Date: October 3, 2018

Project: Northeast Rehabilitation Hospital at York

Proposal by: Neuro Rehab Associates, Inc.

Prepared by: Larry Carbonneau, Manager - Health Care Compliance Operations, DLC
            Richard Lawrence, Senior Health Care Financial Analyst, DLC

Certificate of Need Unit Recommendation: Approval

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<th>Proposed per Applicant</th>
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I. Abstract

A. From Applicant

Neuro-Rehab Associates, Inc. d/b/a Northeast Rehabilitation Hospital Network (NRHN), a New Hampshire domestic for-profit corporation in good standing, is proposing to create a new Inpatient Rehabilitation Facility (IRF) on the campus of York Hospital (York), which is located at Loving Kindness Way, York, Maine. The new facility will be part of NRHN and will be known as Northeast Rehabilitation Hospital at York (referred to in this Application as “NRH @ York”). It will provide a comprehensive rehabilitation program for inpatients who must be able to tolerate three (3) hours of intense rehabilitation services per day, and will be the type of facility that the Centers for Medicare & Medicaid Services (CMS) has defined for this level of post-acute care. The major goal of this project is to provide the population of York County with access to comprehensive IRF services. Currently there are no IRF level beds within York County.

The project includes the construction, by York, of a single story, 20,030 square foot facility abutting York’s Strater Wing, which will allow direct access to York Hospital from the IRF. Site Plans and Floor Plans for the project are attached. (See Exhibit 1) York’s cost for site work and constructing the core and shell of the new building is estimated to be $7.1 million. York will own the new addition and lease it to NRHN in accordance with the terms of a long term, fair market value lease. NRHN will invest approximately $6.4 million on interior design, fit-up, fixtures, furniture and equipment in order to implement the project. For planning purposes, NRHN anticipates that this new health service will commence on April 1, 2020.

Licensed as a specialty inpatient rehabilitation hospital and operated solely by NRHN, NRH @ York will function as a satellite of NRH @ Salem, NRHN’s free-standing IRF located in Salem, New Hampshire. York and NRH @ York will maintain their separate and distinct facilities, from both an operational and a governance perspective. NRH @ York’s medical staff, rehabilitation staff, and nurses will be credentialed and under the complete control of NRHN. NRHN and York will develop contracts for ancillary and support services, similar to the contractual relationships that NRHN has developed with host hospitals at its two other satellite IRF facilities in Nashua and Manchester, NH. The essential terms and conditions of the project will be set forth in a Lease and an Ancillary Services Agreement to be entered between NRHN and York. The current iteration of the memorandum of understanding (MOU) describing these agreements and the parties’ intention to enter into them is attached. (See Exhibit 2)

1 See Table 24 of the Financial Module.

2 A satellite facility is defined by CMS as: a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital that meets certain criteria. See 42 C.F.R. §412.22(b).
NRH @ York will offer twenty (20) private rooms, a spacious therapy gym, as well as amenities, technology and specialty programming to support patient recovery. NRH @ York will seek to be Joint Commission accredited. NRH @ York also intends to pursue Joint Commission Specialty Accreditation for its Stroke, Brain Injury, and Amputee Rehabilitation programs. More specifically, NRH @ York will:

- Be licensed as a Maine specialty inpatient rehabilitation hospital
- Be a MaineCare participating provider
- Have on-site, full time physicians who specialize in rehabilitation and hospital medicine
- Have on-site, full time certified rehabilitation registered nurses on staff
- Employ full-time therapy staff which specializes in hospital level rehabilitation
- Provide at least 15 hours per week of comprehensive therapy services to each patient
- Include an Activities of Daily Living (ADL) kitchen and bedrooms so that patients can practice and master activities of daily life in a home-like environment
- Include a relaxing lounge for patients and families
- Be designed to promote an atmosphere of healing and recovery
- Allow access to all amenities offered at York
- Be conveniently located five minutes from Interstate 95 with ample free parking

NRH @ York will have the added advantage of being able to leverage the clinical expertise of the entire Northeast Rehabilitation Hospital Network, including, but not limited to, access to NRHN’s seasoned clinical staff and its well-established specialty rehabilitation programs and policies.

NRH @ York will also benefit from the economies of scale that allow care to be delivered in a more cost-effective manner due to NRHN’s centralized administration and overhead functions.

**CONU Comment #1: Reviewable**

According to 22 M.R.S.A §329 4-A a certificate of need is required for:

A new health care facility with capital expenditures exceeding $3,394,609 and a new health service with third year incremental operating costs exceeding $1,131,536.

**CONU Comment #2: Directly Affected Party**

Pursuant to MRS Title 22, Chapter 103-A, §328 (22) E, New England Rehabilitation Hospital of Portland, Southern Maine Health Care and Maine Medical Center requested status as a directly
affected party per letter dated February 28, 2018. This letter states that “New England Rehabilitation, Maine Medical Center, and Southern Maine healthcare provide the same or similar services proposed by Northeast Rehabilitation Hospital Network to patients residing in the health service area; and this proposed transaction could directly and substantially affect New England Rehabilitation, Maine Medical Center, and Southern Maine Healthcare services”. CONU accepted this as a matter of record.

**CONU Comment #3: Public Hearing**

In accordance with 22 M.R.S.A §339 2 a public hearing was held on June 7, 2018, 1:00 pm at the York Public Library, York, ME to allow the applicant, other directly affected persons and the public to have an opportunity to present information, documentary evidence, arguments, and comments regarding this proposal. The transcript of this hearing and other written comments submitted to the Certificate of Need Unit are on file. These comments, as well as the applicant’s response to these comments, will be addressed in the body of this preliminary analysis.

**CONU Comment #4: Definition**

Throughout the public comments reference is made to the 60% rule. This is an important rule related to reimbursement as an Inpatient Rehabilitation Facility (IRF) instead of at the regular rates as an acute care inpatient hospital. Compliance with this rule is important for the IRF to receive a higher level of reimbursement. CONU is including a description of the 60% taken from Center for Medicare & Medicaid Services Inpatient Rehabilitation Facility prospective payment system booklet:

“To be excluded from the Acute Care Hospital Inpatient PPS specified in 42 CFR 412.1(a)(1) and instead be paid under the IRF PPS, an inpatient rehabilitation hospital or rehabilitation unit of an acute care hospital (or CAH) must meet the requirements for classification as an IRF stipulated in Subpart B of 42 CFR Part 412. One criterion specified at 42 CFR 412.29(b) Medicare uses for classifying a hospital or unit of a hospital as an IRF is that a minimum percentage of a facility’s total inpatient population must require treatment in an IRF for one or more of 13 medical conditions listed in 42 CFR 412.29(b)(2). This minimum percentage is known as the compliance threshold. Beginning July 1, 2006, the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (Public Law 110-173) stipulated that the compliance threshold should be set no higher than 60 percent. Thus, we now refer to this regulatory requirement as the 60 percent rule. The Medicare, Medicaid, and SCHIP Extension Act of 2007 also stipulated that IRFs must continue to use comorbidities that meet certain criteria as specified in 42 CFR 412.29(b)(1) to determine the compliance threshold as they have been since the May 7, 2004, final rule.”
60% Rule

“The 13 medical conditions that qualify for the 60 percent rule, as specified in the May 7, 2004, final rule, are:
1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Fracture of femur (hip fracture)
7. Brain injury
8. Neurological disorders, including: Multiple sclerosis, Motor neuron diseases, Polyneuropathy, Muscular dystrophy, Parkinson’s disease
9. Burns
10. Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living (ADLs)
11. Systemic vasculitides with joint inflammation resulting in significant functional impairment of ambulation and other ADLs.
12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more weight bearing joints (elbow, shoulders, hips, or knees but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, and significant functional impairment of ambulation and other ADLs.
13. Knee or hip joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
   - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission
   - The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
   - The patient is age 85 or older at the time of admission to the IRF.”
II. Fit, Willing and Able

A. From Applicant

A. Introduction to Northeast Rehabilitation Hospital Network (NRHN)

NRHN was founded in 1981 to establish an inpatient rehabilitation hospital in Southern New Hampshire and the Merrimack Valley, so that patients and their families would not have to leave the area to obtain appropriate inpatient rehabilitation services. NRHN’s first IRF opened in Salem, New Hampshire, with 102 beds in 1984. Since then, NRHN has grown into a Rehabilitation Network with four IRFs in New Hampshire, over twenty (20) outpatient clinics in both New Hampshire and Massachusetts, and a CMS certified home care agency. This allows NRHN to effectively span the continuum of post-acute rehabilitation care for its patients.

NRHN employs over 1,100 individuals. Licensed personnel include more than 20 physicians, 200 nurses and 300 therapists (physical, occupational, speech, and others). Each IRF maintains physicians who specialize in physical medicine and rehabilitation (physiatrists) and hospital medicine (hospitalists), therapists, and specially trained and Certified Rehabilitation Registered Nurses. NRHN IRFs feature therapy gardens and mobility parks, where patients can practice navigating the varied terrain that they will encounter upon returning home. All NRHN inpatient facilities have an activities of daily living (ADL) kitchen and bedroom for patients to practice critical skills to support their independence after discharge. Over 900 individuals and their families entrust their care to NRHN’s inpatient, outpatient, and home care services, on a daily basis.

NRHN is guided by its mission to rebuild lives through hope, compassion, and dedication to excellence. It strives to be the preferred provider for all rehabilitation needs in the communities it serves. NRHN’s philosophy of patient care is outlined in its Employee Service Pledge Commitment, which is signed by every NRHN employee. (See Exhibit 3a). Moreover, each NRHN owner, officer, director and employee is bound by NRHN’s comprehensive Code of Conduct that addresses, among other matters, NRHN’s Corporate Compliance Program, its philosophy of patient care, quality of care and patient rights, confidentiality of protected health information and conflicts of interest. (See Exhibit 3b)

B. NRHN’s Executive Team

All NRHN entities are overseen by the NRHN Executive Team. The NRHN Executive Team practices a “hands-on approach” which allows for heightened visibility at all its locations. NRHN’s operating philosophy promotes teamwork whether in providing individual patient care or managing operations across its network. NRHN believes that having one executive team overseeing all of its locations promotes cost-efficient and high-quality patient care, communications, and employee engagement.
NRHN Executive Team
- John F. Prochilo, MS, FACHE, Chief Executive Officer
- A. Deniz Ozel, MD, Chief Medical Officer
- Charles D. Champagne, Chief Financial Officer
- Shirley Lussier, CCP, CBP, Vice President of Human Resources
- Joel Rudin, Vice President of Special Projects
- Helene Thibodeau, MSN, RN, NEA-BC, CRRN, Vice President, Patient Care Services/Chief Nursing Officer

The curriculum vitae of the NRHN Executive Team members are attached. (See Exhibit 4a)
The NRHN organizational chart is also attached. (See Exhibit 4b)

C. NRHN's Clinical Structure

NRHN's clinical structure at the system level consists of a Chief Medical Officer, who is a Board-Certified Physiatrist, a Board-Certified Medical Director of Hospital Medicine, and a Vice President of Patient Care Services/Chief Nursing Officer (VP/CNO).

The VP/CNO is a Board-Certified Nurse Executive who has overall responsibility of the system's non-physician clinical services provided by therapists and nurses. The clinical leadership team reporting to the VP/CNO include Inpatient Nurse Managers, an Inpatient Therapy Director, Director of Pharmacy, Director of Case Management, Director of Quality and Patient Safety, Director of Patient Experience, and a Director of Infection Control. This leadership team provides clinical support to each inpatient facility and coordinates standards of practice and assists with performance improvement plans and compliance with federal and state regulations.

D. NRHN's - Clinical Locations

1. NRHN - Inpatient Facility – Salem, NH
   In 1984, NRHN established its first freestanding IRF at 70 Butler Street, in Salem, NH. NRHN currently operates 67 IRF beds at this location.

2. NRHN - Inpatient Facility – Nashua, NH
   In 2005, NRHN established its first satellite IRF in collaboration with the 188-bed Southern New Hampshire Medical Center (SNHMC). The hospital satellite, Northeast Rehabilitation Hospital @ SNHMC West, is located at 29 Northwest Boulevard, SNHMC West Campus, Nashua, NH. NRHN operates twenty (20) IRF beds at this location, and contracts with SNHMC for ancillary and support services.

3. NRHN - Inpatient Facility – Portsmouth, NH
In 2011, NRHN developed its second freestanding IRF, Northeast Rehab Hospital @ Pease, located at 105 Corporate Drive, Pease International Tradeport, Portsmouth, NH. NRH @ Pease operates thirty-three (33) IRF beds.

**NRHN – Inpatient Facility – Manchester, NH**

In 2015, NRHN established a second satellite IRF in collaboration with the 296-bed Elliot Hospital (EH), in Manchester, NH. The hospital satellite, Northeast Rehabilitation Hospital @ Elliot, is located on the 7th floor of Elliot Hospital's Main Campus, which is located at 1 Elliot Way, Manchester, NH. NRHN operates fifteen (15) IRF beds at this location. Like the arrangement with SNHMC, NRHN contracts with EH for ancillary and support services.

In the State of NH, surveyors visit the inpatient location prior to granting a State Facility License. Annually, the license must be renewed and NRHN submits attestations for each facility as requested by the State of New Hampshire.

The most recent State Licenses for the IRFs in Salem, Nashua, Portsmouth and Manchester are attached. (See Exhibit 5)

4. **NRHN – Outpatient Facilities**

NRHN provides outpatient rehabilitation services to individuals impacted by a loss of function. As part of the continuum of rehabilitative care, NRHN offers outpatient programs at over twenty (20) convenient locations in Southern New Hampshire, the Seacoast of New Hampshire and the Merrimack Valley of Massachusetts.

NRHN’s specialized outpatient services include programs for adults needing treatment for orthopedic and neurological conditions. Highly trained physical, occupational and speech therapists work closely with the patients, their families and their physicians, to provide a customized plan of care. Patients and their team work on maximizing strength, endurance, mobility, communication, memory and functional skills. A list of all NRHN outpatient locations and services is attached. (See Exhibit 6)

5. **NRHN - Homecare Services**

NRHN’s Homecare Services (NHCS) are committed to caring for patients in the best setting for their continued recovery. After discharge, some patients are not functional enough to continue their therapy at an outpatient clinic. Like other homecare providers, NHCS provides nursing and rehabilitation services. However, NHCS’s specialty training and experience providing physical, occupational and speech therapies set these homecare services apart.
Homecare may be the bridge a patient needs after discharge to continue rehabilitation. NHCS’s team of homecare clinical staff includes nurses, wound-care specialists, physical, occupational and speech therapists, social workers and home-health aides. NHCS understands the importance of developing trusting relationships with the patients and the families it serves. As a result, patients are served by a medical team that works with the patients, their families and their caregivers, to develop a plan of care that best fits the patient’s needs.

NHCS was named to the 2016 HomeCare Elite™, a compilation of the top-performing home health agencies in the United States. ³

6. NRHN - Network Map

A map of the entire NRHN Network is attached. (See Exhibit 7)

E. NRHN’s – Clinical Programs

NRHN’s accredited Inpatient Rehabilitation Programs utilize a partnership approach to care with patients, families and its clinical staff, with a focus on assisting each patient to reach the highest level of function, independence and quality of life. Patients admitted to an inpatient facility are cared for by a team of qualified professionals, including physiatrists, hospitalists, registered nurses, physical, therapists, occupational therapists, speech and language pathologist, care coordinators, nutritionists, respiratory therapists and pharmacists.

The NRHN staff are known for their expertise, compassion and dedication to patients and their families. A physiatrist collaborates with the members of the patient care team

³HomeCare Elite® is an annual recognition of the top performing Medicare-certified home health agencies in the United States. This market-leading recognition program, from ABILITY® Network and DecisionHealth, names the top 25% of home care providers in key home health quality and performance measures. The Top 100 and Top 500 agencies nationwide receive special honors through HomeCare Elite. The HomeCare Elite winners list is announced annually at the NAHC conference in October. The HomeCare Elite ranking utilizes publicly available data from Home Health Compare and the Centers for Medicare & Medicaid Services (CMS) Cost Reports. To be included in the annual calculation a home health agency must be Medicare-certified and have data for at least three outcome measures in Home Health Compare. Five domains of performance are analyzed:

1. Quality of Care
2. Quality Improvement and Consistency
3. Patient Experience (HHCAHPS)
4. Process Measure Implementation
5. Financial Performance
to customize and direct the treatment plan for each patient’s individual needs. Patients participate in at least three hours of therapy per day with physical, occupation and speech therapists. Specialized rehabilitation registered nurses provide patient care and are available 24/7. The inpatient programs also provide education to prepare patients and families for a successful rehabilitation discharge, including coordination of equipment and home modifications and referral to community resources for continued health, recovery and independence. NRHN provides a seamless continuum of care for its patients with home care services, outpatient clinics and a comprehensive array of transitional resources available through collaboration with its community partners.

NRHN’s inpatient rehabilitation care is provided to patients with a variety of conditions, complications and diagnoses, through several specialized programs, including the following:

1. Stroke Rehabilitation Program
   The Stroke Rehabilitation Program at NRHN is an intensive, functional, outcome-oriented program including care for medical complications, physical, cognitive, and emotional impairments. Treatment goals include maximizing function in mobility, activities of daily living, communication and cognition, swallowing and bladder and bowel management. The Stroke Rehabilitation Program utilizes innovative technology and practices for stroke care including:

   - Bioness-functional electrical stimulation
   - Lite Gate-Partial weight-bearing gait therapy
   - B.I.T.S. (Bioness Integrated Therapy System)
   - Mirror Therapy.

2. The Brain Injury Rehabilitation Program
   The Brain Injury Rehabilitation Program at NRHN is led by a fellowship trained and board-certified Brain Injury Medical Director and Certified Brain Injury Specialists (CBIS) nursing and therapy staff. Brain injury program goals include providing support and advocacy for the brain injured individual and family, to improve the patient’s thought processes, memory skills, perception and judgment through cognitive retraining activities and to improve behavioral issues. The program also focuses on community outreach to promote re-integration and development of a comprehensive discharge plan by working with the patient and family to identify needed resources and services for the brain injury survivor.
3. **Amputee Rehabilitation Program**  
The Amputee Rehabilitation Program at NRHN provides specialized, intensive rehabilitation for patients who have suffered limb loss from trauma or disease. The Amputee Rehabilitation Program uses the latest technology in combination with traditional hands-on interventions to ease the trauma resulting from amputation and to assist patients to adapt both physically and emotionally to maximize recovery. NRHN utilizes a multistep, progressive approach with inpatient therapy focusing on preventing post-surgical complications, strengthening and preparing the patient for a prosthesis while the limb is healing. Once fit for a prosthetic, treatment focuses on training for its use, regaining optimal mobility, increasing endurance and maximizing comfort and function. This program provides for continuity of services through home care, outpatient care and access to community follow up services.

4. **Spinal Cord Injury Rehabilitation Program**  
Under the direction of a fellowship trained and board-certified physiatrist, NRHN’s Spinal Cord Injury Rehabilitation Program provides comprehensive acute inpatient rehabilitation and medical management for patients with spinal cord dysfunction due to trauma or disease. This program offers the expertise of a specialized interdisciplinary care team of rehabilitation professionals who help patients cope with their injuries, relearn basic skills of everyday life, maximize functional independence and reintegrate back into their communities.

5. **Orthopedic Rehabilitation Program**  
NRHN’s Orthopedic Rehabilitation Program provides comprehensive acute inpatient rehabilitation services and medical management to meet the needs of patients following multiple trauma, hip fractures, or joint replacements with other complications or revisions. This program offers a comprehensive multidisciplinary approach to rehabilitation with the goal of maximizing recovery and assisting in reentry to the community. The rehabilitation team also closely follows all postsurgical protocols put in place by the orthopedic surgeons and ensures a safe transition to home with follow up services in place.

6. **Neuro and General Rehabilitation Care**  
Comprehensive rehabilitation care is provided to patients who have experienced complications from neurologic disorders such as Guillain-Barre syndrome, Parkinson’s disease, post-polio conditions, myopathies, multiple sclerosis, meningitis and other neurological problems. NRHN also cares for other patient
conditions requiring rehabilitation and medical management, including, but not limited to, Parkinson’s disease, stroke, diabetes and obesity.

F. NRHN’s Quality Programs

1. NRHN’s Approach to Quality
NRHN has a commitment to providing high quality care and is engaged in continuous quality improvement at all levels of the organization. NRHN uses the quality improvement methods recommended by the Institute for Healthcare Quality Improvement (IHI) and incorporates principles and tools from IHI’s Model for Improvement as well as Lean, Robust Process Improvement (RPI), change management theory and safety culture strategies. In addition, NRHN performance improvement teams use the Joint Commission Root Cause Analysis (RCA) tool to review any adverse event or near miss/good catch to understand the causes so that effective corrective actions can be taken. NRHN is committed to the use of data to maintain accountability, prioritize improvement projects and measure the results of change to ensure that the organization has achieved and sustained improvement.

2. NRHN’s Quality Structure & Process
NRHN’s Director of Quality and Risk Management (QRM) has responsibility for the day to day operations of the quality improvement programs. NRHN develops an annual Quality Improvement Plan which details the structure of the quality program and goals for the coming year. The Director of QRM coordinates the monthly Quality and Patient Safety Committee (Q&PS Committee), which oversees the quality programs for all inpatient, outpatient and home care services. The Q&PS Committee includes the VP/CNO, the Chief Medical Officer, and representatives from clinical and operational departments.

Internally, quality measures are reported as part of NRHN’s robust performance improvement and safety program. Quality measures are reported throughout the organization to leadership groups, such as the Q&PS Committee, the Medical Executive Committee (MEC) and the Governing Board, to frontline providers of care and to patients and their families.

Externally, NRHN reports quality measures as part of the CMS Inpatient Rehabilitation Facility Quality Reporting Program (IRF-QRP) and to the New Hampshire and Massachusetts Department of Public Health Serious Event Reporting programs. The MEC and the Governing Board receive quarterly quality reports that include a dashboard as well as a summary of the quality meetings and the hospital’s performance improvement teams. In addition to the Q&PS Committee and the project/performance improvement teams, NRHN also organizes Unit Practice Councils (UPCs), extraprofessional teams that engage unit-based providers in quality
improvement projects. Each unit has a quarterly Clinical Operations Meeting that is led by the VP/CNO where unit-based outcomes and quality initiatives are discussed to identify continued opportunities for improvement.

NRHN submits data to CMS as part of the IRF-QRP and receives benchmarking data comparing NRHN to other IRFs. This data drives NRHN’s performance improvement initiatives.

3. NRHN’s Quality Outcomes
IRFs receive quality comparison data from CMS through the IRF-QRP online tool in which NRHN can access Certification and Survey Provider Enhanced Reports (CASPER). IRFs have access to their own CMS Measures and their own comparison group, which is approximately 1,100 IRFs. The data from all IRFs make up the national average against which IRFs are compared. The data included in the CASPER reports is obtained primarily through the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), which is required by CMS for every inpatient admission. According to NRHN’s most recent CASPER report, NRHN performed at or above the national average on most measures. (See Exhibit 8)

Overall, NRHN demonstrated:

- Lower than average Pressure Ulcers – new or worsened (NRHN had ZERO occurrences)
- Higher than average improvement of Self-Care scores
- Higher than average number of patients appropriately given the Influenza vaccine
- Higher than average Influenza vaccination for personnel (NRHN had a 99% compliance rate whereas the national average was 87%)
- Meeting national benchmark for Catheter Associated Urinary Tract Infections (CAUTI) and C-Diff Infections
- Meeting national benchmark for patients discharged with Functional Assessments and Care Plans
- Meeting national benchmark for all cause unplanned 30-day Readmission measure and potentially preventable within stay readmissions (acute transfers). (Id.)

NRHN performed marginally below the national average in only two measures (Id.), and has engaged in initiatives to improve its performance as follows:
- Potentially preventable 30-day post discharge re-admission: NRHN has increased focus on navigating the care continuum for identified high risk populations and has implemented processes to ensure timely physician follow up post discharge and high-risk telephone screening.

- Community Discharge: NRHN has convened a multidisciplinary improvement team, established high-risk clinical pathways, and implemented a nurse navigator program, which has resulted in a significant improvement in NRHN’s discharge rate to the community.

G. NRHN’s Accreditations

NRHN is accredited by The Joint Commission (TJC) (See Exhibit 9a) and is certified by the Centers for Medicare and Medicaid Services (CMS) (See Exhibit 9b). NRHN is also proud to have earned TJC Disease Specific Care Certification in Stroke Rehabilitation, Brain Injury Rehabilitation, and Amputee Rehabilitation. (See Exhibit 9c)

The most recent TJC survey was conducted in March, 2016. TJC surveyed all four inpatient sites, all outpatient sites, and NHCS. At the conclusion of the survey, TJC granted full accreditation to NRHN and NHCS through March 19, 2019, and recommended NRHN and NHCS for continued Medicare certification.

NRHN is also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The most recent CARF survey was conducted in April, 2017. The survey covered Inpatient Rehabilitation Hospital Programs for Adults, Children and Adolescents. In addition, the survey covered Inpatient Rehabilitation Hospital Brain Injury Programs for adults as well as Inpatient Rehabilitation Hospital Stroke Specialty Programs for adults. Based on this survey, NRHN was granted a three-year CARF Accreditation through May 31, 2020. (See Exhibit 9d)

H. NRHN’s Patient Satisfaction

NRHN is committed to a Patient and Family Centered Care model of care. NRHN realizes that it must treat not only the patient, but the entire family in the context of the patient’s new disability or injury. NRHN’s dedication to Patient and Family Centered Care means that it respects and collaborates with patients and families and encourages their participation in the designed plan of care and overall decision-making. This model of care creates a welcoming environment that promotes healing and recovery for patients and their families.
NRHN has been voluntarily measuring patient satisfaction since 2012. Press Ganey results for 2017 indicate that NRHN has attained a rank of 81% nationwide for “overall satisfaction”, and a rank of 86% nationwide for “likelihood to recommend”.

B. **Certificate of Need Unit Discussion**

i. **CON Standards**

Relevant standards for inclusion in this section are specific to the determination that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.

ii. **CON Unit Analysis**

Northeast Rehabilitation Hospital Network (NRHN) operates four Inpatient Rehabilitation Facilities (IRF) in Salem, Nashua, Portsmouth and Manchester, New Hampshire, with a total of 135 beds. The Salem and Portsmouth facility are freestanding IRF’s while the Nashua and Portsmouth facilities are satellite IRF’s in collaboration with Southern New Hampshire Medical Center and Elliot Hospital respectively. NRHN operates twenty outpatient clinics in both New Hampshire and Massachusetts and a CMS certified home care agency.

As stated previously by the applicant the State of New Hampshire surveys each inpatient location prior to granting a State Facility License. This license must be renewed annually with NRHN submitting attestations for each facility as requested by the State of New Hampshire. The applicant submitted licenses for each IRF. Details follow:
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<td>67</td>
<td>John F Prochilo</td>
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<td>Northeast Rehabilitation Hospital</td>
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CONU utilized the Inpatient Rehabilitation Facility Compare data available from the Medicare.gov website as well the most recent CASPER Report to review quality of patient care information. As noted by the applicant NRHN performed better than or equal to national benchmarks on most quality of patient care measures. The applicant identified these measures and included a plan of correction as follows:

- Potentially preventable 30-day post discharge re-admission:
  NRHN has increased focus on navigating the care continuum for identified high risk populations and has implemented processes to ensure timely physician follow up post discharge and high-risk telephone screening.

- Community Discharge:
  NRHN has convened a multidisciplinary improvement team, established high-risk clinical pathways, and implemented a nurse navigator program, which has resulted in a significant improvement in NRHN’s discharge rate to the community.

NRHN is accredited by The Joint Commission for both Hospital and Home Care Services and is certified by the Centers for Medicare and Medicaid Services.

The Commissioner can rely on data available to the department regarding the quality of health care provided by the applicant as allowed at M.R.S. 22 §337 (3).
Deeming of Standard

As provided for at 22 M.R.S. § 335 (7)(A), if the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.

NRHN is not currently licensed to provide IRF services in the state of Maine. The Deeming Standard does not apply.

Directly Affected Party Comments:

New England Rehabilitation Hospital of Portland (NERHP) submitted the following comments pertaining to the Fit, Willing and Able standard:

NERHP acknowledges that the existing New Hampshire locations of NRHN meet basic licensing and accreditation standards. However, NERHP has serious questions and reservations as to the ability of the Applicant to provide high-quality care that would meet or exceed the needs of patients in York County and all pertinent standards at a new 20-bed IRF unit for the reasons discussed below.

Concerns around operational feasibility, staffing, quality assurance, and adherence to CMS regulations cast serious doubt on the Applicant’s compliance with the fit, willing, and able criterion.

Feasibility of Operationalizing a 20-bed IRF Unit

At the June 7 Public Hearing, NERHP witnesses raised multiple concerns regarding the feasibility of operationalizing a 20-bed IRF Unit in York, Maine.

Challenges to Recruit Sufficient Numbers of Registered Nurses

Industry best practices recommend patient-to-nurse staffing ratios of 7:1 at IRFs. In her June 16, 2018 letter to DHHS, Christina J. Cote, D.O., a board-certified physical medicine and rehabilitation physician employed by NRHN primarily through its Salem facility, states: “The IDEAL ratio in the setting of acute inpatient rehab is 6-7 patients per rehab nurse.” (Appendix, Exhibit C-4.) Commenting on the ongoing challenge of maintaining this ratio, Jeanine Chesley and Marge Wiggins stressed in their testimony the growing shortage of registered nurses in Maine, which is projected to increase significantly in the coming years as baby-boomers retire. In her testimony, Ms. Chesley offers supplemental comments on this key issue and the ongoing challenge it poses to NERHP (Appendix, Exhibit A-3):
"Registered nurse recruitment and retention has been an ongoing problem. Ensuring the nursing staff are clinically competent to manage the types of patients we care for is also a struggle. During 2017, New England Rehabilitation Hospital of Portland (NERHP) paid our nursing staff for orientation and education hours totaling approximately $250,000. This does not include the costs of the courses they may have attended, only the hourly wage times the number of education and orientation hours.

According to the Maine Nursing Infographic, attached as Exhibit A-4, 40% of the registered nurses in York and Cumberland County are over the age of 55 and can be expected to leave the workforce over the next ten years. The age of the RNs working at NERHP are consistent with this statistic. We can expect to have to replace 40% of our nurses (not including normal turnover) in the next 10 years, during a time when the number of nurses available is predicted to be at least 400 per year short of the demand.

Nursing vacancies and call outs are something that the hospital deals with every day. In order to cover our vacancies or call outs and insure that the patients receive the care they need, during 2017 NERHP paid more than $900,000 in premium pay and overtime hours for nursing staff. The hospital hired a full-time nursing scheduler to ensure that nursing staffing is appropriate. There have been times in the past, before we changed our approach about nursing retention, when the hospital has held admissions due to lack of nursing staff to care for the patient. Even with the improvements in retention, the concern is as the nursing shortage continues to grow, the hospital could be put back into the position of holding admissions, therefore not allowing patients who need and deserve acute rehabilitation the opportunity to get it. Acute rehabilitation will not be the only ones affected by the nursing shortage, skilled nursing facilities, home health, physician practices and acute care hospitals will find it increasingly difficult to recruit and retain qualified nursing staff.

Adding another acute rehabilitation hospital in southern Maine will only exacerbate the nursing shortage, creating even more demand on a diminishing workforce."

Marge Wiggins, NERHP Board Member and Chief Nursing Officer for Maine Medical Center, shared additional concerns that call into question the feasibility of a 20-bed IRF unit (Appendix, Exhibit A-6):

"The last point I would like to make is that a 20-bed facility is not only unnecessary, it is an inefficient use of staff. Whether the unit has a few patients or 20, it needs to be minimally staffed creating a waste of precious resources. Maine is facing a significant shortage of clinical staff. In nursing alone, we are expecting to be up to 400 nurses short in our graduating classes each year for the next 8 years or 3,200 nurses less than what we need. Left unaddressed, that will create a 30 percent vacancy rate in our state. Although we have made significant effort in the state, our educational systems have not been able

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4 The testimony inadvertently says "65" instead of "55."
to expand to meet the predicted need due to faculty shortages. Our state is not alone. The entire United States will encounter this shortage as baby boomers, a large cohort of nursing, retire. The decrease of precious resources should encourage us to search for efficient use of clinical capacity, not create more excess capacity which will draw on already limited resources.”

Multiple Difficulties in Staffing Joint Commission Certified Specialty Rehabilitation Programs
Dr. Tom Morrione, the Medical Director for NERHP, provided extensive and insightful testimony at the public hearing (Appendix, Exhibit A-5) regarding the many difficulties facing the Applicant in staffing Joint Commission certified specialty rehabilitation programs, which NRH @ York proposes to offer for stroke, brain injury, and amputee rehabilitation (page 3 of the application).
Dr. Morrione first provided background on NERHP’s Joint Commission certified programs in stroke, amputation, hip fractures, and traumatic brain injury, and highlighted the importance of having sufficient patient volumes within each of these certified programs in order to justify employing specialized providers:

“NERH is proud to have 4 joint commission certified programs. Our oldest and most accomplished is our stroke program headed by Dr. Kazmi, now into its 11th year. In addition, we have joint commission certification programs in rehabilitation for amputation, hip fracture, of which I am also the program medical director, and traumatic brain injury, our newest of 3 years. Jeanine mentioned previously that approximately 20% of our patients are stroke, 10% traumatic brain injury, 10% hip fracture and about 5% amputation for a total of 45% of our patient population. These programs were developed to meet the volume of need that we had seen in the patient population admitted to NERH. They were constructed based on our own experience.”

He stressed that the much smaller daily census at a 20-bed IRF calls into question its ability to achieve and maintain certified status:

“Northeast states in the certificate of need also having certification programs in stroke, brain injury and amputation. Based on an expected average daily census of 16 per the certificate of need with a similar distribution that would equate to an average daily in-house population of 3 stroke patients, 1-2 patients with brain injury and less than 1 patient in the amputation program.

With these numbers, it would be difficult to develop and maintain successful focused programs. In fact, there are several programs that we have looked at that while we wish we could develop the specialty, we recognize we would not have the volume of admitted
patients to maintain the expertise and therefore, would be doing a disservice to not only the patient but also the community.

In addition to a separate dedicated physician with focused expertise as the program medical director, the team is comprised of a program leader as well as therapists and nurses who become the institutional specialists. One expectation for the program medical director is to be actively involved in guiding The Joint Commission certification performance improvement initiatives.”

Dr. Morrione noted still other shortcomings arising from a smaller-sized IRF that could impede its ability to develop relevant expertise and negatively impact the quality of services provided:

“Without a substantive number of patients, it is difficult to develop a relevant performance improvement initiative for a population. Without that critical number, it is even more difficult to evaluate the efficacy of the initiative. Our success in these programs is directly related to the volume of the patients that participate. It allows the team to become experts with not only the applicable published guidelines but also to foster the homegrown innovation that can only come from exposure with volume.

This expertise is generated by the number of participating patients which is then supplemented by time. To become truly specialized, you need not only the training but also the opportunity to put it into practice in a consistent and meaningful way.

For example, the volume of the stroke patients allows us to have therapists that focus on stroke rehabilitation almost exclusively. This accommodates further differentiation within the realm of stroke rehabilitation which is a critical component of specialization. We have developed the expertise in technology and treatment plans perfected by frequency of utilization. We now understand what will work best for what type of patient in a particular situation or circumstance and we continue to push that treatment envelope in an ever-shrinking time frame.”

He finally noted the negative impacts on any Joint Commission certified amputee specialty program:
"Another concern I have for the proposed programs is with an average length of stay of 2 weeks at 5% of the total patient population, the proposed amputation program would consist of about 24 patients over the year. As outlined above it would be difficult to develop a specialized program for 24 patients. Unfortunately, this would not be the only impact as there is a fixed number of these patients in a given year in the region. These 24 patients would subsequently reduce our patient population at New England Rehabilitation Hospital. This reduction then would impact our ability to maintain the specialization that comes with the volume."

Together, these multiple concerns call into serious question the ability of NRH @ York to recruit, retain, and train specialized staff to provide high-quality rehabilitative care to patients and maintain the three Specialty Rehabilitation Programs it lists in the application—in stroke, brain injury, and amputee rehabilitation.

Critical Importance of the Medicare 60% Rule to NRH @ York
The NRH @ York application is premised on this new hospital receiving payments under Medicare’s Prospective Payment System as an in-patient rehabilitation hospital or in-patient rehabilitation unit (referred to by CMS as an “IRF”). These PPS IRF payments are significantly higher than PPS payments made to general acute care hospitals for similar services. To receive these enhanced IRF prospective payments, an IRF must serve, over each 12-month period, an in-patient population of which at least 60% require intensive rehabilitation services for one or more of the 13 conditions set forth in the rule, 42 C.F.R. § 412.29 (Appendix, Exhibit A-1) (hereinafter sometimes referred to as the “60% Rule”).

New IRF hospitals and units are considered “new” for their first five years, and must have written certification of compliance for their first year. § 412.29(c). If the 60% Rule is not fulfilled based on actual data, the new IRF is subject to retroactive adjustments. § 412.29(f). (In Part B (1) below, and also in a letter (Appendix, Exhibit B-1), Rob Wisner, Senior Vice President of Reimbursement for Encompass Health, reviews the adverse consequences of failing to comply with the 60% Rule.)

Likewise, existing IRFs must show compliance with the 60% Rule on an ongoing basis for each Medicare cost reporting period. § 412.29(b)(1). Under subparagraph (b)(2), the 13 required conditions are summarized as follows: (1) stroke; (2) spinal cord injury; (3) congenital deformity; (4) amputation; (5) major multiple trauma; (6) fracture of femur; (7) brain injury; (8) neurological disorders; (9) burns; (10) Rheumatoid Arthritis and other arthritic conditions; (11) systematic vasculitides with joint inflammation; (12) severe or advanced Osteoarthritis; (13) knee or hip joint replacement (if stipulated criteria are met).

Maintaining ongoing compliance with the 60% Rule is a significant challenge for NERHP as well as many other IRFs around the country. For example, for its last reporting period of September 1, 2016 to August 31, 2017, NERHP was able to demonstrate that 62% of its patients were being treated for one of the 13 required conditions. NERHP viewed the remaining 38% as proper admissions, and the patients benefited from treatment for a wide range of other conditions, or conditions that fell within the above listing, but did not have all of the attributes called for under the 60% Rule (such as cardiac or pulmonary patients).

NERHP has significant concerns about the ability of both NERHP and NRH @ York to simultaneously satisfy the 60% Rule on an ongoing basis. As Dr. Elissa Charbonneau, Medical
Director for Encompass Health and formerly Medical Director for NERHP, states in her testimony (Appendix, Exhibit A-2):

"[I]n order to maintain our status as an acute rehabilitation hospital, 60 percent of the patients that we admit have to have a diagnosis from 13 diagnostic categories. Our Portland hospital generally operates at about 62 percent of its patients meeting the 60 percent rule. It would be hard to maintain 60 percent with a very small unit or a small-sized hospital. We have serious questions as to the ability of a 20-bed unit, which realistically might have 15 or 16 patients, to meet this important standard. I also question its ability to do so in a way that's economically and financially feasible."

The challenges posed by ongoing compliance with the 60% Rule have also been recognized by Dr. Christina J. Cote, a physical medicine and rehabilitation physician employed by NRHN, at pages 1-2 of her June 16, 2016 letter. (Appendix, Exhibit C-4.) She reviews the multiple clinical and regulatory requirements involved and notes that some patients are not able to fulfill initially "optimistic" expectations that envisioned transitioning them to the community, and they instead are eventually transitioned to a skilled nursing facility. These and many related factors cause Dr. Cote to conclude that "a 20 bed unit is too large for the York Hospital location and the surrounding community." (Dr. Cote’s letter is further reviewed Part C (Public Need) below.) As further shown below in Part C, both facilities will be drawing from overlapping patient service areas. The movement of only a few patients with these conditions from NERHP to NRH @ York would jeopardize NERHP’s fulfillment of the 60% Rule. Likewise, compliance on the part of NRH @ York would pose additional challenges, because the 60% test would operate on a smaller patient base.

Should either NERHP or NRH @ York fail to meet the 60% Rule in a given reporting period, the negative economic consequences to each would be devastating and directly threaten both the care they provide to patients and their economic and financial viability. The losses of PPS IRF payments would also "negatively affect the quality of care of existing providers [NERHP]."

Satellite Facility Requirements
The proposed hospital does not appear to fulfill all of the federal Medicare regulatory requirements governing satellite facilities. The application asserts at page 3 that:

NRH @ York will function as a satellite of NRH @ Salem, NRHN’s free-standing IRF located in Salem, New Hampshire.

An accompanying footnote references 42 C.F.R. § 412.22(h) as conferring satellite status on facilities that are part of a hospital or on the same campus. Importantly, NRH @ York is not seeking satellite status in connection with the York Hospital but rather asserts that it will have that status with respect to NRH @ Salem. It must therefore meet the more detailed requirements of 42 C.F.R. § 413.65(e)(3)(i), governing the location of off-campus facilities that seek provider-based status. The regulation states:
(i) The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider.

The York campus is outside of the required 35-mile radius (it is 44 miles from NRH @ Salem by car and 37.5 miles as the crow flies), and therefore does not qualify under CMS rules.

**Serious Questions Regarding MaineCare Participation Based on NRHN’s Medicaid Track Record**

The past actions and track record of the NRHN hospital system relating to New Hampshire’s Medicaid program raise serious questions as to NRHN’s level of commitment to serving the entire community, and whether the proposed NRH @ York will participate in any meaningful way in the MaineCare program.

This track record, measured by NRHN’s documented low levels of Medicaid patients and inconsistent and contradictory public statements and actions, demonstrates a strong antipathy to the Medicaid program and an unwillingness to accept Medicaid beneficiaries at NRHN hospitals. This information points directly to the conclusion that the proposed NRH @ York:

- Will not be “… fit, willing and able to provide the proposed services at the proper standard of care,” which necessarily requires acceptance of MaineCare participants on an equal and non-discriminatory basis (Criterion A, Section 335 (7)(A) of the CON law); and

- Will not fulfill “public need” under each of the Criteria C (1)-(4), Section 335 (7)(C) of the CON law, particularly Criterion C (3), requiring that “the project will be accessible to all residents of the area proposed to be served.”

**Application Shows No Projected Revenue from MaineCare**

The NRH @ York application states that the new hospital will participate in MaineCare, but the accompanying projections do not show any revenues coming from MaineCare for any of the first three years, FY 2021 through 2023.

The application at page 4 states that NRH @ York will “be a MaineCare participating provider.” And, at pages 21-22, it states as follows with respect to “state costs”:

“NRHN does not believe that costs to the State of Maine will increase because of NRH @ York. NRHN currently has both a Provider Agreement and Reimbursement Agreement with MaineCare. NRHN anticipates that MaineCare will extend the current agreements to cover services provided by NRH @ York at the existing reimbursement rates.”

However, in the application, there are no projections regarding the services that NRH @ York contemplates providing to MaineCare beneficiaries. The pro forma projections in the application do not include a Medicaid line. Rather, at page 14, the application includes a projection of “Free Care” ranging from $234K to $259K for FY 2021 through 2023. These same projections appear at Table 9B, and in the projected income statement for the project at Exhibit 10A. They also appear at Table 21 of Exhibit 10A, which provides selected financial ratios. No breakout is provided for services provided to MaineCare beneficiaries.
The application states at Exhibit 2 (page 2) that NRH @ York will adopt a Free Care Policy consistent with York’s policy. Presumably, the figures projected in the application are tied to the care to be provided under this Free Care Policy (and not Medicaid) in an attempt to comply with DHHS Rule Chapter 150, Free Care Guidelines, that sets forth the following standard for free care at section 1.02 (C):

*The Department establishes its income eligibility guidelines for free care based on one hundred and fifty percent (150%) of the Federal Poverty Level Guidelines (FPL).*

As the Department is well aware, Free Care and Medicaid are not synonymous and are never correctly combined in financial projections. Typically, such projections have distinct line items for Medicaid, Bad Debt and Free Care/Charity Care. The absence of financial projections relating to Medicaid beneficiaries is troubling but becomes more understandable upon review of NRHN’s track record and policies regarding Medicaid and free care.

NRHN Has Told SMHC and MMC that it Does Not Accept Patients Covered by Medicaid

NRH @ York represents in its application that it will be a “participating MaineCare provider” and that NRHN has a participating provider agreement with MaineCare. The MaineCare MyHealthPAS website currently lists Northeast Rehab Hospital and Neuro Rehab Associates as participating MaineCare providers. However, care managers at both Maine Medical Center and Southern Maine Health Care have long experienced the reality that NRHN hospitals will not accept Medicaid patients or patients without insurance. (Appendix, Exhibit A-7 (letter of Mary E. McNulty, MSN, RN, CCM, Senior Director, Case Management and Interpreter Services, Maine Medical Center), and Exhibit A-8 (letter of Helen Troy, Associate Vice President, Quality and Case Management, Southern Maine Health Care).)

These letters make clear that:

- NRHN hospitals in New Hampshire refuse to accept admissions of both MaineCare participants and uninsured patients who seek to be placed at these NRHN hospitals upon discharge from either MMC or SMHC; and

- Case managers seeking such placements have been told consistently that NRHN hospitals do not have contracts with MaineCare, when these hospitals are listed as participating providers on the MaineCare MyHealthPAS website.

This pattern of behavior and the refusal of NRHN – as an enrolled MaineCare provider – to accept MaineCare participants violates several provisions of MaineCare Benefits Manual 10-144 Ch. 101, Section 1.03-8, which states in pertinent part that enrolled providers must not:

- Interfere with a member’s freedom of choice in seeking medical care from any qualified MaineCare provider (1:03-8(C)); or

- Discourage or interfere with a member accessing medically necessary MaineCare services for which the member is eligible (1:03-8(D)).
NRHN Hospitals Show Very Low Levels of Participation in Medicaid
NRH @ York’s aversion to Medicaid beneficiaries is not surprising based upon NRHN’s long-standing reluctance to serve that population. A review of Medicaid cost reports filed for the NRHN system for the years 2012-2017 reveals major deficiencies in the level of care provided to Medicaid beneficiaries. NERHP has reviewed Medicare cost report data downloaded from www.CostReportData.com for the NRHN system, which is “derived from raw electronic data obtained from Medicare and Medicaid Services (CMS).” These reports show the following levels of Medicaid participation by the combined NRHN hospitals over the past six years:

<table>
<thead>
<tr>
<th>NRHN Medicaid Data</th>
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</thead>
<tbody>
<tr>
<td><strong>Cost Report</strong></td>
</tr>
<tr>
<td>2012 (year ending 5/31/12)</td>
</tr>
<tr>
<td>2013 (year ending 5/31/13)</td>
</tr>
<tr>
<td>2014 (year ending 5/31/14)</td>
</tr>
<tr>
<td>2015 (year ending 5/31/15)</td>
</tr>
<tr>
<td>2016 (year ending 5/31/16)</td>
</tr>
<tr>
<td>2017 (year ending 5/31/17)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

Clearly, NRHN has a poor record of serving the financially vulnerable in our communities. In sharp contrast, NERHP typically served between 7% and 10% Medicaid patients over the same period:

<table>
<thead>
<tr>
<th>NERHP Medicaid Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost Report</strong></td>
</tr>
<tr>
<td>2012 (year ending 12/31/12)</td>
</tr>
<tr>
<td>2013 (year ending 12/31/13)</td>
</tr>
<tr>
<td>2014 (year ending 12/31/14)</td>
</tr>
<tr>
<td>2015 (year ending 12/31/15)</td>
</tr>
<tr>
<td>2016 (year ending 12/31/16)</td>
</tr>
<tr>
<td>2017 (year ending 12/31/17)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

NRHN’s Opposition to New Hampshire Medicaid Enhancement Tax Further Reflects NRHN’s Antipathy to Medicaid

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5 Note to CONU staff: Due to the volume of these www.CostReportData.com reports, each of which is approximately 90 pages, NERHP is sending them electronically to CONU staff, with copies to counsel for NRH @ York. NERHP requests that these reports be made part of the record.
In 2013, NRHN supported legislation introduced in the New Hampshire Legislature, SB 130, which proposed to exempt specialty rehabilitation hospitals from the New Hampshire Medicaid Enhancement Tax. The PowerPoint presentation that the Chief Executive Officer of NRHN presented to the New Hampshire Senate Ways and Means Committee on February 5, 2013, in opposition to the provider tax assessment against his hospitals, is set forth in the Appendix (Exhibit A-9). The PowerPoint stated in pertinent part:

We provide inpatient and outpatient rehabilitation services to primarily elderly and disabled patients who are primarily insured by MEDICARE – not Medicaid
Over 70% of patients in our hospitals are insured by MEDICARE
About 4% of our patients are insured by Medicaid – similar to other rehab hospitals

The New Hampshire legislature did not enact SB 130, however.

The Maine Hospital Tax, 36 M.R.S. § 2891, et seq. applies broadly to all hospitals, including inpatient rehabilitation providers such as NERHP. For the state fiscal year 2018, NERHP paid $807,706 in hospital tax based on 2.23% of its net operating revenue. It has continuously made payments dating back to the enactment of the tax in 2001. While NERHP and other MaineHealth-affiliated hospitals have from time to time sought reductions in the level of the hospital tax, which ultimately impacts costs to patients and payors, they also have recognized that the hospital tax leverages significant additional federal Medicaid matching funds that assist the State in meeting its Medicaid program funding obligations.

By contrast, the documented track record and historical antipathy that NRHN has shown to Medicaid beneficiaries and uninsured patients raise serious doubts as to NRH @ York’s commitment to those patient populations.

Remaining Questions on MaineCare/Medicaid and Free Care
This track record, held by the parent entity of a new proposed provider in Maine, must be a primary focus of attention in the course of this review, as it impacts multiple CON review criteria. The Applicant should properly be asked, among other questions:

- Do NRHN hospitals in New Hampshire accept patients who are Medicaid participants at admission?
- Or do their Medicaid revenues arise only from patients qualifying for Medicaid following admission?
- Do the NRHN hospitals have free care policies? If so, what are those policies and how are they implemented?
- How would free care be implemented at NRH @ York?
- Will NRHN provide a policy clarification, as well as patient volume data by payer for the NRH Network as a whole and for the NRH @ Pease facility individually?

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6 As reflected in NRHN’s cost reports from that same time period, the NRHN CEO’s testimony to the legislative committee massively overshot NRHN’s Medicaid track record (by double). As an aside, in comparing NRHN’s Medicaid numbers to others in the industry, the NRHN CEO’s testimony also underreported the Medicaid track record of hospitals such as NERHP, which provided approximately 7-10% Medicaid during the same time period.

7 Ultimately, NRHN successfully sued for exclusion from the New Hampshire Medicaid provider tax. Materials and reports related to those legal proceedings are attached in the Appendix at Exhibits A-10 and A-11.
• Will NRH @ York participate in MaineCare? If so, at what levels? And what are the projections? Why was this category not listed in the projection?

**Applicant Response:**

**Nurse Staffing Shortages:**

NERHP’s assertions that its staffing problems will impact NRHN or that the new facility in York will negatively impact its ability to recruit staff have no basis in fact. NRHN is not in a position to explain NERHP’s recruiting difficulties. NRHN has attractive and state of the art facilities, capable management and team spirit among its employees, during its 30 plus years in existence NRHN has been able to attract and retain sufficient numbers of qualified staff. And, because of the location of its facilities, NRHN is able to successfully recruit from Maine, New Hampshire and Massachusetts. NRHN is fully confident that it will be able to appropriately staff the York facility. Because NRHN is a network of four other hospitals, if the need arises, it can readily move resources between hospitals – something that NERHP apparently is unable to do as easily.

**20 Bed Facility is Unnecessary and is an Inefficient Use of Staff**

NRHN points out that Encompass/HealthSouth opened three 20 -22 bed IRF’s in Massachusetts between 2012 and 2015 and cited its small size as an advantage because of providing more one on one care. NRHN is a true network that shares resources and expertise across all of its IRF’s. Accordingly, NERHP does not really have a specialized expertise in Inpatient Rehab as a result of its size. NRHN has 135 beds to NERHP’s 100 beds.

**Joint Commission Specialty Program Certification**

NRHN has had no difficulty obtaining TJC accreditation or specialty certifications, and fully anticipates being able to successfully achieve such accreditation for the York facility. With four IRF’s, over twenty outpatient clinics and a Home Care Division, NRHN truly operates as a Network. NRHN’s entire network is fully accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities. It has Disease specific care certification in stroke, brain and amputee rehabilitation.

**Medicaid Participation**

NERHP accuses NRHN of having a history of “avoiding Medicaid patients” and a “clear aversion to Medicaid. NERHP claims that: (i) the Application does not break out projected Medicaid revenue for NRH @ York (ii) NRHN does not accept Medicaid, (iii) NRHN treats a very low percentage of Medicaid patients and (iv) NRHN supported a bill before the New Hampshire
legislature in 2013 that would have exempted IRFs from the New Hampshire Medicaid Enhancement Tax.

It is important that NRHN provide an accurate snapshot of Medicaid participation by both NRHN and NERHP’s manager and part owner, Encompass/HealthSouth.

NRHN – Actual Medicaid Participation

| FY17 Medicaid Net Revenue as a % of Total Net Revenue | 8.1% |
| FY17 Medicaid Patient Days as a % of Total Patient Days | 5.4% |
| FY17 Medicaid Outpatient Visits as a % of Total Visits | 25.3% |

Encompass/HealthSouth – Actual Medicaid Participation

| FY17 Medicaid Net Revenue as a % of Total Revenue | 2.5% |
| FY18 Q1 Medicaid Net Revenue as a % of Total Revenue | 2.4% |

The CON financial module does not require a payor breakout but NRHN provides the following breakout which shows a Medicaid payor mix of 5.5%

<table>
<thead>
<tr>
<th>Payer</th>
<th>Days</th>
<th>%</th>
<th>Net Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>4243</td>
<td>75.0%</td>
<td>$ 6,918,321</td>
</tr>
<tr>
<td>Medicaid</td>
<td>311</td>
<td>5.5%</td>
<td>$ 248,930</td>
</tr>
<tr>
<td>HMO</td>
<td>688</td>
<td>12.2%</td>
<td>$ 756,672</td>
</tr>
<tr>
<td>Other</td>
<td>243</td>
<td>4.3%</td>
<td>$ 307,740</td>
</tr>
<tr>
<td>Free Care</td>
<td>173</td>
<td>3.0%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5658</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>$ 8,231,662</strong></td>
</tr>
</tbody>
</table>

NERHP utilized incorrect figures from the NRHN’s cost report when it stated that NRHN had only a 2.07% Medicaid payor mix. NERHP did not include NRHNS managed Medicaid patient days. If this data was included the actual percentage of Medicaid patients was 5.8%.

NRHN’s Support of New Hampshire Senate Bill 130
The purpose of SB 130 was to exempt IRFs from New Hampshire’s Medicaid Enhancement Tax (“MET”). Opposition to a tax has absolutely nothing to do with a provider’s inclination to care for Medicaid patients.

In 1991, the New Hampshire legislature was facing a significant budget deficit. To address this, it devised a new tax structure (the MET) to increase the amount of federal financial participation the State would receive from the federal government for its Medicaid program. Here’s how it worked.

On the morning of a particular day (determined by the State), the State would wire money to hospitals in the form of a Disproportionate Share Hospital (“DSH”) payment. In the afternoon of the same day, the hospitals were required to wire the exact same amount of money back to the State in the form of a MET payment. Under the Medicaid program, the federal government would then match 50% of the MET payments collected by the State, and the State would use those funds to balance the budget.

NRHN participated in the MET solely to assist the State in collecting the 50% match from the federal government. In fact, in order to get the hospitals in New Hampshire to originally agree to the MET, several state legislators, along with the then Commissioner of Health and Human Services and the then Commissioner of Revenue guaranteed the hospitals that the State would either hold them harmless (i.e., provide each with a full reimbursement for MET taxes in the form of equal DSH payments), or reduce the MET tax rate to zero if DSH payments ever became unavailable.

For almost 20 years, this is how the MET worked. And because the flow of DSH and MET payments was always a wash, most hospitals like NRHN did not even include the DSH/MET transaction on their books.

Then, in 2011, things changed dramatically and the MET became a real tax for NRHN. Because, by their nature, IRFs treat mostly Medicare patients, and do not offer the types of services that are most often utilized by Medicaid patients (e.g., primary care, emergency rooms, obstetrical, gynecological), many states do not include IRFs in provider taxes like the MET. Thus, once the MET became a real tax, NRHN sought to be exempt from it through SB 130, and challenged the constitutionality of the MET in court.

Therefore, NRHN’s support of SB 130 had absolutely nothing to do with any kind of “aversion to treating Medicaid patients.” It was all about doing the right thing for IRFs once the MET became a real tax. It should also be noted that Encompass/HealthSouth supported this bill.

Free Care

NRHN notes that all of its facilities have implemented free and reduced cost care policies. These policies have been in place for several years. NRHN accepts uninsured patients and provides free care in accordance with its Financial Assistance and Collection Policy. This policy provides for free care at 175% of the Federal Poverty Guidelines (“FPG”), which is more generous than Maine’s
Free Care Guidelines, 10-144 C.M.R. Ch. 150, that require free care at 150% of FPG. NRHN also provides discounted care up to 400% of FPG. Again, to show the unmitigated hypocrisy in NERHP’s comments, NRHN’s policy is actually more generous than NERHP’s free care policy, which provides for free care at 150% of FPG.

Though not entirely clear, NERHP appears to assert that NRHN does not accept Medicaid patients who are on Medicaid at the time of admission, and that NRHN requires uninsured patients to apply for Medicaid in order to obtain free or reduced-cost care. In response, first, NRHN treats Medicaid patients, including patients already on Medicaid when they are admitted. Second, requiring uninsured patients to apply for Medicaid in order to receive free or reduced-cost care is a universal practice by hospitals and there is nothing nefarious about it. NERHP’s own policy requires the same thing.

**CON Unit Final Analysis and Comments regarding Contradictory Commentary**

The CON statute at 22 MRS §335 (4) requires that any comments that are received be appropriately referenced in the record. If the application is subsequently acted upon by the commissioner the decision letter must specifically address comments received and made part of the record that favor action contrary to the final decision. In this case the CONU has included and commented upon all aspects of the applicant’s submission and now will discuss all the comments from the interested party, the vast majority of which do not reflect kindly on this proposal. Since there is a voluminous record and submission from both parties and they agree on little the decision letter, whichever the case, will necessarily be long and descriptive. The objective is to include all the information presented by the parties and make the necessary determinations required by the statute.

The comments below follow the issues brought up by the interested party that for the purposes of clarity will be referred to as New England Rehab. The interested party supplied their comments in reference to various parts of the application and CONU determined to review the questions as they applied in to the specific criteria CONU opinion and not necessarily in the sections referenced by the applicant. For example, some comments identified as belonging to this section have been identified as more appropriate to discuss during the presentation and review of high-quality outcomes. The interested parties’ comments are included in this section because, just as CONU does not determine where applicants make their comments, we do not rewrite the interested parties’ comments. If comments were not repeated we would repeat their presentation in the section of the preliminary analysis that was more properly addressed by the comments.

**Concerns around operational feasibility, staffing, quality assurance, and adherence to CMS regulations cast serious doubt on the Applicant’s compliance with the fit, willing, and able criterion.**
At the public hearing and in written submission related to the issues mentioned in the hearing, NERHP witnesses raised multiple concerns regarding the feasibility of operationalizing a 20-bed IRF Unit in York, Maine. These comments included:

- that there are significant challenges to recruiting sufficient numbers of Registered Nurses.
- The fact that there is a growing shortage of Registered Nurses in Maine, which is projected to increase significantly in the coming years as baby-boomers retire.
- The fact that adding another acute rehabilitation hospital in southern Maine will only exacerbate the nursing shortage.
- The concern that a 20-bed facility is not only unnecessary, it is an inefficient use of staff.

As a matter of public record NRHN does have several facilities with bed capacity of 20 beds as does one of the co-operators of New England Rehab. The issue of most effective means of providing that care is a topic of another section. This section is related to determining if the proposed services can be provided at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards. As discussed above this is clear that NRHN meets this specific standard as applied by the Department and therefore conjecture and opinion regarding this issue does not outweigh the evidence that NRHN or operations under its control do provide the current proposed services in a manner that meets or exceeds industry services.

NRHN’s history of avoiding Medicaid patients raises concerns regarding its intention to provide care to all members of the community.

In regards, to the comments regarding accepting Medicaid CONU believes the comments more properly lie in the Need section as there is a determination needed to be made that the program will be accessible to all people that need the service and as such is not germane to the section that New England Rehab responded to.

iii. Conclusion

The Certificate of Need Unit recommends that the Commissioner find that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.
III. Economic Feasibility

A. From Applicant

A. Financial Projections

NRHN has prepared financial projections for the first three years of operation of NRH @ York. Below is a summary of the financial projections which demonstrate the ability of NRHN to support operations and cash flow. (See Table I) The full details are included in the financial module. (See Exhibit 10a) Attached to the financial module is a Financing Proposal from Enterprise Bank for $5,630,000 for the project. (See Exhibit 10b) The interest rate in the Financing Proposal is the anticipated rate. However, because the financing will not occur until 2020, the final interest rate may vary, but will be commercially reasonable.

<table>
<thead>
<tr>
<th>Table I – Financial Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Proposed Year 1</td>
</tr>
<tr>
<td>2021</td>
</tr>
<tr>
<td>Net Patient Care Revenue</td>
</tr>
<tr>
<td>Total Operating Expense</td>
</tr>
<tr>
<td>Net Operating Income (Loss)</td>
</tr>
<tr>
<td>Non-Operating Revenue (Taxes)</td>
</tr>
<tr>
<td>Excess (Deficit) of Rev Over Exp</td>
</tr>
</tbody>
</table>

B. NRHN’s Ability to Support the Project Over its Useful Life

As reflected in its financial ratios for the network (2017), and the project (2021-2023), NRHN has the capacity to establish and successfully operate NRH @ York. NRHN has demonstrated financial success with its other facilities and has conducted a rigorous analysis and planning process for NRH @ York (Table II - Financial Performance Indicators).
### Table II - Financial Performance Indicators

<table>
<thead>
<tr>
<th>Financial Performance Indicators</th>
<th>2017</th>
<th>2018</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profitability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Margin</td>
<td>10.50%</td>
<td>20.92%</td>
<td>20.98%</td>
<td>20.08%</td>
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<tr>
<td>Net Margin</td>
<td>9.20%</td>
<td>10.73%</td>
<td>10.80%</td>
<td>10.26%</td>
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<tr>
<td>Return on Total Assets</td>
<td>30.34%</td>
<td>12.05%</td>
<td>11.67%</td>
<td>10.66%</td>
<td></td>
</tr>
<tr>
<td>Operating Surplus</td>
<td>$ -</td>
<td>$ -</td>
<td>$1,721,813</td>
<td>$1,754,731</td>
<td>$1,685,012</td>
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<tr>
<td>Total Surplus</td>
<td>$ -</td>
<td>$ -</td>
<td>$883,068</td>
<td>$902,839</td>
<td>$861,007</td>
</tr>
<tr>
<td>Liquidity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Ratio</td>
<td>1.70</td>
<td>-</td>
<td>1.77</td>
<td>2.59</td>
<td>3.24</td>
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<tr>
<td>Days in Account Receivable</td>
<td>46.00</td>
<td>-</td>
<td>47.42</td>
<td>47.29</td>
<td>47.42</td>
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<tr>
<td>Days Cash on Hand</td>
<td>17.30</td>
<td>-</td>
<td>5.37</td>
<td>45.40</td>
<td>80.07</td>
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<tr>
<td>Average Payment Period</td>
<td>22.50</td>
<td>-</td>
<td>12.69</td>
<td>13.69</td>
<td>14.23</td>
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<tr>
<td>Solvency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equity Financing</td>
<td>179.0%</td>
<td>-</td>
<td>47.7%</td>
<td>75.0%</td>
<td>109.9%</td>
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<tr>
<td>Debt Service Coverage</td>
<td>18.15</td>
<td>-</td>
<td>2.99</td>
<td>3.00</td>
<td>2.86</td>
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<tr>
<td>Cash Flow to Total Debt</td>
<td>57.9%</td>
<td>-</td>
<td>30.5%</td>
<td>39.1%</td>
<td>46.1%</td>
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<tr>
<td>Fixed Asset Financing</td>
<td>58.81</td>
<td>-</td>
<td>73.42</td>
<td>68.37</td>
<td>62.30</td>
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<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Asset Turnover</td>
<td>0.30</td>
<td>-</td>
<td>0.12</td>
<td>0.12</td>
<td>0.11</td>
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<tr>
<td>Fixed Asset Turnover</td>
<td>1.90</td>
<td>-</td>
<td>0.14</td>
<td>0.15</td>
<td>0.15</td>
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<td>Current Asset Turnover</td>
<td>0.42</td>
<td>-</td>
<td>0.74</td>
<td>0.48</td>
<td>0.35</td>
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<tr>
<td>Other</td>
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<tr>
<td>Total Net Assets</td>
<td>-</td>
<td>-</td>
<td>2,150,384</td>
<td>3,006,441</td>
<td>3,826,861</td>
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<tr>
<td>Board-Designated Funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gross Patient Service Revenue</td>
<td>-</td>
<td>-</td>
<td>16,310,573</td>
<td>16,415,802</td>
<td>16,521,032</td>
</tr>
<tr>
<td>Net Patient Service Revenue</td>
<td>-</td>
<td>-</td>
<td>8,231,662</td>
<td>8,363,404</td>
<td>8,393,463</td>
</tr>
<tr>
<td>Free Care</td>
<td>-</td>
<td>-</td>
<td>254,588</td>
<td>234,535</td>
<td>259,592</td>
</tr>
</tbody>
</table>

C. NRHN’s Ability to Operate NRH @ York in Accordance with Existing and Reasonably Anticipated Future Changes in Federal, State, and Local Licensure and Other Applicable or Potentially Applicable Rules

NRHN has a thirty-year history of operating IRFs in accordance with federal, state, and local licensure and other applicable rules. NRHN has experienced many changes in rules and payment methodologies and has repeatedly demonstrated the ability to successfully adapt to these changes and continue to meet the need of its patients and families.

### B. Certificate of Need Unit Discussion

i. CON Standards
Relevant standards for inclusion in this section are specific to the determination that the economic feasibility of the proposed services is demonstrated in terms of the:

- Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

- Applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.

ii. CON Unit Analysis

The applicant provided a memorandum of understanding between NRHN and York Hospital which gives a detailed description of this transaction and the responsibilities of each party. This project includes the construction of a single story, 20,030 square foot facility by York Hospital for a projected cost of $7,173,150. York Hospital will maintain ownership of the facility and will be responsible for site work and construction of the shell of the building and the main entry canopy. NRHN will be responsible for construction and improvements inside the shell, constructing an outdoor activity area, and performing designated renovations for a budgeted cost of $6,406,734. NRHN plans to finance approximately $5,630,000 of this expenditure and has submitted a financing proposal from Enterprise Bank offering interest rates between 4.98% and 5.63% with a fixed rate locked in for either 5 or 10 years. York Hospital will lease the building to NRHN at fair market value for an initial term of twenty years. The rent to be paid by NRHN to York will be twenty-two dollars per square foot per year plus an additional seven dollars per square foot per year for common area maintenance (approximately $580,870). NRHN will pay an estimated $805,000 to York for Ancillary (Pharmacy, Laboratory, Pastoral Care, Radiology, Respiratory Therapy, Diagnostic Testing and Emergency Medical Response) and Support Services (Clinical Engineering, Dietary, Housekeeping, Laundry/Linen, Maintenance, Patient Transport and Security). NRHN will own and operate the beds in the facility as a licensed inpatient rehabilitation hospital. All of the clinical staff and administrative staff will be NRHN employees. NRHN will be responsible for all licenses and regulatory compliance relating to the operation of the inpatient rehabilitation hospital, including Medicare certification.

The applicant submitted a complete financial module and compiled a table of financial indicators to demonstrate its capacity to financially support the project over its useful life. As stated by the applicant the 2017 ratios were derived from actual operating results of the NRHN network during this time period. In addition, CONU requested and received a copy of Neuro Rehab Associates Inc. d/b/a Northeast Rehabilitation Health Network audited financial statements for the years ended May 31, 2017 and 2016. Ratios for 2021 through 2023 were derived from financial projections contained in the CON financial module.

Based on a review of the applicants' financial projections and financial performance indicators CONU believes that the underlying assumptions regarding future performance are reasonable. In
Neuro Rehab Associates, Inc. New Inpatient Rehabilitation Hospital at York Hospital

Preliminary Analysis

addition, NRHN has sufficient resources to support this proposed project in the event that financial projections are not realized.

**Changing Laws and Regulations**

Certificate of Need Unit staff is not aware of any imminent or proposed changes in laws and regulations that would impact the project.

**Deeming of Standard**

As provided for at 22 M.R.S. § 335 (7)(B), if the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this standard if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with the applicable licensing and certification standards.

The applicant has not operated an IRF in Maine therefore the deeming standard does not apply.

**Bureau of Insurance Analysis:**

Pursuant to 22 M.R.S §335 (5-A) (I) the Superintendent of Insurance provided the following statement regarding the impact of this application on the cost of health insurance in the State:

"Due to the size of the project and the statement in the application that 70% of the services will be provided to Medicare eligible individuals that are not included in this analysis, the premium impact of this CON project on statewide and regionally private health insurance for the Northeast Rehab project in non-material or less than 0.1%.”

**Directly Affected Party Comments**

In Part A (Fit, Willing and Able) above, NERHP reviewed the challenges and difficulties encountered in achieving compliance with the Medicare 60% Rule, 42 C.F.R. § 412.29. Failure to achieve and maintain compliance would result in negative financial consequences and threaten the financial viability of the proposed NRH @ York.

To qualify for payment under the IRF PPS, an IRF must show that during its most recent compliance period it served an inpatient population where “at least 60 percent required intensive rehabilitation services for treatment of one or more of the [thirteen] conditions specified at paragraph (b)(2) of this section” (see Part A (2) above for a listing of the thirteen conditions). Failure to do so results in the loss of excluded status and reduces reimbursement to rates established under the Acute Care Inpatient Prospective Payment System (IPPS), which are significantly lower than those available under the IRF PPS.
These financial penalties extend for at least one full cost reporting period. As noted in 42 C.F.R. § 412.22 (d):

... for purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.

The loss of IRF PPS payments has devastating financial consequences. As the attached letter from Rob Wisner, Encompass Health’s Senior Vice President for Reimbursement (Appendix, Exhibit B-I), explains:

“Per 42 CFR 412.29, one of the requirements an Inpatient Rehabilitation Facility (IRF) must meet to be excluded from the Acute Care Inpatient Prospective Payment System (IPPS) is that the IRF must show that, during its most recent compliance period, it served an inpatient population ‘whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section’ (commonly referred to as the 60 percent rule). Furthermore, as noted in 42 CFR 412.22 (d), ‘for purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of the hospital are made only at the start of a cost reporting period.’ Therefore, if an IRF fails to meet the 60% compliance threshold, the IRF would lose its excluded PPS status at the beginning of the next cost reporting period and would be unable to regain its excluded status for at least 12 months (until the start of the subsequent cost reporting period) or longer if the IRF has not proven that it can meet the compliance threshold. The financial impact of losing the PPS exclusion is substantial. The underlying national base rate per discharge for a Maine hospital/satellite would decrease from $15,687 under the IRF PPS to $6,515 under the acute care IPPS or a reduction in payment of approximately 58 percent.”

Adverse Consequences of Failure to Achieve Satellite Status for York Campus
An IRF on the York campus cannot meet the 35-mile radius requirement because the distance between the two campuses is 37.5 miles. (See map at Part A (3), page 6 above.) In Part A of this submission, NERHP describes the Medicare regulations governing the location of off-campus facilities that seek provider-based status as a satellite under 42 C.F.R. § 413.65(e)(3)(i). If NRH @ York fails to qualify as a satellite location, it will have to qualify as a new freestanding hospital for Medicare certification. Doing so would result in a severe negative impact on year one revenue estimates.

CMS considers satellite locations as expansions of service. While a satellite location also undergoes a Medicare survey when it opens to ensure that the space is compliant with all federal requirements, it is exempt from the requirement to forego reimbursement for a minimum of thirty patients prior to the initial Medicare survey necessary to qualify as a Medicare provider.

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Based on FY 2018 final national standard base rates under the IRF PPS and Acute Care IPPS Centers for Medicare and Medicaid Services final rules. (Emphasis added.)
Neuro Rehab Associates, Inc.                      New Inpatient Rehabilitation Hospital at York Hospital
Preliminary Analysis

Freestanding facilities are not exempt. The number of treated patients may also be higher depending
on the time it takes to pass the survey. Until it does so, the proposed facility would be
effectively providing “free care” to all Medicare recipients.

Collectively, these thirty patients reflect approximately 10% of total projected year one Medicare
volume. The revenue projections on page 13 of the application estimate net patient revenue in
year one as $8,231,662. Multiplying the assumed 15.4 ADC by 365 provides an estimated 5,621
patient days. Dividing the estimated net patient revenue by the estimated patient days results in
approximately $1,464 in net patient revenue per patient day. A precise estimate is impossible
because the application provides limited information about payer mix and differing
reimbursement levels, but a reasonable approximation can be made by assuming equal payment
for all patients.

Thirty cases at the assumed ALOS of 11.8 days equals 354 days of foregone revenue equaling
$514,716. Net patient revenue for year one would drop to $7,716,946, a 6.3% reduction, while
operating expenses remain the same. While not as severe as failure to meet the 60%
requirement, this reduction casts doubt on the accuracy of the provided financial projections.

Failure to Address Lease Expense in Pro Forma Income Statement
The economic feasibility of the proposed NRH @ York facility is further called into question by
the fact that the pro forma income statement provided in Table 9B of the application appears to
omit any lease expense. The Operating Expenses category of the pro forma income statement
includes the following categories: Salaries, Benefits, Supplies, Depreciation, and Interest. There
is no provision for an operating lease (or rent) included.
The May 31, 2013, Cost Report for NRHNI, the parent corporation, submitted as a condition for
the approval of the CON to renovate its Salem hospital, provides additional categories: Other
Facility and Operating Costs, Purchased and Contracted Services, General and Administrative
Expenses, and Rent for Hospital Facilities.
The table below provides a common size analysis of selected income statement items provided in
the pro forma and taken from the 2013 and 2017 cost reports for NERH. Net Patient Revenue
(NPR) for Year 1 for the proposed project was calculated by subtracting contractual allowances
($7,824,323) and “free care” ($254,588) from an estimated $16,310,573 in Gross Patient
Revenue (GPR). These amounts represent 48.8% and 1.6% of GPR respectively.
NPR for 2013 for the parent was calculated by subtracting contractual allowances ($82,745,317)
and “bad debt” ($700,000) from $156,901,991 in Gross Patient Revenue (GPR). These amounts
represent 52.7% and 0.5% of GPR respectively. The NPR for 2017 was determined in a similar
manner.
Note that the Total Operating Expense ($65,588,948) for the parent in 2013 does not include that
year’s net interest expense of $681,497. The pro forma income statement from the CON
application includes this item. If it had been included in the parent’s financials, the total
operating expenses would have been $66,270,445, or 90.2% of NPR. Similarly, the 2017
amount would have risen to $94,408,159, leaving Net Operating Income at $7,619,641, or 7.5%
of NPR.

<table>
<thead>
<tr>
<th>Item</th>
<th>Table 9B Year 1</th>
<th>% of NPR</th>
<th>NERH Parent Financials</th>
<th>% of NPR</th>
<th>NERH Parent Financials</th>
<th>% of NPR</th>
</tr>
</thead>
</table>

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The Memorandum of Understanding (MOU), which is Exhibit 2 to the application, states that the proposed facility will have approximately 20,030 square feet and that the lease payment will be $29/SF, which reflects $22/SF for the building alone and $7/SF for maintenance of the common areas. The estimated annual cost will be $580,870. If this is added to the Total Operating Expense estimate in the application, the Total Operating Expense will rise to $7,090,719, or 86.1% of NPR, and reduce Net Operating Income to $1,140,943, or 13.9% of NPR. This percentage is somewhat closer to NRHN’s historical experience, lending credibility to the suggestion that the pro forma income statement omits the lease expense.

It is unclear whether the payment of an estimated $805,000 for support and ancillary services mentioned in the MOU (section 2(e)) is included within the five categories provided in the pro forma income statement for Year 1. In addition, the MOU appears flawed in key respects. Section 2(a), defining “NRH’s Role,” appears to be incomplete. There is no section 2(b), which section 2(c) cross-references as defining the nature of these ancillary services. NERHP requests that the applicant file a complete MOU, and that NERHP be given the opportunity to comment further on its provisions should it determine the need to do so.

In contrast, this category of support and ancillary services is included in the 2013 income statement of NERHP, as mentioned above. If this amount were added to the revised Total Operating Expense as calculated above, the new Total Operating Expense would be $7,895,662, further driving Net Operating Income down to $335,943, or 4.0% of NPR. This scenario represents a reduction of 80.5% in Net Operating Income as presented in the CON application, raising substantial questions about the economic feasibility of the proposed facility. NERHP urges that CON staff pursue further these important financial issues, both to determine: (1) that the proposed project is economically feasible, and (2) that the financial arrangements fully comply with pertinent federal laws and regulations governing referrals between health care practitioners and entities in which they have ownership or investment interests. These include the Stark Law, section 1877 of the Social Security Act, 42 U.S.C. 1395nn, and the Anti-Kickback Statute, section 1128B of the Social Security Act, 42 U.S.C. 1320a-7b(b).

The Stark Law and its implementing regulations set forth a broad prohibition on referrals for the provision of certain “designated health services” by physicians (including those in group practices) to entities in which they have investment interests, unless the arrangements fulfill certain statutory and regulatory exceptions and safe harbors. These designated health services include inpatient and outpatient hospital services and physical and occupational therapy, among others. 42 C.F.R § 411.351.

The Anti-Kickback Law and its implementing regulations set forth a broad prohibition on payment or receipt of any “remuneration . . . in return for referring an individual to a person for
the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program,” 42 U.S.C. 1320a-7b(b). This remuneration can be in the form of a return on investment interests or payments for space rental, among others. Several exceptions and safe harbors are provided. 42 C.F.R. §1001.952.
A critical element in the safe harbor governing payments for “space rental” is that the compensation or remuneration involved must be compliant with the following provisions of 42 C.F.R. §1001.952(b)(5):

“(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.”

The CON application states at page 3 that there will be “a long term fair market value lease.” The MOU, section 2(d), properly recites that the rental payments will incorporate the key language from §1001.952(b)(5) quoted above. Consistent with the applicant’s stated intentions, it is important that lease payments and expenses and payment for ancillary and support services be included and accurately stated in pro forma income statements and related schedules in sufficient detail to permit CON staff and the Commissioner to determine whether the financial arrangements are fully compliant with these fundamental regulatory requirements and are economically feasible.

Applicant Response:

NRHN has consistently met the 60% rule and fully expects that its 20 bed IRF on the campus of York Hospital will meet the 60% rule. All NRHN inpatient hospitals have achieved full compliance with the criteria set forth in the payment classification system. Compliance is measured and reported to CMS on an annual basis.

At this point, we would like to address NERHP’s supposition, here and elsewhere, that the Project would cause NERHP to lose volume. NRHN has never proposed pulling volume from NERHP to justify the need for the Project. There is substantial evidence of need based on the current volume of Maine patients being cared for at Pease and as expressed by the New Hampshire hospital CEOs at the public hearing. NRHN cannot explain NERHP’s relatively low volume, especially when NERHP has the distinct advantage of a very large feeder hospital and partner, Maine Medical Center (“MMC”), as well as other MaineHealth affiliate hospitals including Southern Maine Medical Center (“SMMC”). Yet, as Mr. Prochilo described at the public hearing, NRHN is receiving hundreds of referrals from MMC and SMMC, at its New Hampshire facilities.

NRHN does not intend to seek provider-based status because it is unnecessary. Provider-based status applies to facilities if the status of the facility as provider-based or freestanding affects the amount of payment under Medicare or the cost-sharing of a beneficiary in or at the facility. None
of these factors are affected whether NRH @ York is a satellite or a freestanding IRF, making provider-based status irrelevant.

**CON Unit Final Analysis and Comments regarding contradictory comments.**

The comments below follow the issues brought up by the interested party that for the purposes of clarity will be referred to as New England Rehab. The interested party supplied their comments in reference to various parts of the application and CONU determined to review the questions as they applied to the specific criteria. If comments were not repeated we would repeat their presentation in the section of the preliminary analysis that was more properly addressed by the comments.

NERHP doubts the Applicant’s financial viability based on its failure to meet satellite designation and the challenges the proposed hospital would face if not in compliance with the CMS 60% Rule. These doubts render the Applicant unable to satisfy the economic feasibility criterion in their opinion.

Maintaining ongoing compliance with the 60% rule is a significant challenge for NERHP as well as many other IRF’s around the country. NERHP has concerns about the ability of both NERHP and NRH@York to simultaneously satisfy the 60% rule on an ongoing basis. Both facilities will be drawing from overlapping patient service areas. The movement of only a few patients with these conditions could affect the ability of NRH@York and NERHP to meet this standard. Failure to meet this standard would have negative economic consequences.

NERHP does not believe that NRH@York will fulfill all of the federal Medicare regulatory requirements governing satellite facilities. The York campus is outside of the required 35-mile radius of the NRH@Salem facility.

CONU points out that the applicant’s other facilities meet the 60% requirements and therefore demonstrate the organizations ability to meet the standards. Doubts from another provider are not demonstrable facts.

**iii. Conclusion**

Certificate of Need Unit staff recommend that the Commissioner determine that the applicant has met their burden to demonstrate: (1) the capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and (2) the applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.
IV. Public Need

A. From Applicant

1. Rationale

There is a need for an IRF in York County, since none currently exist. Patients from the area must leave the county and travel to New England Rehabilitation Hospital of Portland, Maine, NRH @ Pease in Portsmouth, NH, or further distances, to access medically necessary hospital-level rehabilitation services.

NRHN believes that establishing a 20-bed IRF at York will alleviate the difficulties York County residents currently encounter in accessing IRF services. NRH @ Pease does not have the capacity to meet this need, since its bed capacity (33 beds), when approved under the then New Hampshire CON statute and rules, was only predicated on the IRF service needs of New Hampshire patients living in the so-called Seacoast Health Planning Region. In reality the need for beds was substantially greater since patients not only from New Hampshire, but also from Maine and Massachusetts, utilize NRH @ Pease. As a result, the occupancy rate at NRH @ Pease for the last three (3) years has been 93%, 94%, and 94% respectively. This limits patient access.

2. Projecting Need

NRHN engaged Stroudwater Associates of Portland, Maine, to conduct a demand analysis for acute rehabilitation care. The methodology and results of that analysis are set forth below.

Case estimates for NRH @ York are based on current data from the Maine Health Data Organization (MHDO), rehabilitation appropriate diagnoses as assigned by CMS, population growth estimates from Truven Health Analytics, and averages and observations from NRHN internal data sourced from its four current IRF locations.

According to data supplied by the MHDO, in 2016 there were 322 York County, Maine, residents discharged from Maine hospitals to an IRF or a Skilled Nursing Facility (SNF) with a diagnosis that mapped to one of the thirteen (13) acute rehabilitation appropriate diagnoses (determined by CMS IGCs (Impairment Group Codes) (referred to as “compliant” for IRF admission). This number serves as the baseline number of CMS compliant cases available for a potential York County IRF. NRHN assumes a conservative 60% market share capture of these cases, which would result in an estimated NRH @ York case volume of 193 in 2016. (See Table III below)

Truven Health Analytics data for York County show an estimated annual population growth of 0.88%, which is then applied to the 2016 estimated NRH @ York case volume, to provide a case volume of 202 in NRH @ York’s first full year of operations (April 1, 2020 – March 31, 2021). (See Table III below)
Additionally, CMS allows that 40% of patients at an IRF may come from conditions outside of the thirteen (13) acute rehabilitation appropriate diagnoses, if they meet other requirements, including the need for hospital-level IRF care. This provides an additional 135 cases. (See Table III below)

Therefore, the total number of estimated NRH @ York IRF cases for the first full year of operations, is 336. (See Table III below)

NRHN patient data from its four current IRF locations shows an average length of stay (ALOS) of 11.8 days for the period 2014-2016. Applying this ALOS to the estimated cases of 336, results in a total patient days count of 3,970. This results in average daily census (ADC) of 10.9 at the proposed NRH @ York. (See Table III below)

NRHN internal patient data shows an average of 8.4 patients daily at NRH @ Pease who are residents of Southern Maine. 3.9 of these 8.4 patients were discharged from a Maine Hospital and admitted to NRH @ Pease. These patients were included in the data supplied by the MHDO. The remaining 4.5 patients are patients residing in Maine who were discharged to NRH @ Pease from a hospital located in Massachusetts or New Hampshire. Because the MHDO database does not include Maine residents who were discharged from non-Maine hospitals, a constant ADC of 4.5 has been added to each year of the estimate calculator. (See Table III below)

Based on the methodology above, NRH @ York can therefore expect an ADC of 15.4 in its first full year of operations, increasing to 15.9 in 2026, and 16.4 in 2031. (See Table III below) This census represents a conservative estimate of 80% occupancy for NRH @ York in its first year of operation.
Table III – NRH @ York Volume Assumptions and Census Projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Total CMS 13 IGC Cases</th>
<th>NRHN Market Share Capture Estimate</th>
<th>Estimated 2016 NRHN York County CMS 13 IGC Cases</th>
<th>NRHN Current ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>322</td>
<td>60%</td>
<td>193</td>
<td>11.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NRHN York County Volume Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>2020</td>
</tr>
<tr>
<td>2021</td>
</tr>
<tr>
<td>2022</td>
</tr>
<tr>
<td>2023</td>
</tr>
<tr>
<td>2024</td>
</tr>
<tr>
<td>2025</td>
</tr>
<tr>
<td>2026</td>
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<td>2027</td>
</tr>
<tr>
<td>2028</td>
</tr>
<tr>
<td>2029</td>
</tr>
<tr>
<td>2030</td>
</tr>
<tr>
<td>2031</td>
</tr>
</tbody>
</table>

a. Patient Origin at Pease
In 2017, NRH @ Pease admitted 255 patients who originated from a Maine address. As noted above, this facility is undersized, in part because of regulatory constraints imposed by the former New Hampshire CON requirements that applied its bed/population ratio of 12/100,000 only to the New Hampshire Seacoast Health Planning area in its analysis of need. Thus, demand from Maine as well as Massachusetts was excluded. The under sizing of NRH @ Pease has been exacerbated by an ever-increasing demand for IRF services from patients residing in southern York County, Maine, which now consumes twenty five percent (25%) of the daily NRH @ Pease bed capacity (See Graphic I).
Graphic I - NRH@ Pease – Patient Origin Map

- Admissions from Maine
- Admissions from New Hampshire
- Admissions from Massachusetts
b. Service Area
Based on the patient origin data for NRH @ Pease, NRHN decided to study York County as the service area for the proposed NRH @ York. (See Graphic II)
c. Population Growth
The population in York County is expected to increase overall. Most significant increases will be realized in the 65+ population, which has the highest demand for IRF services. Note the 15.5% increase in projected population of residents in York County who are 65 years old and older. (See Graphic III – Service Population)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>39,327</td>
<td>37,840</td>
<td>-1,487</td>
<td>-3.8%</td>
</tr>
<tr>
<td>18-44</td>
<td>62,123</td>
<td>62,749</td>
<td>626</td>
<td>1.0%</td>
</tr>
<tr>
<td>45-64</td>
<td>63,123</td>
<td>61,781</td>
<td>-1,342</td>
<td>-2.1%</td>
</tr>
<tr>
<td>65+</td>
<td>37,532</td>
<td>43,430</td>
<td>5,898</td>
<td>15.7%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>202,105</td>
<td>205,800</td>
<td>3,695</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Source: Truven Health Analytics Demographic Projections

d. Provider Landscape
Currently, York County, depicted on the map below within the blue circle, does not have an IRF. (See Graphic IV) Patients and families from York County must travel north to New England Rehabilitation Hospital of Portland, south to NRH @ Pease, or to other facilities.

The map below depicts the existing regional IRFs, with orange markers identifying IRFs owned and operated by NRHN, and blue markers identifying all other IRFs. (Id.)
3. Impact on Health Status of the Population

As outlined in Part II of this application, NRHN has a commitment to providing high quality care and regularly monitors quality through a variety of sources. In the majority of instances, NRHN consistently performs at or above the national average in quality measures and demonstrates year over year improvement. NRHN will utilize its existing quality structure and processes and community education programs to ensure the same high-quality care is delivered to patients at NRH @ York.

4. Accessibility to Service Area Patients

NRH @ York will be accessible to all patients requiring IRF services. NRHN provides its communities with excellent services offered with dignity, caring, and respect. NRHN is committed to providing financial assistance to patients who are eligible to receive services, but are uninsured, underinsured, do not qualify for governmental assistance, or who are otherwise unable to pay for medically necessary care. Financial assistance is provided without regard to color, national origin, disability, marital status, race, religion, gender, age, ethnicity, social or immigration status, sexual orientation or insurance status. Additionally, NRH @ York will provide free and reduced cost care consistent with Maine’s free and reduced cost care laws and rules for hospitals.
Attached is a copy of NRHN's Financial Assistance and Collection Policy which defines the income eligibility criteria, the type of financial assistance, and the services that are included and excluded under this policy. (See Exhibit 11) Of course, the Policy as it applies to NRH @ York will be modified as necessary to comply with Maine law and rules.
B. Certificate of Need Unit Discussion

i. CON Standards

Relevant standards for inclusion in this section are specific to the determination that there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

- Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;
- Whether the project will have a positive impact on the health status indicators of the population to be served;
- Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
- Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

ii. CON Unit Analysis

The applicant is proposing to add 20 IRF beds in York, Maine. To determine public need, CONU analyzed demographic and service use trends in NRHNs' proposed service area (York County, Maine). CONU utilized the Older Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition, prepared by the Muskie School of Public Service and the U.S. Census Bureau’s website located at http://quickfacts.census.gov.

York County Maine is the second most populous county in Maine with an estimated population of 204,191 as of July 1, 2017 with approximately 19.7% of the population age 65 or older. This population is the primary consumer of IRF services. Maine’s 65 and above age group continues to grow at a rate faster than New England and the United States. The Muskie School projects growth in York County’s older population (65+) between 2012 and 2022 as an increase of 20,870 people (from 33,078 to 53,948 people) or a growth rate of approximately 63%.

NRHN engaged Stroudwater Associates of Portland, Maine to conduct a demand analysis for IRF services. Based on 2016 Maine Health Data Organization (MHDO) data regarding discharges from Maine Hospitals to an IRF or Skilled Nursing Facility (SNF) and an assumed market share of 60% NRH @ York is projecting a volume of 193 cases. This number only includes patients falling under the 13 acute rehabilitation diagnostic codes. Using Truven Analytics population growth estimates of .88% the first year of operation in 2021 is projected to have a case load of 200 patients plus an additional 135 cases that don’t fall under the 13 diagnostic codes. This would lead to a 336, 3,970 patient days and an average daily census of 10.9 days. An additional 4.5 days are added to account for Maine patients who are not discharged from a Maine Hospital. This brings the total projected average
daily census to 15.4 days or a 77% occupancy rate for 2021. NRHN further documented need by summarizing its' experience at its 33 bed Pease facility. Approximately 25% of its patient census consists of residents of southern York County, Maine.

Adding additional IRF beds would substantially address specific health problems associated with an aging population which is increasingly requiring more intensive care.

The applicant will offer the services affected by the project to all residents of the area proposed to be served and therefore will ensure accessibility of the service.

The project will provide demonstrable improvements in the outcome measures for patients that require IRF services. The applicant will utilize its existing quality structure and processes to ensure that high-quality care is delivered to patients at NRH @ York.

**Public Comments:**

A number of York County residents spoke in favor of this proposed project. In summary the commenters believe that:

There is a shortage of IRF services in the area which leads to waiting times.
Patient volume warrants the increase of 20 IRF beds.
There is a growing 65+ population in the York County area needing IRF services.
Convenience is important because family/friends involvement is important to the recovery process.
There is a lot of local support for the project.
Patients would benefit from private rooms at York Hospital.
Commenters recounted positive experiences with York Hospital and NRHN.

One commenter stated that there is a medical necessity for IRF services in York County but believes that 20 beds may be too large. The commenter believes that 12-14 beds would be more appropriate.

**Directly Affected Party Comments**

Based on the analysis that NERHP conducted and the further submissions and testimony cited below, there is not a demonstrated public need for the proposed services as demonstrated by certain factors, including:

Service Area
A health service facility's service area is typically defined as the geographic footprint from which 80% of the patients receiving services at that facility reside. When identifying the location of a new healthcare facility, it is important to acknowledge the location of existing healthcare facilities and their service areas. Typically, a healthcare facility’s service area surrounds the facility with a radius determined by the level of care provided at that facility.
The graph on page 22 of the CON application (Graph IV – Area Inpatient Rehab Facilities) identifies the existing inpatient rehabilitation facilities in Massachusetts, New Hampshire, and Southern Maine. A circle was added to this map that implied a lack of services provided in the York County, Maine area. For reference, this graph is included below as Figure 1:

Figure 1 - NRHN's Graph IV from Page 22 of the CON Application


When taking into account the service areas of existing IRF providers, claims of a gap in service are unfounded. Figure 2 illustrates NERHP’s primary service area and the estimated service area of NRH @ Pease. NERHP does not have access to data to accurately map NRH @ Pease patient origins but believes Figure 2 represents the reasonably assumed service area, considering the information provided in the application and the size of the NRH @ Pease facility.
Figure 2 illustrates that an overlap exists between NRH @ Pease and the existing NERHP facility in Portland. A need for an inpatient rehabilitation facility in York, ME is not present.

IRF Bed Availability

The application proposes a project that would add licensed inpatient rehabilitation beds to the market to alleviate the difficulty of accessing IRF services due to limited capacity at the applicant’s Pease facility of 33 beds. The applicant provided the occupancy rates at its Pease facility for the last three years, which were 93%, 94%, and 94%, respectively; in other words, an estimated average daily census of 31 patients. These statistics alone do not demonstrate a public need for an additional 20 inpatient rehabilitation beds in York County. In order to evaluate a need for additional beds, bed capacities of other IRFs in the service area should be considered.

The bed occupancy rate at NERHP for the same timeframe was between 66% and 71%, or an average daily census of roughly 67 patients. This is as much as 29.4%-33.3% excess capacity throughout each of these three years. This works out to NERHP having capacity for an additional 29-33 patients (or 26-30 based on staffed beds) at any given time. For comparison,
bed occupancy rates for inpatient rehabilitation facilities in Lowell and Beverly, Massachusetts are provided in Figure 3.

Figure 3 - Bed Occupancy in Lowell and Beverly Massachusetts 2015-2017

<table>
<thead>
<tr>
<th></th>
<th>Lowell</th>
<th>Beverly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Beds</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>2015 Occupancy</td>
<td>68.2%</td>
<td>55.9%</td>
</tr>
<tr>
<td>2016 Occupancy</td>
<td>66.8%</td>
<td>60.8%</td>
</tr>
<tr>
<td>2017 Occupancy</td>
<td>74.1%</td>
<td>72.5%</td>
</tr>
</tbody>
</table>

Source: Encompass Health Internal Data

Furthermore, at HealthSouth Rehabilitation Hospital of Concord, occupancy rates for calendar years 2015, 2016, and 2017 hovered between 62-65%. Licensed as a 50-bed facility, HealthSouth Rehabilitation Hospital of Concord has had capacity for an extra 18-19 patients at any given time.

This data illustrates that there are currently beds available at IRFs in the service area that are not being used. Based on the service area map above, patients in need of inpatient rehabilitation services have adequate services available today and a need for an additional 20-bed facility in York County is not present.

Provider Network Adequacy

In addition to bed availability, another way to measure reasonable access to care is by looking at the determined network adequacy as defined by the National Association for Insurance Commissioners.

According to the National Association for Insurance Commissioners, which is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, “Network adequacy refers to a health plan’s ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract.”

In other words, health plans must offer members reasonable access to a network of health care providers. Nearly half the states and the Medicare Advantage program have developed quantitative measures to assess network adequacy. Network adequacy measures typically focus on the following standards:

1. Wait Times;
2. Geography (time, distance, urban versus rural); and
3. Provider/Enrollee Ratio or Minimum Number of Providers (depending provider type).

Nearby, both New Hampshire and Vermont have developed quantitative measures to assess the adequacy of health plan provider networks. New Hampshire, for instance, requires access to most provider-types to within 45 miles. Similarly, Vermont requires access to most provider-types to within 60 minutes. Commercial insurers in Maine must submit an Access Plan to the Superintendent of Insurance. The plan must include a list of the network’s providers and facilities, provider/enrollee ratios by county, written standards for providing an adequate network, quantifiable and measurable standards for access to primary and high-volume specialty care, and timely access to care guidelines, among others. Currently, all major commercial insurers offer products in York County and all are deemed to have an adequate network.

Medicare Advantage plans now account for almost 30% of all Medicare enrollments in Maine. These plans are required to meet reasonable network access standards in order to offer a product within a county. Today, York County has approximately 15,000 Medicare Advantage enrollees representing 30% of the Medicare eligible with seven different insurance companies offering products. Medicare Advantage plans are not permitted to offer products where they do not meet these standards.

Residents of York County currently have access to high-quality inpatient rehabilitation care within all three typical network adequacy measurement standards: wait times, geographic considerations, and provider/enrollee ratios. With reasonable access to services in both Portland, Maine and Portsmouth, NH, the network as constituted today is substantially adequate and an increase in inpatient rehabilitation beds in York County is unwarranted.

Forecast Methodology
There are many factors that should be considered when planning long-term investments in healthcare services and facilities. The impacts of these factors vary depending on the service. Factors impacting healthcare planning include:

- Observed patient volumes;
- Changes in population;
- Epidemiology of disease;
- Economics of healthcare;
- Legislative and market-driven reform to payment and policy;
- Innovations in care delivery and new technologies; and
- The evolution of the systems of care.

The applicant’s demand forecast is based on current data from the Maine Health Data Organization (MHDO), rehabilitation-appropriate diagnoses as assigned by CMS, population growth estimates from Truven Health Analytics, and averages and observations from NRHN’s internal data sourced from its existing IRF locations. The factors listed above have influenced
NRHN’s historic data and MHDO, but it is not clear how these factors are accounted for in the applicant’s demand forecast. In addition, it is unclear how the flat trend of IRF patient volumes according to MHDO was accounted for, as seen in Figure 4.

Figure 4 - MHDO Inpatient Discharges by County from an Inpatient Rehabilitation Facility FY2014 - FY2017

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discharges</td>
<td>Days</td>
<td>ALOS</td>
<td>Days</td>
</tr>
<tr>
<td>Cumberland</td>
<td>1,023</td>
<td>14,611</td>
<td>14.3</td>
<td>999</td>
</tr>
<tr>
<td>York</td>
<td>474</td>
<td>6,706</td>
<td>14.1</td>
<td>479</td>
</tr>
<tr>
<td>Kennebec</td>
<td>358</td>
<td>4,530</td>
<td>12.7</td>
<td>355</td>
</tr>
<tr>
<td>Androscoggin</td>
<td>198</td>
<td>2,417</td>
<td>12.2</td>
<td>242</td>
</tr>
<tr>
<td>Penobscot</td>
<td>359</td>
<td>4,981</td>
<td>13.9</td>
<td>300</td>
</tr>
<tr>
<td>Aroostook</td>
<td>130</td>
<td>1,935</td>
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<tr>
<td>Oxford</td>
<td>77</td>
<td>1,121</td>
<td>14.6</td>
<td>89</td>
</tr>
<tr>
<td>Hancock</td>
<td>144</td>
<td>1,697</td>
<td>11.8</td>
<td>221</td>
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<tr>
<td>Sagadahoc</td>
<td>79</td>
<td>1,249</td>
<td>15.8</td>
<td>82</td>
</tr>
<tr>
<td>Somerset</td>
<td>98</td>
<td>1,451</td>
<td>14.8</td>
<td>117</td>
</tr>
<tr>
<td>Waldo</td>
<td>67</td>
<td>890</td>
<td>13.3</td>
<td>111</td>
</tr>
<tr>
<td>Washington</td>
<td>94</td>
<td>1,337</td>
<td>14.2</td>
<td>77</td>
</tr>
<tr>
<td>Franklin</td>
<td>51</td>
<td>666</td>
<td>13.1</td>
<td>56</td>
</tr>
<tr>
<td>Lincoln</td>
<td>65</td>
<td>1,335</td>
<td>17.5</td>
<td>74</td>
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<tr>
<td>Knox</td>
<td>48</td>
<td>726</td>
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<td>53</td>
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<td>Piscataquis</td>
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<td>553</td>
<td>9.4</td>
<td>79</td>
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<tr>
<td>Carroll</td>
<td>45</td>
<td>505</td>
<td>12.6</td>
<td>33</td>
</tr>
<tr>
<td>Blank*</td>
<td>5</td>
<td>54</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>3,372</td>
<td>46,624</td>
<td>13.8</td>
<td>3,512</td>
</tr>
</tbody>
</table>

*Blank are discharges of residents of Maine, with missing zip code data
Source: MHDO 2014-2017

NERHP uses Sg2 Healthcare Intelligence and existing trends to forecast demand for services. The factors that are included in any Sg2 demand forecast are available in the Appendix (Exhibit C-1). Figure 5 demonstrates how these factors are estimated to impact the demand for inpatient rehabilitation services in York County by 2026.
Figure 5 - Sg2 Impact Factors Driving Change in IRF Volume in York County 2016-2026

- 10.1% Net Change in Demand for Inpatient Rehabilitation Services

Source: Sg2 Healthcare Analytics

Figure 6 - Sg2 Impact Factors Driving Change in IRF Volume in Maine & New Hampshire 2016-2026

- 11.5% Net Change in Demand for Inpatient Rehabilitation Services

Source: Sg2 Healthcare Analytics
The demand for inpatient rehabilitation services in York County is anticipated to decline by 10.1% and in Maine and New Hampshire as a whole demand is anticipated to decline by 11.5% over the next 10 years, as seen in Figure 6.

The impact these factors can have on the demand for inpatient rehabilitation services are apparent in a few examples.

In orthopedic care, joint replacements historically accounted for a large proportion of inpatient rehabilitation volume whereas today it accounts for only a fraction, as mentioned in Dr. Charbonneau’s letter (Appendix, Exhibit A-2). This trend is anticipated to continue, as published in Sg2 Intelligence: “Increased penetration of bundled payment models for total joint replacement will dramatically reduce use of inpatient rehab for these (orthopedic) patients.” (Appendix, Exhibit C-2, article entitled, System of Care Guide – Inpatient Rehabilitation.)

In stroke care, there are changes happening today that are improving recovery times of ischemic stroke that are anticipated to reduce the need for extensive follow up and inpatient rehabilitation care. Studies from Sg2 of post-acute care trends illustrate a 9% reduction in volumes of IRF by 2028 and a 15% reduction in payments. Lower use of inpatient rehab and efficient SNF care reflect the market’s focus on improved efficiency. (Appendix, Exhibit C-3, article entitled, Planning Ahead of the Continuing Care Curve.)

Bed Need Analysis
A bed need analysis is typically conducted to determine the amount of inpatient beds that are needed based on the projected number of patient days. Patient days accounts for the anticipated length of stay. A bed need analysis of the current and forecasted inpatient rehabilitation patient days in Cumberland and York Counties, and in the State of Maine, suggests there are sufficient inpatient rehab beds today. The bed need analysis shows a decrease in bed need in the next 10 years. In order to compare this data with the applicant’s data, it is important to note that NRHN uses Truven projections that are fixed and that focus on population growth, while NERHP uses Sg2 projections that are more contemporary and accurately reflect Northern New England market conditions as listed in the above section, “Forecast Methodology.” The following bed need estimate is for Cumberland and York counties and Maine as a whole. Occupancy targets of 80%, 85%, and 90% are provided to describe the variability in the need for these services day-to-day.
## Figure 7 - Actual Bed Demand Figures for Cumberland and York Counties FY2014-FY2017

<table>
<thead>
<tr>
<th>County</th>
<th>FY2014</th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DISCHARGES</td>
<td>DAYS</td>
<td>DISCHARGES</td>
<td>DAYS</td>
</tr>
<tr>
<td>Cumberland</td>
<td>1,021</td>
<td>14,611</td>
<td>999</td>
<td>14,279</td>
</tr>
<tr>
<td>Cumberland ADC</td>
<td>1,021</td>
<td>14,611</td>
<td>999</td>
<td>14,279</td>
</tr>
<tr>
<td>York</td>
<td>474</td>
<td>6,706</td>
<td>479</td>
<td>6,797</td>
</tr>
<tr>
<td>York ADC</td>
<td>474</td>
<td>6,706</td>
<td>479</td>
<td>6,797</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1,495</td>
<td>21,317</td>
<td>1,478</td>
<td>21,026</td>
</tr>
<tr>
<td>Total Combined ADC</td>
<td>58</td>
<td>58</td>
<td>50</td>
<td>51</td>
</tr>
</tbody>
</table>

Source: MHDO 2014-2017

## Figure 8 - Forecasted Bed Demand Figures for Cumberland and York Counties 2018-2027

<table>
<thead>
<tr>
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<td>28</td>
<td>27</td>
<td>27</td>
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<tr>
<td>York</td>
<td>5,770</td>
<td>5,623</td>
<td>5,400</td>
<td>5,085</td>
<td>4,737</td>
<td>4,502</td>
<td>4,361</td>
<td>4,310</td>
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Source: MHDO 2014-2017

## Figure 9 - Estimated Bed Need Accounting for Targeted Occupancy Rates of 80%, 85%, and 90% for Cumberland and York Counties 2018-2027

### Bed Need at 80% Occupancy

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<tr>
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<tr>
<td>York</td>
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### Bed Need at 85% Occupancy

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<td>York</td>
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### Bed Need at 90% Occupancy

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<td>44</td>
<td>43</td>
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<td>43</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: Sg2 Healthcare Analytics; New England Rehabilitation Internal Data

As demonstrated in Figure 7, Figure 8, and Figure 9 above, Cumberland and York Counties currently have a bed need below 100 beds and can meet that need today.

When evaluating the need for IRF beds in the state as a whole, a similar conclusion can be made.
As demonstrated in Figure 10, Figure 11, and Figure 12 above, the state of Maine currently has a bed need below 150 beds and can meet the need today. In addition, the anticipated bed need will decline over the next 10 years.

NRHN Physician Concurs that 20-Bed Unit is not Needed
Additional analysis of bed need is laid out in the June 16, 2018 letter of Dr. Cote, offered from her salient experience as a physiatrist now employed by NRHN and formerly employed by NERHP. (Appendix, Exhibit C-4.) She reviews data on the number of acute and rehab beds at MMC, NERHP, Mercy Hospital and the NRHN hospitals, and notes that a 13-1 ratio (13 acute beds to 1 rehab bed) emerges. Applying this 13-1 ratio to York Hospital, she comments that “only a 6 bed inpatient rehabilitation facility would be needed” and concludes that “a 20 bed unit is too large for the York Hospital location and the surrounding community.” Her letter goes on to state that “a more realistic size for the proposed inpatient facility NRH @ York would be about 12 (to 14) beds.”

NERHP’s analysis in parts C (1)-(5) above demonstrates that no additional beds are needed and current and projected needs can be well handled by existing capacity at NERHP.

Staffing Shortage
There is a shortage of qualified nurses in Maine. Inpatient rehabilitation services rely on nurses that are specially trained in rehabilitative care and who are Certified Rehabilitation Registered Nurses (CRRN). The applicant does not address the difficulties of recruiting highly specialized
Neuro Rehab Associates, Inc. New Inpatient Rehabilitation Hospital at York Hospital Preliminary Analysis

care providers and their ability to provide access to all patients at the proposed NRH @ York facility.

The current and anticipated shortage of qualified care providers and the proposed facility has the potential to impact the quality of care provided at NERHP as elaborated upon previously in Part A of this document (Fit, Willing, and Able).

Conclusion: No Public Need
A public need does not exist for the proposed 20-bed NRH @ York facility due to the following factors demonstrated above:

- When considering the service areas of the existing IRF providers, there is not a need for a new inpatient rehabilitation facility in York, ME.
- There are currently beds available at the existing IRFs in the service area. Patients in need of inpatient rehabilitation services have adequate services available today.
- Residents of York County currently have access to high-quality inpatient rehabilitation care within all three typical network adequacy measurement standards: wait times, geographic considerations, and provider/enrollee ratios. An increase in inpatient rehabilitation beds in York County is unwarranted.
- When taking into account factors outside of population growth, the demand for inpatient rehabilitation services in York County is anticipated to decline by more than 10% in Cumberland and York Counties and in the state of Maine over the next 10 years.
- Maine currently has a bed need below 150 beds and can meet the need today. In addition, the anticipated bed need will decline over the next 10 years.
NERHP believes the Applicant has failed to fulfill the public need criterion, as residents of York County currently have access to high-quality inpatient rehabilitation care within all three typical network adequacy measurement standards. With existing bed availability at IRFs in the service area, an increase in inpatient rehabilitation beds in York County is unwarranted.

A public need does not exist for the proposed 20-bed NRH @ York facility due to the following factors demonstrated above:

- When considering the service areas of the existing IRF providers, there is not a need for a new inpatient rehabilitation facility in York, ME.
- There are currently beds available at the existing IRFs in the service area. Patients in need of inpatient rehabilitation services have adequate services available today.
- Residents of York County currently have access to high-quality inpatient rehabilitation care within all three typical network adequacy measurement standards: wait times, geographic considerations, and provider/enrollee ratios. An increase in inpatient rehabilitation beds in York County is unwarranted.
- When taking into account factors outside of population growth, the demand for inpatient rehabilitation services in York County is anticipated to decline by more than 10% in Cumberland and York Counties and in the state of Maine over the next 10 years.
- Maine currently has a bed need below 150 beds and can meet the need today. In addition, the anticipated bed need will decline over the next 10 years.

**Applicant Response**

As described in the Application and reiterated in its public comments, NRHN used a conservative and sound method to study the public need for the project. Relying on data from the Maine Health Data Organization (MHDO), The Centers for Medicare and Medicaid Services (CMS), Truven Health Analytics and NRHN’s internal data sources from its four (4) IRFs, and with the assistance of Stroudwater Associates, NRHN studied the need for Inpatient Rehabilitation Services in York County, ME very carefully, and determined that there is a demonstrated need for a minimum of a 20 Bed IRF in York, ME. None of the arguments made by NERHP undercut NRHN’s analysis or show in any reliable way that “there is no public need” for the project.

**Service Area:**

NERHP argues that its self-defined service area covers York County, thus there is no need for an IRF facility in York County. There is a lack of services provided in York County. There is a gap in services as shown in the Application, NRHN’s presentation at the public hearing, and public comments, including those of community members and hospital executives from the Seacoast.
NERHP’s map attempts to show that there is an adequate supply for IRF services for York County. First, this is an overly simplistic way to analyze need, and it is invalid. It appears NERHP is arguing that no new IRF service should be built within a 44.4 mile radius (driving distance from York Hospital campus to NERHP), or 40.4 miles as the crow flies (York Hospital campus to NERHP) just because its self-defined service area covers most of York County. NERHP portends that it, and it alone, possesses the sole franchise to serve York County. This is easily rebutted by the fact that hundreds of Maine patients currently leave York County, as well as other Maine locations, to obtain services from NRHN’s IRFs in New Hampshire.

As stated previously, NRHN receives hundreds of referrals from MMC and SMMC and its Pease facility admits several Maine patients a day. NERHP does not refute these facts. Clearly, NERHP is not fully serving the needs of this service area.

**Bed Availability:**

NERHP argues that its self-reported average daily census of 67 patients out of 100 licensed/90 staffed beds shows there is no public need in York County. NERHP further points to low occupancy rates at HealthSouth facilities in Concord, NH, Lowell, MA, and Beverly, MA, for further support. NRHN cannot and should not be required to explain why NERHP’s and other HealthSouth facilities have low census. NRHN can only report that they have consistently high occupancy rates in all of its facilities, and it serves hundreds of Maine patients. NERHP’s arguments about need also completely dismiss patient choice and ignore the desire and substantial benefits of having IRF services closer to home. NERHP’s low census does not change the reality that southern York County is a long distance from NERHP. Moreover, NERHP’s lack of appreciation for the issues associated with travel distances, especially for the elderly and their families/caregivers, is evident in its assertion that Lowell and Beverly, MA and Concord, NH are in the service area. These facilities are 62.2, 50.4, and 65.8 miles, respectively, from the York campus.

**Network Adequacy:**

Public need and network adequacy are apples and oranges. They serve entirely different purposes. Public need addresses serving the need of all residents in a given area. Network adequacy is a tool used to determine whether an insurance carrier’s contracted provider network is sufficient to serve its insured members. It is not an appropriate measuring stick because commercial carriers do not serve all residents. The number of insureds are fewer than all residents in an area. NERHP’s analysis ignores the need of regular Medicare, MaineCare, and uninsured patients.

NERHP is arguing, against best evidence, that it is appropriate to require patients and their families and friends to drive 45-60 miles (NH and VT network standards) for IRF services. Other than for primary care providers, specialists, and behavioral health, Maine does not have specific requirements for facility access or mileage. See 02-031 C.M.R. Ch. 850, § 7.

**Forecast Methodology and Bed Need Analysis**
NRHN provided a very detailed bed need analysis in its CON application and used market specific data in determining the need for IRF beds. NERHP utilizes Sg2’s analysis of trends but it’s conclusions do not reflect what is actually in the Sg2 reports. In particular Sg2 is forecasting an increase in IRF volumes, supports a strategy to redistribute rehabilitation beds into local communities to provide higher-quality and more convenient care and supports a reduction in travel time for families visiting rehab patients.

Turning to NERHP’s analysis of MHDO data to conclude that demand for IRF services is flat, this analysis suffers from a fatal flaw: The MHDO data only includes Maine residents who were discharged for IRF Services from Maine acute care hospitals. It does not include Maine residents who were discharged for IRF Services from New Hampshire or Massachusetts acute care hospitals. These patients are not in the MHDO data and NRHN included them in the Bed Need Analysis it presented in its CON Application.

NERHP’s Bed Need Analysis in their July 9, 2018 comments is based on assumptions that are completely contradictory to the forecasts provided by its managing member, Encompass/HealthSouth. In direct contrast to the increased demand which Encompass/HealthSouth is touting to its investors, NERHP’s need analysis forecasts a 10.1% decrease in the demand for IRF services for the period 2018 – 2027.

**CON Unit Final Analysis and Comments regarding contradictory comments**

The interested party makes a valient effort to explain away the issue that a significant number of persons needing care in Maine end up in IRF’s in New Hampshire instead of the beds available in Maine. As far as bed need, CONU realizes that this calculation is not an exact science as making a cut from 20 beds to 16 is not with the consent of the applicant or in relationship to the ability of the hospital to provide services. When there is a thought out methodology presented in the application and CONU generally accepts this methodology if it does not contain errors. The interested party is not stating that the methodology is in error, rather that one commentator suggested that the right size for the facility might be 12-14 beds. Likewise, the interested party notes that their facility is only at 66% occupancy with an ADC of around 67. It should be noted that the record contains comments from the interested party that NERHP has a license for 100 beds but has only capacity for 90. This is always an issue in reviewing services, especially when considering adding a provider. MaineHealth has the “inside-track” with providing the vast majority of patients that would require these services and CONU agrees that for a certain portion of York County it will be more likely to utilize the services of the applicant instead of the interested party. The CONU feels that a significant enough number of persons are regularly deciding not to invoke the services of NERHP and the fact that they have vacancies is more related to patients opting for other choices rather than there being a lack of patients.

**iii. Conclusion**

The Certificate of Need Unit recommends that the Commissioner find that the applicant has met their burden to show that there is a public need for the proposed project.
V. Orderly and Economic Development

A. From Applicant

A. Impact on Total Healthcare Expenditures

NRH @ York will further the orderly and economic development of health resources for York County by ensuring the continuation of needed services close to the homes of patients and families. The need for IRF services (presented in Part IV – Public Need) demonstrated that in 2016, over 300 York County residents discharged from hospitals in Maine qualified for IRF care based on CMS compliant diagnostic coding data. In addition, there are York County residents who are discharged from New Hampshire and Massachusetts hospitals who require IRF care (these cases are not included in the Maine data set). Many of these patients currently travel from York County, Maine to receive IRF care at NRH @ Pease. In 2017, 255 Maine residents sought treatment at NRH @ Pease, representing an average daily census of 8.4 patients. The greatest economic impact of NRH @ York will be to increase the access to clinically appropriate IRF level beds in York County. NRH @ York will also reduce the financial burden on patients and families who currently are forced to travel out of state for IRF care.

Nationally, patients who require IRF care and are admitted to an IRF experience fewer emergency room visits and significantly fewer hospital readmissions after their IRF episode of care. Two (2) studies of patient outcomes of rehabilitative care provided in IRFs are attached. (See Exhibit 12) In general, readmissions increase the overall cost of care for patients and increase strain on the patient and family. NRH @ York will provide high quality care that transitions patients into appropriate community outpatient care and/or home care services, thereby reducing the patient’s overall cost of care and burden on the patient and family. NRHN is an affordable IRF provider. According to data on Medicare Spending per Beneficiary (MSPB) for IRFs, NRHN performed better than the national average; spending $1,746 less per episode than IRFs nationally. (See Exhibit 8)

NRH @ York will offer a new economic engine for York County by keeping patients and families in the state. NRH @ York will purchase ancillary and support services from York Hospital and will be responsible for real estate, employment, and other taxes generating direct income for state and local municipalities. NRH @ York will create new jobs within the state and offer market competitive wages and benefits. Overall NRH @ York will have positive economic impact on York County.

B. State Costs

NRHN does not believe that costs to the State of Maine will increase because of NRH @ York. NRHN currently has both a Provider Agreement and Reimbursement Agreement
with MaineCare. NRHN anticipates that MaineCare will extend the current agreements to cover services provided by NRH @ York at the existing reimbursement rates.

Approximately 70% of NRHN’s patients are insured through the Medicare system. This percentage is consistent with IRF experience nationally. Medicare pays on a per discharge basis. Medicare establishes a national rate that is adjusted for regional variations in labor costs. The payment is further adjusted at the patient level based on medical diagnosis and functional status. We expect NRH @ York’s average Medicare reimbursement to approximate the amount paid to other IRFs located in Maine.

Most nongovernmental payers reimburse NRHN on a negotiated contractual per diem rate. NRHN believes the rates reimbursed for their services are consistent with reimbursement to other IRFs in this market.

C. Likelihood that more effective, accessible or less costly alternative service delivery may become available

There are no more effective and less costly alternatives to IRF care for the population of patients that are appropriate for this level of care. According to CMS, patients requiring acute rehabilitation hospitalization have diagnoses and co-morbid conditions that require close management by a physician specializing in rehabilitation, 24-hour rehabilitation nursing care, and an intensive course of interdisciplinary therapy consisting of at least 2 different disciplines (PT, OT and/or SLP) such that these therapies are provided at least 3 hours/day, at least 5 days/week, or 15 hours over 7 days. The patients who require this level of care due either to their medical complexity or significant and complex functional problems related to their diagnoses, could not be safely or effectively managed in a potentially lower cost level of care such as at home or in a skilled nursing facility (see Medicare Benefits Policy Manual Section 110 below):

110 - Inpatient Rehabilitation Facility (IRF) Services (Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10) The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to 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 IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF.
IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary. Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting. IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR §§412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR §412.23(b)(2)(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary’s individual care needs.

D. Alternatives to NRH @ York

1. Do Nothing – this alternative does not meet the need for York County IRF care. York County patients requiring placement in an IRF would continue to be forced to travel for care outside the county and more often outside the state.

2. Construct a Freestanding IRF, similar to NRH @ Pease – this alternative is more costly and would require duplication of support services and resources that already exist at York Hospital.

3. Have York Hospital establish an IRF – this alternative would require York to develop a new, CON reviewable, clinical service, which it does not currently provide. York would need to secure resources to develop and duplicate the skill-sets required to administer complex IRF services that NRHN has already developed. York would not have access to the clinical expertise of the entire Northeast Rehabilitation Hospital Network, including access to its seasoned clinical staff or its established specialty rehabilitation programs and policies. York would not benefit from the cost-effective economies of scale that NRHN is able to leverage in delivering care that flows from its centralized administration and overhead functions.

B. Certificate of Need Unit Discussion

i. CON Standards

Relevant standards for inclusion in this section are specific to the determination that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:
• The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

• The availability of state funds to cover any increase in state costs associated with utilization of the project’s services; and

• The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available.

ii. CON Unit Analysis

The decision to build a new 20-bed IRF in partnership with York Hospital addresses a demonstrated need for additional IRF services in York County. The increase in IRF beds will improve patient’s access to needed services in the area. In addition, significant benefits are derived from patients who are admitted to an IRF. These benefits include a significant decline in hospital readmissions and a smoother transition to less costly outpatient and/or home care services.

There will be minimal, if any increased costs associated with the construction of the 20 bed IRF. The applicant provided a detailed analysis of its service areas and included utilization data for IRF services. This data shows that the increase in proposed services are a necessary component of health care in Maine. Increased use of MaineCare funds will be mostly due to inflation or changes in volume unrelated to this transaction.

State funds should not be materially impacted by this transaction. Based on historical and projected data, increased utilization due to this project should be minimal. Approximately 90% of services are Medicare, Private Insurance or other sources of funding. NRHN currently has provider agreements with MaineCare and anticipates that these agreements will be extended to cover services provided by NRH @ York.

The applicant considered and rejected three alternatives to this project:

A) Do nothing – resident needs will not be met
B) Construct free standing IRF – this would be more costly.
C) Have York Hospital establish IRF – not cost effective and York does not have experience level of NRHN.

It is unlikely that a more effective, more accessible or less costly alternative for providing needed IRF services is available.

Public comments:

Several commenters stated that positive outcomes would result from having additional IRF beds in the York County area. Increased access to IRF beds would shorten local inpatient stays, as well as quicker and more positive recovery on the rehab side by having family and friends closer. Having family and friends visiting on a daily basis has a dramatic impact on their recovery.
Directly Affected Party Comments:

Based on the analyses completed by NERHP, and the further submissions and testimony and appendix exhibits cited below, the approval of the proposed project and the initiation of the proposed services would not be consistent with the orderly and economic development of health facilities and health resources for the state, as demonstrated by:

Impact on Total Healthcare Expenditures

NERHP believes that duplication of services within the service area will increase the total cost of healthcare in Maine. As demonstrated in the Public Need section of this document (Part C), the existing IRF beds sufficiently meet the need for IRF care in the State of Maine. The proposed NRH @ York facility would duplicate services within Cumberland and York Counties.

In addition, the proposed NRH @ York facility is a 20-bed unit. According to the latest annual MedPac report to Congress, “IRFs with fewer beds had much higher standardized costs per discharge.” (MedPac.gov, March 2018 Report to Congress.10)

Figure 13 - Median Standardized Cost Per Discharge by Type of IRF

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<th>Type of IRF</th>
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<td>All IRFs</td>
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<td>Hospital based</td>
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<td>Freestanding</td>
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<td>17,813</td>
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<tr>
<td>Urban</td>
<td>15,185</td>
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<tr>
<td>Rural</td>
<td>17,914</td>
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<table>
<thead>
<tr>
<th>Number of beds</th>
<th>Median standardized cost per discharge</th>
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<td>1 to 10</td>
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<td>11 to 24</td>
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<td>25 to 64</td>
<td>14,239</td>
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<tr>
<td>65 or more</td>
<td>12,103</td>
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Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for differences in area wages, mix of cases, and prevalence of high-cost outliers, short-stay outliers, and transfer cases. Government-owned facilities operate in a different financial context than other facilities, so their costs are not necessarily comparable.

Source: MedPAC analysis of Medicare cost report and Medicare Provider Analysis and Review data from CMS.

Source: MedPAC.gov, March 2018 Report to Congress

Based on review of national Medicare data, MedPac’s analysis found that IRFs between 11 and 24 beds had median cost per discharge of $16,408, as seen in Figure 13. The same report found

10 Available at http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0.
that IRFs with 65 beds or more had median cost per discharge of $12,103. Discharges at an IRF of 20 beds in size (such as that proposed by NRH @ York) were 36% more expensive than a comparable discharge from a large IRF during the study period. MedPac’s analysis therefore clearly indicates that a small 20-bed IRF is more costly to our healthcare system than a large IRF.

Further, the same MedPac analysis indicates that small IRFs, like the proposed NRH @ York facility, are not able to generate profits from Medicare, while large IRFs are able to profit from their Medicare services (due to factors like greater economies of scale). MedPac studied Medicare profitability of IRFs of similar size to the proposed NRH @ York facility from 2004 to 2016. Over that period, Medicare margins for small IRFs decreased by 97%, while large IRFs of 65 beds or more had relatively stable margins—growing by 2% over the period.

**Figure 14 – Aggregate IRF Medicare Margins IRF Bed Size**

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<thead>
<tr>
<th>Type of IRF</th>
<th>Share of Medicare discharges, 2016</th>
<th>Margins</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 10</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>11 to 24</td>
<td>22</td>
<td>10.5</td>
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<tr>
<td>25 to 64</td>
<td>48</td>
<td>18.3</td>
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<tr>
<td>65 or more</td>
<td>28</td>
<td>21.5</td>
</tr>
</tbody>
</table>

**Note:** IRF (inpatient rehabilitation facility), N/A (not applicable). Government-owned facilities operate in a different financial context than other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"). Where applicable, percentages may not sum to 100 due to rounding.

Source: MedPAC.gov, March 2018 Report to Congress

NERHP’s examination of previous MedPac reports to Congress on national IRF performance reveals that these two trends are not new; small IRFs have consistently been more costly to the Medicare system, and less able to generate Medicare profits. Low cost provision of care and an ability to generate profits are critically important criteria for an IRF, as they allow the IRF to reinvest in facilities, staffing, patient resources, and operations.
Based on this evidence, NERHP believes that it is important for DHHS to consider the impact of approving a cost-inefficient IRF provider, with respect to impact on the regional and national health system costs and the precedent that would be set. From a cost of care perspective, approving the CON for this small, high-cost IRF would effectively represent approval of higher-cost care when a lower cost care option is already available. Setting this type of precedent has obvious and negative implications for other CON requests going forward.

Alternatives to NRH @ York

The applicant briefly explored alternatives to the proposed NRH @ York facility. These include:

1. Do nothing;
2. Construct a freestanding IRF; and
3. Have York Hospital establish an IRF.

The applicant failed to explore alternatives to the proposed NRH @ York facility that may better align with more effective, more accessible, or less costly alternative technologies or methods of service delivery in Maine. Some of these alternatives may include:

1. Expand at an existing NRHN facility; and
2. Explore other methods of rehabilitation care delivery.

These alternatives are further explored below.

Unaddressed Alternative 1: Expand at an Existing NRHN Facility

On June 25, 2018, New Hampshire’s governor signed into law New Hampshire House Bill 1468, which imposes a moratorium on certain categories of health care facility beds, as set forth at RSA 151:2, VI. Section 3 of New Hampshire House Bill 1468. Effective upon enactment, the bill imposes a moratorium on new licensed beds for any nursing home, skilled nursing facility, intermediate care facility, or rehabilitation facility including rehabilitation hospitals and facilities offering comprehensive rehabilitation services, but also provides certain exceptions permitting the transfer and relocation of certain types of beds within the state. (Appendix, Exhibit D-1 (HB 1468).)

Section 3 of HB 1468 repealed and reenacted RSA 151:2 VI(a) as follows:

VI.(a) No new license shall be issued for and there shall be no increase in licensed capacity of any nursing home, skilled nursing facility, intermediate care facility, or rehabilitation facility including rehabilitation hospitals and facilities offering comprehensive rehabilitation services. This moratorium shall not apply to any rehabilitation facility whose sole purpose is to treat individuals for substance use disorder or mental health issues.

Importantly, RSA 151:2 VI(c) goes on to state that:
(c) This moratorium shall not prohibit the relocation or transfer of beds to a rehabilitation facility, including rehabilitation hospitals and facilities offering comprehensive rehabilitation services; provided that the beds to be transferred or relocated were licensed on July 1st, 2016. This restriction on transfers shall not apply to any beds transferred from one entity to another before the effective date of this paragraph.

On August 31, 2017, Crotched Mountain Specialty Hospital, located in Greenfield, New Hampshire, closed its facility. It is NERHP’s current understanding that NRHN acquired 62 SNF beds from Crotched Mountain and has been actively seeking legislative and/or regulatory approvals to reclassify those beds into inpatient rehabilitation beds and to relocate them to an existing NRHN hospital. However, NRHN has not referenced its New Hampshire legislative and regulatory efforts relating to potential bed relocations within New Hampshire in its Maine CON filings, or the potential that success in those efforts might undermine its arguments in support of a CON for 20 new beds in Maine.

Due to the above legislation and the other efforts underway by NRHN related to the Crotched Mountain beds, NERHP urges that CON staff more closely examine how the possible reclassification of all or some of those 62 SNF beds into IRF beds could impact the need to open an IRF facility in York. NRHN believes that, as part of its review of the pending project, the Maine CON staff should inquire more deeply into NRHN’s plans in New Hampshire for the relocation and reclassification of the Crotched Mountain beds, not only because they might offer an effective alternative to the proposed project in Maine, but also because NRHN failed to disclose this key background in its CON application.

Unaddressed Alternative 2: Explore Other Methods of Rehabilitation Care Delivery
As provided in detail in Part B of this document (Economic Feasibility), the need for inpatient rehabilitation services is anticipated to decline over the next ten years. NERHP believes that the impacts of innovations in care delivery and new technologies will result in more minimally-invasive procedures and a need for outpatient or home-based rehabilitation or skilled nursing care. This shift is already occurring in orthopedic care. Sg2 recently published an article titled “Outpatient Rehabilitation: A Critical Element in the Orthopedics System of Care” (Appendix, Exhibit D-2).

NERHP conducted a similar forecast for outpatient rehabilitation services in Maine and New Hampshire. Figure 15 below provides a breakdown of the Sg2 impact factors driving change in outpatient rehab volume over the next 10 years and the anticipated growth rate. The demand for outpatient rehab services is anticipated to increase by 6% over the next 10 years.
6% Net Change in Demand for Outpatient Rehabilitation Services

Source: Sg2 Healthcare Analytics

Conclusion: No Alignment with Orderly and Economic Development
NERHP believes that the proposed NRH @ York facility is not aligned with the orderly and economic development of healthcare services in Maine. In addition, NERHP believes:

- The proposed NRH @ York 20-bed facility will increase the total cost of healthcare in Maine; and
- The applicant failed to explore reasonable alternatives to the proposed facility.

NERHP believes that the proposed NRH @ York facility is not aligned with the criterion addressing the orderly and economic development of healthcare services in Maine, as the proposed NRH @ York 20-bed facility will increase the total cost of healthcare in Maine.

NERHP believes that duplication of services within the service area will increase the total cost of healthcare in Maine. Existing IRF beds sufficiently meet the need for IRF care in the State of Maine. The proposed NRH @ York facility would duplicate services within Cumberland and York Counties. In addition, IRF’s with fewer beds had much higher standardized costs per discharge and have a more difficult time generating profits due to a lack of economy of scale.
The applicant failed to explore alternatives to the proposed NRH@ York facility that may better aligned with more effective, more accessible, or less costly alternative technologies or methods of service delivery in Maine. These alternatives are:

Expand at an Existing NRHN facility:

On August 31, 2017, Crotched Mountain Specialty Hospital, located in Greenfield, New Hampshire, closed its facility. It is NERHP’s current understanding that NRHN acquired 62 SNF beds from Crotched Mountain and has been actively seeking legislative and/or regulatory approvals to reclassify those beds into inpatient rehabilitation beds and to relocate them to an existing NRHN hospital. However, NRHN has not referenced its New Hampshire legislative and regulatory efforts relating to potential bed relocations within New Hampshire in its Maine CON filings, or the potential that success in those efforts might undermine its arguments in support of a CON for 20 new beds in Maine.

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NRHN Response:

Again, NERHP “cherry picks” information and takes information out of context to make erroneous conclusions. The purpose of the March 2018 MedPAC Study was to answer two questions: “Are Medicare payments adequate in 2018?” and “How should Medicare payments change in 2019?” (MedPAC.gov, March 2018 Report to Congress page 267). These are clearly outlined in the
Executive Summary of the chapter dealing with IRFs. Nowhere in this report does MedPAC state, indicate or conclude that “a small 20-bed IRF is more costly to our healthcare system than a large IRF” as NERHP erroneously states on page 30 of their comments. That was not the purpose of this report. Instead, MedPAC analyzed costs in reviewing IRF margins to determine adequacy of Medicare payments. This report makes no assertions as to the impact of IRF costs to the overall costs of the healthcare system.

On page 30 of their comments NERHP cites only one factor from the MedPAC study (“due to factors like greater economies of scale”) as it relates to IRF profitability and costs. From page 286 of the same MedPAC study, “Several Factors account for the disparity in margins between hospital-based and freestanding IRFs, including differences in economies in scale, stringency of cost control, service mix and patient mix”. NERHP neglected to indicate that MedPAC concludes that size alone is not the only indicator of IRF profitability and that smaller IRF units can be profitable.

NERHP also fails to include the fact that the majority (94%) of smaller IRF units/hospital are hospital based and are classified as a distinct part unit of an acute hospital. Also on page 286 of the MedPAC study MedPAC states: “Notably hospital-based IRFs are far less likely than freestanding IRFs to be for profit and therefore are likely to be less focused on controlling costs to maximize return to investors”.

MedPAC concludes on page 283 that, “one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably”.

MedPAC states on page 287, “The commission’s long-standing position has been that provider costs are not entirely immutable and that many costs are indeed within providers’ ability to control. Providers can control costs by eliminating low-value services and providing a more efficient mix of services, while maintaining quality of care”.

NRHN has previously addressed the need for services in York County and does not agree that there will be a duplication of services. Please see public need section of comments.

NRHN can proudly state that it has a long history of efficiency and profitability allowing it to provide high quality care at its 20 bed Nashua, NH facility and its 15 bed Manchester, NH facility. NRHN will use this experience and knowledge in providing the same high quality and efficient care at the proposed NRHN @ York facility.

Alternatives:

In August 2017, NRHN met with Governor Sununu and The Commissioner of DHHS in NH to discuss the future use of the CM Hospital beds. It was at these meetings where NRHN proposed the following regarding the use of the CM Hospital beds:

- Expand NRH @ Pease by utilizing a portion of the beds from CM Hospital.
- To accommodate NH seacoast patients whose access has been limited because that 33 bed facility is virtually full at all times.
• To provide care for some of the patients who were once served by CM Hospital, i.e., lower level brain injury patients, longer term spinal injury patients, other neurological disabilities.

In response to these discussions NH DHHS agreed to work closely with NRHN to develop a system of care and reimbursement for the patients who are now being sent out of state for care due to the CM Hospital closure. After extensive study, NRHN purchased all 62 CM beds in October 2017, and is continuing to work with the NH DHHS and representatives from New Hampshire Medicaid on these issues. **Whether NRHN will ever be able to expand NRH @ Pease remains unknown.**

This situation is completely separate and has no effect on the NRH @ York project. The NRH @ York CON application specifically addresses an unmet need for IRF services in York County, and will be located at York Hospital. The expansion of NRH @ Pease is intended to accommodate patients coming from the NH Seacoast and Massachusetts, and patients displaced by the closure of CM Hospital. Adding beds to Pease will not solve the lack of access to IRF Beds in York County.

**CON Unit Final Analysis and Comments regarding contradictory comments**

The interested party believes that the proposed NRH @ York facility is not aligned with the criterion addressing the orderly and economic development of healthcare services in Maine, as the proposed NRH @ York 20-bed facility in their opinion will increase the total cost of healthcare in Maine. As reported by the Department of Insurance, their analysis proposed that there will not be a significant increase in the cost of premiums for commercial insurance. That has typically been the Department’s understanding as to how to evaluate if there is an unreasonable increase in State costs. Accordingly, CONU has determined that this project will not unreasonably increase costs.

The interested party believes that addition of services within the service area will increase the total cost of healthcare in Maine. They also propose that existing IRF beds sufficiently meet the need for IRF care in the State of Maine.

The interested party argues that the applicant failed to properly develop alternatives to expanding services in Maine. Suggestions included developing more beds in New Hampshire or expanding outpatient modalities. While these are alternatives, it should also be reviewed based on the impact to costs to the State and its taxpayers. Currently, the record shows that a notable number of people needing this service go to New Hampshire to find the service. As the reviewable costs involved to start this program are considerably low, these alternatives must be necessarily related to the positive impact of providing services to an area in Maine where some have asked for and are prepared to assist in the services to be provided in this project.

The application process is always governed by the applicant’s willingness to provide information. An applicant must provide enough information to allow the CONU staff to make a determination that a specific standard is met. This is a burden that the applicant has to meet. As far as the ability of NRHN to provide additional outpatient rehabilitation services, CONU notes that that is not a regulated service...
and the applicant or others are welcome to provide the services as long as they meet licensing and certification standards.

iii. Conclusion

The Certificate of Need Unit recommends that the Commissioner find that the applicant has met its burden to demonstrate that the proposed project is consistent with the orderly and economic development of health facilities and health resources for the State.
VI. Outcomes and Community Impact

A. From Applicant

A. NRHN’s Commitment to Quality Outcomes

NRHN expects that NRH @ York will positively impact the care provided to York County residents. NRHN has an established record of high quality care and outcomes (as outlined in Part II of this Application) and intends to deliver the same quality of care at NRH @ York. York County residents will have access to NRHN’s experienced team of providers who have demonstrated a record of high quality and high patient satisfaction at a cost less than the national average for IRFs.

B. Community Impact

NRHN is a strong and dedicated community partner in the communities it serves, providing ongoing support to other organizations and the community at large in the areas of prevention, education, advocacy and support.

In general, NRHN:

- Provides direct financial and/or in-kind assistance through sponsorships and donations
- Serves as expert providers and educators on external boards, teams, and committees organized to prevent injury, improve quality of care, and advocate on behalf of patients who experience brain injury, stroke, amputation, or any other debilitating condition requiring lifelong support

A summary of NRHN’s community outreach activities is attached. (See Exhibit 13)

B. Certificate of Need Unit Discussion

i. CON Standards

Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

ii. CON Unit Analysis

NRHN is committed to providing high quality care and is engaged in continuous quality improvement throughout its organization. The addition of 20 IRF beds focusing on inpatient rehabilitation services, in the York County area will have a positive effect on the quality of care delivered and will not have a negative effect on the quality of care delivered by existing service providers. Seniors needing IRF
services care will have a greater likelihood of finding the services offered in the area in which they reside. Increased access to IRF services increase the likelihood that patients completing appropriate treatment will end up returning home and/or to community-based services rather than placed or remaining in a costly long-term care setting. NRHN education programs prepare patients and families for a successful rehabilitation discharge, including use of equipment, home modifications and community resources for eventual recovery and independence. NRHN provides a continuum of care for its patients with home care services and outpatient clinics. This reintroduction of a patient into the at-large community is consistent with the goals of the department and national trends of extending home-based services.

**Directly Affected Party Comments:**

The Applicant has provided insufficient information to determine whether the project will ensure high-quality outcomes and the approval of the NRH @ York project would have a negative effect on the quality of care provided at NERHP.

**High-Quality Outcomes**

According to Medicare.Gov, NRHN performs worse than the national benchmark in catheter-associated urinary tract infections (CAUTI). (Appendix, Exhibit E-1.) The Benchmark rate is 1.126%, while the Medicare.gov reported rate for the Northeast Rehabilitation Hospital Network (reported as Salem) is 2.51%.

According to the Press Ganey database, the mean score for all inpatient acute rehabilitation hospitals for overall satisfaction in 2017 was 89.2% and the mean score for likelihood to recommend was 91.4% (Appendix, Exhibit E-2). NRHN reported its patient satisfaction scores for 2017 to be 81% for overall satisfaction and 86% for likelihood to recommend, significantly lower than the national mean of 89.2% for overall satisfaction and 91.4% for likelihood to recommend. NRHN performs worse than the national benchmark for patient satisfaction. Due to this publicly reported data, NERHP questions the ability of the Applicant to ensure high-quality outcomes and meet patient expectations.

**Negative Impact to the Quality of Care at Other Providers**

As previously mentioned in the Fit, Willing, and Able and Public Need sections of this document (Parts A and C, respectively), a shortage of qualified care staff exists in Maine. The applicant stated at the Public Hearing on June 7, 2018 that the new facility will create 70 jobs in the area. NERHP anticipates that a new facility would encounter extraordinary difficulty in identifying, recruiting, and retaining 70 trained IRF care providers in the area. In combination with recruiting care providers from outside of the area, the proposed 20-bed IRF will draw care team members away from existing IRF providers in the surrounding area.

One caregiver population that is in high demand is the Certified Rehabilitation Registered Nurse (CRRN). In order to be eligible to take the certification exam, a registered nurse must first have two years of experience working in rehabilitation. There is a limited pool of CRRNs in the State of Maine due to the stringent requirements, including specific work experience and the certification exam. Having a large percentage of nursing staff qualified as CRRNs ensures the quality of patient care provided at the facility. Existing IRF providers will be challenged to retain CRRN-designated nurses with the introduction of a new inpatient rehabilitation facility, which will negatively impact the quality of patient care provided there.
Other “negative impacts” to NERHP include the potential negative financial impact should NERHP fail to maintain compliance with the 60% Rule (addressed in Part A (2) and Part B (1)), and the diversion of some York County patients from placements at NERHP to an unneeded 20-bed facility (addressed in Part C).

As noted by Dr. Cote in her June 16, 2018 letter (Appendix, Exhibit C-4):
“...I think this is why New England Rehabilitation Hospital of Portland rightfully feels that if such a large facility is built in York, it would draw patients away from Portland.”

Applicant Response:

NERHP asserts that NRHN would hurt the quality of care provided in Maine on the basis of catheter-associated urinary tract infection (“CAUTI”) rate published by CMS, Press Ganey patient satisfaction survey data, and “other ‘negative impacts’” to NERHP on the basis that the project may cause NERHP to fail to meet the 60% rule and struggle to recruit RNs. NRHN has previously addressed NERHPs concerns about it’s own staffing and compliance with the 60% rule. Beginning with the CAUTI rate, NERHP cites outdated data from Medicare.gov’s IRF compare website. Newer data, included in the CASPER report which NRHN included as Exhibit 8 to its Application, shows that NRHN’s CAUTI rate is in line with the nationwide average.

The Press Ganey documents present two sets of scores: mean and rank. The mean score is the average rating of all patients that complete the survey. The rank score shows how IRFs compare against each other vis-a-vis their mean scores. NRHN reported rank scores in its CON Application. NERHP took NRHN’s rank scores, and tried to argue that they are below the mean scores for “overall care at hospital” and “likelihood of recommending hospital” for 2017. NRHN outperforms NERHP when comparing mean scores.

**CONU FINAL COMMENTS**

According to the interested party, NRHN reported its patient satisfaction scores for 2017 to be 81% for overall satisfaction and 86% for likelihood to recommend, significantly lower than the national mean of 89.2% for overall satisfaction and 91.4% for likelihood to recommend. Due to this data, NERHP questions the ability of the Applicant to ensure high-quality outcomes and meet patient expectations.

A shortage of qualified care staff exists in Maine. The applicant stated at the Public Hearing on June 7, 2018 that the new facility will create 70 jobs in the area. NERHP anticipates that a new facility would encounter extraordinary difficulty in identifying, recruiting, and retaining 70 trained IRF care providers in the area. In combination with recruiting care providers from outside of the area, the proposed 20-bed IRF will draw care team members away from existing IRF providers in the surrounding area. CONU would comment that based on a low-level of unemployment and in most of the State but less so for York and Cumberland counties there is a general shortage of trained
personnel. In fact, it is more likely that trained personnel are already in the general area of New Hampshire and extreme Southern Maine than anywhere else. The applicant’s record indicates an ability to deliver the services required by the CON and at a level that ensure high-quality outcomes. CONU does not feel or see evidence that the proposed facility will necessarily exacerbate the directly affected parties ability to train and recruit staff.

### iii. Conclusion

Certificate of Need Unit recommends that the Commissioner find that the applicant has met their burden to demonstrate that this project will ensure high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.
VII. Service Utilization

A. From Applicant

A. Overview
As described in other Parts of this Application, NRHN recognizes the importance of collaboration with local hospitals, physicians and other health care providers to provide appropriate, high-quality services to the community. NRHN collaborates with local providers to ensure continuity of care and participates in provider efforts to improve the experience, health outcomes and reduce health care costs through focusing on unnecessary utilization. NRHN intends to continue to build collaborative relationships with providers in Maine, many of whom already work with NRHN through NRH @ Pease.

B. Alignment with Maine Quality Forum (MQF) principles

Maine Quality Forum has adopted an overarching mission of monitoring and improving the quality of health care in the State of Maine. Further, MQF supports projects that align with the needs of its stakeholders as it relates to advancing the Institute for Healthcare Improvement’s (IHI) triple aim.

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Many of NRHN’s referring organizations participate in Alternative Payment Models such as ACOs and Bundled Payment Initiatives. NRHN also participates in the individual efforts of its referring hospitals to reduce the cost of care while maintaining quality. NRHN is a “preferred provider” for inpatient rehabilitation for several hospitals throughout New Hampshire and Massachusetts. As part of this commitment, NRHN employs a full-time Director of ACO Programming to manage clinical pathways, provide care coordination, and enhance care transitions with evidence-based practice interventions for patients at risk. NRHN also monitors internal performance on Triple Aim principles by transparent tracking and reporting of patient satisfaction scores through Press Ganey, discharges to community settings, costs of care, network care retention and various care transitions measures (such as warm-hand off, follow-up appointment scheduling with primary care providers, medication reconciliation, etc.)

NRHN also works with ACO partners to identify patients of admission to the facility through use of a secure software platform named Patient Ping. Once patients are identified as being “at-risk”, NRHN flags these patients in the electronic health record as a means of ensuring high-fidelity communication with providers at the bedside. This allows NRHN to provide an additional service to its ACO partners and allows for more reliable data tracking and efficiencies in workflow to ensure outcome objectives are met.
MQF has not adopted principles of evidence-based medicine specifically applicable to IRF’s. Should the MQF develop such principles, NRHN would work to ensure compliance. NRHN will assure that the proposed project will not result in inappropriate utilization of services.

Certificate of Need Unit Discussion

i. CON Standards

Relevant standards for inclusion in this section are specific to the determination that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum as established in Title 24-A, section 6951, when the principles adopted by the Maine Quality Forum are directly applicable to the application.

ii. CON Unit Analysis

NRHN is undertaking this project to meet an increased health care need for improved access to IRF services in York County. This will be accomplished by adding 20 IRF beds in the York County service area. As stated in their application NRHN collaborates with local providers to ensure continuity of care and participates in provider efforts to improve the experience, health outcomes and reduce health care costs through a focus on unnecessary utilization. NRHN intends to further strengthen relationships with providers in Maine, many of whom already work with NRHN through NRH @ Pease.

The Maine Quality Forum has not adopted any principles of evidence-based medicine directly applicable to the application; therefore, this application meets the standard for this determination.

No funding is utilized from the MaineCare funding pool.

Directly Affected Party Comments:

NERHP’s comments and submissions addressing the criteria relating to Public Need (Part C of this submission) demonstrate that 20 additional IRF beds at York Hospital are not needed and constitute an unnecessary duplication of the services that are already being provided to the York County service area.

Accordingly, approval of the proposed NRH @ York Hospital:

- Would promote “inappropriate increases in service utilization, and also [adversely affect quality . . .]”; and
- Would be contrary to Criterion D and the provisions of § 335 (7)(D) of the CON Act.
On these several points, reference is made to the 2004 CON review of the proposed Portland Surgery Center. (Appendix, Exhibit F-1 (February 26, 2004 Initial Decision), and Exhibit F-2 (April 5, 2004 Final Decision of Commissioner Nicholas, denying approval of proposed Ambulatory Surgery Center (“ASC”).) In his Initial Decision, Commissioner Nicholas concluded that the applicant in that matter could not carry its burden of proof under subsection (7)(D) of § 335 because of the potential adverse impacts the proposed ASC would have on both Maine Medical Center and Mercy Hospital. (See page 2 of Exhibit F-1.) Similarly, in his Final Decision, dated April 5, 2004, which followed a March 19, 2004 hearing, Commissioner Nicholas reiterated his view that the proposal did not comport with “orderly and economic development of health facilities,” and noted specifically that:

The evidence in this record supports the conclusion that there will be a negative economic impact on the Hospitals as a result of the different payor mixes between the facilities.

Final Decision, page 2 (emphasis added).

In the Portland Surgery Center matter, the Commissioner found that there were fundamental differences between the charity care currently provided by the hospitals and the charity care that would be provided at the proposed ASC. Id. Even though the proposed ASC contended that it would adopt a charity care policy, the Commissioner reasoned that the hospitals would be damaged and that “the impact flows from a possible shift in the payor mix as the proposed facility [the ASC] assumes a caseload that is possibly healthier and better insured than that assumed by the hospitals, a shift that is not remedied by the facility’s adoption of its proposed charity care policy.” Id.

Such is the case here. NERHP has a payor mix that included approximately 6-7% Medicaid beneficiaries during the time period 2012-2017. Over that same 5-year time period, the hospitals in the NRHN system have a documented Medicaid payor mix of 2%.

NRHN’s historically low level of Medicaid volume strongly suggests that NRHN is selecting patients with Medicare and commercial insurance coverage over those with Medicaid. If these practices are allowed to enter Maine and the service area of NERHP (where there is no unserved need for the service and there is existing excess capacity), it seems highly likely that NRH @ York will cherry pick some percentage of Medicare and commercially insured patients that would otherwise naturally flow to NERHP, without also taking its fair share of Medicaid patients.

The unnecessary duplication of the service where there is no need for an additional provider will lead further to a dilution of the patient pool across two providers and, because of NRH’s clear aversion to Medicaid, an unfairly distributed payor mix between the two facilities. While the decision in the Portland Surgery Center matter rested on charity care (not Medicaid) differences between the payor mixes of the hospitals and the proposed ASC, the concerns expressed by the Commissioner in his 2004 decisions are directly on point in this NRH @ York matter.

Applicant Response:
NERHP argues, again, that the York facility would create “unnecessary duplication”. NRHN has addressed this already above and will not repeat its arguments here. But in a twist, NERHP claims that this duplication will “promote ‘inappropriate increases in service utilization’” Strangely, NERHP does not provide any support for this very serious assertion, but instead discusses at length an irrelevant CON decision from 2004.

In that case the Commissioner was faced with a court ordered deadline within which to render a CON decision. The Commissioner was generally concerned that the record in that case did not “…provide sufficient information and analysis to support all the elements needed to approve the CON. The Commissioner was “… not satisfied that the ‘services affected by the project will be accessible to all residents’ as the applicant has not presented sufficient substantive information about charity care.” He also noted that, unlike here, a majority of the patients for the proposed ambulatory surgical center (“ASC”) (to be located in Portland) would be secured from Mercy Hospital and Maine Medical Center.

While the Commissioner found no significant impact on Maine Medical Center he found the analysis regarding the impact on Mercy Hospital to be insufficient. He was “particularly” troubled by the differences in patient mix between the proposed ASC and the hospitals and was concerned that Mercy, in particular, might be left with a loss. The Commissioner found that “some of this might have been addressed if the applicant had provided a draft of proposed written policies and procedures that is ‘at least as liberal’ as the hospitals, if not more so.” Id. This was of “great concern” to the Commissioner.

In a nutshell the Commissioner was concerned that the proposed ASC, which would not be subject to Maine’s Free Care Guidelines for hospitals, might cherry-pick patients to the detriment of the hospitals. In referring to this 2004 CON decision, NERHP, once again, attempts to compare apples to oranges. Here both NERHP and NRH @ York will be subject to Maine’s Free Care Guidelines; NRH @ York will be located a considerable distance from NERHP, not in the same city as was the case with the proposed ASC; and, NRHN has never proposed or calculated the need for the Project by taking patients away from NERHP. Further, NERHP offers no proof, only speculation that NRHN is going to take its patients, which in any event is an inappropriate consideration under the CON Act (see Section VI).

The claim that NRHN’s 20 Bed IRF on the campus of York Hospital will inappropriately increase utilization is without merit. Insurance coverage decisions, public and private, require medical necessity and meeting eligibility criteria. If a patient doesn’t meet these requirements, the patient will not be admitted.

**CONU FINAL COMMENTS**

The directly affected party is concerned that an unnecessary duplication of services will lead to dilution of the patient pool across two providers and, because of NRH’s “aversion” to Medicaid, an unfairly distributed payor mix between the two facilities.

Notwithstanding, the comments made by the interested party in the last clause of the standard where the important issue is that no standards have been established according to the principles of evidence-
Neuro Rehab Associates, Inc.  New Inpatient Rehabilitation Hospital at York Hospital  
Preliminary Analysis  

based medicine adopted by the Maine Quality Forum as established in Title 24-A, section 6951.  Accordingly there is nothing to review here.  

iii. Conclusion  

Certificate of Need Unit recommends that the Commissioner find that the applicant has met their burden to demonstrate that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.  

VIII. Timely Notice  

A. Certificate of Need Unit Discussion  

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<td>Letter of Intent filed:</td>
<td>September 26, 2017</td>
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<tr>
<td>Technical assistance meeting held:</td>
<td>November 8, 2017</td>
</tr>
<tr>
<td>CON application filed:</td>
<td>April 24, 2018</td>
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<td>CON certified as complete:</td>
<td>April 24, 2018</td>
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<td>Public Information Meeting held:</td>
<td>Waived</td>
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<td>Public Hearing held:</td>
<td>June 7, 2018</td>
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<td>Comment Period ended:</td>
<td>July 7, 2018</td>
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IX. Findings and Recommendations  

Based on the preceding analysis, including information contained in the record, the Certificate of Need Unit recommends that the Commissioner make the following findings:  

A. The applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.  

B. The economic feasibility of the proposed services is demonstrated in terms of the:  

1. Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and
2. Applicant’s ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules;

C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to;

1. The extent to which the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

2. The project has demonstrated that it will have a positive impact on the health status indicators of the population to be served;

3. The project will be accessible to all residents of the area proposed to be served; and

4. The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

1. The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

2. The availability of State funds to cover any increase in state costs associated with utilization of the project’s services; and

3. The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available was demonstrated by the applicant;

E. The project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers:

F. The project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum; and

G. The project is consistent with the nursing facility MaineCare funding pool and other applicable provisions of sections 333-A and 334-A.

For all the reasons contained in this preliminary analysis and based upon information contained in the record, Certificate of Need Unit recommends that the Commissioner determine that this project should be approved.