Public Interest Review

EVALUATION OF A PROPOSED INPATIENT REHABILITATION FACILITY IN ROSEVILLE, MINNESOTA

02/26/2024

Public Interest Review: Evaluation of a Proposed Nobis Rehabilitation Holdings, LLC Inpatient Rehabilitation Facility in Roseville, Minnesota

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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February 26, 2024

To the Honorable Chairs and Ranking Members:

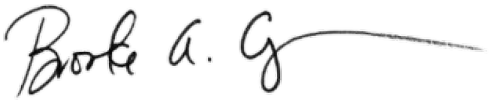
Minnesota Statutes, section 144.552, requires that any organization seeking to obtain a hospital license, submit a plan to the Minnesota Department of Health (MDH) for review and assessment as to whether it is in the public interest. On January 31, 2023, Nobis Rehabilitation Partners submitted a letter of intent to construct a new rehabilitation hospital to serve patients residing in the seven-county Twin Cities Metropolitan Area. Nobis was notified on September 29, 2023, that the application submitted to MDH in August and September was complete and that the review could begin.

This letter accompanies MDH's report presenting the public interest review. In the report MDH concluded that **the establishment of a new hospital, as presented to MDH, is *not* in the public interest.**

The finding is based on the assessment of the statutory criteria for documented need, analysis of potential financial impact on other acute care hospitals, the ability for current hospitals to maintain staff, the extent to which the new hospital would serve nonpaying or low-income patients, and the views of affected parties. In addition, this determination took into consideration that the proposed hospital would represent a further move toward profit-driven, private equity financed, freestanding specialty hospital ownership, away from the existing largely not-for-profit community hospital model.

If you have questions or concerns regarding this review, please contact Stefan Gildemeister, Minnesota's State Health Economist, at 651-201-3554 or stefan.gildemeister@state.mn.us.

Sincerely,



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Contents

Introduction

The hospital public interest review process

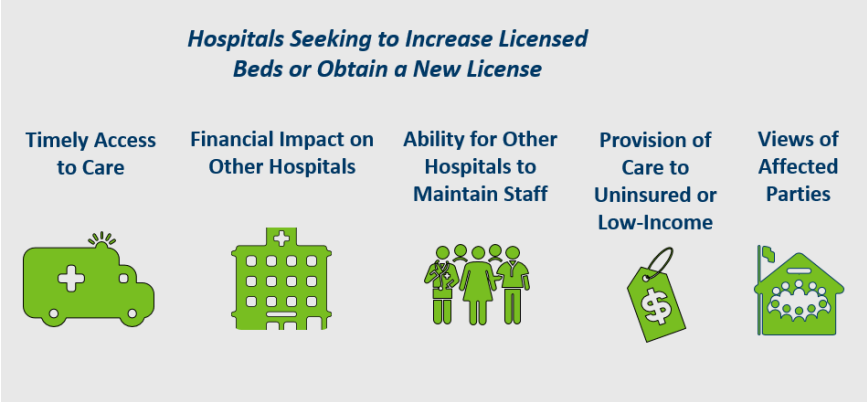
Since 1984, Minnesota law has prohibited the construction of new hospitals, expansion of bed capacity at existing hospitals, or redistribution of beds within the state without specific authorization from the Minnesota Legislature.[1] As originally enacted, the law included specific exceptions to the moratorium for new hospital capacity. More exceptions were added over time in response to individual proposals; the statute currently includes 33 exceptions. In addition, the legislature recently enacted a temporary five-year exception for any expansion of mental health bed capacity or establishment of a new mental health hospital under certain conditions.[2]

To aid the legislature's deliberations and decision-making on proposed exceptions, it established a procedure for reviewing proposals for exceptions to the hospital moratorium statute. Under this procedure, hospitals seeking an exception must submit a plan to the Minnesota Department of Health (MDH) for a "public interest review." The purpose of the public interest review is to provide the legislature with an independent, evidence-driven assessment by MDH as to whether the additional beds are or are not in the public interest. In conducting a public interest review, Minnesota Statutes, section 144.552 directs MDH to consider all relevant factors, but—at a minimum—it must consider five factors (see Figure 1).

[1] Minnesota Statutes, section 144.551.

[2] Minnesota Statutes, section 144.551, subd. 1a. The conditions specified are as follows: using all newly licensed beds exclusively for mental health services, accepting Medical Assistance and MinnesotaCare enrollees (programs funded by the federal Medicaid program), abiding by the Minnesota Attorney General Hospital Agreement on discounted care for uninsured patients, having an arrangement with a tertiary care provider or a sufficient number of medical specialists to determine and arrange appropriate treatment of medical conditions, and submitting requested information necessary for MDH to conduct a study of inpatient mental health access and quality. For more information on this topic, please visit the following website: MDH Mental Health Bed Monitoring - MN Dept. of Health (state.mn.us) (https://www.health.state.mn.us/data/economics/mhbedmonitoring/index.html).

Figure 1: Public interest review general considerations



More specifically, the statutes specifies that MDH must consider the following detail in its review:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services.
- What financial impact the new hospital or hospital beds will have on existing acute-care hospitals with emergency departments in the region.
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff.
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region.
- The views of affected parties.

As part of the review, it is MDH's responsibility to issue a finding; authority to approve exceptions to the hospital moratorium rests with the Minnesota Legislature.

Key milestones for the review process

Organizations seeking to obtain a new hospital license must issue a letter of intent to MDH, specifying the community in which the proposed hospital would be located and the number of beds it would establish.[3] Once this letter of intent is received, MDH publishes an announcement in the *Minnesota State Register* that includes the information received by the organization and a notice that any other organization must notify MDH within 30 days if they are interested in seeking a hospital license that would serve the same or similar service area. If no other responses are received from this notice, MDH notifies the organization that it is required to submit a plan for public interest review.

[3] This requirement for new hospitals is found in Minnesota Statutes, section 144.553.

The public interest review statute requires that any plan be submitted to the MDH no later than August 1 of the calendar year prior to the year when the exception would be considered by the Minnesota Legislature. The statute also specifies that MDH must issue a finding within 150 days after notifying the organization that the application materials are complete for a review. When multiple plans are received, MDH is instructed by statute to review them in the order that they were received.[4]

Considering this review, on January 31, 2023, MDH received a letter from **Nobis Rehabilitation Partners** seeking a hospital license and intent to build a 60-bed inpatient rehabilitation hospital to be constructed in Minneapolis (later plans moved the site to Roseville). MDH issued a *State Register* notice[5] after which no alternative plans materialized during period specified in Minnesota Statutes. MDH provided instructions to Nobis Rehabilitation Partners about what materials must be contained in their proposal, and on August 1, 2023, Nobis IRF Holdings, LLC ("Nobis")—a parent company of the organization as well as a number of other entities that appear to operate under the Nobis umbrella—submitted a formal proposal. To fill gaps in the proposal, MDH requested additional information on September 14, 2023, and sent a notice indicating that application was complete on September 29, 2023. The proposal and all correspondence are available online at Nobis Rehabilitation Partners - MN Dept. of Health (state.mn.us)[6].

The applicant

Press releases from similar Nobis projects have stated that the company brings together hospitals, developers, and investment partners to develop, operate, and manage inpatient rehabilitation facilities. Nobis' proposal states that Kennor Cross Holdings, LLC, a privately held investor and real estate owner, would act as the developer. MDH identified some of the investors in Nobis Rehabilitation Partners, LLC, which include Stanton Road Capital, Matterhorn Capital Advisors, and H2C Securities in conjunction with Fifth Third Capital Markets. It was unclear from the information MDH had access to, including material on the corporate structure submitted by Nobis during the application process, which of these (and other) entities would have any economic and governing interests in the proposed hospital or Nobis. MDH did, however, determine based on research of the Texas Comptroller of Public

[4] Two other applications for public interest review were sent to MDH within the statutory deadline of August 1. They included a plan from Regency Hospital (a subsidiary of Select Medical) on July 31 to establish a new long-term acute care hospital in St. Paul and a proposal from Allina Health on August 1 seeking a hospital license for a 100-bed inpatient rehabilitation hospital to be located in the Twin Cities Metropolitan Area to serve patients on a statewide basis. Allina withdrew its letter of intent on December 1, 2023.

[5] To see the notice, please visit this website link (PDF): Minnesota State Register Volume 47 Number 38 (mn.gov) (https://mn.gov/admin/assets/SR47_38 - Accessible_tcm36-570056.pdf).

[6] Nobis Rehabilitation Partners – MN Dept. of Health (https://www.health.state.mn.us/data/economics/moratorium/nobis/index.html)

Accounts, that Nobis, Cross, and a number of investment entities share addresses, naming conventions, managers or agents, or a combination of these items.

The Nobis proposal to open a freestanding rehabilitation hospital in Minnesota follows similar projects across the country. In fact, just since January of 2021, Nobis has opened 13 rehabilitation hospitals (one of which was sold in 2023) and is in the process of opening another six rehabilitation hospitals as of September 14, 2023. Table 1 provides a list of these hospitals, except for Reunion Rehabilitation Hospital Dublin in Dublin, Ohio that was sold to a joint venture including Select Medical Corporation.[7] This table shows, that within a span of about three years, Nobis has opened, or will open, 812 inpatient rehabilitation beds across 20 facilities in twelve states.[8]

Table 1: Nobis inpatient rehabilitation hospitals

Hospital Name	City	State	Opening	Beds	Status
Indianapolis Rehabilitation Hospital	Carmel	IN	Feb-21	40	Open
Reunion Rehabilitation Hospital Denver	Denver	CO	Mar-21	40	Open
Reunion Rehabilitation Hospital Phoenix	Phoenix	AZ	Jan-22	48	Open
Shreveport Rehabilitation Hospital	Shreveport	LA	Jan-22	40	Open
Reunion Rehabilitation Hospital Inverness	Englewood	CO	Feb-22	40	Open
Milwaukee Rehabilitation Hospital	Greenfield	WI	Feb-22	40	Open
Johnson County Rehabilitation Hospital	Overland Park	KS	Jul-22	40	Open
Tulsa Rehabilitation Hospital	Tulsa	OK	Sep-22	40	Open
Oklahoma City Rehabilitation Hospital	Oklahoma City	OK	Oct-22	40	Open
Reunion Rehabilitation Hospital Peoria	Peoria	IL	Mar-23	40	Open
Reunion Rehabilitation Hospital Arlington	Arlington	TX	Apr-23	40	Open
Reunion Rehabilitation Hospital Plano	Plano	TX	May-23	48	Open
San Antonio Rehabilitation Hospital	San Antonio	TX	Sep-23	48	In Development
Reunion Rehabilitation Jacksonville	Jacksonville	FL	Oct-23	48	In Development
Cincinnati Rehabilitation Hospital	Blue Ash	OH	Nov-23	40	In Development
Bradenton Rehabilitation Hospital	Bradenton	FL	TBA	60	In Development

[7] Reunion Rehabilitation Hospital Dublin, a 40-bed IRF, was sold to a joint venture between Select Medical Corporation and OhioHealth in 2023. [See: OhioHealth to Acquire Reunion Rehabilitation Hospital – (Smart Business Dealmakers.com) (https://www.smartbusinessdealmakers.com/articles/topic/ohiohealth-to-acquire-reunion-rehabilitation-hospital/)]. Select Medical Corporation has owned what is now Regency Hospital in Golden Valley, MN since 2004.

[8] The Nobis website lists 21 locations as of January 17, 2024 [Locations | Nobis Rehabilitation Partners (nobisrehabpartners.com) (https://www.nobisrehabpartners.com/locations)]. Additional locations included hospitals in Cleveland, Ohio and Orlando, Florida.

Hospital Name	City	State	Opening	Beds	Status
Tucson Rehabilitation Hospital	Tucson	AZ	TBA	40	In Development
Clarksville Rehabilitation Hospital	Clarksville	IN	TBA	40	In Development

Source: Applicant

The project

Nobis proposes to establish a 60-bed freestanding rehabilitation specialty hospital, otherwise known as an inpatient rehabilitation facility (IRF), on a 4.5-acre lot within a business park in Roseville, Minnesota that would be named the "Minneapolis Rehabilitation Hospital."[9] Nobis submitted materials to MDH asserting that it believes such a facility is in the public interest because of a perceived low supply of inpatient rehabilitation care options in the primary service area relative to the population. Nobis is basing that assessment on comparisons of population-level capacity in the primary service area, to the supply and use rates of rehabilitation beds nationally. Nobis believes the low ratio of population to inpatient rehabilitation beds in Minnesota will be exacerbated in the coming years due to an aging population, the primary users of inpatient rehabilitation services. Nobis also assumes that the expansion of inpatient rehabilitation beds will not negatively impact other hospitals because the presumed undersupply has created demand that would offset any loss in volume at other facilities. MDH will address these points as part of the review.

Plans submitted to MDH indicate that this IRF would serve primarily the senior population (ages 65+) of Medicare beneficiaries living in the seven-county Twin Cities Metropolitan Area. The proposed facility would include a 63,200 square foot, three-story building with 60 private rooms, each with private bathrooms, and both indoor and outdoor space and equipment for patient rehabilitation activities. Table 2 shows, at a high level, the breakdown of the $42.9 million construction project, which amounts to approximately $714,200 in capital spending per newly licensed bed. The cost per bed is higher than the range of $445,500 to $600,000 construction costs per newly licensed bed in recent public interest reviews.[10] The source of funding for the project would include borrowing capital through debt secured by collateral (first lien loan) as well as equity financing through the developer and real estate owner mentioned above.

[9] The application submitted by Nobis indicated that this was the "identified site" that "could change due to availability and access."

[10] In 2022, Children's Minnesota estimated the cost of reconfiguring space for the 22 new mental health unit to be approximately $9.8 million ($445,500 per bed); in 2022, Fairview Health Services and Acadia Healthcare estimated a cost of between $63 and $70 million for their new 144 bed hospital ($437,500 to $486,100 per bed); in 2021 PrairieCare estimated the cost of 30 new beds, including adding on to their existing building, at $18 million ($600,000 per bed). All new beds were mental health beds.

Table 2: Capital expenditure commitment

Building construction	**$34,475,200**
Land	$3,484,800
Furniture, fixtures, and equipment	$1,949,443
Sales tax	$2,943,321
Total	**$42,852,764**

Source: Applicant

Inpatient rehabilitation: A background

Patients can require specialized rehabilitative care following an illness, injury, or surgery that is delivered in various settings. Inpatient rehabilitation, the heart of the Nobis proposal, is an intensive program that is designed to help such patients when it is determined that they can benefit from and tolerate certain rehabilitative therapies. In these programs, patients are monitored by a rehabilitation physician trained in physical medicine and rehabilitation (physiatrist), or by a neurologist with specialized rehabilitation training, and receive around-the-clock nursing care. According to recent information from the Medicare Payment Advisory Commission (MedPAC), an independent legislative agency that provides analysis and advice on the Medicare program, the average length of stay in an inpatient rehabilitation unit is 12.9 days, and the most common condition treated is stroke, followed by other neurological conditions, debility, and brain injuries.[11] Inpatient rehabilitation requirements are defined by the federal Centers for Medicare & Medicaid Services (CMS) for payment purposes.

The program generally consists of the following characteristics:

- Interdisciplinary specialized care in physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy. Physical or occupational therapy must be provided.
- A minimum of three hours of therapy per-day for at least five days per-week.
- Face-to-face visits with physicians[12] three days a week.
- 24-hour nursing care.[13]

[11] Medicare Payment Advisory Commission. (March 2023). Report to the Congress: Medicare Payment Policy. *Washington, DC: MedPAC*. Accessed November 6, 2023 at: MedPAC March 2023 Report to the Congress: Medicare Payment Policy (medpac.gov) (https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf).

[12] A licensed rehabilitation physician must supervise face-to-face patient therapy to assess medical needs, functionality, and necessary modifications to improve a patient's capacity to benefit from the rehabilitation program.

[13] Patients must be sufficiently stable at the time of admission to actively participate in the inpatient rehabilitation therapy program.

Delivery of inpatient rehab care can happen in different settings. Among them, Inpatient Rehabilitation Facilities (IRFs), such as the Nobis proposal, are paid by Medicare under a different system than acute inpatient hospitals that provide rehabilitative care.[14] In addition to criteria determining which patients are able to receive inpatient rehabilitative care, there are several requirements that CMS (the majority payer of inpatient rehab services) places on freestanding or hospital-based IRFs for payment:[15]

- Have a comprehensive preadmission screening process that is conducted 48 hours before admission to determine if each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program.
- Provide a program ensuring that the patient receives close medical supervision[16] and provided—through qualified personnel—rehabilitation nursing and other therapy disciplines.
- Have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units.
- Use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment.
- Have a treatment plan for each patient—which is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.
- Initiate a full course of intensive rehabilitation therapy according to the patient's overall plan of care within 36 hours following midnight the day-of-admission.

[14] Medicare has developed a prospective payment based on principal diagnosis or impairment, that is stratified by patient characteristics such as age, level of motor and cognitive function, as well as four different tiers based on certain co-existing or co-occurring conditions that require additional resources. There are also outlier payments to IRFs for certain particularly costly patients. Hospitals that are classified as Critical Access Hospitals (CAH) are generally reimbursed per service; other hospitals are paid using a prospective payment system (PPS) which is a bundled payment for all services based on the classification of the stay.

[15] Programs such as Medicare Advantage or Medicaid do not have the same documentation requirements for payment as traditional Medicare unless the programs voluntarily adopt the same policies [Op. Cit. Medicare Payment Advisory Commission. (2023)]; however, Nobis has indicated that it intends to participate in the traditional Medicare program.

[16] As mentioned above, IRFs must provide face-to-face physician visits with a patient at least three days a week. Beginning with the second week of admission to the IRF, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

- Meet the compliance threshold, which requires that no less than 60% of patients admitted to an IRF have at least 1 of 13 conditions specified by CMS as a primary diagnosis or comorbidity.[17]

The plan submitted to MDH by Nobis described offering services to meet these requirements, including the following: physical and medicine rehabilitation physicians, medical management, rehabilitative nursing, occupational therapy, physical therapy, psychology, respiratory therapy (contingent on medical director and patient population), speech language pathology, case management, clinical nutrition, pharmacy, as well as contracting for laboratory services, radiology, and dialysis.

Evaluation of the proposal according to statutory criteria

In this section of the report, MDH assesses if the proposed 60-bed licensed rehabilitation specialty hospital meets public interest criteria for each factor specified by Minnesota Statutes, section 144.552, as well as other factors of relevance. Considerations according to these factors are based on the following sources of information:

- Materials supplied, and requested by MDH, from Nobis.
- Feedback from interested parties through written comments, informal interviews or conversations, and a public meeting.
- Public reporting by hospitals to state and federal government entities on financial, utilization, and services data.
- Staffing data for inpatient rehabilitation units from the Minnesota Hospital Association.
- Hospital quality data from CMS IRF Quality Reporting Program.
- De-identified hospital discharge data on diagnoses, utilization, and patient demographics.
- Academic literature and governmental reports.

The information that follows was drawn, as much as possible, from empirical evidence. Any conclusions or observations are based on objective information, studies, or other validated information wherever possible. However, as noted above, the proposed free-standing specialty hospital would be the first of its kind to be established in Minnesota. This means there is no prior evidence in the Minnesota hospital market on which to base assessments of the proposal's impact.

[17] The conditions include amputation, arthritis, brain injury, congenital deformity, fracture of femur, joint inflammation, knee or hip joint replacement, major multiple traumas, neurological disorders, osteoarthritis, stroke, and spinal cord injury. CMS had formerly set this threshold at 75% by Final Rule in 2004 and reduced the level to 60% following federal legislation passed in 2007.

Factor 1: Whether there is a need for the proposed new hospital to provide timely access to care or access to new or improved services

The initial step in MDH's evaluation of the proposed new hospital was to examine how the targeted patient population currently receives inpatient rehabilitation services in the proposed primary service area. This research involved examining the geographic distribution, capacity, and scope of services that currently exist. It also included an evaluation of potentially existing access barriers and how the proposal could impact those potential barriers.

Second, MDH assessed whether the plan, as proposed, would meet the needs of Minnesota patients—through personnel, technology, and other supportive resources—at a level that meets or exceeds the quality-of-care currently provided (improvement in services). The proposed staffing plan, for instance, can be compared to existing hospital-based rehabilitation. Performance on quality measures can be compared to similar facilities nationally and for Minnesota hospitals to determine if proposed services may represent an improvement upon the status quo.

Finally, we consider to what extent new or improved services are balanced with the efficient and cost-effective distribution, capacity, and scope of equivalent care currently provided in the proposed geographic service area. For example, a new rehabilitation hospital would need to match the demand for those specialty beds so that facilities in the entire service area operate at an optimal level of occupancy. Assessing need also involves exploring how lower-cost rehabilitation alternatives in subacute settings influence the need for the construction of a new hospital.

Geographic distribution, capacity, and scope of rehabilitation services in Minnesota

MDH generated a picture of inpatient rehabilitation care in Minnesota, and specifically, the seven-county primary service area proposed by Nobis between 2016 and either 2021 or 2022 (depending on available data) by summarizing annual reports and actual use based on discharge data. MDH used a five-year span to insulate the analysis from the disruptions in bed availability and care use at Minnesota hospitals during the COVID-19 pandemic.[18]

In 2022, there were 277 acute inpatient rehabilitation beds in Minnesota located at 11 hospitals with more than half (54.5% or 151 beds) located at six hospitals in the Twin Cities Metropolitan Area (Table 3). The remaining beds were in the urban areas of Duluth, Rochester, and St. Cloud. All Minnesota hospitals that currently provide inpatient rehabilitation care are larger acute care hospitals that also operate a dedicated rehabilitation unit. The number of rehabilitation beds reported at these hospitals has been stable since 2016. One hospital that is not listed, Sanford Health Bemidji, was in the process

[18] Three Key Trends for Minnesota Community Hospitals in 2020, March 2022 (state.mn.us) (https://www.health.state.mn.us/data/economics/docs/hosptrendsbrief031522.pdf)

of closing its inpatient rehabilitation unit during this review. Leaders from the hospital mentioned in a public hearing on the closure that three factors mainly contributed to this closure:

1) An unsustainable low patient volume.
2) Changes in practice patterns and patient preferences to receive care outside of the hospital.
3) High costs of having dedicated staff, such as a medical director and nurses, that must remain in the unit.

Table 3: Minnesota hospitals with inpatient rehabilitation beds, 2022

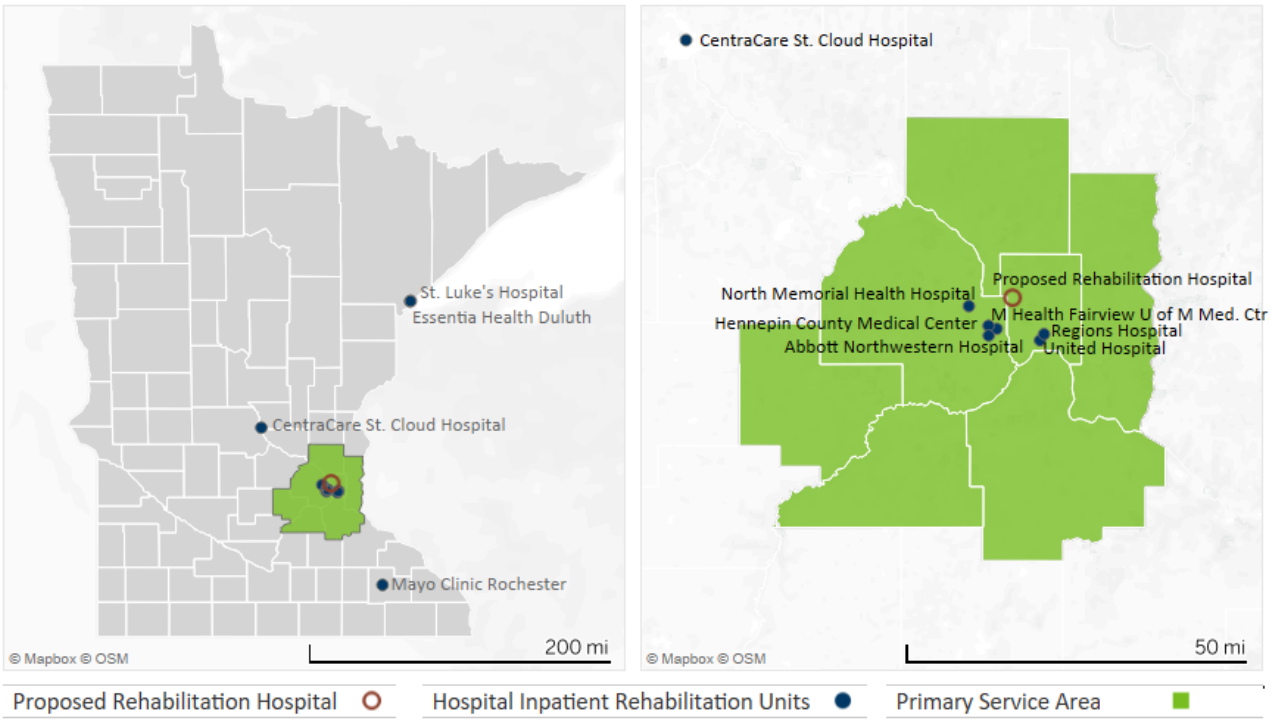
Hospital Name	City	County	Region	Rehabilitation Beds
Abbott Northwestern Hospital	Minneapolis	Hennepin	Metro	39
Hennepin County Medical Center	Minneapolis	Hennepin	Metro	27
M Health Fairview U of M Medical Center	Minneapolis	Hennepin	Metro	30
North Memorial Health Hospital	Robbinsdale	Hennepin	Metro	18
Regions Hospital	St. Paul	Ramsey	Metro	21
United Hospital	St. Paul	Ramsey	Metro	16
CentraCare Health – St. Cloud Hospital	St. Cloud	Stearns	Central	19
Essentia Health – Duluth	Duluth	St. Louis	Northeast	36
St. Luke's Hospital	Duluth	St. Louis	Northeast	19
Mayo Clinic Hospital – Rochester	Rochester	Olmsted	Southeast	36

Source: MDH analysis of Minnesota Hospital Annual Reports. This table excludes Gillette Children's Specialty Healthcare's 17 inpatient rehabilitation beds because this hospital was not identified in the Nobis application as a competitor.[19]

Figure 2 illustrates that the concentration of inpatient rehabilitation beds is in the urban core of the Twin Cities Metropolitan Area with a surrounding primary service area of the seven counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. Within the Metro Area, the only hospital outside of Minnesota's largest cities of Minneapolis and St. Paul is in Robbinsdale, an adjacent suburb that borders the northwest of Minneapolis. The proposed hospital would be close to these six hospitals, as shown on the map, with a distance of eight miles to both M Health Fairview University of Minnesota Medical Center and North Memorial Health Hospital.

[19] Other hospitals are excluded because they stopped reporting inpatient rehabilitation beds—including CentraCare Health Monticello (10 beds from 2016-2018), and Lake Region Healthcare (14 beds from 2016-2018). As noted, Sanford Bemidji Medical Center will no longer offer inpatient rehabilitation services as of April 1, 2024. For more information on this closure, please visit: Sanford Bemidji Medical Center Public Hearing - MN Dept. of Health (state.mn.us) (https://www.health.state.mn.us/about/org/hrd/hearing/sanford.html).

Figure 2: Existing hospital-based inpatient rehabilitation units in Minnesota, proposed rehabilitation hospital, and proposed primary service area



Source: MDH analysis of Minnesota Hospital Annual Reports as well as the proposed hospital location and counties identified by the Applicant.

The number of inpatient rehabilitation stays at Minnesota hospitals from 2016 through 2022 ranged from around 4,200 per year to a peak of about 4,900 in 2019 (Table 4), with the number of stays in 2020 and 2022 marginally lower than previous years. The average length of stay did see growth in later years, with Minnesota hospitals seeing an average length of stay of 13.1 days in 2022 exceeding the national average of 12.8 days. Nearly all hospitalizations for rehabilitation statewide in Minnesota (over 99%)[20] were at the 11 hospitals listed in Table 1 from 2016 to 2022. The share of hospital stays at Metro hospitals was largely similar to the share of the number of beds from 2016 to 2019, but increased during 2020 and 2022 to a larger share than bed supply—possibly due to factors related to the COVID-19 pandemic.[21] The average age of patients with hospital stays was between 62 and 65 years of age, with a younger average age observed between 2020 and 2022 compared to previous years.

[20] MDH analysis of hospital discharge data used administrative records that identify facility revenue center charges for rehabilitation and diagnosis related groups for rehabilitation care. Mental health and substance abuse disorder rehabilitation records were excluded from this analysis.

[21] Patient origin and travel will be discussed later in this document.

Table 4: Inpatient rehabilitation stays at all Minnesota hospitals, 2016-2022

Year	Number of Hospital Stays	Average Length of Stay	Percent of Stays at MN Hospital with a Rehab Unit	Percent of Stays at a Metro Hospital with a Rehab Unit	Average Patient Age
2016	4,590	11.3	99.2%	54.3%	63.5
2017	4,708	10.6	99.0%	54.1%	64.5
2018	4,867	11.8	99.2%	55.6%	63.6
2019	4,905	12.8	99.0%	55.6%	63.3
2020	4,656	12.6	99.6%	57.8%	62.2
2021	4,499	12.5	99.9%	59.6%	62.2
2022	4,218	13.1	99.8%	58.6%	62.1

Source: MDH analysis of Minnesota hospital discharge data from 2016-2022. Rehabilitation stays are identified by records having a revenue center code for rehabilitation or Medicare-Severity Diagnosis Related Group of 945 or 946.

The most common condition of patients receiving inpatient rehabilitation at Minnesota hospitals during this time was for diseases of the circulatory system (primarily stroke)—accounting for nearly two in five (38.6%) rehabilitation hospitalizations (Table 5). Other common diagnoses for patients receiving rehabilitation were neurological conditions followed by brain injuries that were traumatic and nontraumatic. Most patients had at least one chronic or co-occurring condition, with the most common being hypertension (high blood pressure), diabetes, and cancer.

Table 5: Rehabilitation hospital stays by Rehabilitation Impairment Category, 2016-2022

Rehabilitation Impairment Category (RIC)	Number of Discharges	Percent of Discharges
Stroke	12,538	38.6%
Neurological conditions	4,372	13.5%
Brain Injury	3,687	11.4%
Cardiac conditions	1,276	3.9%
Spinal cord injury	1,257	3.9%
Orthopedic conditions	1,236	3.8%
Major multiple trauma	955	2.9%
Fracture of lower extremity	778	2.4%
All other conditions	6,344	19.6%
Total	**32,443**	**100.0%**

Source: MDH analysis of Minnesota hospital discharge data from 2016-2022 for Minnesota hospitals using the CMS IRF-PAI Manual Version 4.0.

Anticipated need for Inpatient rehabilitation beds

Nobis projected a need for 334 inpatient rehabilitation beds in the Twin Cities metropolitan area by 2035, 183 more than the current inventory of 151 inpatient rehabilitation beds in the region. This estimate was based primarily on national utilization rates per capita,[22] national annual growth in bed utilization, and demographic shifts towards an aging population.[23] As part of its proposal, Nobis noted that Minnesota has among the lowest utilization rates per capita of inpatient rehabilitation beds compared to other states and argued that this is likely due to insufficient bed availability.

In other words, the Nobis projections rely on two major assumptions. First, that the proposed service area currently lacks capacity to meet patient demand because Minnesota does not have the same number of rehabilitation beds per-person as the national average. Second, that need should be determined by applying national utilization rates, rather than observed historical practice patterns. Each of these assumptions deserve scrutiny when evaluating such a proposal.

Demand for inpatient rehabilitation services

There is evidence of wide variation in the use and availability of inpatient rehabilitation services across the United States,[24] and there is no universal standard for the optimal number or use of inpatient rehabilitation across states.[25] In 2023, MedPAC, in its annual report to Congress, stated there was adequate supply of inpatient rehabilitation beds across the United States to meet the needs of Medicare beneficiaries. This conclusion was based on strong marginal profits earned by both freestanding and hospital-based IRFs,[26] the overall number of IRFs, evidence of excess capacity with occupancy rates ranging from 65% to 71%, and the presence of alternative settings for rehabilitation care. Some states set a *maximum* number of beds per 100,000 population while others use projections or, like Minnesota, have no defined criteria in regulations. Furthermore, there does not exist published

[22] The national use rates Nobis used were from the MedPAC annual reports to congress, with Medicare constituting by far the largest payor for rehabilitation care.

[23] Notably, population growth in the region is projected to be disproportionately high for those aged 65+, the primary population utilizing inpatient rehabilitation care. This population is expected to increase in population size by 16.2% over the next 10 years while the rest of the population may increase by only 5.5% according to Minnesota State Demographer's Office's long term population projections.

[24] Kane, R. L., Lin, W. C., & Blewett, L. A. (2002). Geographic variation in the use of post-acute care. *Health Services Research*, *37*(3), 667-682.

[25] Butler, Johanna, Adney Rakotoniaina, and Deborah Fournier. "50-State Scan Shows Diversity of State Certificate-of-Need Laws." *National Academy for State Health Policy, webpage, May* 22 (2020). 50-State Scan Shows Diversity of State Certificate-of-Need Laws - NASHP (https://nashp.org/50-state-scan-shows-diversity-of-state-certificate-of-need-laws/).

[26] MedPAC described, "In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. Op. Cit., MedPAC. March 2023.

literature MDH is aware of proposing a standard for an optimal number of beds or use of inpatient rehabilitation services for a geographic area.

Minnesota falls in the lower end of the spectrum of IRF beds per population in 2021 as pointed out by Nobis in their application.[27] This lower level of rehabilitation beds in the state, relative to other parts of the country, is not a new phenomenon. In 2009, a national report found that Minnesota ranked 45th of 50 states and Washington D.C. for the number of IRF beds per population.[28] Another study examining more detailed service areas in 2013 and 2014 similarly found that the availability of IRF beds near the bottom of states with only Oregon, Hawaii, and Maryland with less available IRF capacity relative to service areas.[29]

If the assumption that the comparatively low rate of rehabilitation beds in Minnesota translates to the state lacking sufficient capacity, one would expect that the existing rehabilitation beds would be full and there would be challenges with admitting patients due to capacity constraints. However, Table 6 shows rehabilitation beds in the primary service area to be operating at relatively low occupancy. On average, occupancy ranged from a high of 66% in 2019 to a low of 57.1% in 2017—substantially below the occupancy rate of 80% proposed by Nobis.

Of the six hospitals with rehabilitation beds, only one routinely experienced days of high occupancy (average occupancy above 80%) in 2021 and 2022.[30] Given the excess capacity in the area, this is not a signal that there is any capacity constraint (Table 6). Other recent public interest reviews that demonstrated a need for expansion for pediatric mental health, for example, found that hospitals were

[27] Nobis mentioned in the submission that Minnesota and the seven-county service area, both have 60% fewer rehabilitation beds than the national average number of beds per population.

[28] Bogasky, S., Gage, B., Morley, M., Spain, P., & Ingber, M. (2009). Examining post acute care relationships in an integrated hospital system. URL: *Examining Post Acute Care Relationships in an Integrated Hospital System | ASPE (hhs.gov) (https://aspe.hhs.gov/reports/examining-post-acute-care-relationships-integrated-hospital-system-0). Published February 1*. Other states with fewer rehabilitation beds per population in the study were California, Iowa, Alaska, Connecticut, Oregon, and Maryland.

[29] Reistetter, T. A., Dean, J. M., Haas, A. M., Prochaska, J. D., Jupiter, D. C., Eschbach, K., & Kuo, Y. F. (2023). Development and Evaluation of Rehabilitation Service Areas for the United States. *BMC Health Services Research*, *23*(1), 204.

[30] MDH is not identifying certain data on individual hospitals in this report because they are derived from data requiring a 21-day review by each hospital, a process MDH was not able to accommodate within the time for this public interest review.

routinely over 85% occupancy[31] and adult mental health beds were over 95% occupied.[32] While the most recent year saw increases in days above 85%, those days appear to be largely outliers during the year.

Table 6: Rehabilitation occupancy at Twin Cities hospitals, 2016-2021

Year	Average Daily Census	Average Daily Occupancy Rate	Percent of Days Above 85% Occupancy	Percent of Days Above 95% Occupancy
2016	88	57.6%	5.5%	1.2%
2017	83	57.1%	5.0%	0.9%
2018	95	61.6%	10.9%	2.1%
2019	100	66.0%	11.4%	1.7%
2020	98	64.2%	10.2%	1.1%
2021	94	64.1%	18.2%	5.3%
2022	92	64.4%	18.1%	5.6%

Source: MDH analysis of hospital annual reports and hospital discharge data from 2016-2021. The occupancy rate was determined based on the maximum daily census for the calendar year. Percent of days above an occupancy rate is the percent of days when any one of the six hospitals reached 85% or 95% occupancy, respectively, based maximum census, not when all beds are 85% or 95% occupied.

Another possible indicator of insufficient supply of beds is that patients may be forced to seek needed care outside their immediate community. According to hospital discharges from 2022, travel for inpatient rehabilitation is extremely rare for residents of the proposed primary service area with over 96% of discharges occurring at Twin Cities hospitals. There was a very small share (less than 3% of discharges) traveling to Rochester and less than 1% traveling to Duluth and St. Cloud for inpatient rehabilitation services. Both locations had ample occupancy below 80% to accommodate hospital stays for rehabilitation care by Twin Cities patients during this time.

Utilization of inpatient rehabilitation in Minnesota compared to United States

Nobis' projections also used 2020 national inpatient rehabilitation hospitalization and length of stay rates from patients with traditional Medicare (rather than all of Medicare, inclusive of Medicare

[31] Children's Minnesota Public Interest Review: Evaluation of Proposal for Expansion of Pediatric Inpatient Psychiatric Bed Capacity (state.mn.us) September 8, 2023 (https://www.health.state.mn.us/data/economics/moratorium/childrensmn/docs/childrensfinalrpt2023.pdf).

[32] Fairview-Acadia Public Interest Review: Evaluation of Proposal for a New Adult Mental Health Hospital (state.mn.us) November 30, 2022 (https://www.health.state.mn.us/data/economics/moratorium/fairviewacadia/docs/fvwacadappendixc.pdf).

Advantage).[33] Evidence shows there are several reasons to be skeptical of these projections and the argument that national rates and length of stay ought to be reflective of the Minnesota health care landscape:

1. **Index Year**: Due to the pandemic, 2020 rates may not be the best index year upon which to base projections of future use. In Minnesota and nationally, acute care admissions decreased by more than 10% from 2019 to 2020 due to the global COVID-19 pandemic.[34] In addition, the proportion of patients who were admitted to inpatient rehabilitation and the conditions for which they were admitted were likely different during the pandemic than three years later and during a typical year.

2. **Index Population**: Relying on data from traditional Medicare to project future use will be biased, because of the higher rates of inpatient rehabilitation among that population compared with Medicare Advantage, which accounts for an increasing share of total Medicare in Minnesota.[35,36] Analysis of hospital discharge records found that in 2022, the expected payer for more than one in four of inpatient rehabilitation hospital stays in Minnesota (27.2%) was Medicare Advantage (Table 7). Nobis, noting in its application that such patients were admitted 30%-35% less to inpatient rehabilitation than traditional Medicare patients, assumed 17% of discharges would be from Medicare Advantage patients—much lower than the actual percent of discharges found in Minnesota.[37]

[33] This figure was cited by Nobis as the 2022 average length of stay for inpatient rehabilitation from the Uniform Data Systems for Medical Rehabilitation, a proprietary database of 75-80% of national inpatient rehabilitation discharges.

[34] Three Key Trends for Minnesota Community Hospitals in 2020, March 2022 (state.mn.us) (https://www.health.state.mn.us/data/economics/docs/hosptrendsbrief031522.pdf)

[35] Huckfeldt, P. J., Escarce, J. J., Rabideau, B., Karaca-Mandic, P., & Sood, N. (2017). Less intense postacute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs*, *36*(1), 91-100.

[36] Skopec, L., Huckfeldt, P. J., Wissoker, D., Aarons, J., Dey, J., Oliveira, I., & Zuckerman, S. (2020). Home Health and Postacute Care Use in Medicare Advantage And Traditional Medicare: A comparison of Medicare Advantage and traditional Medicare postacute care–including care provided by skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. *Health Affairs*, *39*(5), 837-842.

[37] Recent data for Minnesota found that 47.4% of Medicare beneficiaries in Minnesota were enrolled in Medicare Advantage. See: Chartbook Section 5: Public Health Insurance Programs (state.mn.us) (https://www.health.state.mn.us/data/economics/chartbook/docs/section5.pdf)

Table 7: Expected payer for inpatient rehabilitation discharges at Twin Cities hospitals, 2016-2022

	2016	2017	2018	2019	2020	2021	2022
Medicare	49.9%	54.3%	55.8%	55.6%	54.3%	51.5%	51.0%
Medicare FFS*	39.2%	41.4%	42.5%	33.5%	30.9%	25.8%	23.9%
Medicare Advantage	10.7%	12.9%	13.3%	22.1%	23.4%	25.6%	27.2%
MCHP (Medicaid)	16.2%	14.7%	13.4%	14.3%	16.5%	16.7%	17.8%
Medicaid FFS*	8.2%	6.2%	6.5%	7.4%	7.4%	6.6%	7.6%
Medicaid Managed Care	8.0%	8.6%	6.9%	6.9%	9.2%	10.1%	10.2%
Commercial	31.4%	28.4%	28.3%	27.9%	27.1%	29.5%	28.4%
Self-Pay	1.0%	0.9%	1.4%	1.2%	1.3%	1.5%	1.4%
Other	1.5%	1.6%	1.1%	1.0%	0.8%	0.9%	1.4%
Total	100%	100%	100%	100%	100%	100%	100%

*FFS is fee-for-service, often also referred to as "traditional Medicare".

Source: MDH analysis of hospital discharge data from 2016-2022. Discharge records that were coded as commercial for patients 65 and older were assumed to be Medicare Advantage.

Recognizing these limitations, while also acknowledging the reality of a growing elderly population, MDH commissioned independent projections to estimate future demand for the number of inpatient rehabilitation beds. These projections drew upon hospital discharge data that was Minnesota-specific and spanned both pre-pandemic (2016-2019) and pandemic (2020-2021) time periods as well as All Payer Claims Data that was more current (quarter one of 2021 to quarter three of 2023).[38]

This baseline data was used to develop per-person use rates by age and gender groups along with market-specific growth rates at the county-level to allow local variation and fit to the proposed service area for five (2029) and ten years (2034) into the future. Growth rates for inpatient rehabilitation were derived from the Advisory Board's market scenario planner that primarily relied upon demographic shifts that were specific to the local population and use rate factors such as insurance pressures, disease prevalence, care management transformation, and technology adoption. The estimated use also assumed that there would be consistent average length of stay that was identical to figures Nobis used in its projections to develop future patient days by county. Finally, five- and ten-year bed need

[38] Estimated use of inpatient rehab for more recent years (2022 and 2023) in Minnesota were likely over-inflated from all payer claims data (3.99% and 13.16% respectively) since more recent data at MDH showed a 1.5% increase in 2022. For 2024, 3 statistical growth models were applied to the previous two years of data to get an estimate of expected growth for 2024. A best fit model, compound annual growth rate (CAGR) model, and exponential model were all calculated. An average of the three models was taken and applied to the 2023 utilization numbers to calculate the 2024 estimate.

was compared to current supply of beds for the proposed service area with an 80% target occupancy (20 percentage points above current occupancy levels, as assumed by Nobis).

The MDH projections in Table 8, which aim to address the shortcomings of the Nobis analysis, demonstrate that Minnesota will have excess capacity over the next five years and might have a modest deficit (29 beds) within ten years that existing hospital providers likely can accommodate without the capital costs associated with a new facility. In addition, these projections remain worst-case scenario, in that they do not account for the ongoing impact of advanced surgical techniques that will reduce the need for inpatient rehabilitative care.

Among the shortcomings the MDH projections address are the use of Minnesota use rates, reflecting to somewhat unique practice patterns in state and use of non-hospital post-acute care options (rather than employing national use rates). This yields a very different starting point in estimating current need (a difference of 155 beds in 2024 that is greater than the current number of available rehabilitation beds).

Table 8: Estimated bed need models from Nobis and MDH

	Nobis projection	MDH-commissioned projection
Current bed supply	151	151
Estimated bed need at 80% occupancy, 2021-2024	281	126
Estimated bed need at 80% occupancy, 2025-2029	303	152
Estimated bed need at 80% occupancy, 2030-2035	334	180

Source: Applicant and projections made by Pivotal Analytics for MDH.

In summary, by overestimating demand (and need) for inpatient rehabilitative care and needing to rely on transfers from other hospitals that are operating *below* their full capacity, the proposed Nobis hospital will likely operate for many years far below capacity.

Potential improvements in rehabilitation services

Nobis asserts that the proposed hospital would improve the quality of rehabilitation care available for the service area. To support this claim, Nobis lists quality data from a proprietary data system. While some of the quality measures listed in Table 21 of the application are included in the CMS IRF Quality Reporting Program (QRP), several measures from the CMS IRF QRP are omitted.

MDH assessed publicly available quality measurement data through the CMS IRF QRP to compare Nobis facilities to existing facilities in the proposed Minnesota service area. Unfortunately, there were several limitations constraining MDH's ability to rigorously assess the expected quality-of-care at the proposed facility:

- Of the 12 operational IRFs listed in Table 1, five have not been open long enough to have quality measure data available.
- Seven of the operational IRFs have limited quality measure data.
- All available quality measurement has been conducted during various stages of the COVID-19 pandemic; MedPAC advises quality measured during the pandemic should not be used to draw conclusions about quality trends in IRFs.[39]

With these constraints in mind, MDH assessed publicly available quality measurement data for the 2021-2022 reporting cycle[40] for seven Nobis facilities and for all six of the existing IRFs in the proposed service area (Figure 1). MDH compared quality measure data from Nobis IRF facilities and existing facilities in the proposed service area to national benchmarks for the 12 quality measures in the IRF QRP that had data available for most of the facilities of interest.

- On six measures, Nobis IRFs and existing IRFs in the service area scored similarly, relative to national benchmarks.
- On two measures, Nobis IRFs overall scored better than existing IRFs, relative to national benchmarks.
- On four measures, Nobis IRFs overall scored worse than existing IRFs, relative to national benchmarks.

Overall, Nobis IRFs and existing IRFs in the proposed service area largely follow similar quality trends among the CMS IRF QRP measure set based on available data (See Appendix B for a more detailed breakdown of the IRF QRP measures used in MDH's comparison).[41]

[39] MedPAC noted that factors like risk adjustment are not yet able to account for the pandemic's impact on care in IRFs. Op. Cit., MedPAC. March 2023.

[40] Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Measures Information. *CMS*. December 1, 2023. https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-quality-reporting-measures-information.

[41] The recently opened Nobis IRF in Wisconsin scored below national rates for most of the measures in this measure set, although these results are based on a shorter measurement period than is usually required.

The facility proposed by Nobis is different from other rehabilitation hospitals because it would be a freestanding facility, and it would be operated by a for-profit company.[42] MedPAC reviewed the potential relationship between freestanding facilities and ownership on quality outcomes.

- First, MedPAC evaluated trends in risk-adjusted quality measures for IRFs based on the type of facility. The analysis looked at the rate of hospitalization for any reason during an IRF stay and found that nonprofit, for-profit, hospital-based, and freestanding IRFs all had similar rates in 2021.
- MedPAC also compared the rate of successful discharge of IRF patients to community. For this measure, for-profit IRFs had slightly lower rates than nonprofit IRFs, and freestanding IRFs had lower rates than hospital-based IRFs in 2021.

Data from before the COVID-19 pandemic in 2017 and 2019 reflect starker differences between these types of facilities, with for-profit and freestanding IRFs performing at lower levels of quality, displaying higher rates of hospital admissions and lower rates of successful discharge to community than their nonprofit and hospital-based counterparts, respectively.[43]

Research evidence have also linked nurse staffing to health care quality and patient outcomes across a variety of facilities and levels of patient care complexity. Two meta-analyses found that higher nurse-to-patient ratios in settings including acute care were associated with lower hospital-related mortality, fewer hospital-related infections and other adverse events, and shorter patient stays.[44] Findings from other studies suggest that lower staffing levels in inpatient hospitals is associated with higher mortality risk.[45] In terms of quality-of-care, lower staffing levels may reduce the ability to provide timely services, including assisting with activities of daily living, administering medications, or simply talking to

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[42] Currently, Minnesota has two for-profit specialty hospitals, Regency Hospital in Golden Valley, which offers long-term acute care, and PrairieCare in Brooklyn Park, which offers inpatient mental health primarily for children and adolescents. A third hospital, co-owned by Fairview Health Services and Acadia Healthcare, is expected to open in St. Paul in late 2024 or early 2025 and offer adult inpatient mental health services.

[43] Op. Cit. Medicare Payment Advisory Commission. (2023).

[44] Kane, Robert L et al. "Nurse staffing and quality of patient care." *Evidence report/technology assessment,* 151 (2007): 1-115. Driscoll, A., Grant, M. J., Carroll, D., Dalton, S., Deaton, C., Jones, I., Lehwaldt, D., McKee, G., Munyombwe, T., & Astin, F. (2017). The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: a systematic review and meta-analysis. *European Journal of Cardiovascular Nursing*, 17(1), 6–22. https://doi.org/10.1177/1474515117721561

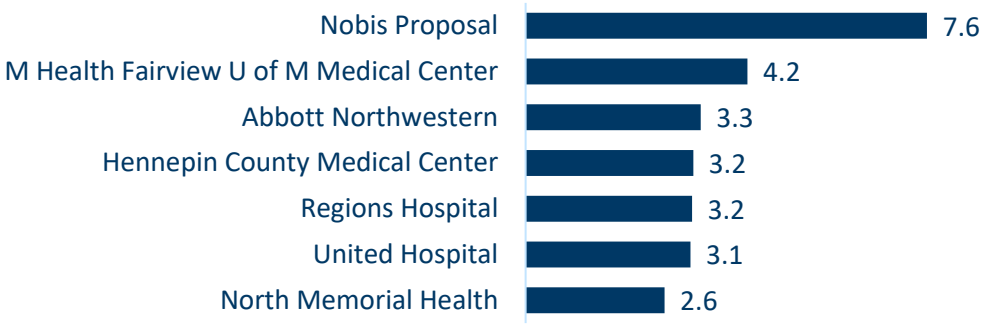
[45] Needleman, J., Liu, J., Shang, J., Larson, E. L., & Stone, P. W. (2020). Association of registered nurse and nursing support staffing with inpatient hospital mortality. *BMJ Quality & Safety*, 29(1), 10-18. Griffiths, P., Ball, J., Drennan, J., Dall'Ora, C., Jones, J., Maruotti, A., ... & Simon, M. (2016). Nurse staffing and patient outcomes: Strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for Health and Care Excellence Safe Staffing guideline development. *International journal of nursing studies*, 63, 213-225

patients and attending to their needs. These findings suggest that nurse-to-patient ratios at the proposed IRF could be an important indicator of expected patient outcomes and quality-of-care.

Nobis targets an occupancy rate of 80% of its 60-bed hospital (48 occupied beds) once fully operational. Its staffing plan calls for 26.5 full-time equivalent nurses, combining Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). This equates to an average of 6 to 7 nurses for an estimated 48 patients, or approximately 7 to 8 patients per nurse on a typical shift.

Based on Minnesota Hospital Association data aggregated from the most recent four quarterly reports available (2022 Q3-2023 Q2), the six hospitals currently offering inpatient rehabilitation services in the proposed service area ranged from 2.0 to 4.4 patients per nurse on average (Figure 3). The total average of 3.3 patients per nurse in existing units represents more than twice the nurse staffing proposed in Nobis' plan. The four other hospitals providing inpatient rehabilitation care in greater Minnesota fell within the same range of nursing ratios in the time-period, varying from 2.3 to 4.0 patients per nurse on average. The significantly lower staffing at the proposed Nobis facility raises concerns about quality-of-care and/or patient safety.

Figure 3: Number of patients per nurse at proposed hospital and Minnesota hospitals with inpatient rehabilitation beds, four quarters ending Q2 2023



Source: MDH analysis of staffing plan and anticipated patient volume submitted by the applicant as well as Minnesota Hospital Association data of actual staffing and patient days during the fourth quarter of 2022 through the third quarter of 2023.

Alternatives to inpatient rehabilitation

In addition to inpatient facilities, rehabilitation care can also be provided in subacute settings, such as skilled nursing facilities (SNFs),[46] home health agencies, comprehensive outpatient facilities, and independent therapy providers. Rehabilitation care provided in these subacute settings can be very similar, less costly, but often are more limited in scope. For example, patients in SNF and transitional care unit (TCU) settings can receive physical, occupational, and/or speech therapy about one to two

[46] Rehabilitation is often provided in a higher-level skilled nursing facility for more complex patients transitioning from hospital to home called a transitional care unit (TCU).

hours daily (rather than 3 hours minimum in IRFs); these facilities lack requirements for providing certain levels of routine medical monitoring and have infrequent physician visits.[47] However, there is some uncertainty about the benefit of higher-cost inpatient rehabilitation care or further expansion. The Medicare Payment Advisory Commission (MedPAC) recently noted:

> "Although there are IRF admissions criteria, it is not clear when IRF care is required for a given patient. Other potentially lower-cost post-acute care (PAC) providers such as skilled nursing facilities (SNF) can provide similar care. The absence of IRFs in some areas of the country implies that beneficiaries in these areas receive similar services in other settings."[48]

Nobis states that its proposed rehabilitation specialty hospital would provide daily physician oversight and acute care-level nursing care with therapeutic services in line with federal Medicare requirements and beyond those offered in sub-acute settings. For example, according to the applicant, patients might have lost function or need to learn adaptive techniques in an intensive way to meet their functional needs and objectives only through an IRF stay. The applicant notes that the new facility would work with local short-term acute care hospitals, area physicians, social workers, and other post-acute providers to admit patients that meet inpatient admissions criteria.

Expanding access to IRF services instead of subacute rehabilitation, in Nobis' view, would improve access to rehabilitation care that has been under-used in Minnesota. Still, SNFs and TCUs may be substitutes for inpatient rehabilitation services to some extent and there is mixed or limited evidence on the optimal setting for patients requiring rehabilitation care and differences by types of conditions. For instance, there has been an accumulation of evidence supporting care delivery for stroke patients in inpatient rehabilitation facilities over skilled nursing facilities.[49,50,51] Due to this and other evidence, the American Stroke Association recommends clinical practice guidelines that IRF, rather than SNF treatment, should be used for stroke patients as noted by Nobis in the application. Similarly, trauma patients receiving acute rehabilitation have been found to experience better outcomes for functional

[47] Transitional care units have an equivalent license and regulatory requirements (i.e., as a skilled nursing facility in Minnesota.

[48] Op. Cit. Medicare Payment Advisory Commission. (2023).

[49] Hong, I., Goodwin, J. S., Reistetter, T. A., Kuo, Y. F., Mallinson, T., Karmarkar, A., ... & Ottenbacher, K. J. (2019). Comparison of functional status improvements among patients with stroke receiving postacute care in inpatient rehabilitation vs skilled nursing facilities. *JAMA network open*, *2*(12), e1916646-e1916646.

[50] Alcusky, M., Ulbricht, C. M., & Lapane, K. L. (2018). Postacute care setting, facility characteristics, and poststroke outcomes: a systematic review. *Archives of Physical Medicine and Rehabilitation*, *99*(6), 1124-1140.

[51] Mees, M., Klein, J., Yperzeele, L., Vanacker, P., & Cras, P. (2016). Predicting discharge destination after stroke: a systematic review. *Clinical Neurology and Neurosurgery*, *142*, 15-21.

independence, discharge to home, one-year rehospitalization, and one-year mortality.[52] However, the clear evidence on superior outcomes for inpatient rehabilitation has not been as consistent for other conditions such as hip fracture or joint replacement.[53,54,55] In addition, research has found that, after controlling for organizational characteristics and practice patterns, for-profit IRFs had significantly higher readmission rates than not-for-profit IRFs.[56] An investigation on patient-reported outcomes cast doubt on any advantage IRFs had in improving rehabilitation goals by analyzing multiple settings (inpatient, outpatient, home, or other).[57]

MDH analyzed the Minnesota All Payer Claims Database (MN APCD) in order to assess how common it is in Minnesota for patients from the Twin Cities Metro Area receive similar rehabilitation care outside of IRF settings.[58] In this analysis, SNF claims[59] from 2019 and 2021 were identified as highly likely to include rehabilitation care by relying on a combination of required diagnoses and evidence of physical or occupational therapy on the SNF claim.[60] The rehabilitation volume at SNF facilities for Twin Cities patients contributed between 61.1% and 70.9% of additional rehabilitation stays beyond inpatient care in 2019 and between 55% and 74.3% in 2021.[61] To put these numbers in context, a recent national

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[52] Nehra, D., Nixon, Z. A., Lengenfelder, C., Bulger, E. M., Cuschieri, J., Maier, R. V., & Arbabi, S. (2016). Acute rehabilitation after trauma: does it really matter? *Journal of the American College of Surgeons*, *223*(6), 755-763.

[53] Mallinson, T., Deutsch, A., Bateman, J., Tseng, H. Y., Manheim, L., Almagor, O., & Heinemann, A. W. (2014). Comparison of discharge functional status after rehabilitation in skilled nursing, home health, and medical rehabilitation settings for patients after hip fracture repair. *Archives of Physical Medicine and Rehabilitation*, *95*(2), 209-217.

[54] Tian, W., DeJong, G., Horn, S. D., Putman, K., Hsieh, C. H., & DaVanzo, J. E. (2012). Efficient rehabilitation care for joint replacement patients: skilled nursing facility or inpatient rehabilitation facility. *Medical Decision Making*, *32*(1), 176-187.

[55] DeJong, G., Horn, S. D., Smout, R. J., Tian, W., Putman, K., & Gassaway, J. (2009). Joint replacement rehabilitation outcomes on discharge from skilled nursing facilities and inpatient rehabilitation facilities. *Archives of Physical Medicine and Rehabilitation*, *90*(8), 1284-1296.

[56] Daras, L. C., Ingber, M. J., Deutsch, A., Hefele, J. G., & Perloff, J. (2018). Geographic region and profit status drive variation in hospital readmission outcomes among inpatient rehabilitation facilities in the United States. *Archives of Physical Medicine and Rehabilitation*, *99*(6), 1060-1066.

[57] Gell, N. M., Mroz, T. M., & Patel, K. V. (2017). Rehabilitation services use and patient-reported outcomes among older adults in the United States. *Archives of Physical Medicine and Rehabilitation*, *98*(11), 2221-2227.

[58] MDH analysis of the Minnesota All Payer Claims Database (MN APCD) Extract 26.

[59] The majority of SNF claims were for Medicare beneficiaries (69% of SNF stays in 2019 and 65% in 2021).

[60] The analysis exclusively used diagnosis codes identified as qualifying for rehabilitation care by the Centers for Medicare & Medicaid Services (CMS). For more information, see: CMS-1767-F | CMS (https://www.cms.gov/medicaremedicare-fee-service-paymentinpatientrehabfacppsirf-rules-and-related-files/cms-1767-f). These regulations require that at least 60% of admissions comprise certain diagnosis codes or conditions with co-occurring diagnoses.

[61] The two data points in ranges represent inpatient rehabilitation counts from Minnesota hospital discharge data and inpatient stays from the MN APCD that differ, at least in part, because commercial self-insured plans fall under the Employee Retirement Security Act (ERISA) and are not required to submit data to the MN APCD.

study that combined both IRF and SNF rehabilitation care found that service use in the Twin Cities service area ranked in the middle of that of other regional markets (178 of 292), rather than a low-use outlier. [62]

Factor 2: The financial impact of the new hospital on existing hospitals with emergency departments

Nobis indicated its belief that the lack of inpatient rehab capacity would limit any financial impact on existing hospitals. To assess factor 2, and in addition to the preceding analysis on that question, it is important to consider the proposed hospital's business and care model, which differs significantly from other Minnesota hospitals with inpatient rehabilitation capacity. Two factors have the potential to financially affect other hospitals: as a freestanding facility, the proposed hospital will not have acute medical care capacity on site; and as a for-profit, equity-financed institution, it likely will be driven by different incentives than existing non-profit facilities delivering inpatient rehabilitative care. There are three potential ways in which adverse financial impact on existing hospitals in the proposed service area might materialize:

1. **Reduction in volume** of inpatient rehabilitation, generally a well-reimbursed service, because patients are being diverted to the new hospital.
2. **Adverse shift in payer mix** (toward more patients with Medicaid coverage) with higher-reimbursed patients (Medicare and commercial) being diverted to the proposed facility.
3. **Adverse shift in patient mix** with lower medical needs and higher-margin services (based on diagnoses and resource intensity) being diverted to the proposed facility.

Potential reduction in volume at existing hospitals

It is likely that there would be a shift of inpatient volume to the new facility, simply because Nobis would be the single largest provider of inpatient rehabilitation in the service area. Nobis estimates that the new facility will comprise 30% of the overall patient volume and that 92% of admissions would be from direct referrals of other hospitals (presumably those in the service area, but perhaps not those with existing capacity). If the bed need projections set forth by Nobis prove to be overstated, as MDH's

[62] Averill, R. F., Fuller, R. L., & Mills, R. E. (2021). Geographic variation in post-acute care facility admissions. *Salt Lake City, UT: 3M Clinical and Economic Research.* Retrieved December 20, 2023 from PDF-Link-Report-Geographic-variation-in-post-acute- care-facility-admissions.pdf (3m.com) (https://multimedia.3m.com/mws/media/2051382O/report-geographic-variation-in-post-acute- care-facility-admissions.pdf).

analysis finds, lost patient volume would **not** be subsequently backfilled by increased demand. As such, the assumption that volume growth will alleviate any financial impact simply does not hold.

Furthermore, it is likely that the community of hospitals providing rehabilitation services, composed of existing ones and the proposed facility, would face a somewhat "shrinking pie" of diagnoses. While this was not explicitly considered by MDH's projections vendor, there continues to be a general trend away from inpatient services to outpatient settings, with CMS removing nearly 300 procedures from the "Inpatient Only" list in 2021.[63] Specific to rehabilitation, a recent study found an increase in the number of stroke patients being discharged home when medically appropriate with outpatient rehabilitation.[64] The aforementioned decision by Sanford Health to close certain rehabilitation beds was tied in part to changes in surgical techniques resulting in fewer patients requiring inpatient rehab services.

Potential adverse payer mix and patient mix at existing hospitals

The freestanding model to be fed by transfers from the 12 other Twin Cities Metro general acute care hospitals without rehabilitation units would allow Nobis to have more control than other facilities over the admission of patients as it relates to payer mix and patient complexity. In other words, by declining transfers, Nobis could optimize its patient and payer mix and thereby its per-patient profitability. As noted earlier, it isn't entirely clear to what extent hospitals operating below capacity would seek to make transfers to the proposed facility.

In contrast to Nobis' ability to manage referrals, three of the six Twin Cities Metro hospitals are level 1 trauma centers, all six are comprehensive stroke centers, and as such, they take all arriving patients. The payer and patient mix proposed by Nobis, if it were to materialize, could only happen by impacting the payer mix and patient mix at existing hospitals, affecting their reimbursement levels.

Confirming that observation is research from the 2023 MedPAC report to Congress that found profit margins for the Medicare program (the intended patient population for the new facility) for freestanding IRFs were 25.8% compared to 5.8% for hospital-based rehabilitation units.[65] The report also mentioned that IRFs with a lower proportional share of low-income patients (0% to 5%) had profit margins of 20% compared to 9.7% for IRFs with greater than 25% share of low-income patients despite receiving additional payments to offset resource issues related to this demographic. Specific to

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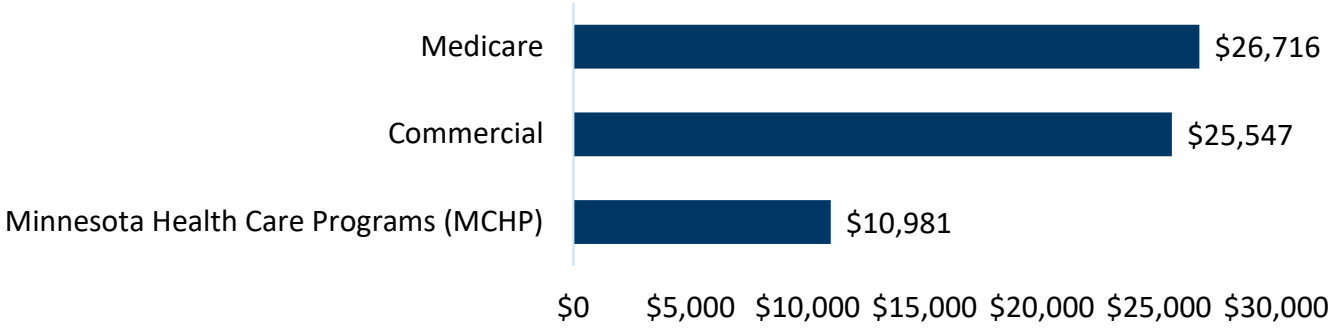
[63] CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC) | CMS (https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0)

[64] Olasoji, E. B., Uhm, D. K., Awosika, O. O., Doré, S., Geis, C., & Simpkins, A. N. (2022). Trends in outpatient rehabilitation use for stroke survivors. *Journal of the Neurological Sciences*, *442*, 120383.

[65] Op. Cit., MedPAC. March 2023.

Minnesota, hospitals that admit low-income patients covered by Minnesota Health Care programs, see lower levels of reimbursement for these patients, on average, than for Medicare (58.9% less) and commercially insured patients (57% less) as shown in Figure 4.

Figure 4: Average allowed amounts for Minnesota residents' inpatient rehabilitation stays by major category of payer, 2021



Source: MDH analysis of Minnesota All Payer Claims Database (MN APCD) data for calendar year 2021 (Extract 26).

Nobis anticipates that the facility will have 70.4% of admissions covered by Medicare while existing Minnesota hospital-based IRFs had little over half (52.1%) of discharges that were expected to be Medicare from 2016 through 2021.[66] Without a significant increase in Medicare patient volume across the services area, existing facilities would likely lose a percentage of their high-margin Medicare admissions. Similarly, a nearby hospital with an inpatient rehabilitation unit shared payer breakout information with MDH, which showed that the hospital only admitted about one third Medicare patients and about 5-7% uninsured. In contrast, Nobis reported that its facilities admitted about one percent of hospital stays that were self-pay (presumed to be uninsured).

Similarly, the clinical conditions for which patients would be admitted for rehabilitative care at the new facility might further affect existing hospitals. The MedPAC March 2023 report found that certain conditions such as "other neurological" were more profitable than stroke stays.[67] Information submitted to MDH from Nobis indicated that the facility anticipates admitting 16.4% of lower-margin stroke patients while analysis of Minnesota hospital discharge records from the six service area hospitals found that 43.7% of discharges were from stroke patients, slightly higher than statewide.

Nobis anticipates that the new hospital would treat fewer stroke patients and have a higher proportion of traumatic and nontraumatic brain injury patients, fractures of the lower extremity, and other

[66] MDH analysis of hospital discharge data from 2016-2021.

[67] Op. Cit., MedPAC. March 2023.

orthopedic patients than the national average.[68] This is consistent with documentation of similar facilities systematically targeting high-margin cases and avoiding lower-margin cases such as stroke. To reiterate, MedPAC noted that freestanding for-profit IRFs admitted lower-margin stroke cases as a percent of total were 8% lower than hospital-based nonprofit IRFs.[69] Taken together, it is highly likely that existing facilities would be shouldering a greater proportion of lower-margin cases, affecting them financially as a result.

Factor 3: How the new hospital will affect the ability of existing hospitals to maintain staff and the impact of the new hospital on existing workforce

Nobis describes its staffing plan once the facility reaches target occupancy as requiring approximately 140 full-time equivalent workers (FTEs) across about 40 occupations. It plans to include about 17 registered nurse (RN) FTEs and 3.5 pharmacist FTEs. Nobis describes these numbers as small enough to have negligible impact on other providers' ability to staff because the Twin Cities metropolitan area has almost 40,000 RNs and 4,000 pharmacists. It further argues that the trend of health care worker burnout is beginning to be reversed and has seen many workers return to the workforce when presented with an opportunity in a lower-stress environment, suggesting their proposed facility would attract such workers.

Minnesota is currently facing significant challenges in health care staffing (including hospitals). According to the latest estimates of Minnesota's Department of Employment and Economic Development (DEED), in 2022 the state's overall vacancy rate for all health care practitioners was 9.9%, significantly higher than the state's 6.9% vacancy rate for all jobs.[70] As shown in Figure 5, overall vacancies in health-related occupations have skyrocketed in recent years in the Twin Cities Metro Area, topping out at nearly 14,600 in 2021, with minimal improvement in 2022. Among individually tracked jobs relevant to Nobis' proposed facility, physical therapists have a job vacancy rate of 7.8% while occupational therapists have a 7.1% job vacancy rate. DEED does not have data specific to rehabilitation RNs or physicians, but RN positions overall have a vacancy rate of 8.2% in the state. All these vacancy rates are higher than the average for all jobs, suggesting difficulty in filling these roles already exists in the state.

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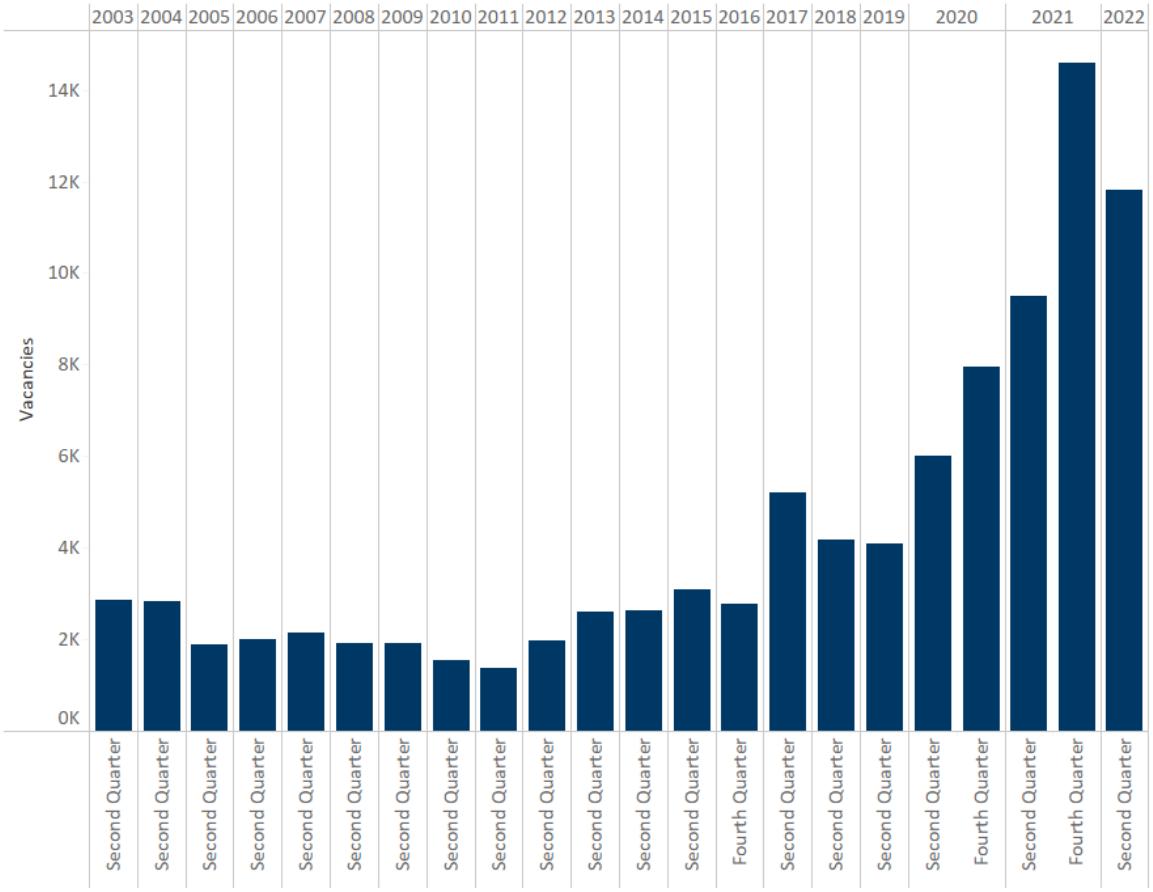
[68] Gina Thomas Letter to Diane Rydrych at the Minnesota Department of Health, September 14, 2023.

[69] Op. Cit., MedPAC. March 2023.

[70] Job Vacancy Survey, 2nd Quarter, 2022 / Minnesota Department of Employment and Economic Development (mn.gov) (https://mn.gov/deed/data/data-tools/job-vacancy/)

Figure 5: Number of vacancies for rehabilitation-related occupations in the Twin Cities Metro Area, 2003-2022



Source: MN Department of Employment and Economic Development Labor Market Information Office Job Vacancy Survey Program, for the 2nd quarter of each year. It also shows the most recent 4th quarter data for 2020 and 2021.[71]

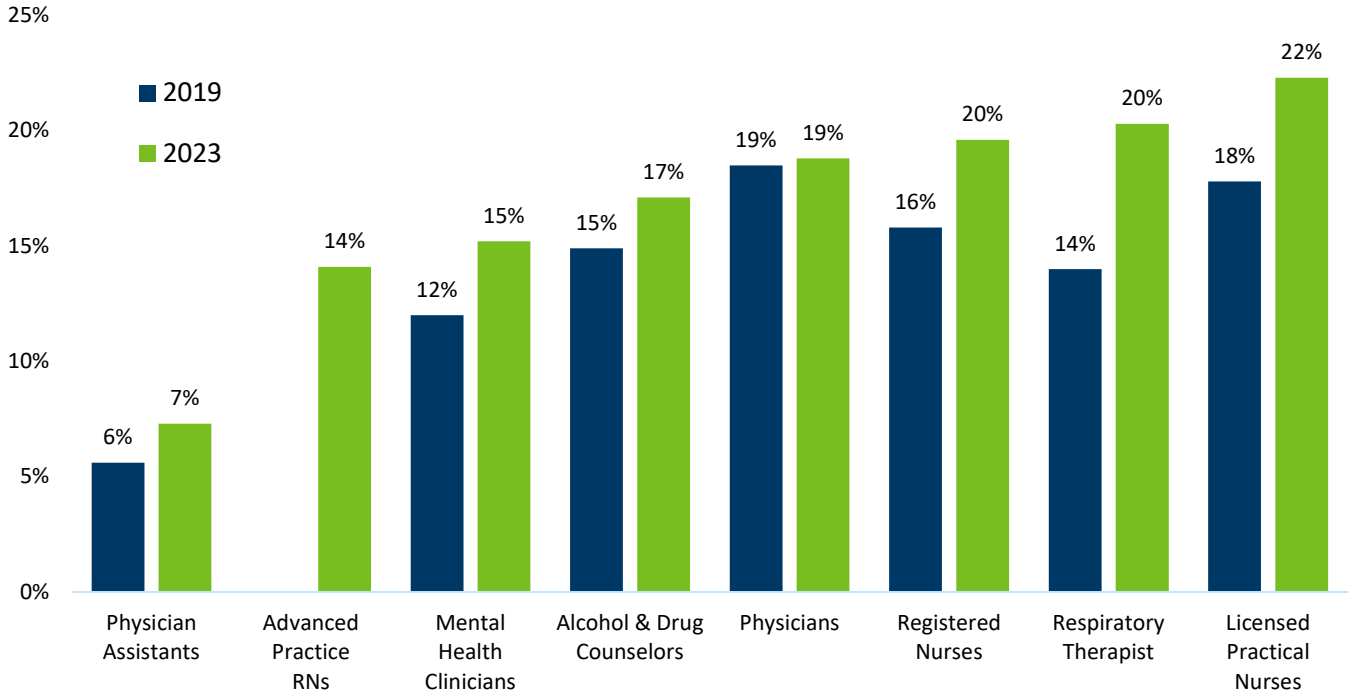
A 2023 analysis by Minnesota's Office of Rural Health and Primary Care at MDH found that Minnesota's health care workforce is in severe shortage, with many workers experiencing burnout and exiting prematurely, and a pipeline of new workers that is not keeping up with current or future hiring demand or population needs. The study found that numerous licensed healthcare professions—including registered nurses, licensed practical nurses (LPN), and physicians—left patient care roles

[71] Related occupations include the following: All Physicians, Cardiovascular Technologists and Technicians, Dietetic Technicians, Dietitians and Nutritionists, Health Information Technologists, Healthcare Support Workers, Licensed Practical and Licensed Vocational Nurses, Medical Assistants, Medical Equipment Preparers, Nurse Practitioners, Nursing Assistants, Occupational Therapists, Occupational Therapy and Physical Therapist Assistants, Orderlies, Other Healthcare Practitioners and Technical Occupations, Pharmacists, Pharmacy Aides, Pharmacy Technicians, Phlebotomists, Physical Therapists, Physician Assistants, Physicians, Recreational Therapists, Registered Nurses, Respiratory Therapists, Speech-Language Pathologists, and All Other Therapists.

between 2019 and 2023, leaving a smaller proportion of licensees working in health care settings like hospitals.

This shrinking of the health care workforce comes as reported work satisfaction rates drop, and more clinicians say they plan to leave their professions within the next five years. For example, Figure 6 shows that in 2023 one in five RNs and 22% of LPNs intend to leave the profession in the next five years increasing from 16% and 18% respectively in 2019. Another survey conducted by the Minnesota Nurses Association from late December 2022 through early February 2023 found that the top factor driving nurses from leaving hospital occupations was insufficient staffing.[72] These studies suggests that hospitals' ability to staff new and existing units likely is and will remain a serious issue. Therefore, the effect of adding a new facility on other systems' ability to staff may be significant and result in added staffing costs.

Figure 6: Share of licensees who plan to leave their profession within the next five years, 2019 vs. 2023



Source: MN Department of Health's Healthcare Workforce Survey, including data from the complete calendar year of 2019 and February through May of 2023.

[72] Minnesota Nurses Association. (2023). Why We Left: Nursing Workforce Report - Minnesota Nurses Association (mnnurses.org) (https://mnnurses.org/issues-advocacy/issues/why-we-left-nursing-workforce-report/).

Nobis describes their proposal as creating jobs and drawing caregivers from schools and the community without impacting staffing at existing hospitals. Nobis states it will accomplish this by developing relationships with local colleges that offer physical therapy, occupational therapy, speech therapy, and nursing programs, and by collaborating with local community groups to help connect job-seeking caregivers with its team. As of Nobis' proposal submission and its response to the Minnesota Department of Health's follow-up questions, it has not identified specific schools or community groups for its partnerships but pointed to success in developing such relationships in other markets. Nobis also did not specify how these partnerships would reduce the risk of diverting staff from existing hospitals' ability, particularly considering its lower intensity working hours compared to traditional acute care hospitals. Nobis did additionally note that it has its own national nurse travel program to fill any gaps in its staffing if needed, but MDH lacks detail to determine if this program would meaningfully contribute to staffing needs and how the facility operator would absorb the higher staffing costs.

Factor 4: Provision of services to low-income and nonpaying patients

All Minnesota hospitals with inpatient rehabilitation services shown in Table 1 have some official financial assistance policy listed on their website that specifies the support patients who are uninsured, underinsured, or otherwise unable to pay can be eligible for. The financial assistance programs (often called charity care or community care) require an application that typically includes information about income sources, assets, household size, and any other financial assistance (federal, state, county, city) programs, including where eligibility was denied. Some hospitals have catastrophic assistance for households or reduced payments if a patient is paying entirely out-of-pocket. Most hospitals list payment plans as options and some list third-party organizations that can work directly with patients to find the right kind of financial assistance.

Nobis notes in its material submitted as part of its proposal that it follows similar policies aimed at providing charity care, catastrophic coverage, and special medical coverage as the hospitals with existing rehabilitation beds. However, while Minnesota hospitals operate websites that list a full policy, a version of the policy in plain language, and a paper application available in multiple languages, Nobis neither maintains an official webpage with financial assistance information, nor does it have an application form publicly available for most locations. For example, the nearest Nobis facility, Milwaukee Rehabilitation Hospital at Greenfield (Wisconsin), has a website that instructs patients to call its billing office for "more information" without providing information on policies that are publicly transparent and accessible.

Existing Minnesota inpatient rehabilitation hospitals use language in their charity care or community care policies that indicates their commitment to providing financial assistance to all qualified patients. Nobis' statements, on the other hand, lack clarity. Nobis initially states in its application that eligible patients "will qualify" but later claims that patients only "may qualify" for financial assistance. It is

unclear how firm of a policy Nobis intends to create for its charity care program. Furthermore, there are two aspects of its *proposed* policies that differ substantially from charity care policies maintained by hospitals currently providing inpatient rehab care:

1. Nobis' Financial Assistance policy indicates that patients must be a citizen of the United States (U.S).
2. Nobis also states that any application for financial assistance must be completed and approved *prior* to admission.

No other Minnesota hospital in Table 1 has these requirements in their charity care policies. Concerning citizenship status, some Minnesota hospitals ask about citizenship status, but none defined citizenship as an eligibility criterion. Nobis' citizenship policy raises questions about equity and inclusion, especially because Nobis could turn away patients who are not U.S. citizens but are legally and lawfully allowed to reside in the United States.[73] As it relates to the provision about completing and approving financial assistance application *before* an admission, it is in stark conflict with Minnesota practices. In other Minnesota hospitals, patients are generally able to apply within a year of service and, if their application is complete, will receive a response within 30 days. With rehabilitation care often taking place after an unexpected event, such as a stroke, patients and their families may not be able to complete an application for care before admission.

Nearly all Minnesota hospitals have signed on to financial assistance policies that are established in an agreement called the Minnesota Attorney General Hospital Agreement[74] and they include provisions such as offering a payment plan to patients, providing "a reasonable opportunity" for patients to apply for financial assistance, not charging an uninsured patient more than what a primary insurer would pay, and establishing a debt collections procedure.[75] In its application, Nobis was noncommittal about signing on to the Attorney General's Agreement on billing practices.

While Nobis may have its own internal billing policies that are not disclosed to the general public, the 2023 Minnesota Legislature passed a law requiring hospitals to screen low-income and nonpaying patients prior to taking action to collect medical debt and assist patient's in determining their eligibility

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[73] According to the US Department of Homeland Security, the total number of lawful permanent residents 18 years and older in Minnesota during the fiscal year 2021 was 7,406, of which 328 were 65 years and over. See Profiles on Lawful Permanent Residents: 2021 State | Homeland Security (dhs.gov) (https://www.dhs.gov/ohss/topics/immigration/lpr/profiles/2021/state) for more details.

[74] See: The Office of Minnesota Attorney General - Health Care (state.mn.us) (https://www.ag.state.mn.us/Consumer/Health/).

[75] Attorney General Ellison protects Minnesotans from unfair billing and collections with extension of Hospital Agreement July 27, 2022 Press Release (state.mn.us) (https://www.ag.state.mn.us/Office/Communications/2022/07/27_HospitalAgreement.asp).

for financial assistance.[76] Patients must be screened within 30 days of receiving services and may decline financial assistance if they choose. The statute does not distinguish between for-profit and not-for-profit hospitals.

Under the provision, a hospital must also wait until the screening of charity care is complete before proceeding with additional actions such as enrolling the patient in a payment plan, referring the patient to debt collections, or denying the patient health care services. The hospital must also post information about the charity care policies in specific locations which include areas where patients are admitted or registered, emergency departments, and financial services or billing departments that are accessible to patients. Furthermore, the full policy, a plain-language summary, and application form must be available on the hospital's website, and both the summary and application "must be available in all languages spoken by more than five percent of the population in the hospital's service area." These provisions appear more demanding than what Nobis has considered so far and potentially conflict with their planned processes and financial incentives leading perhaps to systematic (but not illegal) avoidance of low income or uninsured patients.

Factor 5: The views of affected parties

MDH took the following steps to invite the views of affected individuals, organizations (including other hospitals), stakeholders, and other interested people:

- Posting an official notice in the *Minnesota State Register* on March 20, 2023, and again on November 27, 2023, requesting public comments on the proposal.
- Sending letters to Minnesota hospitals on December 5, 2023, requesting feedback.
- Issuing a notice to 350 contacts via the MDH Stroke Program, as well as contacting several stakeholders directly.[77]
- Hosting a virtual public meeting on December 6, 2023, after issuing a press release, sending email notifications to Minnesota hospitals, and posting information on the MDH website.

[76] Minnesota Statutes, section 144.587 (https://www.revisor.mn.gov/statutes/cite/144.587).

[77] Organizations contacted by MDH included the following: American Physical Therapy Association – Minnesota, Minnesota Speech-Language-Hearing Association, Minnesota Brain Injury Alliance, Minnesota Stroke Association, Minnesota Spinal Cord Injury Association, Wiggle Your Toes or Amputee Coalition, American Cancer Society – Minnesota, American Diabetes Association of Minnesota, Anoka County Services for Seniors, Carver County Office of Aging, Dakota County Aging and Disability Services, Hennepin County Seniors Disabilities Supports, Ramsey County Senior Assistance, Washington County Disabilities Adult/Child/Senior, MS Society, Minnesota Nurses Association, Care Providers of Minnesota, SEIU Healthcare Minnesota & Iowa, MN Dept. of Human Services Office of Ombudsman for Long-term Care, Minnesota Nursing Home Social Workers Association, AARP, Elder Justice, Elder Voice, Minnesota Board on Aging, and Senior Linkage Line.

In total, MDH received 10 public comments via an online form, seven emails,[78] five letters, and five comments from a public meeting on the proposal. MDH also received valuable input from verbal communication with health care providers with first-hand experience running and maintaining inpatient rehabilitation units in Minnesota.

All written comments submitted to MDH are included in Appendix C. Responders included health care systems, hospitals, rehabilitation care providers (including nurses, therapists, managers, and physicians), professional associations, unions, and advocacy organizations. Nearly all the comments specific to the rehabilitation hospital were opposed to the proposal. The single response that was clearly in favor of the proposal disputed the premise of the state moratorium law rather than the merits of the project according to established evaluation criteria. Two of the responses were in favor of different services such as long-term physical therapy/occupational therapy and rehabilitation programs serving individuals with chemical dependency, experiencing homelessness, or criminal backgrounds. These are not services explicitly proposed by Nobis.

In response to the question of if the new hospital is needed for timely access to care or access to improved services, most respondents said that bed availability was not the most pressing issue in improving patient flow. For example, in the public meeting, an individual working in an inpatient unit said that patients may be waiting to be admitted to inpatient beds, but it is not typically rehabilitation patients. This was also repeated by physicians at another hospital. In submitted comments and private conversations with MDH, other providers also mentioned that patient flow challenges are not due to rehabilitation placement, and when they are, it is for medically and behaviorally complex patients who would not be served by the proposed freestanding hospital. Similarly, a hospital outside of the service area acknowledged a need for additional rehabilitation beds in Minnesota yet did not support a proposal that focused on the Twin Cities patients (rather than Greater Minnesota). The hospital representative raised questions about whether the new hospital would limit admissions to higher paying patients while those on state public programs or patients with disabilities or issues of the central nervous system who require a lot of equipment or nursing care, would be systematically left to other preexisting units causing more strain. Another hospital operating a rehabilitation unit in the proposed service area and one in Southern Minnesota did not see demand supporting such a large expansion in rehabilitation capacity.

An admissions coordinator for another hospital-based rehabilitation unit in the proposed service area observed that rehabilitation units were not running at full capacity on a regular basis and admissions issues are more directly related to issues beyond bed supply, such as availability of insurance payment for non-acute or home care options. Considering the freestanding nature of the proposed hospital, respondents were also concerned about the potential for fragmented care (between health systems),

[78] One individual sent an online form submission and additional details in an email.

the location of the new proposed hospital, the potential discriminatory practice of selecting which patients to accept, and quality performance at a recently opened Nobis rehabilitation hospital in Milwaukee, Wisconsin.

A rehabilitation physician told MDH that while Minnesota will face challenges due to pressures from an aging population, siphoning off more profitable patients will undermine the supply of existing capacity and disrupt the continuity of care patients receive at current rehabilitation programs. The physician was one of five respondents who asked MDH, as part of the finding, to consider three questions: 1) Who will have access to these services? 2) What will this provider's long-term roots be in the community? and 3) How will they integrate across the continuum? The respondents encouraged MDH to make sure its final recommendations consider whether the Nobis proposal would be "accessible, reliable, and beneficial" for all Minnesotans.

In a similar vein, many of the comments mentioned that the opening of the Nobis facility would add additional financial strains to existing hospitals with emergency departments. A local health system operating a level one trauma center and rehabilitation unit mentioned that such an expansion would put a strain on the sustainability of existing services. One respondent felt that this would be an "economic grab" for only the most profitable part of the rehabilitation experience, leaving existing hospitals to increase their costs to cover the less profitable services. Other respondents asked if Nobis has published its rate of acute readmissions and raised concerns about Nobis not being connected to a specific hospital system or emergency department.

Respondents also emphasized that the Nobis proposal would negatively impact the ability of existing hospitals to maintain staff because it could draw away existing staff (already facing a shortage), be difficult for staff to float between units, thin the pool of available staff, and worsen the current shortfall, thereby compromising patient care. One respondent noted that the current job market for staffing hospitals is incredibly complex and challenging in the post-pandemic environment and the expansion in overall capacity may compromise their existing unit. Health care systems said that the current challenges in Minnesota's rehabilitation care revolve less around the number of inpatient beds and more around staff capacity, particularly in subspecialized areas of nursing.

A number of respondents expressed deep concern that Nobis might not accept and support uninsured and underinsured patients who tend to be the longest stay patients, calling for the need to accept these patients at the rate comparable to the total uninsured/underinsured patients in the community. One respondent wanted to see a track record of Nobis' medical assistance plan acceptances and questioned what Nobis would do if an insurance company stopped paying for a service in the middle of a stay, asking if Nobis would discharge a patient as soon as they are unable to pay. Others echoed this concern, citing the high risk that Nobis would choose not to provide service to low income or non-paying patients or those who are unhoused, disabled, elderly, or under Medicaid as this would not be profitable for its business model. Some health systems with rehabilitation units saw this new facility as

highly likely to limit admissions based on who the patient's payer was or that patient's ability to pay. One respondent named this as threatening discrimination to patients based on their socioeconomic status.

Other themes that emerged from the public comments were about the fact that the proposed hospital would be a for-profit institution which could potentially bring disruption to the existing care environment for patients. One Minnesota inpatient rehabilitation provider noted that a for-profit motive can influence whether a patient more appropriately receives rehabilitation care at home or even the type of care patients might receive that could be suboptimal such as group occupational therapy sessions. Respondents stated their concerns that Nobis does not intend to provide services that are less profitable and there is no intention for it to include generous charity care policies, research, education, and other community benefits in its facility as is done by existing nonprofit hospitals with rehabilitation units. This, respondents said, threatens the existing facilities that are already providing these services across the continuum by increasing their cost and burden. Specifically, a standalone facility without a hospital affiliation "will have little benefit to the overall rehabilitation needs of the community and may even burden the community" said one respondent.

Additional considerations

1. Implications for health care spending and cost growth in Minnesota

In 2013, the National Academies of Sciences found that variation in total Medicare spending across geographic areas was driven largely by differences in the use of post-acute care (PAC) facilities (including IRFs) rather than acute care services.[79] Subsequently, PAC facilities have been identified as one of the most rapidly growing areas of costs and a primary driver of health care spending.[80,81,82,83]

[79] Kibria, A., Mancher, M., McCoy, M. A., Graham, R. P., Garber, A. M., & Newhouse, J. P. (Eds.). (2013). Variation in health care spending: target decision making, not geography. Variation in Health Care Spending - NCBI Bookshelf (nih.gov) (https://www.ncbi.nlm.nih.gov/books/NBK201647/)

[80] Mechanic, R. (2014). Post-acute care—the next frontier for controlling Medicare spending. *New England Journal of Medicine*, *370*(8), 692-694.

[81] Sacks, G. D., Lawson, E. H., Dawes, A. J., Weiss, R. E., Russell, M. M., Brook, R. H., ... & Ko, C. Y. (2016). Variation in hospital use of postacute care after surgery and the association with care quality. *Medical Care*, 54(2), 172-179.

[82] Keohane, L. M., Freed, S., Stevenson, D. G., Thapa, S., Stewart, L., & Buntin, M. B. (2018). Trends in postacute care spending growth during the Medicare spending slowdown. *Issue Brief (Commonwealth Fund)*, *2018*, 1-11.

[83] Montgomery, J. R., Cain-Nielsen, A. H., Jenkins, P. C., Regenbogen, S. E., & Hemmila, M. R. (2019). Prevalence and payments for traumatic injury compared with common acute diseases by episode of care in Medicare beneficiaries, 2008-2014. *JAMA*, *321*(21), 2129-2131.

Estimates from CMS found that Medicare spent $8.8 billion on IRF services in 2021 (10.5% of $840 billion spent overall that year).[84]

Recent national data also show that 92% of Medicare fee-for-service PAC-eligible patients were admitted to a SNF rather than an IRF within four days of discharge with average payments that were about $14,700 less per admission than IRFs despite having a longer length of stay on average (18.7 days vs 12.6 days).[85] In Minnesota, data show that this difference ranged from about $15,600 per stay in 2019 and nearly $18,000 per stay in 2021.[86] Concern over the growth of PAC spending has led to federal legislation in 2014 mandating the development of a new system of Medicare payment that is based on the medical complexity and therapy needs of the patient rather than the current method of payments based on setting of care.[87] MedPAC proposed a system of "site neutral payments" between IRFs and SNFs for Medicare patients with select conditions. The recommendations noted that the "Placement decisions often reflect local practice patterns, the availability of PAC in a market, patient and family preferences, and financial arrangements between a PAC provider and the referring hospital."[88] To implement site-neutral payments, Congress would need to act.

Although the presence of utilization management by private health insurance such as Medicare Advantage may limit rehabilitation use in the new hospital for a subset of the population,[89] there is other evidence that suggests increased IRF competition can increase lengths of stay and costs for hip fracture patients.[90] Other innovations such as value-based purchasing in health care have also become increasingly common in Minnesota. These arrangements include, for example, bundled payments where hospital referrals and business arrangements include a broader set of post-acute care providers

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[84] Medicare Payment Advisory Commission, Databook (2023). Health care spending and the Medicare program. *Washington, DC: MedPAC.* Accessed on November 7, 2023: https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf

[85] Op. Cit. Averill, R. F., Fuller, R. L., & Mills, R. E. (2021).

[86] MDH analysis of the Minnesota All Payer Claims Database Extract 26 for calendar years 2019 and 2021.

[87] Improving Medicare Post-Acute Transformation Act of 2014, 42 USC 1395.

[88] Medicare Payment Advisory Commission. (2015, March). Medicare's post-acute care: Trends and ways to rationalize payments. In *Report to the congress: Medicare Payment Policy*.

[89] As noted above, private health insurance such as Medicare Advantage has lower admission rates compared to traditional Medicare. Op. Cit. P.J. Huckfeldt et al., (2017).

[90] Colla, C. H., Escarce, J. J., Buntin, M. B., & Sood, N. (2010). Effects of competition on the cost and quality of inpatient rehabilitation care under prospective payment. *Health Services Research*, *45*(6p2), 1981-2006. The study also found that increased competition for IRFs for stroke decreased both lengths of stay and reduced costs but led to worse outcomes.

rather than IRFs alone and have been shown to lower health care costs.[91,92] From the information submitted by Nobis, it is unclear that any relationships with Minnesota providers or organizations have been developed. Moreover, hospital-based IRFs, compared to freestanding IRFs, have been found to have lower lengths of stay while preserving or improving health outcomes.[93] There are also reasons to believe that technological advances could continue to reduce the need for inpatient rehabilitation care. A study recently showed that robotic assisted surgery for total knee arthroplasty and different approaches to pain medication, such as local infiltration analgesia, reduced the overall need for inpatient rehabilitation.[94,95] Elsewhere, MDH referenced data on stroke patients who are beginning to successfully recover in home settings with post-acute rehab options.

The introduction of penalties for hospital readmissions and alternative payment models have encouraged health care providers to pay more attention to the full continuum of care—including post-acute care.[96] However, freestanding and for-profit IRFs—such as the proposed facility—would be financially and clinically disconnected from a patient's care journey before and after receiving inpatient rehabilitation. In addition, patients receiving care at the freestanding facility who require unexpected medical stabilization beyond the capabilities of the facility would need to be transported by emergency medical services and possibly transferred back to the facility to complete their rehabilitation program. This would create new health spending and result in the kind of fragmentation of care that public comments centered on. Some studies have found that for-profit hospitals also have higher readmission

[91] Agarwal, R., Liao, J. M., Gupta, A., & Navathe, A. S. (2020). The Impact Of Bundled Payment On Health Care Spending, Utilization, And Quality: A Systematic Review: A systematic review of the impact on spending, utilization, and quality outcomes from three Centers for Medicare and Medicaid Services bundled payment programs. *Health Affairs*, *39*(1), 50-57.

[92] Agarwal, D., & Werner, R. M. (2018). Effect of hospital and post-acute care provider participation in accountable care organizations on patient outcomes and Medicare spending. *Health Services Research*, *53*(6), 5035-5056.

[93] Sood, N., Shier, V., Huckfeldt, P. J., Weissblum, L., & Escarce, J. J. (2021). The effects of vertically integrated care on health care use and outcomes in inpatient rehabilitation facilities. *Health Services Research*, 56(5), 828-838.

[94] Pierce, J., Needham, K., Adams, C., Coppolecchia, A., & Lavernia, C. (2020). Robotic arm-assisted knee surgery: an economic analysis. *American Journal of Managed Care*, *26*(7), e205-e210.

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rates when accounting for patient characteristics.[97,98] Finally, the March 2023 MedPAC report described that there is a higher proportion of hospital-based nonprofit rehabilitation IRFs that had consistently low costs per discharge and high quality relative to for-profit freestanding facilities.[99]

2. The Nobis model in Minnesota

As described in this report, the proposed for-profit, freestanding facility represents a new model of care in the Minnesota health care market for inpatient rehabilitative services. While Nobis has, over a short period of time, opened 20 such facilities (or will open them), that investment has not yet yielded sufficient insights into care quality, ability to staff, health care costs, engagement with other providers, corporate behavior within the marketplace, and the extent to which it would lead to market segmentation. Without clear advantages and the functional concerns raised in the review, this should give policymakers pause.

Moreover, there are considerable concerns about the extent to which the operational and financial incentives of a for-profit, equity financed investment would align with how the Minnesota hospital market has been functioning[100] and patient needs. While there is evidence that equity financing can bring needed capital to sustain industries or foster efficiencies and certainly drive investor value, private equity financing in health care organizations has increasingly been shown to lead to poorer outcomes, higher costs, and often further sale of assets or closure of facilities.[101,102] That should not be a surprise given that the equity financing model most often hinges on generating short-term value for investors, generally over a window of less than 10 years, using a variety of business techniques that have the potential to redistribute care in markets and affect the priorities in care delivery.[103]

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Finding

After completing this public interest review, **MDH finds that the proposed new rehabilitation hospital is *not* in the public interest**. MDH has reached this conclusion based on the following evidence and considerations:

1. **There appears to be adequate capacity.** Based on analysis of occupancy levels and miles traveled by patients to obtain care, it appears that the existing six hospitals in the proposed service area with inpatient rehabilitation units have sufficient capacity to serve patient needs. This is the case, in part, because in Minnesota a substantial volume of patients receives rehabilitation care in non-hospital settings. Though it is feasible that the state's aging population may require a modest need for additional rehabilitation care in the next decade, the available evidence suggests that there is surge capacity within existing facilities that, in place of a new, freestanding hospital, would help patients maintain continuity of care. The projected future bed need based on a revised analysis does not support a 60-bed hospital. Further, increased demand from an aging demographic will likely be offset somewhat over time by the ongoing advancement in surgical techniques that may further reduce the demand for inpatient rehabilitation services.
2. **It is unclear that the proposed facility would deliver higher value services.** MDH's comparison of publicly available data associated with Nobis and existing hospitals in Minnesota does not suggest that the proposed facility would offer higher quality-of-care. On the contrary, there is a strong possibility that lower staffing ratios may diminish care quality for some patients. Additionally, alternative settings, such as skilled nursing facilities, offer a cost-effective alternative for many patients in the proposed service area, and because of favorable reimbursement levels, they have a financial incentive to maintain capacity targeted at rehabilitation patients.
3. **There are considerable concerns that the proposed hospital would have a negative financial impact on existing facilities.** While estimating the exact financial impact the proposed hospital would have on existing hospitals in the rehabilitation space is fraught with uncertainties, existing excess capacity suggests that, at minimum, patient volume at existing hospitals is likely to fall because of the addition of the proposed facility, resulting in revenue loss. Moreover, characteristics of the proposed model–the facility will function as a freestanding entity–will make it possible for the hospital to manage patient referrals in favor of higher reimbursement patients. This could lead to segmentation in the market by which existing hospitals more routinely serve patients with higher needs or lower reimbursement, resulting in a negative

financial impact.[104] Finally, based on available information, it is not clear that Nobis could staff its facility without diverting staff from existing hospitals, which would create operational challenges and additional staffing costs for these existing hospitals.

4. **There is a lack of clear commitment from Nobis toward providing care to low-income and nonpaying patients in Minnesota.** MDH is concerned that as a for-profit facility, the proposed hospital has incentives to limit services to low-income and uninsured patients. While Nobis will be expected to follow Minnesota laws regarding screening for public program eligibility and financial assistance, MDH found that financial assistance practices were markedly different than existing nonprofit hospitals and noted that Nobis is not planning to sign on to the Minnesota Attorney General's agreement on collection practices. Of particular concern is the Nobis provision that patients must complete a financial assistance application *before* being eligible to receive services. Another concern is the explicit exclusion of charity care from Minnesotans that lawfully reside in the state but do not have citizenship status.

Many of MDH's concerns derived from empirical evidence and the literature were also mirrored in public comment, further strengthening MDH's finding. The public comments expressed to MDH regarding the proposed hospital mostly opposed or expressed concerns about adding inpatient rehabilitation care capacity in the proposed service area and along the lines of the proposed model. Likewise, most responses were concerned about negative impacts in terms of financial status and staffing capabilities, as well as skepticism that the hospital would provide care to low-income and nonpaying patients. Finally, comments from providers of rehabilitation care expressed concern that permitting a stand-alone facility will further fragment care received by patients who often require the full continuum of rehabilitation from inpatient, outpatient, community services, and vocational services.

[104] Op. Cit., MedPAC. March 2023.

Appendix A: Data sources used in review

The Minnesota Department of Health used data from the following sources in completing this public interest review:

- **Hospital Annual Report:** All hospitals in Minnesota file annual reports with the Minnesota Department of Health. Data used in this report included a*vailable beds*: for the number and type of available beds (acute care beds that are immediately available for use or could be brought online within a short period of time) in the most recent fiscal year. Available beds are also separated into dedicated specialty units (i.e., rehabilitation) as reported by the hospital.[105]

- **Hospital Discharge Data**: The Minnesota Hospital Association collects administrative billing data from hospitals in Minnesota and for Minnesota residents who were patients in North Dakota. The unit of analysis is the hospital stay, or emergency department discharges, at short-term, non-Federal, non-State, and non-specialty, general acute care hospitals. Inpatient hospital stays and emergency department visits were identified and analyzed using the following sources:
    - Hospital billing codes developed by the National Uniform Billing Committee
    - Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Manual Version 4.0 Effective October 1, 2022
    - Medicare Severity Diagnosis Related Groups (MS-DRGs) developed by the Centers for Medicare and Medicaid Services

- **Minnesota All Payer Claims Database (MN APCD)**: The MN APCD is a state repository of de-identified health care claims data for Minnesota residents that is derived from billing records sent by medical providers to insurance companies, plan administrators, and public payers. This analysis relied on extract 26 of the MN APCD. Please note that commercially self-insured plans fall under the Employee Retirement Security Act (ERISA) and are not required to submit data to the MN APCD but may submit their claims voluntarily. For this report, the unit of analysis is the encounter level for both skilled nursing facility and inpatient hospital claims and includes the allowed amounts for both.

[105] These categorizations are based on self-reported hospital data; because hospitals can designate beds to be used for specific purposes within the hospital (such as obstetrics, intensive care unit, cardiac care, etc.) there are only two specific designations on both a state and federal level (the state uses federal designations in licensing.): “excluded psychiatric units” and “rehabilitation units.” Hospitals designate beds as mental health/psychiatric beds on the Hospital Annual Report that are not licensed as such under federal and state law.

  - Inpatient Hospital Rehabilitation Claims: Hospital billing codes developed by the National Uniform Billing Committee such as type of bill and revenue codes to identify inpatient rehabilitation.
  - Skilled Nursing Claims: Type of Bill Code was used to identify skilled nursing facility claims. Claims were then filtered for having specific therapy CPT/HCPCS codes and specific ICD-10-CM diagnosis codes as defined by CMS. The source for these codes is the Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program Year 2024.

- **Pivotal Analytics Utilization and Population data**: Projections of bed need relied on all payer claims data obtained from PurpleLab and population projections from ESRI. Both data sources were specific to a basket of services defined as "inpatient rehabilitation" and geographic areas in Minnesota.
- **Quality data**: Quality reporting for IRFs is required by federal law and implemented through the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP). Analysis of quality measures in this report is based on publicly available quality measure data from the IRF QRP that are reported annually through CMS. See Table B1 for a list of the specific quality measures used.

Appendix B: Comparison Nobis Facilities and Existing Facilities to National Benchmarks

Inpatient Rehabilitation Facility Quality Reporting Program Measures

Table B1: CMS Quality Measures Assessed and Results for Nobis and Minnesota facilities compared to national benchmarks

IRF QRP Measure #	Measure Name	Nobis facilities and existing facilities in service area scored **similar** compared to national benchmark	A higher proportion of **Nobis facilities** than existing facilities in service area scored **better** than national benchmark	A higher proportion of **Nobis facilities** than existing facilities in service area scored **worse** than national benchmark
1	Application of Percent of Residents Experiencing One or More Falls with Major Injury			X
2	Discharge Self-Care Score for Medical Rehabilitation Patients		X	
3	Discharge Mobility Score for Medical Rehabilitation Patients	X		
4	Drug Regimen Review Conducted with Follow-Up for Identified Issues			X
5	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury			X
12	Influenza Vaccination among Healthcare Personnel	X		
13	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	X		
14	COVID-19 Vaccination Coverage among Healthcare Personnel (HCP)			X
15	Medicare Spending per Beneficiary (MSPB)		X	
16	Discharge to Community	X		
17	Potentially Preventable 30-Day Post-Discharge Readmission	X		
18	Potentially Preventable Within Stay Readmission Measure	X		

Notes on these comparisons:

- MDH used publicly available IRF QRP data to compare existing Nobis IRFs and existing IRFs in the proposed service area to national benchmarks. For each measure listed, MDH noted the proportion of Nobis facilities that scored higher than the national benchmark, lower than the national benchmark, and no different from the national benchmark. These proportions were compared to proportions of existing IRF facilities in comparison to the national benchmark.
- This comparison was used to help assess whether the proposed IRF might be expected to score better on quality measures relative to national benchmarks, in comparison to the facilities that already exist in the proposed service area.
- National benchmarks were used from publicly available CMS data from the same period for each measure.

Notes on types of measures:

- The CMS IRF QRP includes three groups of measures: Patient Assessment Instrument (PAI) Assessment-Based Measures, CDC National Healthcare Safety Network (NHSN) Measures, and Medicare Fee-For-Service Claims-Based Measures.
    - IRF QRP Measures #1-5 are part of the PAI measure group
    - IRF QRP Measures #12-14 are part of the NHSN measure group
    - IRF QRP Measures #15-18 are part of the Medicare Fee-For-Service Claims-Based measure group

Notes on excluded measures:

- IRF QRP Measures #6-10 were excluded because of lack of data for the most recent publicly available data (2021-2022). Data collection for these measures started in 2022 or after.
- IRF QRP Measure #11 was excluded because no data was listed for any Nobis facilities.

Appendix C: Public Comments

Comments Received in Public Hearing

Minnesota Statutes, section 144.552 directs MDH to host a public meeting to solicit feedback from the community about any public interest reviews. On December 6, 2023, from 6pm to 8pm, MDH held a remote meeting via a web-streaming platform (Webex) that was posted on the MDH website, listed in the state register, and published in a press release. The meeting began with an overview of the moratorium policy from MDH and then and overview of the Nobis proposal, following by a second proposal from Regency Hospital.[106]

The first comment raised concerns about staffing levels and current facilities already expressing concerns about finding enough staff. The second comment came from a registered nurse who was concerned about the for-profit nature of the facility. She expressed concerns about how the proposed facility would not allow all Minnesotans access to care as decisions would be made the prioritized making money for board members. These decisions could include choosing patients with the highest insurance reimbursements and thus leaving out Medicare and Medicaid patients. She went on to talk about how this could impact other state hospitals who would have to tighten their budgets and having less money for research and less money to attract and retain staff. This nurse also raised concerns about staffing at the needed levels amid statewide staffing shortages. She also mentioned that the closest Nobis facility in Milwaukee lags in quality as determined my CMS indicators. She continued to talk about the problematic nature of standalone facilities in case a patient needs immediate medical care and her concerns over the staff training to recognize such a need. Her final point was about the need for follow-up care after discharge without a connection to a hospital system. In conclusion, she agreed that additional health care facilities are needed, but expressed concern that a for-profit institution was the correct approach.

The third comment was also from a nurse. He talked about how he sees patients who have been there for over a month and often these patients become stuck in the system or have no place to go once discharged. This is a problem not just at his hospital, but statewide and that in turn becomes a crisis. He also mentioned his opposition to a for-profit model that prioritizes wealth over patients and again cited poor care at the Nobis facility in Wisconsin. He expressed his hesitation in the medical care reaching those in need without denying coverage.

[106] MDH received a second publish interest review from Regency Hospital. MDH is directed by law to review proposals in the order in which they are received but held one public meeting to collect comments for both hospitals. Most public comments received at this event were directed at Nobis with only the first comment referencing Regency Hospital.

The fourth comment was from a physiatrist who highlighted the importance of the continuum of care where there is no follow-up after discharge. She mentioned that inpatient rehab is highly specialized that has multiple components and expressed concern for the potential fragmented care without connections to other care communities. The respondent also mentions that we currently have five inpatient rehab units that do a good job at taking care of patients across the continuum of care. She concluded by suggesting that one of our current health systems take on the role of adding new beds, if needed.

The final comment came from an IRF program director. She expressed that IRF capacity is not a problem for flow challenges, but that there is a need for more long-term beds for medically and behaviorally complex patients. She echoed the sentiment that existing hospital systems have IRF systems in their systems and argues that research supports IRF care connected to a health care system. She was also unable to find any nationally ranking Nobis facilities. Finally, she stated that the 60-bed proposal is too high and would require a substantial increase in use of inpatient rehab beds which would likely increase health care costs for Minnesotans.

Written Comments Submitted to MDH are available on the MDH website (https://www.health.state.mn.us/data/economics/moratorium/nobis/index.html).

- Allina Health (PDF)[107]
- Anne Tita (PDF)[108]
- Arun Idiculla (PDF)[109]
- CentraCare St. Cloud Hospital (PDF)[110]
- Elizabeth Friederich (PDF)[111]
- Hennepin Healthcare (PDF)[112]
- Kathryn Pieper (PDF)[113]

[107] Allina Health (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/allinacouragekennypir.pdf)

[108] Anne Tita (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/annetita.pdf)

[109] Arun Idiculla (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/arunidiculla.pdf)

[110] CentraCare St. Cloud Hospital (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/centracarestcloudpir.pdf)

[111] Elizabeth Friederich (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/elizabethfreiderich.pdf)

[112] Hennepin Healthcare (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/hennepinhcpir.pdf)

[113] Kathryn Pieper (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/kathrynpieper.pdf)

- Kristine Spiewak (PDF)[114]
- Liat Goldman (PDF)[115]
- Melinda Anderson (PDF)[116]
- Minnesota Nurses Association (PDF)[117]
- North Memorial Health (PDF)[118]
- MDH Form Submission - Brenna Chell (PDF)[119]
- MDH Form Submission - Debra Musgrove (PDF)[120]
- MDH Form Submission - Elizabeth Beck (PDF)[121]
- MDH Form Submission - Erin Odell (PDF)[122]
- MDH Form Submission - Kayla Brinkman Theimer (PDF)[123]
- MDH Form Submission - Kristin Stoner (PDF)[124]
- MDH Form Submission - Kristine Spiewak (PDF)[125]
- MDH Form Submission - Latiya McGee-Whitson (PDF)[126]

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[114] Kristine Spiewak (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/kristinespiewak.pdf)

[115] Liat Goldman (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/liatgoldman.pdf)

[116] Melinda Anderson (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/melindaanderson.pdf)

[117] Minnesota Nurses Association (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/mnapir.pdf)

[118] North Memorial Health (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/nomemorialpir.pdf)

[119] MDH Form Submission – Brenna Chell (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formbrennachell.pdf)

[120] MDH Form Submission – Debra Musgrove (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formdebramusgrove.pdf)

[121] MDH Form Submission – Elizabeth Beck (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formelizabethbeck.pdf)

[122] MDH Form Submission – Erin Odell (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formerinodell.pdf)

[123] MDH Form Submission – Kayla Brinkman Theimer (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formkaylabrinkmantheimer.pdf)

[124] MDH Form Submission – Kristin Stoner (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formkristinstoner.pdf)

[125] MDH Form Submission – Kristine Spiewak (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formkristinespiewak.pdf)

[126] MDH Form Submission – Latiya McGee-Whitson (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formlatiyamcgeewhitson.pdf)

- MDH Form Submission - Salena Nikolaisen (PDF)[127]
- MDH Form Submission - Tanya Hildman (PDF)[128]

[127] MDH Form Submission – Salena Nikolaisen (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formsalenanikolaisen.pdf)

[128] MDH Form Submission – Tanya Hildman (https://www.health.state.mn.us/data/economics/moratorium/nobis/docs/formtanyahildman.pdf)

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