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November 16, 2015

VIA ELECTRONIC MAIL
AND HAND DELIVERY

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: In the Matter of Recovery Center of America Upper Marlboro
Docket No. 15-16-2364

Dear Ms. Potter:

Enclosed are an original and six copies of Interested Party Comments of Pathways on CON Application for filing in the above-referenced case.

Should you have any questions, please let me know. Thank you for your attention to this matter.

Sincerely,

Marta D. Harting

Marta D. Harting

MDH:rlh
Enclosure

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF	*	
RECOVERY CENTER OF AMERICA UPPER MARLBORO	*	**Docket No. 15-16-2364**

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INTERESTED PARTY COMMENTS OF PATHWAYS

Pursuant to COMAR 10.24.01.08E(3)(a)(ii), Anne Arundel General Treatment Services, Inc., d/b/a/ Pathways ("Pathways") provides these comments regarding the certificate of need application (the "Application") filed by Recovery Centers of America ("RCA") to establish an alcohol and drug abuse intermediate care facility ("ICF") in Upper Marlboro, Maryland.

1. INTRODUCTION

As a longstanding community provider of addictions services in Maryland, Pathways is keenly aware of the heroin and opioid addiction epidemic and the overall problem of substance use and co-occurring mental health disorders that we face in this State and as a nation. Every day, Pathways sees firsthand the heavy toll the epidemic is taking on Maryland families and communities. The existence of the problem and the need to find effective ways to address it are beyond dispute.

Through this CON application and two others, RCA seeks to construct three ICFs in the State (two in Southern Maryland and one on the Eastern Shore) to serve the privately insured population, with 140 new detox beds and 200 residential beds. RCA has filed hundreds of pages of newspaper headlines and articles, and local, national, and even international reports regarding the heroin addiction and prescription drug abuse epidemics. Demonstrating the existence of the problem does not, however, demonstrate the need for the three projects RCA has proposed. The

unfortunate reality about the substance use epidemic is that the people who need treatment often do not recognize that fact and/or do not seek it out. RCA points to the expansion of insurance coverage under the Affordable Care Act and mental health parity requirements, but fails to account for the reality of public and private insurer coverage limitations, high deductibles and copays, and utilization rules that significantly impact access to inpatient treatment. RCA's applications are unsupported by evidence of utilization of existing ICF beds in the state or waiting lists for existing beds in the state. RCA significantly overestimates what its proposed beds would generate from commercial payors (demand, length of stay and payment rates) and at the same time asks the Commission to relieve it from the State Health Plan requirement to provide care to the Medicaid and Gray Area populations so that RCA can generate a 15% profit margin.

While there may be need for some level of additional ICF beds in the State, RCA has not demonstrated the need for the large number of beds it seeks in order to serve the commercially insured population, or the financial viability of the proposed project. Further, approving the application would threaten the financial viability of existing community providers like Pathways that have long served the Medicaid population, but are now faced with the elimination of Medicaid coverage for inpatient adult admissions and for outpatient services provided to adults in need of residential care. As set forth below, RCA's application is contrary to several State Health Plan standards and review criteria and should therefore be denied.

2. BACKGROUND

a. Pathways

Pathways, a subsidiary of Anne Arundel Medical Center, is a nonprofit alcohol and drug treatment center located at 2620 Riva Road in Annapolis, Maryland. Pathways is an ICF with 40 beds (32 adult and 8 adolescent). In those beds, Pathways is licensed to provide American Society of Addiction Medicine (ASAM) level III.7D – Medically Monitored Inpatient Detoxification and ASAM level III.7 --Medically Monitored Intensive Inpatient Treatment, among other levels of care. See Ex. 1.

Open 24 hours a day, seven days a week, Pathways is an innovative inpatient and outpatient alcohol and drug treatment facility offering programs for adolescents and adults with substance use and co-occurring mental health disorders. Pathways offers a continuum of medical, inpatient, outpatient and rehabilitative treatment services tailored to the special needs of each person, implementing evidenced-based programs, practices and measures. Pathways' strategic goal is to provide the highest quality care through a comprehensive system involving a partnership of employees, physicians, patients, families, and the community, reducing the stigma of these diseases and involving patients and families in the planning and delivery of services that lead to physical and mental health.

Pathways' programs include:

- Adult substance use and co-occurring treatment
- Adolescent substance use and co-occurring treatment
- Family therapy and education
- DWI/DUI programs
- Adventure therapy
- Prevention and education to the community
- Substance use disorder nurse liaison/navigator located within Anne Arundel Medical Center

Every patient has a complete team working together for him or her to create and oversee a comprehensive and fully customized drug rehab and/or alcohol treatment plan. The treatment team includes:

- Psychiatrist
- Nursing coordinator
- Clinical Director
- Mental health clinician
- Registered nurses
- Lead clinical counselor
- Primary case manager
- Intake Counselor
- Family therapist
- Adventure therapist
- Certified teacher

Medical care is delivered by nurses, physician's assistants and physicians who specialize in substance abuse and mental health treatment.

Pathways' facility is on a wooded campus outside of downtown Annapolis that features:

- Private adolescent rooms and double-occupancy adult rooms—all with private bathrooms
- Gymnasium
- Cafeteria
- Outdoor ropes course for adventure therapy
- Patio for outdoor dining and gathering
- Student classrooms for adolescent School Program
- Group meeting and counseling rooms

In addition to its patient-centered treatment programs, Pathways is a regionally recognized resource dedicated to preventing and educating the community about addiction and substance use. The tools it offers families and communities include a health library of resources on addiction, alcoholism, substance use and recovery, co-occurring disorders and evidence-based substance use prevention education programs for schools and community groups that are proven to reduce early use of tobacco, alcohol and illicit drugs.

Pathways has always accepted Medicaid. Effective January 1, 2015, however, Medicaid no longer covers residential or outpatient services provided to adults between the ages of 21 and 64 who are admitted to an ICF with more than 16 beds. This is a result of the federal "IMD" ("institution for mental diseases") exclusion under 42 CFR 435.1009(a)(2) that affected

Medicaid reimbursement in Maryland beginning January 1, 2015 with the mental health carve-out from the Health Choice program. While Medicaid reimbursement is still available for outpatient services if the patient is not in need of residential care, there has been a substantial reduction in Medicaid reimbursement beginning January 1, 2015 for those services. The impact of the IMD waiver on Pathways' payor mix has been significant. During calendar year 2014, Medicaid represented 36% percent of Pathways payor mix, whereas currently it represents 13%. At the same time, the commercial payor mix has increased from 62% in calendar year 2014 to 85% currently.[1] Reflecting this change in Medicaid coverage, Pathways' residential volume during the first three calendar quarters of 2015 is approximately 18% less than it was during the first three calendar quarters of 2014

In the more than twenty years since it was established, Pathways has treated more than 45,000 patients. Pathways' patients are primarily Anne Arundel County residents, but its extended service area includes the Eastern Shore, Prince George's County and Southern Maryland.

Pathways is accredited by The Joint Commission with Gold Seal Approval in behavioral health care. As a result of its most recent survey, in July 2013, the Joint Commission commended Pathways as being in the top 99th percentile for compliance with standards and cited Pathways as an exemplary, model program. Additionally, Pathways has platinum status with Optum (a commercial insurance carrier with which Pathways works), its highest ranking, by meeting or exceeding tis metrics every month. Pathways receives a score of 94% in "likelihood to recommend to others," a key patient satisfaction measure. Patients who discharge against

[1] While Pathways accepts Medicaid and receives limited grant funding for referrals from the Anne Arundel County Health Department, Pathways is not a "funded" (or "Level II") facility. Even prior to January 1, 2015, Pathways did not receive more than 50% government funding for its services.

medical advice (AMA), a key quality measure, at Pathways is 5.5% compared to a national average of 10%.

b. The Proposed Project

Through its CON application in this matter, RCA seeks to establish a new ICF in Upper Marlboro in Prince George's County (Southern Maryland planning region) with 55 "detox/assessment" beds that it would license as ASAM level III.7D – Medically Monitored Inpatient Detoxification, and 70 residential beds that it would license as ASAM level III.5 – Clinically-Managed High-Intensity Residential Treatment. The proposed capital cost of the project is $21 million. This is in addition to the new ICF in Waldorf in Charles County (also in the Southern Maryland planning region and less than 21 miles from the proposed location in Upper Marlboro) with 64 detox beds and 102 residential beds that RCA seeks to establish pursuant to the Application in Docket No. 15-08-2362. In addition to these two large facilities in Southern Maryland, RCA also seeks to establish another new ICF in Earleville (in the Eastern Shore planning region) with 21 detox beds and 28 residential beds pursuant to the Application in Docket No. 15-07-2363. Thus, through all three applications (which are not couched in the alternative), RCA seeks to establish 140 new detox beds and 200 new residential beds in the State. All three facilities would serve adults only.

RCA has defined overlapping and expansive service areas for each proposed new facility that extend as far as 110 miles from the proposed project as part of a "large regional market strategy." Application at 34. The Upper Marlboro facility would encompass Annapolis (and all of Anne Arundel County) within a 30 mile radius, while Annapolis is just outside of a 30 mile radius of the proposed Waldorf facility and is well within a 60 mile radius of the proposed Earleville facility on the other side.

While it highlights the expansion of Medicaid eligibility in Maryland under the ACA in its Application, RCA would not accept Medicaid at any of its three proposed new ICFs in Maryland, choosing instead to exclusively serve the privately insured market (except for the reduced amount of charity care it has proposed in response to a State Health Plan standard).

2. PATHWAYS QUALIFIES AS AN INTERESTED PARTY

Pathways is authorized to provide the same services as RCA seeks to provide (alcohol and drug abuse intermediate care facility treatment services (including ASAM level III.7D – Medically Monitored Inpatient Detoxification) in a planning region (Central Maryland) adjacent to the planning region in which RCA seeks to establish the new facility in Upper Marlboro (Southern Maryland).[2] Further, Anne Arundel County is within RCA's proposed "catchment area" and Pathways itself is located within RCA's immediate (30-mile radius) proposed catchment area. See Application, at 34. Pathways is located only 17 miles from the proposed Upper Marlboro location, and less than 30 miles driving distance. Thus, the proposed new facility could reasonably provide services to residents in the contiguous area, and is intended by RCA to do so as part of its "large regional market strategy." Application at 34. Further, Pathways would be adversely impacted by the approval of the Application as described below.

3. STATE HEALTH PLAN STANDARDS AND REVIEW CRITERIA NOT MET BY RCA

COMAR 10.24.14.05 (Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities)

[2] Under COMAR 10.24.01.01B(20), an interested party includes "a person who can demonstrate to the reviewer that the person would be adversely affected, in an issue area over which the Commission has jurisdiction, by the approval of a proposed project." Under COMAR 10.24.01.01B(2)(a), a person is "adversely affected" if the person "is authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan or in a contiguous planning region if the proposed new facility or service could reasonably provide services to residents in the contiguous area."

.05A Approval Rules Related to Facility Size

Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or expand either a Track One or a Track Two intermediate care facility. ***

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

The Application is inconsistent with this standard because it seeks 55 detox beds and 70 residential beds, and RCA has not demonstrated why this standard should not apply. In support of its request to be exempted from this standard, RCA argues that the maximum size standard should not apply because the beds it seeks are needed. If the existence of need is a basis to exempt an applicant from this standard, there would be no reason to have a maximum size standard, and the standard would be deprived of any meaning or effect. Need is a separate and distinct requirement for CON approval. In applying the maximum size standard, it must be assumed that there is a need for the beds. This standard concerns not the existence of need, but how need is to be met under the State Health Plan, and reflects a preference for smaller facilities over large facilities. Moreover, as discussed below, RCA has significantly overstated the level of net need.[3]

RCA also suggests that the standard should not apply because having a larger number of beds will allow it to have additional staff and programming at the facility than it could support at a smaller facility. RCA has not provided any information on the clinical programming it could not afford without the additional beds, let alone a quantitative analysis showing how that programming would be unsupportable with a smaller number of beds. As to staffing, RCA

[3] As it does elsewhere in its application, RCA claims again here that only 30 of its detox beds will be used for Maryland residents. As discussed below, this supposed "limitation" is illusory and unenforceable, and should be disregarded. If the out of state patients do not materialize, there is nothing that would prevent RCA from seeking to fill all of its beds with Maryland residents.

suggests that the additional beds will allow it to have a full time Medical Director, as well as "one or more" full time psychiatrists. Its work force information (Table L), however, does not include a full time Medical Director, and reflects only a 1.1 FTE psychiatrist. Additionally, RCA has not presented any quantitative analysis to demonstrate that without the additional beds it could not support these positions. Given the profit margin at which RCA projects it will operate, such a claim would lack credibility in any event.

.05B Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need

An applicant seeking Certificate of Need approval to establish or expand an intermediate care facility for substance abuse treatment services must apply under one of the two categories of bed need under this Chapter:

(a) For Track One, the Commission projects maximum need for alcohol and drug abuse intermediate care beds in a region using the need projection methodology in Regulation .07 of this Chapter and updates published in the Maryland Register.

The Application fails to meet this standard. RCA seeks a total of 119 detox beds in Southern Maryland between the Upper Marlboro Application and the Waldorf Application. As modified in its August 31, 2015 completeness responses, RCA argues that the application of the need methodology in the State Health Plan produces a net need between 102 and 124 beds in the Southern Maryland region, and 449 to 602 beds state-wide. RCAs need projection methodology is flawed, however, and fails to comply with the State Health Plan methodology.

The need projection methodology in the State Health Plan defines prevalence rates and treatment rates for the overall population. These rates are to be applied to the overall population to estimate the demand for addictions treatment services because they are based on national population studies that include the overall population (including Medicaid, commercial insured and self-pay). However, RCA did not apply these rates to the overall population, and instead

applied the rates to the commercial-only population, where the prevalence rate would be expected to be lower.

Additionally, in calculating net need, RCA made an unauthorized adjustment to the number of existing ICF beds in Southern Maryland. Specifically, RCA reduced the inventory of beds at Anchor/Walden-Sierra by 60%, from 20 beds to 8 beds taking the position that only 40% of the beds in an ICF are "true" detox beds.[4] There is no basis for this adjustment. Under the State Health Plan methodology, the adjusted inventory of beds is calculated by subtracting only the number of funded beds. The Commission most recently applied this methodology in the Commission's 2013 decision on the Father Martin's Ashley CON application (Docket No. 13-12-2340) (the "FMA Decision"), in which the Commission calculated the total number of beds in the inventory excluding only funded beds. Accordingly, there is no basis for this adjustment, causing RCA's need projection in Southern Maryland to be overstated for this reason alone by 12 beds. Likewise, as shown in Application Table 9 (as modified in August 31, 2015 completeness responses), RCA inappropriately reduced the state-wide inventory on this basis, and inappropriately failed to count the 32 beds at Pathways (which are not funded beds and were counted by the Commission in the existing inventory for the need projection in the FMA Decision). Existing ICF inventory becomes 315 rather than 92 as calculated by RCA, a difference of 223 beds.

Moreover, RCA is relying on the wrong net need calculation. Specifically, RCA calculated the net level of private bed need (the beds needed to serve the privately insured population that it seeks to serve), and then calculated total bed need by adding back in the

[4] In the Modified Application, RCA reduced these existing beds by 80 percent, but in its August 31, 2015 completeness responses, changed the reduction to 60 percent.

population not covered by private insurance. Application, at 33 ("Because Applicant first projected the need only for the population its beds will primarily serve – privately insured patients, Applicant added a step to demonstrate the total adult bed need in the State.") In suggesting that the level of bed need in Southern Maryland is between 102 and 124 beds (and between 449 and 602 statewide), however, RCA is referring to its calculation of total net bed need, not net private bed need. See Modified Tables 7 and 10. The relevant projection is that of net private bed need, which, after accounting for the understatement of existing beds, is as follows:

RCA Net Private Bed Need Projections 2019 (Corrected)[5]		
	Southern MD	**Statewide**
Min	61	226
Max	77	379

It is also important to note that the service areas for the two proposed facilities in Southern Maryland significantly overlap, with RCA double counting the same population for each application. The net need in Southern Maryland for private beds is – at most – only 61 to 77 beds total; it is not 61 to 77 beds per project, far below the 119 beds sought by RCA.[6]

RCA suggests that only a portion of its beds would be used for Maryland residents (25 at Upper Marlboro and 30 beds at Waldorf by 2019). It calculated the "Maryland beds" simply by calculating the percentage that Maryland residents represent within the total population in the 90-

[5] This assumes for the sake of argument only (without conceding) that RCA's need methodology complies with the State Health Plan methodology in all respects other than the understatement of existing beds.
[6] As will be discussed further below, Pathways submits that even that projection is overstated.

mile radius (up to 110 miles) from the proposed facility, and applying that percentage to the total number of beds it seeks at each facility. The Application includes a list of providers in neighboring states with information about bed counts, rates, services and distances for each (see Modified Table 12), but provides no waiting list data or other information to demonstrate that these facilities are not meeting the need for services in those states such that their residents would travel out of state to receive care. RCA's table also fails to reflect hospital providers of inpatient detox services in the neighboring states, a set of providers particularly relevant to the out of state utilization projected.[7]

This is inconsistent with the need projection methodology in the State Health Plan. That methodology accounts for out of state utilization by requiring the number of out of state discharges in the base year to be excluded. On page 30 of the Application, however, RCA states that it did not perform this calculation. Its methodology should be rejected for the reasons discussed above. The additional beds sought by RCA to serve out of state residents would not be restricted to serving out of state residents, and RCA has not demonstrated that there is a demand for those beds amongst out of state residents. Further, RCA has not demonstrated that there is demand within the State for the 55 beds in Southern Maryland for Maryland residents.

In the FMA Decision, the Commission found that on average seven of the fifteen new beds that FMA sought would be used for Maryland residents. However, this was based on FMA's actual historical data on the origin of its patients. Here, RCA has no such data, and simply bases its number of "Maryland beds" on the percentage of Maryland residents within the total population in its proposed service area. Accordingly, the FMA Decision does not provide

[7] For example, a number of hospitals in the northern Virginia market alone (one of the regions included in the target market) provide inpatient detox services, including INOVA Fairfax Hospital in Fairfax, Virginia Hospital Center in Arlington, and Fairfax Detox Center in Chantilly.

support for RCA's calculation of the number of its beds that would be needed to serve Maryland residents.

.05D Provision of Service to Indigent and Gray Area Patients

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must ...(c) commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) ****

(3) In evaluating an existing Track One intermediate care facility's proposal to provide a lower required minimum percentage of bed days committed to indigent or gray area patients in Regulation D(1) or an alternative proposal under Regulation D(2), the Commission shall consider:

(a) The needs of the population in the health planning region; and

(b) The financial feasibility of the applicant's meeting the requirements of Regulation D(1).

RCA has not demonstrated why its proposed project should not be subject to the 15% requirement or, in any event, why its proposed 6.15% requirement is appropriate under this standard. In support of its request for a lower charity care requirement, RCA focuses on the expansion of access to coverage (both Medicaid and private insurance) under the Affordable Care Act. Citing a Kaiser Family Foundation report, RCA states that six in ten previously uninsured Marylanders gained access to coverage either through Medicaid or private coverage under the Exchange, with most of that population accessing coverage through Medicaid. Specifically, according to the report, with Maryland's decision to expand Medicaid eligibility under the ACA, forty percent of previously uninsured Marylanders who are newly eligible for coverage under the ACA are eligible for Medicaid. Application at 42-43, Exhibit 13.

RCA's argument in support of a reduced indigent and gray area bed days percentage actually supports the opposite result. The "indigent population" is defined in the State Health Plan as "those persons who qualify for services under the Maryland Medical Assistance

Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment." Thus, the standard is designed to ensure access to services on the part of Medicaid recipients (whether Medicaid reimburses for the services or not). Accordingly, Medicaid expansion and the fact that more previously uninsured Marylanders now have access to Medicaid demonstrates (if anything) why the 15% standard should not be reduced, not why it should be reduced.

RCA maintains that there is an adequate supply of beds to serve the Medicaid population, even as the projected growth in demand will be fueled largely by the Medicaid population. It states that, while it will not serve patients covered by Medicaid, "the expansion in Medicaid coverage means that treatment services are now available to more Maryland residents at other facilities that are already in existence", and that because of the ACA, "59% of the previously uninsured nonelderly people in the state will now have access to seek Medicaid coverage and be eligible for treatment at these facilities." Application at 43. In other words, existing facilities will treat the expanded Medicaid population to enable RCA to treat the privately insured population. Elsewhere in its Application, RCA ignores or gives short shrift to the existing community providers in the State, yet in this context, RCA bases its request to reduce the charity care requirement entirely on the existing ICFs caring for the expanded Medicaid population.

RCA has not, as required by this standard, demonstrated (1) how a reduced obligation is consistent with the needs of the indigent and gray area population, or (2) that it would not be financially feasible to comply with the standard as written. RCA has only shown that, with a 15% charity care requirement, it would make less money but would still generate a healthy 12% margin. See August 31, 2015 Completeness Responses, at p.13 ("If RCA were to provide 15%

of its annual adult intermediate care facilities bed days to Indigent or Gray Area patients at Melwood, the total profit margin will decrease to 12.2%") and Table 18.

The IMD exclusion does not, contrary to RCA's suggestion in its August 31, 2015 completeness responses, support its request for a lower charity care percentage; to the contrary, the IMD exclusion is a basis to reject that request. As described above, as a result of the IMD exclusion (and the mental health carve out in Maryland), effective January 1, 2015, Medicaid no longer covers residential or outpatient services provided to adults (ages 21-64) who are admitted to an IMD. The State Health Plan standard, however, does not depend on Medicaid coverage. As mentioned above, the definition of "indigent population" in the State Health Plan includes Medicaid-eligibles, "regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment." (emphasis supplied).[8] Further, the standard applies to gray area patients as well.

It is also important to note that the State has applied to CMS for a waiver of the IMD exclusion. Although the application is pending and the result uncertain, if it is granted, RCA could provide residential care to Medicaid patients if it chose to. RCA has filed hundreds of pages of newspaper articles, reports, etc., in this matter in attempt to show the existence of a large level of unmet need for addictions beds in the State. If there is any unmet need for addictions beds, the Medicaid-eligible population is a significant part of the population in need of those beds and RCA has not demonstrated why it should not be required to help ensure access

[8] As will be discussed further below, the IMD exclusion exacerbates the adverse impact of the proposed project on existing community providers like Pathways. RCA suggests that existing community providers can survive on the Medicaid expansion population, leaving RCA to serve the privately insured population. Because Medicaid no longer covers inpatient or outpatient services provided to an adult Medicaid recipient (from the expansion population or the pre-ACA eligible population) who is admitted to an IMD, existing community providers like Pathways are more heavily dependent on serving the commercially insured population in order to maintain financial viability than they were prior to January 1, 2015.

to care within that population. If, on the other hand, CMS does not grant the waiver, RCA can satisfy this standard in other ways, including by providing care to gray area patients. Further, Medicaid covers addictions outpatient programs for individuals who are not admitted for residential care.

There is also no basis for the alternative minimum percentage proposed by RCA. RCA reduced the State Health Plan minimum percentage (15%) by the Kaiser Family Foundation's estimate of the percentage of previously uninsured Marylanders who gained access to public or private coverage under the ACA (59%) (59% of 15% is 6.15%). The Kaiser Family Foundation estimated the increase in access to insurance coverage amongst the previously uninsured in Maryland as a result of the ACA. The State Health Plan standard is designed to ensure access to care for Medicaid and gray area patients. It makes no sense to reduce a requirement designed to ensure access to care by the level of increase in access to insurance coverage. If anything, the State Health Plan requirement to ensure access should be increased by the percentage increase in access to coverage, not decreased.[9]

RCA puts misplaced reliance on the FMA decision as precedent for its request. FMA, a non-profit ICF in operation for more than twenty years that does not participate in Medicaid, sought, and the Commission approved, a lower charity care requirement of 6.3%. This was based on a showing by FMA that a 15% requirement was not financially feasible and would have resulted in a significant operating loss. No such showing has been made by RCA. To the contrary, as shown in Table 16 of RCA's August 31, 2015 completeness response (at page 15), even at a 15% charity care requirement RCA has a positive margin of 12.2% (after taxes).

[9] Further, the 59% by which RCA reduced the State Health Plan standard is the percentage of previously uninsured individuals who got access to public or private coverage. According to the Kaiser Family Foundation report, only 40% of previously uninsured individuals got access to Medicaid.

Accordingly, RCA has not demonstrated a basis for any reduction of the bed days minimum percentage, let alone a reduction to 6.15%.

Further, there are other important distinctions between FMA's project and what RCA is requesting here. FMA is a longstanding nonprofit ICF established in 1982. Further, FMA only sought to add 15 beds to its 85-bed facility as part of a renovation capital project. Under these circumstances, combined with the showing made by FMA that requiring more than 6.3% of bed days would cause it to operate in the red, the Commission approved this lower percentage. In contrast, here, the Commission is being asked to give a new commercial operator an even lower indigent and gray area bed days percentage (6.15%) for a large influx new ICF beds in the State so that RCA can generate a 15% margin rather than a 12% margin at the Upper Marlboro facility. RCA's request is unprecedented and should be rejected.

COMAR 10.24.01.08 (Criteria for Review of An Application for Certificate of Need)

G(3)(b) Need For purposes of evaluating an application under this subsection, the Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs. Please discuss the need of the population served or to be served by the Project. Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

Pathways incorporates by reference the discussion under COMAR 10.24.14.05B above and submits that it also demonstrates how the Application also fails to satisfy this standard. In addition, the Application is inconsistent with this criteria requiring a demonstration of need. The voluminous newspaper articles, reports and other materials that RCA has filed regarding the

heroin addiction and prescription drug abuse epidemics may demonstrate the problem but do not demonstrate a need for the additional inpatient detox beds RCA is requesting. Those in need of inpatient detox care may not seek it, and those that do seek it may not have insurance coverage for this level of care, or face coverage limitations, notwithstanding the expanded access to insurance coverage under the ACA and mental health parity requirements. Pathways applauds the priority that Governor Hogan has placed on addressing the heroin and opioid emergency through (among other things) the work being done by the Lieutenant Governor and the Heroin and Opioid Emergency Task Force that he chairs. However, the broad finding in the August 24, 2015 Interim Report of the Task Force (the "Task Force Interim Report") that there is a shortage of inpatient and outpatient capacity in the State does not demonstrate the need for 55 new detox beds (119 total) in Southern Maryland to serve the commercially insured population. Nor could this finding, based on unsworn testimony by unidentified individuals before the Task Force, constitute a quantitative showing of need for purposes of this proceeding.[10]

Further, as described above, Medicaid does not cover inpatient detox treatment at all and, as described in the same Report, private insurance coverage can involve "excessively long waiting periods, high deductibles and copays" as well as delays in required prior authorizations. Although it relies on the expansion of access to insurance coverage to demonstrate need, RCA has failed to account for these limitations.

RCA is required to provide, among other things, a quantitative analysis that describes not only the proposed service area and population numbers within it, but also a quantitative analysis of the population's characteristics and expected growth. RCA did not provide a quantitative

[10] Likewise, the national statistics on illicit drug use and alcohol use listed on pages 23- 27 of the Application do not demonstrate the need for 119 new ICF beds in Southern Maryland.

analysis of the characteristics of the population in its proposed service area (other than their age categories), or the expected growth. RCA provided no data on utilization of the detox beds in the existing ICFs and other providers in Maryland and other states that already serve the population that RCA proposes to serve. Nor did it provide data on what, if any, waiting list exists for detox beds in those facilities. Pathways had a waiting list only on approximately 5% of the last 90 days, and the average wait time in rare those instances was only 24 to 48 hours.

Additionally, Pathways submits that RCA's request for a large number of detox beds must be evaluated in light of newer models for outpatient detoxification. A clinical trial funded by the National Institute on Drug Abuse demonstrated that a three-step outpatient detoxification program using Suboxone was effective with a group of opioid abusers whose profile is comparable to RCA's target population. JAMA Psychiatry, December 2013 70-12, 1347-1354. This calls into further doubt the need for the inpatient detox beds sought by RCA.

G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

RCA is inconsistent with this standard. Its application assumes that existing providers are unable to provide the necessary inpatient detox service to meet the need, but has failed to provide any quantitative analysis to demonstrate this. It has not presented any data on waiting lists for detox beds in the state, or on whether (and the extent to which) individuals seeking out treatment have been denied treatment by existing providers. In question #20 of Staff's completeness questions on the Modified Application, Staff asked RCA to provide a "quantitative analysis on the number of people who have not received or been denied treatment for substance abuse and alcoholism in Maryland." In its August 31, 2015 response, RCA attached over 500

pages of newspaper clippings and local, national and even international reports on the heroin and opioid addictions problem and alcohol abuse, but did not respond to Staff's request. RCA cross referenced its need projection, but as discussed above, RCA's need projection methodology is flawed and does not demonstrate need for the number of beds it seeks in Southern Maryland. In any event, the need projection is not responsive to Staff's question under this separate and distinct review criteria regarding the availability of more cost effective alternatives.

RCA's answer also attached the Task Force Interim Report, and referred to its finding based on public testimony at the six regional summits that there is a shortage of inpatient and outpatient treatment capacity in Maryland. A summary of testimony from unidentified, unsworn witnesses before the Task Force is hardly a quantitative analysis demonstrating that individuals seeking inpatient detox services are being turned away by the existing ICFs.[11] As discussed above, Pathways had a waiting list only on approximately 5% of the last 90 days, and the average wait time in rare those instances was only 24 to 48 hours.

RCA's answer also referred to a statistic from a Substance Abuse and Mental Health Services Administration (SAMHSA) publication concluding that two percent of individuals 18 years or older were reported to need but not receive treatment in the State of Maryland. It is unclear from this statistic whether this two percent actually sought treatment and were refused, whether the treatment sought was inpatient detox treatment versus other forms of treatment, or whether the refusal was due to insurance coverage limitations as opposed to insufficient capacity, or whether inpatient detox care as opposed to other types of care. Accordingly, it does not demonstrate the lack of more cost effective alternatives.

[11] The recommendations in the Interim Task Force Report do not include increasing the number of detox beds in the State.

G(3)(d) Viability of the Proposal For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements as well as the availability of resources necessary to sustain the project.

RCA has not demonstrated the viability of its proposed project. First, RCA's projections assume an average length of stay of 30 days -- 14 days in detox and 16 days in rehab. This is an unrealistic and unreasonable assumption. Pathways' average inpatient length of detox stay was only 3.92 days in FY 15 and 4.039 in the first quarter of FY16.

Second, RCA's projections are founded on unrealistic and unreasonable daily rates. RCA assumed a daily rate of $860 for its detox beds and $724 for its residential beds. See Statement of Assumptions for Financial Projections, at 2. RCA's assumed daily rate for detox beds is approximately 40 percent higher than Pathways average rate from commercial payors. RCA's assumed daily rate for its residential beds (ASAM level III.5) is approximately 33 percent higher than Pathways average rate from commercial payors for its rehab beds (ASAM level III.7) that represent a higher level of care.

The data that RCA relied on for its proposed rates (from Medevance, Truven and American Addition Centers) is not Maryland-specific data, so it does not reflect Maryland's commercial payor environment. Moreover, the data largely represents out of network claims, but RCA provides no data upon which to determine what percentage of the population it proposes to serve will have an out of network benefit.

Third, RCA has not demonstrated how it will attract and retain the staffing levels shown on Table L in order to support the large number of beds is proposes. There is a very limited supply of qualified addictions professionals in Maryland. It took Pathways (an established

provider) two years before it was able to find and hire a qualified full time psychiatrist earlier this year. Hiring certified addictions specialists is also challenging – on average it takes Pathways six months to hire qualified, certified addictions specialists. In just the last three months, Pathways has had to use an agency to find several addictions specialists – two supervisory positions and two counseling positions – at significant added expense. RCA relies on the finding in the Task Force Interim Report that there is insufficient inpatient and outpatient treatment capacity in the state, but ignores another finding (at p. 3) that there is a "critical shortage of qualified treatment professionals in the State." RCA has not demonstrated how it will achieve adequate staffing at the expense levels assumed in its projections or, if it does, how it will not be at the expense of existing community providers that are already struggling to find and retain adequate qualified staff. [12]

> **G(3)(f) <u>Impact on Existing Providers</u> For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers. Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.**

RCA's breezy response to this standard is that its proposed project will not have a material adverse impact on existing ICFs in the State because it "only" seeks 55 detox beds (only

[12] Pathways also notes that RCA has not identified a network of referral sources in the State to generate the volume of cases necessary to achieve the 85 percent occupancy level that its projections assume. It has produced only two referral agreements (Hope House and Care Consultants). Under the agreements, both Hope House and Care Consultants agree to "receive referrals" from RCA, and both parties agree to "refer patients to the other if there is a clinical, administrative or geographic need." See Exhibit 17 to Modified Application and Exhibit 26 to August 31, 2015 Completeness Responses. However, RCA does not provide any information about these providers or what referrals are expected to result from them. Hope House is supported by State and County funds and most of its patients are Medicaid patients, so this is an unlikely source of referrals to RCA since it will only serve commercially insured patients.

25 of which will be used for Maryland residents) and 70 residential beds. As discussed above, there is no basis for RCA's suggestion that only 25 of the detox beds will be used for Maryland residents. At 55 detox beds, the project would be one of the largest ICF's in the state, located only 17 miles away from Pathways (and less than 30 miles drive time). Further, the proposed project in Upper Marlboro cannot be considered in isolation from the other two projects RCA proposes in Maryland which, when combined, represent the addition of 140 new inpatient detox beds and 200 residential beds in the state, all within 60 miles of Pathways. For each proposed facility, RCA has defined a 90 mile radius (that it refers to as its "neighborhood" in the Application at 62) from which it proposes to draw its patients, so Pathways' service area is squarely within RCA's proposed "neighborhood."[13]

The adverse impact from RCA's proposed project will only be exacerbated under the IMD exclusion. As described above, Medicaid reimbursement is no longer available for residential or outpatient services provided to adults admitted to residential care at an IMD (including Pathways) and there has been a substantial reduction in Medicaid reimbursement beginning January 1, 2015 for those services. The commercially insured population that is the same population that RCA proposes to exclusively serve and compete to attract to its three Maryland projects. As described above, Pathways' payor mix is now 85% commercial payors and only 13% Medicaid (as compared to 36% Medicaid and 62% commercial in calendar year 2014). Reflecting this change in Medicaid coverage, Pathways' residential volume during the first three calendar quarters of 2015 is approximately 18% less than it was during the first three calendar quarters of 2014 If RCA were to deprive Pathways of even 20 percent of its commercial inpatient volume (equating to approximately $266,877 in revenues), this would cause Pathways

[13] As discussed above, Pathways patients are primarily Anne Arundel County residents, but its extended service area includes the Eastern Shore, Prince George's County and Southern Maryland

to operate at a loss in 2015 Surrounded by the three new Maryland facilities proposed by RCA that would serve the commercially insured market almost exclusively, a loss of 20 percent of Pathways' commercial inpatient volume is reasonably foreseeable.[14]

In its Application (at 61), RCA also asks the Commission to take note of the "lack of providers" that will directly compete with RCA's proposed projects in Maryland. It attempts to support this "lack of providers" with a list of fourteen existing providers with a combined total of nearly 1,100 beds, all within RCA's 90-mile-radius "neighborhood." Even this long list is incomplete because it excludes Pathways' 32 adult beds, and does not include hospital providers of inpatient detox services in neighboring states, including three in the northern Virginia market (INOVA Fairfax Hospital in Fairfax, Virginia Hospital Center in Arlington, and Fairfax Detox Center in Chantilly). Thus, there is a wealth of providers that are already providing inpatient detox services in RCA's expansive "neighborhood," and RCA has presented no data to demonstrate that these providers have long waiting lists or are turning away the commercially insured patients RCA proposes to serve.

Additionally, RCA's project will adversely impact Pathways' ability to attract and retain qualified addictions staff. There are 79 FTEs associated with the proposed project in Upper Marlboro, another 85 for the Waldorf Project and 32 for the Earleville project, for a grand total of 187 FTEs for all three projects. As discussed above under Viability, there is a very limited supply of qualified addictions professionals already in Maryland, and RCA's proposed projects will only exacerbate the problem to the detriment of Pathways and other existing providers.

[14] RCA suggests that there will be no adverse impact because, nationally, 89% of Americans who meet the criteria for substance use or dependence do not get treatment. This is not a Maryland statistic and, in any event, grossly overstates demand because meeting the criteria for treatment is not the same thing as seeking treatment, and this statistic does not account for insurance coverage. This is also contrary to RCA's August 31, 2015 completeness response (question #20) that only 2 percent of Maryland adults need but do not receive treatment.

Pathways is already increasingly required to turn to staffing agencies to find qualified addictions professionals, which is a costly alternative. At current rates (which will only increase with more demand), it costs Pathways 30 percent more for an agency-contracted staff member, and an additional $18,000 for a direct hire through an agency.

This is before the demand for 187 FTEs that RCA would create, only exacerbating the problems that Pathways is already facing with staffing. These projects will increase Pathways' staffing costs and make it more difficult to fill positions that allow it to continue to provide quality care to its patients. Increased staffing costs will be reflected in the cost of treatment. Further, if Pathways is unable to fill positions necessary to provide quality care as a result of the additional pressure on the labor market created by RCA, it will adversely impact access to care.

CONCLUSION

For the reasons stated above, the Application should be denied. Pursuant to COMAR 10.24.09.01A(3), Pathways requests oral argument before a recommended decision is prepared.

Respectfully submitted,

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Counsel for Pathways

EXHIBIT 1

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
ALCOHOL AND DRUG ABUSE ADMINISTRATION

SPRING GROVE CENTER
VOC REHAB BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

General Certificate of Approval

SAMIS No. 102667 Registration No. 905325

Issued to:

Pathways
2620 Riva Road
Annapolis, Maryland 21401

Type of Facility or Community Program:

Level 0.5 - Early Intervention
Level I - Outpatient Treatment
Level I.D - Ambulatory Detoxification without Extended On-Site Monitoring
Level II.1 - Intensive Outpatient
Level II.5 - Partial Hospitalization
Level II.D - Ambulatory Detoxification with Extended On-Site Monitoring
Level III.7 - Medically Monitored Intensive Inpatient Treatment
Level III.7.D - Medically Monitored Intensive Inpatient Treatment - Detoxification
Level 0.5 - Early Intervention - DWI Education

Date Issued: 09/12/2014

Authority to operate in this State is granted to the above entity pursuant to the Alcohol and Drug Abuse Act, Section 8-403, Annotated Code of Maryland. This Approval is non-transferable and may be revoked for cause by the Alcohol and Drug Abuse Administration.

Expiration Date: 09/12/2016

Patricia Tomsko Nay, M.D.
Director, Office of Health Care Quality

AFFIRMATION

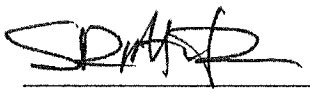
I hereby declare and affirm under the penalties of perjury that the facts stated in the Interested Party Comments of Pathways are true and correct to the best of my knowledge, information and belief.

Helen Reines

Helen Reines, Executive Director

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Interested Party Comments of Pathways are true and correct to the best of my knowledge, information and belief.



Sandra L. Huffer, Director of Financial Operations, Anne Arundel Medical Center