 percent or 37 beds. With this reduction, OHA estimates a current unmet need of 114 IRF beds.

2. Criterion: Will the proposed project result in an improvement in patients' reasonable access to services? OAR 333-580-0040(3).

OHA Findings: Yes, the proposed project will result in an improvement in patients' reasonable access to services.

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

. The applicant states they will have clinical liaisons who will work closely with hospital discharge planners to discuss the best placement for IRF-eligible patients, as, according to the applicant, approximately 70 percent of IRF admissions are from hospitals.[8] In addition, the applicant intends to participate in a CMS risk sharing demonstration process to serve Medicaid patients[9].

During the informal hearing process, affected parties expressed concerns regarding the applicant's payor mix, including their ability to contract with Medicare Advantage members and their ability to serve the Medicaid population. The applicant estimates ten percent of their patients will be from the Medicaid-eligible population. OHA finds that this is consistent with available MedPac data and also notes that of the 41.7 percent of patients discharged to PAC, 8.1 percent were Medicaid[10], which is consistent with the applicant's estimates.

The applicant discussed and provided data in its application to demonstrate that its proposed facility can be easily accessed by patients and their families. The applicant has included tables that illustrate both the drive time and the number of miles between the location of its proposed facility and the existing hospitals with

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Teasell R. *Disability and Rehabilitation*. 2012 Dec 1;34(25):2132-8.

[8] Encompass application. Page 68, 75.

[9] Encompass application. Page 2.

[10] Tian, W. An All-Payer View of Hospital Discharge to Postacute Care, 2013. Healthcare Cost and Utilization Project – Statistical Brief #205.

IRF units located in Multnomah County[11]. The proposed site is 0.2 miles from the Hawthorn Farm MAX station.

During the informal hearing, affected parties stated that OHA did not address patient access and transportation issues. In its analysis, OHA excluded the possibility of direct IRF admission from home or community setting. Instead, OHA analysis focused on IRF patients being admitted directly from area hospitals. Thus, IRF placement for most inpatients has identical issues of family access as does their inpatient placement. As the combination of inpatient and IRF placement can provide for better long-term outcomes, it is also reasonable to expect that this will provide for the least amount of time away from family and home in the long run for patients receiving IRF services. This is due to the fact that IRFs have an average length of stay of 12.7 days, and the rehabilitation services they receive while in an IRF is focused on returning them to their activities of daily living as quickly as possible. In addition, IRF locations are readily accessible from mass transit services for family members.

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

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

B. Availability of Resources and Alternative Uses of those Resources: OAR 333-580-0050

This section addresses available resources and reasonable alternative resources, as required by OAR 333-580-0050 and OAR 333-645.

1. Criterion: Does the proposed project represent the most effective and least costly alternative, considering all appropriate and adequate ways

[11] Encompass application. Page 70. Table 25.

of meeting the identified needs? OAR 333-580-0050(1).

OHA Findings: **Yes, the proposed project is the most effective and least costly alternative, considering all appropriate and adequate ways of meeting identified needs.**

This criterion requires an applicant to, in short:

- Demonstrate that the best price for the proposal has been sought and selected.
- Demonstrate that the proposed project represents the best solution from among reasonable alternatives, both internal alternatives and external alternatives[12].

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

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

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

[12] OAR 333-580-0050(1)(b).

Medicaid Services (CMS).

By contrast, SNF's are designed to focus on long term care for patients that would not recover quickly nor be able to endure the more extensive rehabilitation requirements provided in an IRF. For this reason, the requirements for admission to a SNF are different from those of an IRF. As described above, patients admitted to an IRF require active and ongoing intervention of multiple therapy disciplines (physical therapy, occupational therapy) and require an intensive rehabilitation program of three hours per day at least five days per week[13]. In a SNF, the requirement is for one or more therapies per day for an average of one to two hours per day.

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

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

Additionally, affected parties stated during the informal hearings that referrals for rehabilitation services in SNFs come from hospitals and this practice was likely to continue. OHA does not dispute that hospitals will refer some of their patients to existing SNFs. However, OHA notes that, with literature referenced throughout this proposed decision, some patients will benefit from the services provided by an IRF. Further, the literature states that early and intense intervention of the services offered by an IRF will likely result in better outcomes for those patients, when compared to placement at a SNF. In addition, not all patients being discharged from a general acute care facility will meet the stringent criteria for admission into an IRF and will instead be discharged to a SNF.

OHA received written testimony and letters of support that highlight the

[13] Centers for Medicare and Medicaid Services

advantages of IRF placement over SNF placement for some patients.[14]

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

OHA also looked at the expansion of existing capacity at the two hospital-based rehabilitation units currently in use. The applicant contacted these facilities to discuss an expansion but neither facility was interested in building on their current capacity. Additionally, the applicant interviewed three general hospitals located in Washington County to inquire about the possibility of collaborating on an IRF. As stated in their application, none of the hospitals contacted by the applicant had plans to add an IRF at their site[15]. During the Encompass public meeting, one of the inpatient rehabilitation units stated it only had a 60 percent occupancy rate. There are many factors that may influence occupancy at hospital based IRF units. A 2016 MEDPAC report to Congress stated that, "hospital-based IRFs are typically smaller and have lower occupancy rates compared to free-standing IRFs"[16] Additionally, an individual facility's occupancy at a hospital-based rehabilitation unit and the utilization patterns commonly are not related to underlying population need[17].

The applicant has provided cost-comparison data[18] that compares the costs of its facilities to other free-standing (non-Encompass) facilities as well as hospital-based inpatient rehabilitation units. The data shows that the applicant's costs to provide care are less than care provided at these other facilities.

The applicant provided analysis and information on seven options for

[14] These letters were submitted by the Oregon Rehabilitation Center, Tuality Orthopedic, Sports, Spine, and Rehabilitation Center, Pacific University School of Physical Therapy and Athletic Training, Oregon Health Sciences University Department of Orthopedics and Rehabilitation, SpineCare Chiropractic, and Northwest Functional Neurology.

[15] Encompass application. Page 80.

[16] Report to Congress: Medicare Payment Policy. March 2016. Page 257.

[17] Stein J, Bettger JP, Sicklick A, Hedeman R, Magdon-Ismail Z, Schwamm LH. Use of a standardized assessment to predict rehabilitation care after acute stroke. **Archives of Physical Medicine and Rehabilitation**. 2015 Feb 1;96(2):210-7.

[18] Encompass application. Page 53. Table 19.

providing IRF services, including their proposal[19]. These options include:

- Do not develop an IRF
- Build a 50-bed IRF in Multnomah County
- Proceed with a joint-venture for a 25-bed IRF with another hospital in Washington County
- Build a 50-bed IRF in Washington County
- Proceed with a joint venture with a hospital in another county
- Build a 40-bed IRF in Clackamas County

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

2. Criterion: Will sufficient qualified personnel, adequate land, and adequate financing be available to develop and support the proposed project? OAR 333-580-0050(2).

   OHA Findings: **Yes, there is adequate land, adequate financing, and adequate staff.**

As stated in its application, the applicant will work with local allied health professionals and colleges in the area to ensure it has adequate staff. Additionally, OHA has received several letters of support from Tuality Hospital in Hillsboro as well as Oregon Health Sciences University (OHSU) in Portland voicing their support for the applicant's proposal. The applicant has a proven track record for recruiting adequate staff for their facilities across the country. In addition, the applicant has spoken with faculty at Pacific University regarding internships and training programs for professional staff.

The applicant has control of a nine-acre site, within the service area, that is adequate to support the development of a 50-bed freestanding rehabilitation

[19] Encompass application. Page 78.

hospital[20]. The proposed site is within the City of Hillsboro, and OHA has received letters of support from the Hillsboro Chamber of Commerce and from Washington County Disability, Aging, and Veteran's Services for this proposed site.

Based on review and analysis of applicable criteria, the applicant has demonstrated that it has adequate financing to support this proposal. OHA has reviewed the applicant's financial submissions and these are addressed in Section C., below.

3. Criterion: Will the proposed project have an appropriate relationship to its service area, including limiting any unnecessary duplication of services and any negative financial impact on other providers? OAR 333-580-0050(3).

   OHA Findings: Yes, the proposed project will have an appropriate relationship to its service area and will limit unnecessary duplication of service and negative financial impact.

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

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

[20] Encompass application. Page 102.

There is opposition to the applicant's proposal, centered on two main issues. First, that this need is currently being met at existing facilities, such as SNFs. Second, current utilization at one existing hospital based IRF is low in relation to its licensed capacity. As stated above, while services provided in a SNF are similar to those that would be provided in an IRF, additional resources available at IRFs for the treatment of stroke, brain injury, and other neurological conditions may lead to better outcomes, and long-term costs associated with IRF care can be more efficient because there is a reduced chance of readmissions[21]. As also stated above, OHA does not believe that underutilization at one hospital unit IRF is evidence that patient need in the service area is met. There is a need for IRF beds despite a localized pattern of limited admissions to the existing IRF.

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

   OHA Findings: Yes, the proposed project does conform with relevant state physical plant standards.

The building schematics, floor plans, and additional information provided by the applicant in its application and in response to OHA's follow-up questions demonstrate that the proposed project meets relevant physical plant standards.

C. Economic Evaluation: OAR 333-580-0060

This section of the proposed decision assesses the economic viability of the proposed project and the economic impact the project would have on the cost of health care.

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

   OHA Findings: Yes, the financial status of the applicant is adequate to support the proposed project and it will continue to be

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4952961/

adequate following the implementation of the project.

The applicant states its project is expected to be profitable after three years of operation. The applicant credits this from the knowledge and industry experience of its company, however the applicant does maintain other assurances should forecasts be inaccurate. Encompass Health (the applicant's parent company) will fund unanticipated revenue shortfalls and losses experienced by the applicant to ensure they continue. Attachment 1 to the application shows the commitment by Edmund Fay, Senior Vice President and Treasurer, of Encompass Health assuring the availability of funds to cover expenses. Encompass Health's 2017 financial results show operating revenues of $657M, unrestricted cash of $54.4M, revolving credit of $700M, and $570M in net assets available. $40M of net assets have been earmarked for this project, and the parent maintains sufficient capital to support the applicant should unanticipated failure to meet budgeted results occur.

The entity does not plan to use debt to fund the project. The parent company will fund the project from equity and the entity will make lease payments to the parent company for rent of the property. The absence of debt outstanding from the applicant distorts the debt ratios and causes them to not be applicable as debt is carried by a separate company.

Liquidity ratios are artificially low as cash on-hand is not included in the forecast of operating results and balance sheet projections for the first five years. Liquidity ratios are calculated based on other short-term assets and liabilities; however, they are skewed due to the removal of cash from the forecasting process.

The applicant discusses profitability ratios and the justification for certain forecasted results. Rental expense paid to the parent for the leased building is one item of importance discussed by the applicant, however the impact of rent expense in relation to the forecasted results is insignificant to the profitability. The most significant assumption is the revenue assumptions and whether the growth in patient days will be met, however, as indicated in the application, the parent company has sufficient cash to support losses should they fall short of their expectations.

Operating Margin – The operating margin of the proposed facility is negative for the first three years of operation but turns positive in Year 4. By Year 5, the facility exceeds the 2% guideline. See Attachment 1 of forecasted figures for potential impact to ratios.

Operating Ratio –The ratio is within expected range of similar health care organizations.

Deductibles Ratio – A deductibles ratio between .40 and .45 and is consistent with the parent company's experience in other locations. HMO providers pay at rates established by contract. The difference between the posted facility rates and actual reimbursement is considered to be a contractual allowance that can either increase or decrease revenue when compared to the posted facility rates. The difference is shown on form CN-5 as Provision for Medicare, welfare and other Contractual Adjustments. Medicare, the payer expected to fund the majority of the patients treated at the proposed facility, pays at established reimbursement rates regardless of the entities posted charges. See Attachment 1 forecasted figures for potential impact to ratios. The overall deductibles ratio is consistent with industry standard.

Bottom line ratio – The ratio is similar to the operating margin above. See Attachment 1 of forecasted figures for analysis of potential impact to ratios.

Return on Assets A & B – Benchmark range of 3% - 4% is achieved beginning Year 5. See Attachment 1 for the analysis of forecasted figures for potential impact to ratios. Following the parent company consolidated income statement, the company has consistently exceeded this margin.

Return on Equity A & B – Return on equity is not an effective ratio or financial measurement in the first 5 years of the applicant's forecasted results. Higher beginning costs and normalization of operations does not provide an accurate assessment of the applicant's performance.

Under OAR 333-580-0060(1)(e), the applicant must discuss the availability of other sources of funding, including, but not limited to, donor restricted assets, assets of parent or subsidiary corporations, or a related foundation, which may be acquiring assets and/or producing income that is for the purpose of, or could be used for the purpose of, capital expenditure by the applicant.

OHA finds that the parent company has sufficient cash on-hand and capital available to fund the project. See Attachment 1 for Encompass Health's commitment to provide continued funding.

Under OAR 333-580-0060(1)(f), the applicant must discuss money market conditions in terms of their impact on project financing, including interim financing, if applicable. Patient days, admissions and other units of service used in forecasting projected expenses and revenues, both for the facility as a whole and for services affected by the proposed project, must be consistent with projections used to determine area need

OHA's agrees with the applicant that its parent, Encompass Health, has sufficient experience and expertise to forecast results appropriately and meet projections. Based on other facilities owned and operated across the country, the applicant demonstrates experience in this field. Forecasts have been created based on local jurisdiction data and local rates of labor, construction, etc. Revenue projections are developed based on local conditions, including expected utilization, reimbursement from insurance providers, the anticipated patient mix by payor, and the expected length of stay per discharge. Encompass Health is also familiar with the inputs and critical factors to include in financial forecasts to ensure they are achievable and realistic based on prior experience.

Under OAR 333-580-0060(1)(h), the applicant must identify and explain all inflation assumptions and rates used in projecting future expenses and in completing the forms described in OAR 333-580-0100. It is important that the assumptions used by the applicant in preparing financial forecasts be carefully considered. All relevant factors pertaining to historical experience of the applicant, together with upcoming changes affecting the future, should be considered in forecasting the financial condition of the entity. Specifically, projected changes in wages and salaries should be based on historical increases or known contractual obligations and planned future personnel increases. Considerations should include expected full-time equivalent staffing levels, including increases resulting from the proposal. OAR 333-580-0060(1)(h)(A).

OHA finds that the applicant's financial model forecasts a 2.0% wage increase each year, which is standard for cost of living and inflation nation-wide. This inflation adjustment is appropriate. With the improvement in the economy and scarcity of qualified health care staff, three percent may be seen as a current wage increase based on market forces, but the differences between this and the rate used by the applicant are not significantly different enough to create detrimental deviations. Additionally, Encompass Health states that it has applied this rate for other proposed projects in other jurisdictions and has found it reliable.

Projected deductions from revenues should be explained and justified. OAR 580-0060(1)(h)(B). OHA finds that proposed deductions from operating revenues are due to provisions for Medicare, welfare and other contractual adjustments. Deductions as a percent of revenues are between 42%-45% over the 5-year forecast. This rate is in line with industry standards. Expected changes in the intensity and/or complexity of services provided must be considered in addition to the rate of inflation in arriving at an overall rate of increase in revenues or expenses. OAR 333-580-0060(1)(h)(C).

Encompass Health does not forecast any changes to the payor mix for years two through five, and only slight changes from year one to year two. OHA notes that the applicant anticipates 64 percent Medicare and ten percent Medicaid, while its consolidated financial statements indicated its national payor mix is 82 percent Medicare and three percent Medicaid.

Under OAR 333-580-0060(1)(h)(D)(i) through OAR 333-580-0060(1)(h)(D)(iv), the applicant's projected gross revenue must reflect:

- Patient day increases/decreases
- Outpatient activity increase/decrease
- All debt service coverage requirements
- Other significant impacts the proposal will make on revenue projections

These analyses are attached at the end of this document.

The applicant expects utilization of beds to exceed 80 percent by year five. MedPac data indicates that the national average is approximately 65 percent. The applicant indicated ten facilities it operates have been approved for expansion in the last ten years due to bed utilization in excess of 80 percent. Due to the anticipated need by the applicant in the service area, the applicant states they will reach capacity within a few years.

At least one comment letter indicated that the IRF beds for Legacy Good Samaritan and Providence Portland were underutilized and below the 80 percent utilization, averaging 68 percent, which is slightly higher than the national average identified.

Criterion: Will the impact of the proposal on the cost of health care be acceptable? OAR 333-580-0060(2).

OHA Findings: Yes, the impact of the proposal on the cost of health care will be acceptable.

Under this criterion the applicant must discuss:

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

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

The applicant states the impact on patients will benefit the population due to economies of scale that can be achieved by IRFs, particularly due to the relative portion of the population expected to be covered by Medicare. OHA finds this is a reasonable assumption, however the selection of patients based on their insurance providers (i.e. governmental vs. private insurance companies) would have an impact on the economies of scale which can be achieved if a lesser majority of Medicare/Medicaid patients are covered. The consolidated financial statements of Encompass Health do show that Medicare represents 82 percent of its gross revenues.

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

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

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

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

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

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

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

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

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

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

CONCLUSION/PROPOSED ORDER

For all the reasons cited above, OHA finds that Encompass has met its burden of demonstrating that the CN criteria are met and proposes to grant a certificate of need as proposed, with the following conditions:

1. IRF admissions must not be restricted based on patient insurance or ability to pay. The applicant must provide to OHA de-identified information for each patient identifying the patient's payors and principle reason for admission to the IRF. Applicant will provide these data on a quarterly basis for one year and annually for three years, in a manner prescribed by OHA.

Dated this ___th day of March 2020.

By: _____

Dana Selover, MD, MPH
Section Manager
Health Care Regulation and Quality Improvement
Oregon Health Authority

NOTICE: Pursuant to ORS 442.315(5)(b), an applicant or any affected person who is dissatisfied with this proposed decision is entitled to a contested case hearing before OHA. A request for hearing must be received by OHA within 60 days after service of the proposed decision. A request for hearing may be sent to:

Dana Selover MD, MPH
Section Manager
Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, OR 97232

An applicant or affected person who requests a hearing will be notified of the time and place of the hearing. An applicant or affected person may be represented by legal counsel at the hearing. Legal aid organizations may be able to assist those with limited financial resources. Per ORS 413.041, a party that is not a natural person may be represented by an attorney or by any officer or authorized agent or employee of the party. Parties are ordinarily represented by counsel. OHA will be represented by an Assistant Attorney General. Parties will be provided information on the procedures, right of representation and other rights of parties relating to the conduct of the hearing before commencement of the hearing. Any hearing will be held by an administrative law judge from the Office of Administrative Hearings, assigned as required by ORS 183.635.

If a request for hearing is not received within this 60-day period, the right to a hearing under ORS chapter 183 shall be considered waived. If a hearing is not requested within 60 days, or if the request for hearing is withdrawn, or if the party notifies OHA or the administrative law judge that the party will not appear, or if the party fail to appear at a scheduled hearing, OHA may issue a final order by default. If the OHA issues a final order by default, OHA designates the relevant portions of its files on this matter, including all materials submitted by the applicant or affected persons relating to this matter, as the record for purposes of proving a prima facie case upon default.

Notice to Active Duty Service members. Active duty Servicemembers have a right to stay these proceedings under the federal Servicemembers Civil Relief Act. For more information contact the Oregon State Bar at 800-452-8260, the Oregon Military Department at 503-584-3571 or the nearest United States Armed Forces Legal Assistance Office through http://legalassistance.law.af.mil. The Oregon Military Department does not have a toll-free telephone number.

ATTACHMENT 1

Financial Analysis
(Unaudited Stand-Alone Encompass Health)

As noted in the initial application, the applicant projected the following proforma financial statements (2018.11.02 PDF page 128).

UNAUDITED (PROVIDED BY APPLICANT)

	PROJECTED- STAND ALONE (Income Statement)						Percentage of Patient Revenue				
	2020	2021	2022	2023	2024		2020	2021	2022	2023	2024
Total Patient Revenue	21,774,294	28,969,278	34,473,441	40,186,183	43,039,401	[a]					
Contractual Adjustments	9,903,068	12,219,611	14,591,157	17,066,966	18,340,432		45.48%	42.18%	42.33%	42.47%	42.61%
Total Deductions	9,903,068	12,219,611	14,591,157	17,066,966	18,340,432	[b]	45.48%	42.18%	42.33%	42.47%	42.61%
	0.45	**0.42**	**0.42**	**0.42**	**0.43**						
TOTAL OPERATING REVENUE	**11,871,226**	**16,749,667**	**19,882,284**	**23,119,217**	**24,698,969**						
Salaries, Wages & Benefits	8,397,293	10,109,333	11,436,503	12,812,716	13,537,144	[c]	38.57%	34.90%	33.17%	31.88%	33.69%
Professional Fees/Benefits	697,099	939,611	1,096,186	1,257,944	1,338,134	[c]	3.20%	3.24%	3.18%	3.13%	3.33%
Supplies	588,512	782,977	931,743	1,086,146	1,163,263	[d]	2.70%	2.70%	2.70%	2.70%	2.89%
Purchased Services	2,890,578	3,265,044	3,561,049	3,867,589	4,040,951	[d]	13.28%	11.27%	10.33%	9.62%	10.06%
Insurance	284,430	290,118	295,920	301,839	307,876	[d]	1.31%	1.00%	0.86%	0.75%	0.77%
Provision for Doubtful Accounts	178,068	251,245	298,234	346,788	370,485	[d]	0.82%	0.87%	0.87%	0.86%	0.92%
Depreciation & Amortization	457,768	465,804	477,857	493,929	514,018	[e]	2.10%	1.61%	1.39%	1.23%	1.28%
Interest / Rent Expense	2,494,400	2,544,288	2,595,174	2,647,077	2,700,019	[d]	11.46%	8.78%	7.53%	6.59%	6.72%
Total Operating Expenses	**15,988,148**	**18,648,420**	**20,692,666**	**22,814,028**	**23,971,890**		73.43%	64.37%	60.02%	56.77%	59.65%
Operating Income	**(4,116,922)**	**(1,898,753)**	**(810,382)**	**305,189**	**727,079**						
Operating Margin	-34.68%	-11.34%	-4.08%	1.32%	2.94%						
Interest Income, Rental Income, etc.	1,152,738	531,651	226,907	(85,452)	(203,583)						
Excess Revenue over Expenses	**(2,964,184)**	**(1,367,102)**	**(583,475)**	**219,737**	**523,496**						

[a] Revenue analysis based on applicants project number of patient days

	2020	2021	2022	2023	2024
Number of Adjusted Patient Days	8,395	10,950	12,775	14,600	15,330
Increase in Days	N/A	30.43%	16.67%	14.29%	5.00%

The large increased was addressed by the applicant in the response to preliminary comments. The large increase in 2021 is a function of natural growth, but also artificial growth represented through mathematical presentation rather than gross increase in patients. Increase in patients expected over the 5-year forecast is generally more linear and consistent with the growth experienced in prior Encompass Health facilities.

Net Revenue per Patient Day	1,414	1,530	1,556	1,584	1,611
Expense per Patient Day	1,904	1,703	1,620	1,563	1,564
Net Revenue per Patient Day	(490)	(173)	(63)	21	47
Margin Percentage	-35%	-11%	-4%	1%	3%
Marginal Net Revenue YoY		-183%	-173%	403%	56%
% of Capacity	46.00%	60.00%	70.00%	80.00%	84.00%
Increases in Net Revenue per Patient Day	Year-over-year	7.6%	1.7%	1.7%	1.7%
Decreases in Expense per Patient Day	Year-over-year	-11.8%	-5.1%	-3.7%	0.1%
Increases in Revenue per Patient Day	Yr. 1 thru Yr. 5				**14%**
Decreases in Expense per Patient Day	Yr. 1 thru Yr. 5				**-18%**
Increases in Net Revenue per Patient Day	Yr. 1 thru Yr. 5				108%

**Increases in gross revenues per patient day and decreases in gross expense per patient day result in a roughly 18% increase in margin over a five-year period. Reductions in costs can become increasingly difficult to achieve marginal results. We noted that the Company's Consolidated Financial Statements for 2018 demonstrates a margin of 11.5% on overall operations, thus the 3% margin at the end of year 5 is reasonable.*

Gross revenue per patient day increases significantly each year. Typical forecasts would anticipate flat revenue over the first five years, with potential increases for pricing and average cost increases. Additionally, gross expense per patient day significantly decreases on an annual basis. While fixed costs may be spread out over an increase in patients, most costs will be variable based debt and capital expenditures occurring at the parent level. Significant increases in revenues and reductions in expense is highly aggressive in the first five years of operation, and an increase in net revenue per patient day of 20% over five years is unlikely.

A plan for the significant increases in adjusted patient days should be explained to indicate how the facility will achieve a doubling in the number of patients they will serve in a five-year span, as well as a service revenue breakout to indicate the basis for significant increases in gross revenue per patient day. The facility should also clarify an expense reduction plan to detail the significant areas of cost savings during the first five years of operation.

[b] Deductions from revenue analysis

Total deductions are relatively consistent YoY and range between 42% and 45%, which is within a reasonable range considering industry metrics. Deductions are based on payor, which is expected to be heavily from Medicare. Medicare uses standard payment rates, and as such the deduction percentages can be more heavily based on total revenues.

[c] Salaries and benefits analysis

	2020	2021	2022	2023	2024
Projected FTE	94	111	123	134	139
Salaries per FTE	89,333	91,075	92,980	95,617	97,390
Annual Increase		1.95%	2.09%	2.84%	1.85%
Benefits as % of Wages	8%	9%	10%	10%	10%

The applicant is projecting an increase of approximately 2% each year, which is consistent with a typical cost of living wage adjustment. Average salary per FTE is projected above the average in the area, which is a conservative and appropriate assumption. Benefits as a percent of salaries is lower than the expected average of 20-25%. Increasing benefits 15%, calculated below, does not change the status of the facility moving from net income to net loss in any year.

	2020	2021	2022	2023	2024
Current Benefits Expense	697,099	939,611	1,096,186	1,257,944	1,338,134
Increase	15%	15%	15%	15%	15%
Increase in Forecasted Benefits Expense	104,565	140,942	164,428	188,692	200,720
Net Income (Loss)	(2,964,184)	(1,367,102)	(583,475)	219,737	523,496

[d] Various expenses 2018.11.02 PDF page 127

Rent/Interest Expense					
Total Interest & Rent Expense	2,494,400	2,544,288	2,595,174	2,647,077	2,700,019
Payment Escalation		2%	2%	2%	2%

Rental expense is related to the lease payments, which are forecasted to begin at $2.494M per year, with annual lease payment escalators. Based on the expected lease term of 20 years (with 2 10-year extensions), rent expense each period is overstated depending on the total balance expected to be paid between intercompany entities to recoup the balance of the construction loan.

Supplies	588,512	782,977	931,743	1,086,146	1,163,263
Purchased Services	2,890,578	3,265,044	3,561,049	3,867,589	4,040,951
Total Supplies, Purchased Services	3,479,090	4,048,021	4,492,792	4,953,735	5,204,214
% of Revenue	16%	14%	13%	12%	12%
Insurance	284,430	290,118	295,920	301,839	307,876
Total Patient Revenue	21,774,294	28,969,278	34,473,441	40,186,183	43,039,401
Insurance as % of Revenue	1.31%	1.00%	0.86%	0.75%	0.72%
Provision for Doubtful Accounts	178,068	251,245	298,234	346,788	370,485
Total Patient Revenue	21,774,294	28,969,278	34,473,441	40,186,183	43,039,401
Allowance as % of Revenue	0.82%	0.87%	0.87%	0.86%	0.86%

Allowance for doubtful accounts is within range of industry average, however based on the private insurance providers targeted for the patient services provided, the reduced rate is within expectations.

[e] Depreciation

Based on the construction cost of the building and depreciation over the useful life, depreciation expense each year is roughly 50% of the expected depreciation expense. Ana analysis of the building's continued use after the estimated 40-year period should be performed to explain the reduced depreciation balance per annum.

Construction Price	27,208,400	(Total Constructions Costs less Land)
Estimated Useful Life-years	40	
Expected Annual Depreciation	680,210	

Depreciation based on the total cost of construction over a standard 40-year life is approximately 1/3rd greater than the depreciation expense per the income statement. Further, the applicant has planned to purchase additional fixed assets and includes plans for capital expenditures in the application. Depreciation expense could be up to $200,000 greater than annually projected by the applicant, however, this has some impact, but not significant to deter from the overall financial condition of the company.