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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: December 15, 2016

SUBJECT: Maryland House Detox
Docket No. 16-02-2374

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by Delphi Behavioral Health Group ("Delphi") and DCX Group ("DCX"), doing business as Maryland House Detox ("MHD"), to establish a new Track One Intermediate Care Facility ("ICF") in Linthicum, in Anne Arundel County. The proposed program will operate 16 adult detoxification beds at Level III.7-D, Medically Monitored Inpatient Detoxification. The proposed detox program will occupy the structure at 817 South Camp Meade Road which was formerly occupied by Hospice of the Chesapeake.

The total project cost is estimated at $1,936,275, which includes $1,194,800 for the design, permits, and renovations to the proposed site for MHD, and $741,475 in working capital costs for start-up and carrying costs related to land lease obligations, furniture, and staffing. The applicant will finance the entire cost of this project with cash.

Commission staff analyzed the proposed project's compliance with the applicable State Health Plan criteria and standards and the other applicable CON review criteria at COMAR 10.24.01.08 and recommends that the project be APPROVED with the following conditions:

1. MHD must receive preliminary accreditation by the Joint Commission prior to receipt of First Use Approval and must timely receive final accreditation by the Joint Commission.

2. MHD shall provide a minimum of 15% of patient days of care to indigent and gray area patients, as defined at COMAR 10.24.14.08B(9)&(11), and shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audit reports shall be submitted to the Commission following each MHD fiscal year, from the project's inception and continuing for five years thereafter.

IN THE MATTER OF	*	**BEFORE THE**
	*	
MARYLAND HOUSE DETOX, LLC	*	**MARYLAND HEALTH**
	*	
	*	**CARE COMMISSION**
Docket No. 16-02-2374	*	
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Staff Report and Recommendation

December 15, 2016

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I. INTRODUCTION

A. The Applicant

Maryland House Detox, LLC ("MHD"), a proprietary corporation, will be co-owned by Delphi Behavioral Health Group ("Delphi") and DCX Group ("DCX"). Delphi will hold a 60% ownership share and DCX a 40% share.

Delphi currently operates eight facilities that provide addiction treatment and a variety of detox and treatment programs, with five locations in Florida and three in California.[1] It was formed in the first quarter of 2016 in a merger of several treatment facilities in California and Florida. Delphi claims a successful track record of identifying locations for facilities and securing properties, overseeing zoning, developing facilities, gaining licensure and then integrating the new centers into its treatment facility network in which centers share a common service platform (i.e., bookkeeping, accounting, admissions processing and marketing). In this proposed project Delphi is responsible for funding MHD's operations and supporting the facility with access to capital, and providing the aforementioned centralized corporate services. Delphi also brings considerable knowledge and experience with billing and collection practices, and relationships with commercial insurance carriers. (DI #16, Questions #1) According to the applicant Delphi's strategy is to develop facilities with 16-60 bed potential and high clinician-to-patient ratios. (DI #4, p.71).

DCX will handle the day-to-day operations of patient care at MHD. The applicant states that DCX "has special knowledge of the healthcare landscape in {Maryland} and experience in operating medically monitored inpatient detoxification." (DI #16, Question #1). As the Chief Executive, David Stup will oversee the design, marketing promotion, and the delivery and quality of programs while ensuring that MHD performs the business functions necessary to sustain successful operations. (DI #4, p. 72). President and Chief Operations Officer, Cynthia Curtis, RN, CITRMS, LNC, brings more than 30 years of executive level leadership as a nurse executive and with experience in health care management and business systems analysis. (DI #4, p. 73). Both principles have extensive experience in operating programs that provide substance abuse treatment services.

The applicant maintains that this Delphi/DCX collaboration creates synergy by sharing resources, sharing best practices, and providing localized options for patient care. The applicant's organizational chart is in Appendix 1.

[1] The five facilities that operate in Florida are: Ocean Breeze Recovery; Arete Detox; Pathway to Hope; Recovery Grove; and The Palm Beach Institute. The three California facilities are: California Highlands; Community Rehab; and Elevate Recovery Center. Further information on these facilities is available at: https://Delphihealthgroup.com/facilities/.

B. The Project

MHD seeks to establish a new Track One[2] Intermediate Care Facility ("ICF") in Linthicum, in Anne Arundel County. The proposed program will operate a 16-bed adult detoxification program providing services at Level III.7-D, Medically Monitored Inpatient Detoxification. COMAR 10.47.02.10(F) describes this level of service as "medically monitored inpatient detoxification services offer(ing) 24-hour medically supervised evaluation and withdrawal management by medical professionals at an inpatient facility and may be offered with therapeutic community or medically monitored intensive inpatient treatment."[3]

The proposed detox program will renovate and occupy a structure at 817 S. Camp Meade Road formerly occupied by Hospice of the Chesapeake. The facility will operate with seven residential rooms housing 16 beds. Each room will have a full bathroom and shower. The renovations will include providing space for administrative offices, a medical exam room, laboratory, common staff area, lobby/waiting area, and a residential room compliant with the Americans with Disabilities Act ("ADA"), as well as updates to the mechanical, electrical, and plumbing systems, and the replacement of doors for windows in some patient rooms. The kitchen will be upgraded for commercial use, and the dining area/community room will be extended. (DI #16, Question #4)

The estimated project cost is $1,936,275, which includes $1,194,800 for the design, permitting, and renovations to the proposed site for MHD, and $741,475 in working capital costs for start-up and carrying costs related to land lease obligations, furniture, and staffing. The applicant will fund the entire cost of this project with cash.

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[2] "Track One" or "private" beds are non-governmental ICF beds without significant funding by state or local government. The State Health Plan ("SHP") defines a "Track One" facility as one that provides "no less than 15 percent of the facility's annual patient days for an adult ICF." (COMAR 10.24.14.08B(20)) The SHP defines the "indigent population" 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" (Paragraph .08B(11) and it defines the "gray area population" as "those persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any source is no more than 180 percent of the most current Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services." (Paragraph .08B(9))

[3] Available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.47.02.10.htm.

Table I-1: MHD Project Budget

Use of Funds	
Renovations	
General Conditions	$ 144,862
Site Construction/Demolition	76,104
Renovations	741,802
Equipment	71,237
Furnishings	3,979
Architect/Engineering Fees	46,521
Permits (Building, Utilities, etc.)	6,497
Subtotal	$1,091,002
Other Capital Costs	
Contingency Allowance	103,798
Total Capital Costs	$1,194,800
Working Capital Startup Costs	741,475
Total Uses of Funds	$1,936,275
Sources of Funds	
Cash	$1,936,275
Total Sources of Funds	$1,936,275

Source: Completeness, Exhibit 4, Table E

C. Summary of Staff's Recommendation

Staff recommends approval of the project based on its finding that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff also finds that the impact of the project is positive, primarily because it will improve access to alcohol and drug treatment services, including the population that will benefit from the required charity care that will be offered. Staff recommends that the following conditions related to provision of care to the indigent and gray area population and accreditation by the Joint Commission be attached to the CON. These conditions are stated in their entirety in Part IV of this Recommended Decision.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

B. Local Government Review and Comment

On behalf of the Anne Arundel County Department of Health, Jinlene Chan, M.D., M.P.H., Health Officer, states there is "the need for additional high-quality substance use treatment services to serve the residents of Anne Arundel County and the Baltimore metropolitan region. The 16 bed Level III.7 Medically Monitored Inpatient Detoxification program....will add another treatment avenue for County residents in need of substance use treatment." Dr. Chan expressed her eagerness to work with MHD in the future. (DI #4, Exh. 7).

C. Interested Parties in Review

There are no interested parties in this review.

D. Community Support

Letters supporting the need for this service and support for this project were received from Adrienne Mickler, Executive Director of Anne Arundel County Mental Health Agency, Inc., and Jim Haggerty, CEO of Maryland Recovery. (DI #4, Exhibit 7)

III. REVIEW AND ANALYSIS

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan chapter is COMAR 10.24.14, *State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services* ("ICF Chapter"). The ICF Chapter, at Regulation.05, includes the following sixteen "C*ertificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities."*

.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 to expand either a Track One or a Track Two intermediate care facility.

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(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.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

MHD seeks to establish a new 16-bed adult Track One ICF facility in Anne Arundel County. Therefore, this CON application is consistent with subpart (2) of this standard.

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

(1) 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*.

This standard specifically relates to the need for the number of ICF beds proposed. Track One facilities – i.e., facilities whose admissions are primarily privately funded -- are directed to a need projection methodology that generates bed need projections for five specified regions. Commission staff updated the projections for all regions in August 2015.

While these projections were not published, the applicant used the SHP methodology and projected a need for 145 to 192 additional ICF beds in the Central Maryland region by 2020. (Anne Arundel County is located in the Central region.) Although the applicant made a calculation error which overstated the net need, the correct need projection is 113 (minimum range) to 160 (maximum range) additional beds. The calculation is shown in the following table.

Table III-1: Projected Bed Need for Alcoholism and Drug Abuse ICF Beds Serving Adults (18 years and older) in Central Maryland

	Base Year 2015	MHCC Projected 2020
Projected Population for 18 years and older – Projected 2020[1]	2,010,055	2,078,614
Indigent Population- Central Maryland[2]	236,802	243,385
(a) **Non-Indigent Population**	1,773,253	1,835,229
(b) **Estimated Number of Substance Abusers (a*8.64%**[3]**)**	153,209	158,564
(c1) **Estimated Annual Target Population (b*25%)**	38,302	39,641
(c2) **Estimated Number Requiring Treatment (c1*95%)**	36,387	37,659
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**		
(d1) Minimum (c2*0.125)	4,548	4,707
(d2) Maximum (c2*0.15)	5,458	5,649
(e) **Estimated Range requiring Readmission (10%)**		
(e1) Minimum (d1*0.1)	455	471
(e2) Maximum (d2*0.1)	546	565
Total Discharges from out-of-state	251	262
(f) Range of Adults **Requiring ICF/CD Care**		
Minimum (d1+e1+out of state)	5,254	5,440
Maximum (d2+e2+out of state)	6,255	6,476
(g) **Gross Number of Adult ICF Beds Needed**		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	237	245
(g2) Maximum = ((f*14 ALOS)/365)/0.85	282	292
(h) **Existing Track One Inventory ICF/CD beds**[4]	132	132
(i) Net Private ICF/CD Bed Need		
Minimum (g1-h)	105	113
Maximum (g2-h)	150	160

Source:

(1) MHCC projections –population interpolation from Maryland Department of Planning Total Population Projections for Non-Hispanic White and All Other by Age, Sex and Race (7/8/14).

(2) Medicaid Enrollment of Maryland residents grouped in ages 12 through 17 and ages 18 and older by Maryland counties. The data of enrollees is as of July 31, 2015, DHMH Decision Support System.

(3) The prevalence rate for alcohol or Illicit drug dependence or abuse is 8.31% according to the 2013 SAMHSA Maryland report. http://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2013/NSDUHsaeMaryland2013.pdf

(4) Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) MHCC records & Behavioral Health Administration, DHMH levels of care, which includes the 32 beds at Pathways and all 100 beds at Ashley even though these beds can be used for Levels III.5 and III.3 in addition to Levels III.7 and III.7.D.

The applicable need analysis of the SHP for this type of project supports the bed capacity being proposed. The application is consistent with this standard.

.05C. Sliding Fee Scale. An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

The applicant states that MHD's Financial Assistance Policy will provide financial assistance options to individuals who request such assistance and meet specified financial criteria guidelines for individuals who are either uninsured, underinsured, or otherwise unable to pay for medically necessary care based on their individual financial situation. The patient must submit all requested financial information in order to verify income and eligibility for the program. MHD's Admissions staff will have the responsibility of taking, tracking, and making final determination of the applications for financial assistance. (DI #4, p 21)

MHD will not be certified for Medicare or Medicaid participation.

The Sliding Fee Schedule appears immediately below.

MHD's Sliding Fee Schedule

If Patient's income level is	< 100% of Federal Poverty level (FPL)	75% discount
If Patient's income level is	< 150% but > 100% of FPL	50 % discount
If Patient's income level is	< 200% but > 150% of FPL	25% discount

Source: DI #4, p. 22.

The application is consistent with this standard.

.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:

(a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;

(b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and

(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.

The purpose of this standard is to require applicants for new or expanded Track One ICF's to serve a minimum percentage of indigent and gray area patients. The standard does this by requiring applicants to establish a sliding fee scale for gray area patients consistent with a client's ability to pay and by requiring that applicants commit to providing a specific percentage of its bed days to indigent and gray area patients. The standard permits an applicant to demonstrate why one or more of the requirements should not apply. The standard also offers applicants the opportunity

to propose an alternative to providing the minimum required indigent and gray area patient days that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

In its application MHD requested a variance in the requirement that 15% of bed days be apportioned to the gray area or indigent population. Its plan would be to simplify the meeting of this requirement by specifically allocating two of its 16 beds at all times for patients falling within the indigent income band (qualifying for Medicaid) and gray area income band (income too high to qualify for Medicaid but less than 180% of the Federal Poverty Index). Two beds out of 16 is 12.5% of beds, so theoretically (e.g., if the facility was always full and all lengths of stay were equal) such a process would lead to an outcome of 12.5% of patient beddays allocated to this population, rather than 15%. MHD notes, however, that there is a natural variance in patients' length of stay. MHD will only discharge patients who are medically stable and have the ability to successfully engage in a lower level of treatment, and that MHD expects that the indigent and gray area population may have a longer length of stay, and that the result over time would be an allocation of bed days to indigent and gray area patients higher than 12.5%. (DI#4, p.22,23) MHD describes its proposed process as follows:

> Operationally, MHD will commit a special procedure to reserve 2 out of its 16 beds at all times specifically for indigent and gray area populations. This translates into a 12.5% dedication of total bed days to charity care. In reality, MHD expects that the total portion of bed days committed to actual care of these patients will reach 15% or higher annually. In order to successfully operate a procedure in which beds are dedicated for a special use, MHD must dedicate whole beds. It cannot dedicate a percentage of a bed to attempt to meet this standard.
>
> In order to guarantee the provision of 2 beds to charity care, MHD will identify an open bed, which will subsequently be placed on a 24-hour hold for an individual meeting criteria for this specific population. At all times, the total number of these beds identified, held, and/or occupied will be equal to 2. During this holding period, MHD will accept indigent and gray area patients into these beds. The date and time of the vacated bed will be captured for tracking. At any time, when a discharge occurs, that open bed will be listed on the 24-hour reserve hold unless the 2-bed charity provision is being met with current patients. When the bed remains unoccupied for a complete 25 hours following the commencement of a 24-hour hold reserve, the hold reserve will be released and it will be available to the next potential admission.

While staff believes that the applicant's proposed approach is acceptable, the authority to grant such variance lies with the Commission. Thus, staff asked the applicant to describe its contingency plan to ensure it meets the standard if the variance is not granted. In summary, MHD will implement a rolling monthly calculation that will allow MHD to implement bed assignment for the designated gray area and indigent patient utilization to achieve the 15% target. (DI#26, response to staff's request for the applicant to describe how it would operate if its request for a variance was not granted.) The applicant's complete response is attached as Appendix 3.

The remaining subparts of this standard refer to existing Track One intermediate care facilities and are, thus, not included.

Staff recommends that the Commission find the application to be in compliance with this standard.However, staff recommends that if the Commission approve the application, it attach the following condition:

> MHD shall provide a minimum of 15% of patient days of care to indigent and gray area patients, as defined at COMAR 10.24.14.08B(9)&(11) and shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audit reports shall be submitted to the Commission following each MHD fiscal year, from the project's inception and continuing for five years thereafter.

.05E. Information Regarding Charges. An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

MHD states that it will post information regarding the range and types of services it will provide and a statement of charges in a conspicuous location. (DI #4, p. 25) The applicant is consistent with this standard.

.05F. Location. An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

MHD states that its location at 817 South Camp Meade Road in Linthicum is approximately 12 miles from the University of Maryland Baltimore Washington Medical Center and within the 30 minute one way travel time of this hospital by automobile. (DI #4, p. 25)

Staff concludes that the facility location is consistent with this standard.

.05G. Age Groups.

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.

(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.

(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

MHD is proposing a 16-bed adult detox treatment facility. The applicant states that its Policies and Procedures Manual will contain age specific treatment protocols that will be approved by both the Joint Commission and the Behavioral Health Administration prior to licensure. (DI #4, p. 25) Subparts (2) and (3) are not applicable.

The application is consistent with this standard.

.05H. Quality Assurance.

(1) An applicant must seek accreditation by an appropriate entity, either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in accordance with CFR, Title 42, Part 440, Section 160, the CARF...The Rehabilitation Accreditation Commission, or any other accrediting body approved by the Department of Health and Mental Hygiene. The appropriate accreditation must be obtained before a Certificate of Need-approved ICF begins operation, and must be maintained as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

The applicant states that "Upon CON approval and completion of construction, MHD will apply for state licensure and accreditation through the Joint Commission and the Maryland Behavioral Health Administration ("BHA")."

(2) A Certificate of Need-approved ICF must be certified by the Office of Health Care Quality before it begins operation, and must maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

MHD states that it will seek certification by the Office of Health Care Quality and maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland. (DI #4, pp. 26-27)

The applicant's response meets this standard, but staff recommends that if the project is approved by the Commission, the Certificate of Need contain the following condition:

MHD must receive preliminary accreditation by the Joint Commission prior to receipt of First Use Approval and must timely receive final accreditation by the Joint Commission.

.05I. Utilization Review and Control Programs.

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.

The applicant states that "MHD will vigorously participate in utilization review practices and control programs, will implement treatment protocols, and have written policies governing admission, length of stay, discharge planning, and referral." (DI #4, p. 27) The applicant will utilize the best practices developed and published by the Joint Commission and the Substance Abuse and Mental Health Services Administration in developing MHD's Policies and Procedures Manual.

(2) An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.

The applicant states that "MHD will document that each patient's treatment plan contains referral provisions identified for at least one year of aftercare following discharge." (DI #4, p. 7) To further implement continuity of care oversight, MHD will provide follow-up survey calls at 90, 180, and 365 days to determine the status of sobriety, recovery, and continued engagement in follow-up substance abuse aftercare treatment. The applicant provides an example of the draft Policies and Procedures Manual with the provisions for aftercare following discharge in Exhibit 8 of the CON application.

Staff finds that the applicant is consistent with this standard.

.05J. Transfer and Referral Agreements.

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letters of agreement or acknowledgement from the following types of facilities:

(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);

(d) The jurisdiction's mental health and alcohol and drug abuse authorities;
(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

MHD states that "Transfers and referrals represent one of the most critical functions of MHD," and that it has identified and secured referral partners that "represent the lower levels of care available" with representation from all counties in the Central Maryland Planning region. MHD has secured "agreements to establish a referral agreement and process" with a number of facilities and organizations that are capable of managing cases which *exceed, extend, or complement its own capabilities.* A list of these organizations follows immediately below, and copies of the agreements were included in the application. Further, MHD states an intent "to extend its working referral relationships with every level of care in every county in the state (when applicable) to achieve its mission." (DI #4, p. 27).

MHD states that it has met with both the Anne Arundel County Health Department and the Anne Arundel County Mental Health Agency to discuss plans for these agencies to receive referrals from MHD. (DI #4, p. 29) In lieu of signed agreements that will be arranged upon approval of this project, the two agencies provide letters that support the establishment of MHD's program "to provide medically monitored detoxification services for individuals suffering from chemical dependency." (DI #4, Exh. 7).

With the approval of the applicant's CON, MHD states it will apply with the Maryland Behavioral Health Administration for State licensure.

Table III-2: Maryland House Detox Transfer and Referral Agreements

Category	Facility/Organization	Type of Service Provided
Acute care hospital	University of Maryland Baltimore Washington Medical Center	Emergency Medical and Psychiatric Care
Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs	Maryland Recovery Programs	Partial Hospitalization, Intensive Outpatient, Outpatient, Halfway House, Long-Term Care
	Tranquility Woods	Residential, Partial Hospitalization, Intensive Outpatient, Outpatient
	Congruent Counseling	Intensive Outpatient, Outpatient, Mental Health Individual, Family, Medication Management, Psychiatry
	Bergand Group	Intensive Outpatient, Outpatient, Mental Health, Individual, Family, Medication Management, Psychiatry
	New Life Addiction Counseling Services	Intensive Outpatient
	Hope House Treatment Centers	Residential, Partial Hospitalization, Intensive Outpatient, Outpatient
	Harbor of Grace Enhanced Recovery Center	Residential, Partial Hospitalization, Intensive Outpatient, Outpatient, Individual
	Epoch Counseling Center	Intensive Outpatient, Outpatient
Local community mental health center	University of Maryland Baltimore Washington Medical Center	Inpatient Psychiatry
	Congruent Counseling	Psychiatry
	Bergand Group	Psychiatry
The jurisdiction's mental health and alcohol and drug abuse authorities	Anne Arundel County Health Department Anne Arundel County Mental Health Agency	Plans to work with both agencies regarding referrals to and from MHD.
Alcohol and Drug Abuse Administration and the Mental Hygiene Administration	Maryland Behavioral Health Administration	Will apply with Maryland Behavioral Health Administration for licensure
Agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, etc.	Anne Arundel County Health Department Anne Arundel County Mental Health Agency	Plans to work with both agencies regarding referrals to and from MHD.
Department of Juvenile Justice and local juvenile justice authorities	Not applicable, MHD will not serve adolescents.	N/A

(DI # 4, pp. 28-29)

MHD has initiated contact and entered agreements with providers which complement the services it proposes to deliver. Upon CON approval, the applicant will finalize and enter into arrangements for the transfer and referral of these patients to these local providers. The application is consistent with this standard.

.05K. Sources of Referral.

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area population, including days paid under a contract with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.

Since MHD seeks to establish a Track One facility, this standard is not applicable.

(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent of the facility's annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or gray area populations, including days paid under a contract with the Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

MHD provided copies of seven Referral Agreements (DI #4, Exh. 6) with local agencies and health care providers that are expected to refer a sufficient number of indigent and gray area patients to satisfy this standard. The agreements include such organizations as University of Maryland Baltimore Washington Medical Center, the Anne Arundel County Mental Health Agency, and local programs such as Tranquility Woods, Maryland Recovery Program, Bergand Group, Hope House Treatment Centers, and Harbor of Grace Enhanced Recovery Center. With the approval of their application, the agreements state MHD's "intentions to accept private and a portion of public patients, and if approved, develop a referral process for patients ...so that we may accept these patients ...for detoxification, evaluation, and referral to treatment services."

The application is consistent with this standard.

.05L. In-Service Education. An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

The applicant states that it will manage the ongoing educational and training needs specific to various roles, positions, and tasks to assure the highest level of competence and compliance with all federal, state licensure, and certification level requirements are maintained. (DI #4, p. 30)

Staff concludes that the application is consistent with this standard.

.05M. Sub-Acute Detoxification. An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards, and physical plant configuration.

The applicant states that its policies governing admission standards, treatment protocols, staffing standards, and physical plant configuration will comply with "the American Society of Addiction Medicine's ("ASAM") Patient Placement Criteria and be in compliance with the Joint Commission's guidelines and National Patient Safety Goals and industry standards." (DI #4, p. 31). MHD included a draft of its clinical policies and procedures in the CON application. (DI #4, Exh. 8; DI #16, Question #9).

The application is consistent with this standard.

.05N. Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV). An applicant must demonstrate that it has procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

The applicant states that MHD's executive medical staff has 30 years of expertise in the area of voluntary counseling, testing, and treatment protocols for HIV. (DI #4, p. 31). The facility will train the staff in the treatment, care, and management of individuals affected by all communicable diseases. The Infection Control Policy will identify training for all staff that includes the appropriate methods of infection control, universal precautions, and any special environmental considerations for HIV- positive persons and those living with AIDS. MHD's Infection Control Policy states that MHD will train all staff upon hire and annually thereafter. A copy of MHD's draft policies on Surveillance, Prevention, and Control of Infection is included in Exhibit 8 of the CON application.

The application is consistent with this standard.

.05O. Outpatient Alcohol & Drug Abuse Programs.

(1) An applicant must develop and document an outpatient program to provide, at a minimum: individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility.

(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.

(3) Outpatient programs must identify special populations as defined in Regulation .08, in their service areas and provide outreach and outpatient services to meet their needs.

(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.

(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

Since the applicant proposes to establish a Level III.7.D Medically Monitored Intensive Inpatient Treatment program, MHD did not directly respond to subparts (1) through (4) of this standard with regard to outpatient programs it would provide.

The applicant states that it has obtained and will continue to obtain agreements to develop referral agreements with providers at every level of treatment in the Central Maryland Planning Region and across the state. (DI #4, p. 32). This includes existing outpatient programs that will accept MHD's patients for care upon discharge.

The application is consistent with this standard.

.05P. Program Reporting. Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

The applicant states that after contacting the Behavioral Health Administration ("BHA"), the agency informed MHD that "Effective January 1, 2015 data reporting by substance-related disorder treatment programs was directed away from SAMIS to Beacon Health Options (Value Options), an administrative service organization." (DI #4, p. 32). This organization administers an Outcome Measuring System that includes only publicly funded programs.

MHD expresses a willingness to participate in comparable data collection programs developed internally and as specified by the Behavioral Health Administration in order to "share valuable data with the state and to evaluate its own effectiveness."

Given that BHA has contracted with Beacon Options to only collect data from publicly-funded providers, this standard has become moot.

B. NEED

COMAR 10.24.01.08G(3)(b) Need. 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.

As discussed earlier in this report (at COMAR 10.24.14.05B, *Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need*) the Bed Need Projection Methodology for Track One beds defined in Paragraph .07 of this State Health Plan Chapter shows a need for between 113

and 160 additional ICF/CD beds in the Central Maryland region. This proposal involves the addition of only 16 beds in this region..

In addition to this quantitative analysis, the applicant cited Executive Order 01.01.2015.12 that was issued on February 24, 2015 by Governor Lawrence J. Hogan, Jr.[4] The Executive Order states "Heroin and opioid drug abuse constitutes a public health crisis for the citizens of Maryland" and calls for the "improvement in access to heroin and opioid drug addiction treatment and recovery services across the State." The applicant also cites a number of reports to support the need for additional resources and services to address this issue. These include: the findings issued in the report from the Governor's Heroin and Opioid Emergency Task Force; the 2014 annual report released by the Department of Health and Mental Hygiene on Drug and Alcohol-Related Intoxication Deaths in Maryland; and a study conducted by the Substance Abuse and Mental Health Services Administration ("SAMHSA") titled Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol (TIP 45).

Staff recommends that the Commission find that this project is consistent with the applicable need analysis in the State Health Plan.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c)Availability of More Cost-Effective Alternatives. 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.

The applicant claims that by operating a stand-alone detox facility (Level III.7-D) it will alleviate some of the barriers experienced by patients seeking to enter the treatment system. With shorter lengths of stay, more patients will have access to MHD's detoxification beds than at those of existing substance treatment programs, such as Ashley in Harford County or Pathways in Anne Arundel County, where a bed does not become available until a patient has completed the entire course of treatment, which in some cases may take as long as 28 days. (DI #4, pp. 61- 64)

The applicant states that it does not wish to discredit the traditional model of tying detoxification beds to residential treatment programs as clinically effective, but seeks to establish an alternative and increase access to detoxification beds in the state. However, MHD states that the costs of maintaining a detoxification-only facility will be less than the costs to maintain facilities that house both detoxification and lower levels of care such as residential and partial hospitalization programs. The proposed detoxification program will have the flexibility to refer a patient for subsequent lower levels of care such as residential, partial hospitalization, day program, or outpatient program based on an objective review to determine the most appropriate subsequent level of care. (DI #4, pp. 66- 67)

[4] A copy of the Executive Order is available at: https://governor.maryland.gov/wp-content/uploads/2015/03/EO0101201512.pdf.

Regardless of the specific model of alcoholism and drug treatment and levels of service to be provided, as discussed earlier in this report, the need for a greater supply of detoxification and intensive inpatient treatment services in Central Maryland has been identified in the SHP. The question here is simply whether the project proposed is cost effective vis-a-vis other options, and specifically if the services could be provided more cost-effectively by other existing providers.

Staff recommends that the Commission find that the proposed project has reasonably demonstrated that, with the relationships being developed with post-detoxification providers, the MHD model can be a cost effective alternative for expanding availability of detoxification resources in the region.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Availability of Financial Resources

The estimated cost of establishing the 16-bed Track One ICF is $1,936,275. Included in this amount is $741,476 in working capital for start-up expenses. The applicant states that Delphi believes it has adequate cash flow from operations and access to capital to fund the project. To support this position, the applicant provided a letter from David S. Greenblatt, a CPA who wrote that he is independent with respect to Delphi and MHD and its officers and directors, and has no financial interest with respect to either MHD or Delphi. or any aspects of the Delphi's proposal. (DI #4, Exh. 9, pp. 249-250). His letter stated that he had reviewed Delphi's financial statements and conferred with its management, and his opinion stated that he believes that the financial assumptions submitted with the CON application are achievable, and that MHD and Delphi would generate sufficient free cash flow from continuing operations to fund the project's requirements.

Delphi also stated that it has sufficient equity in unrestricted cash on its balance sheet and that it has entered into a three-year, senior secured credit arrangement with KeyBank, N.A., consisting of a $5.0 million revolving and a $20.0 million term loan. (DI #4, p. 75).

Delphi submitted an Independent Accountants' Review Report (as differentiated from an audited financial statement) which included financial statements for most of the individual entities that subsequently merged into Delphi. The statements covered calendar years 2013 and 2014, and showed healthy bottom line performance and owners equity.

Projected Financial Performance

MHD's financial projections appear in Table III-3 below. MHD's projections assumed that it would begin treating patients on January 1, 2017; the expenses incurred in CY 2016 cover start-up costs and require $741,476 in working capital. (DI #4, pp. 83-84).

The financial projections are built on the assumption that the first year occupancy (CY 2017) will be 75% and that it will reach 100% occupancy beginning in 2018. It plans for an average gross billing rate of $1,667 per day, but expects to collect $1,023 per day. This assumption includes a blended mix of out-of-network and in-network payers and is net of allowance for doubtful accounts and contractual allowances. These projected rates and reimbursement levels came from what MHD describes as a comprehensive analysis of charge and collection data for detoxification services at entities under its control as well as collaboration with its third party billing company. (DI #4, pp. 82-83) MHD expects to breakeven and turn a profit within the first year of operation in CY 2017.

Table III-3: Maryland House Detox Revenue and Expense Projections

	CY 2016	CY 2017	CY 2018	CY 2019
REVENUE				
Inpatient Services	$ -	$ 7,200,000	$ 9,600,000	$ 9,600,000
Gross Patient Service Revenues	-	7,200,000	9,600,000	9,600,000
Allowance For Bad Debt	-	2,400,000	3,360,000	3,360,000
Charity Care	-	1,200,000	1,200,000	1,200,000
Net Patient Services Revenue	-	3,600,000	5,040,000	5,040,000
NET OPERATING REVENUE	**$ -**	**$ 3,600,000**	**$ 5,040,000**	**$ 5,040,000**
EXPENSES				
Salaries & Wages (including benefits)	$ 477,025	$ 2,293,760	$ 2,293,760	$ 2,293,760
Contractual Services	10,000	60,000	60,000	60,000
Supplies	49,000	25,000	25,000	25,000
Other Expenses	205,450	325,060	327,560	327,560
TOTAL OPERATING EXPENSES	**$ 741,475**	**$ 2,703,820**	**$ 2,706,320**	**$ 2,706,320**
INCOME				
Income From Operation	$ (741,475)	$ 896,180	$ 2,333,680	$ 2,333,680
SUBTOTAL	(741,475)	896,180	2,333,680	2,333,680
Income Taxes	-	61,882	933,472	933,472
NET INCOME (LOSS)	**$ (741,475)**	**$ 834,298**	**$ 1,400,208**	**$ 1,400,208**

Source: Completeness, Exhibit 4, Table J.

Staff believes that, while the the occupancy asumptions might be overly aggressive, a positive bottom line is achievable.

Work Force Projections

MHD will hire a total of 29.8 FTES at a cost of $2,293,760 in salaries and benefits, and does not expect to encounter any problems with finding sufficient personnel to staff MHD. (DI#16, Exhibit 4, Table L)

Community Support

As previously mentioned, letters of support for this project were received from Jinlene Chan, M.D., Health Officer, of Anne Arundel County; Adrienne Mickler, Executive Director, Anne Arundel County Mental Health Agency; and Jim Haggerty, CEO of Maryland Recovery. (DI #4, Exhibit 7) In addition. MHD has entered into informal agreements with existing providers that, with the approval of Delphi's proposal, will either refer patients to MHD for detoxification (DI #4, Exhibit 6), or receive patients once they are stabilized from MHD for the appropriate follow-up care or treatment. (DI #4, Exh. 5). These agreements include such organizations as the University of Maryland Baltimore Washington Medical Center and a number of alcohol and drug addiction treatment providers serving the State.

Applicable Performance Requirements

Pursuant to COMAR § 10.24.01.12C(3), once the Commission grants a CON, the applicant will have up to18 months to obligate not less than 51 percent of the approved capital expenditure, as documented by a binding construction contract or equipment purchase order. The applicant will have four months from the effective date of the construction contract to initiate the project, and must complete the project 18 months after the effective date of the binding construction contract to complete the project. COMAR § 10.24.01.12.B(1),(2) & C(3)(c).

Delphi has funding for the MHD project and expects to obligate immediately upon CON approval. (DI #4, p. 77) The applicant states that the project design is complete and construction documents will be finalized upon CON approval. MHD anticipates starting construction immediately, with completion of the project taking about five months to complete. Delphi expects to meet the performance requirements of obligating funds and completion of the project within the referenced time frames stated in this standard.

Staff recommends that the Commission find that the proposed project is viable.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

Neither Delphi Behavioral Health Group, DCX Group, nor Maryland House Detox have never been granted a CON in Maryland.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f)Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed

project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

The applicant expects to have a positive and beneficial impact on the health care delivery system in Central Maryland. (DI #4, p. 86) MHD states that it will have a positive impact on the volume of services provided by existing providers of acute care medical services such as the University of Maryland's Baltimore Washington Medical Center. With the addition of 16 Level III.7 detox beds in Central Maryland, acute care providers will be able to free-up resources in the emergency departments, medical floors, and psychiatric units for appropriate non-substance related services that currently are used by substance abuse patients who occupy beds. MHD expects to receive referrals from such lower level programs such as outpatient treatment and partial hospitalization programs which have patients that need to be successfully stabilized prior to beginning a meaningful treatment episode. By stabilizing these patients and referring them back to their existing provider, MHD will help to increase the ability of these existing providers to retain these patients for subsequent treatment. . (DI #4, pp. 87- 88).

Currently in Central Maryland, Ashley Addiction Treatment (formerly known as Father Martin's Ashley) ("Ashley") with 100 beds and Pathways with 32 beds are the only two Track One facilities operating in this geographic region. In assessing the impact of MHD on the Ashley program, MHD reviewed Commission staff's September 2013 review and report on Ashley's CON application, which states that it "reports only 48% of its admissions are procured from the State of Maryland, and 26% are procured from the Central Region."[5] The fact that only one-fourth of Ashley's patients come from this geographic region, and that it has historically operated with utilization in the mid 90% range, MHD does not expect its 16 bed proposal will have an adverse impact on Ashley Addiction Treatment.

Pathways provides a more comprehensive treatment service that includes residential treatment following detoxifcation, and outpatient programs. Pathways serves residents of the Eastern Shore, Prince George's County and Southern Maryland as well as Central Maryland, Pathways and provides a more comprehensive substance treatment program to a larger geographic region in Maryland.[6] MHD expects "to refer patients into Pathways outpatient programs as well as its residential program after the patient completes detox." (DI #4, p. 88) Therefore, the applicant expects its 16 bed detox program will not adversely affect Pathways but will supplement it.

The applicant does not expect to affect the payer mix of existing providers in any negative way. MDH does not anticipate participating in either the Medicare or Medicaid program. MHD expects it patient mix to be about 85% privately insured and around 15% "public" patients, based on its commitment to provide care to indigent and gray area patients. With respect to retaining private pay patients in the state, the applicant expects to have a positive impact by referring private pay patients from detoxification to in-state private pay providers who provide lower levels of continuing care. (DI #4, pp. 88-89)

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[5] Father Martin's Ashley (Docket No. 13-12-2340) Staff Report, p. 22.

[6] From Pathway's Interested Party comments to RCA CON application, p. 5.

The applicant is projecting to serve 960 patients annually and states that these patients are "individuals who may not have entered detox through existing providers and may not have had the opportunity to access the array of treatment services that are readily available to them following stabilization."[7] If these patients are not able to access detoxification services in a timely manner, the applicant indicates that many will stop looking and lose the opportunity to access all of the treatment services available in the state. (DI #4, pp. 89 - 90) The establishment of MHD will provide patients more access to these needed detoxification beds in the Central Maryland region as demonstrated by staff's analysis and findings in COMAR 10.24.14.05B, *Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need.*

MHD indicates that the establishment of the Level III.7 detox program and its ability to refer patients after treatment to the appropriate level of care for follow-up treatment will help to decrease costs and be a cost effective course for treating substance abuse patients. The applicant states that by operating as a standalone detoxification program, it will have the flexibility to transfer patients to the most appropriate subsequent level of care. MHD points out that as the level of care decreases, the cost to treat the patient decreases. The applicant indicates that if a portion of the patients that MHD discharges are referred to a partial hospitalization, intensive outpatient, or outpatient program, then the health care system will realize an immediate cost saving. (DI #4, p. 91)

In summary, staff concludes that, given the projected need for additional detoxification and intensive inpatient treatment capacity to serve the residents of Central Maryland, approval of this application will not have an adverse impact on existing health care providers and that it will improve geographic and demographic access to alcohol and drug abuse treatment services. In addition, the applicant provides some evidence that by providing an alternative to programs that provide patient treatment through multiple levels of care, it could reduce cost that might otherwise occur in the health care delivery system. Staff recommends that the Commission make these findings with respect to the Impact criterion.

IV. RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, the Commission staff recommends that the Commission find that the project proposed by Maryland House Detox complies with the applicable State Health Plan standards. The applicant has also demonstrated that the project is needed, that it is a cost-effective alternative, and that it is viable, and that it will not have a negative impact on service accessibility, cost and charges, or other providers of health care services. In addition, it will improve access to alcohol and drug treatment services, including the population that will benefit from the required charity care that will be offered.

Accordingly, Staff recommends that the Commission **APPROVE** the application of the Maryland House Detox for a Certificate of Need to renovate an existing facility to accommodate

[7] Maryland House Detox CON application (DI # 4, p. 89)

16 adult detoxification beds at Level III.7-D, Medically Monitored Inpatient Detoxification, at a cost of $1,936,275. Staff recommends that the CON contain the following conditions:

1. MHD must receive preliminary accreditation by the Joint Commission prior to receipt of First Use Approval and must timely receive final accreditation by the Joint Commission.

2. MHD shall provide a minimum of 15% of patient days of care to indigent and gray area patients at COMAR 10.24.14.08B(9)&(11), and shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audit reports shall be submitted to the Commission following each MHD fiscal year, from the project's inception and continuing for five years thereafter.

IN THE MATTER OF	*	**BEFORE THE**
	*	
MARYLAND HOUSE DETOX, LLC	*	**MARYLAND HEALTH**
	*	
	*	**CARE COMMISSION**
Docket No. 16-02-2374	*	
	*	

* *

FINAL ORDER

Based on Commission Staff's analysis and findings, it is this 15th day of December 2016, **ORDERED** that the application for a Certificate of Need submitted by Maryland House Detox, LLC to establish a new 16 bed Track One Intermediate Care Facility providing Level III.7-D, Medically Monitored Inpatient Detoxification, in Linthicum, Anne Arundel County at an estimated cost of $1,936,275, be **APPROVED** subject to the following conditions:

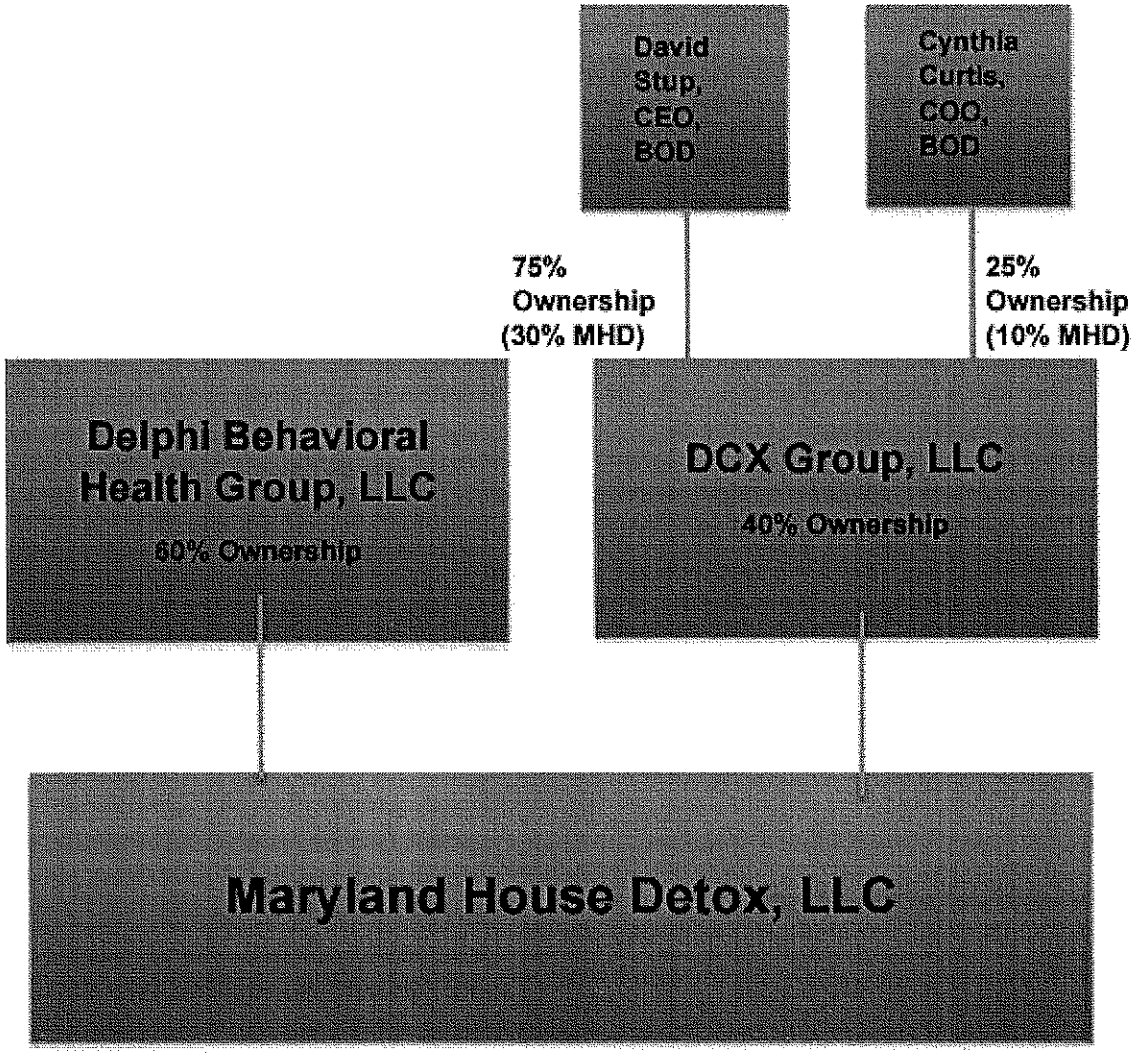
1. MHD must receive preliminary accreditation by the Joint Commission prior to receipt of First Use Approval and must timely receive final accreditation by the Joint Commission.

2. MHD shall provide a minimum of 15% of patient days of care to indigent and gray area patients, as defined at COMAR 10.24.14.08B(9)&(11), and shall document the provision of such charity care by submitting annual reports auditing its total days of care and the provision of days of care to indigent and gray area patients as a percentage of total days of care. Such audit reports shall be submitted to the Commission following each MHD fiscal year, from the project's inception and continuing for five years thereafter.

APPENDIX 1:

MARYLAND HOUSE DETOX ORGANIZATIONAL CHART

Maryland House Detox Organizational Chart



APPENDIX 2:

RECORD OF THE REVIEW

APPENDIX 2:

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	David Stup, Cindi Curtis, and Ryan Collison submitted a joint notice of intent to establish Maryland House Detox, a 16-bed intermediate care facility that will provide Level III.7 Medically Monitored Inpatient Detoxification services located at 817 S. Camp Meade Road in Linthicum, Maryland in Anne Arundel County. Delphi Health Group, LLC and DCX Group, LLC would own and operate Maryland House Detox.	7/23/2015
2	Commission submitted to *Maryland Register* a request for additional letters of intent regarding the notice of receipt of a letter of intent seeking to establish Maryland House Detox, a Track One Alcoholism and Drug Abuse Intermediate Care Facility.	8/21/2015
3	Commission acknowledged receipt of the July 23rd Letter of Intent to file a CON application for Maryland House Detox. MHCC solicited in *Maryland Register* additional letters of intent for Track One Alcoholism and Drug Abuse Intermediate Care Facility in Anne Arundel County; no additional letters of intent were filed.	9/30/2015
4	David Stup submitted a Certificate of Need application proposing the establishment of Maryland House Detox ("MHD"), a 16-bed Track One Intermediate Care Facility that provides level III.7D detoxification services (Docket No. 16-02-2374) located in Linthicum, Anne Arundel County.	3/21/2016
5	Commission acknowledged receipt of the CON application in a letter to Maryland House Detox.	3/22/2016
6	Commission requested publication of notification of receipt of the MHD proposal in the *Baltimore Sun*.	3/22/2016
7	Commission requested publication of notification of receipt of the MHD proposal in *The Capital*.	3/22/2016
8	Commission requested publication of notification of receipt of the MHD proposal in the *Maryland Gazette*.	3/22/2016
9	Commission requested publication of notification of receipt of the MHD proposal in the *Maryland Register*.	3/22/2016
10	*The Baltimore Sun* provided certification that the notice on receipt of application was published on March 31, 2016.	4/1/2016
11	*The Capital* provided certification that the notice on receipt of application was published on April 4, 2016.	4/4/2016
12	E-mail exchange between Kevin McDonald and David Stup regarding the need for MHD to submit projected occupancy utilization figures for Table I, CON application.	4/5/2016
13	*The Maryland Gazette* provided certification that the notice on receipt of application was published on April 6, 2016	4/6/2016

14	Ken Glendenning, President of Linthicum-Shipley Improvement Association, expressed resident's concerns regarding this project and would like to attend a hearing on this project.	4/7/2016
15	Commission sent request for additional information on this project.	4/19/2016
16.	Commission received responses to the April 19th request for additional information.	5/4/2016
17	Karen E. Olscamp, President and CEO of University of Maryland Baltimore Washington Medical Center, submitted a letter of support and looks forward to working with MHD upon CON approval.	5/20/2016
18	Commission notified MHD that its application is docketed for formal review with a notice in the *Maryland Register* published on June 10, 2016. Commission staff also requested a response to a question that would be included in the record of this review, with the response due by June 9, 2016.	5/23/2016
19	Commission requested publication of notification of formal start of review for MHD proposal in the *Maryland Register* with the date of publication on June 10, 2016.	5/23/2016
20	Commission requested publication of the docketing notice in the next edition of *The Capital*.	5/25/2016
21	Commission requested publication of the docketing notice in the next edition of the *Maryland Gazette*.	5/25/2016
22	Commission requested publication of the docketing notice in the next edition of the *Baltimore Sun*.	5/25/2016
23	Commission requested that Anne Arundel Health Department provide review and comment on the MHD CON application.	5/25/2016
24	*The Baltimore Sun* sent notification that notice of docketing was published on June 3, 2016.	6/3/2016
25	David Stup submitted response to MHCC request for additional information in the docketing letter dated May 23, 2016.	6/9/2016
26	David Stup submitted response to MHCC request for additional information in the docketing letter dated May 23, 2016.	6/10/2016
27	*The Capital* sent notification that notice of docketing was published on June 10, 2016.	6/10/2016
28	*The Maryland Gazette* sent notification that notice of docketing was published on June 11, 2016.	6/11/2016
29	Joshua E. Jacobs, Vice President of Anne Arundel Medical Center, requested copies of all filings in connection with the MHD CON application. Commission acknowledged receipt of Anne Arundel Medical Center's request on June 22, 2016.	6/15/2016
30	Ella R. Aiken, Esq., on behalf of Recovery Centers of America ("RCA"), requested copies of all filings in connection with the MHD CON application. Commission acknowledged receipt of RCA's request on June 22, 2016.	6/9/2016
31	Email exchange between McDonald and Stup clarifying language in Financial Assistance Policy	12/7/16

APPENDIX 3:

MHD RESPONSE TO STAFF QUESTION REGARDING HOW IT WILL RESPOND IF ITS REQUEST FOR AN EXCEPTION TO THE "PROVISION OF CARE TO THE INDIGENT AND GRAY AREA POPULATION STANDARD" IS NOT GRANTED.

Please describe how Maryland House Detox will respond if its request for an exception from the standard requiring that "the total portion of bed days committed to actual care of these patients will reach 15% or higher annually" is not granted.

In its official application and its completeness response, MHD described a system in which two of its sixteen beds would be dedicated to providing care for gray area and indigent patients. MHD also noted that because these patient stays were not bound by third party insurance authorizations, it expected that these particular LOS (length of stay) would account for greater than the expected average of 5-7 days for privately insured patients. While the total patient days accrued in these beds may actually account for 15% or greater of the total patient bed days, MHD's original intention was to dedicate two beds for operational simplicity and had requested that its small exception be granted. It is important to note that these responses were meant to reflect operations at full utilization, accounting for a guaranteed minimum 12.5% of bed days dedicated to charity care.

If MHD's request for an exception from the standard requiring that "the total portion of bed days committed to actual care of these patients will reach 15% or higher annually" is not granted, then it will comply with the standard by implementing an accounting system that ensures the total portion of dedicated bed days reaches 15%. As described in the official application, it is expected that MHD will experience a ramp up period in utilization resulting in 75% utilization for the first year and 100% utilization in subsequent years. In order to comply with the standard in question, MHD will utilize a rolling monthly calculation. The calculation will be performed at the end of each calendar month. This calculation will allow MHD to forecast and implement bed assignment for the designated gray area and indigent patient utilization to achieve a full 15%. Below is an example for ease of understanding.

	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Admissions	16	16	16	32	32	32	48	48	64	64	80	80	528
Bed Days	96	96	96	192	192	192	288	288	384	384	480	480	3168
Avg LOS	6	6	6	6	6	6	6	6	6	6	6	6	6
15% days	14.4	14.4	14.4	28.8	28.8	28.8	43.2	43.2	57.6	57.6	72	72	475.2
15% as bed days	14-15 in Feb	14-15 in Mar	14-15 in Apr	28-29 in May	28-29 in June	28-29 in July	43-44 in Aug	43-44 in Sept	57-58 in Oct	57-58 in Nov	72 in Dec	72 in Jan	470--480
Percent													Avg 15%

MHD will use a rolling system by simply allocating 15% of the total number bed days from the previous month to the current month's charity care designation. If the figure results in a fraction of a day, it will be rounded up or down depending on how the day is actually utilized for patient care - i.e. to extend a medically complex case or hold a patient until the next level of care is ready to receive them.

MHD's original request for an exception from the 15% standard was based upon implementation of a simple operation of dedicating two full time beds. If MHD's request for an exception is not

granted, during its ramp-up period of opening months (prior to full utilization), it will not be able to operationally dedicate two full time beds and instead will have to rely on its rolling calculation from previous months to determine charity care bed days. If MHD's request were granted, it would be able to implement a simple operation of dedicating full time beds. This approach would translate into a scenario where during its ramp-up period in the opening months, as well any periods in the future where the occupancy may fall below 100%, the dedication of two full time beds would account for a greater percentage of charity bed days.

MHD is prepared to operate in the manner that is designated by the Commission and will operate in the proposed manner to guarantee the full 15% and comply with the standard.

APPENDIX 4:

MHD LINE DRAWINGS

1 FIRST FLOOR DEMOLITION PLAN
2 SECOND FLOOR DEMOLITION PLAN
TO BE REMOVED
DELPHI HEALTH GROUP
817 S. CAMP MEADE RD
LINTHICUM, MD
RPH ARCHITECTURE
DEMOLITION PLANS
A-0.1
SUBMISSION SET
DATE
DESCRIPTION
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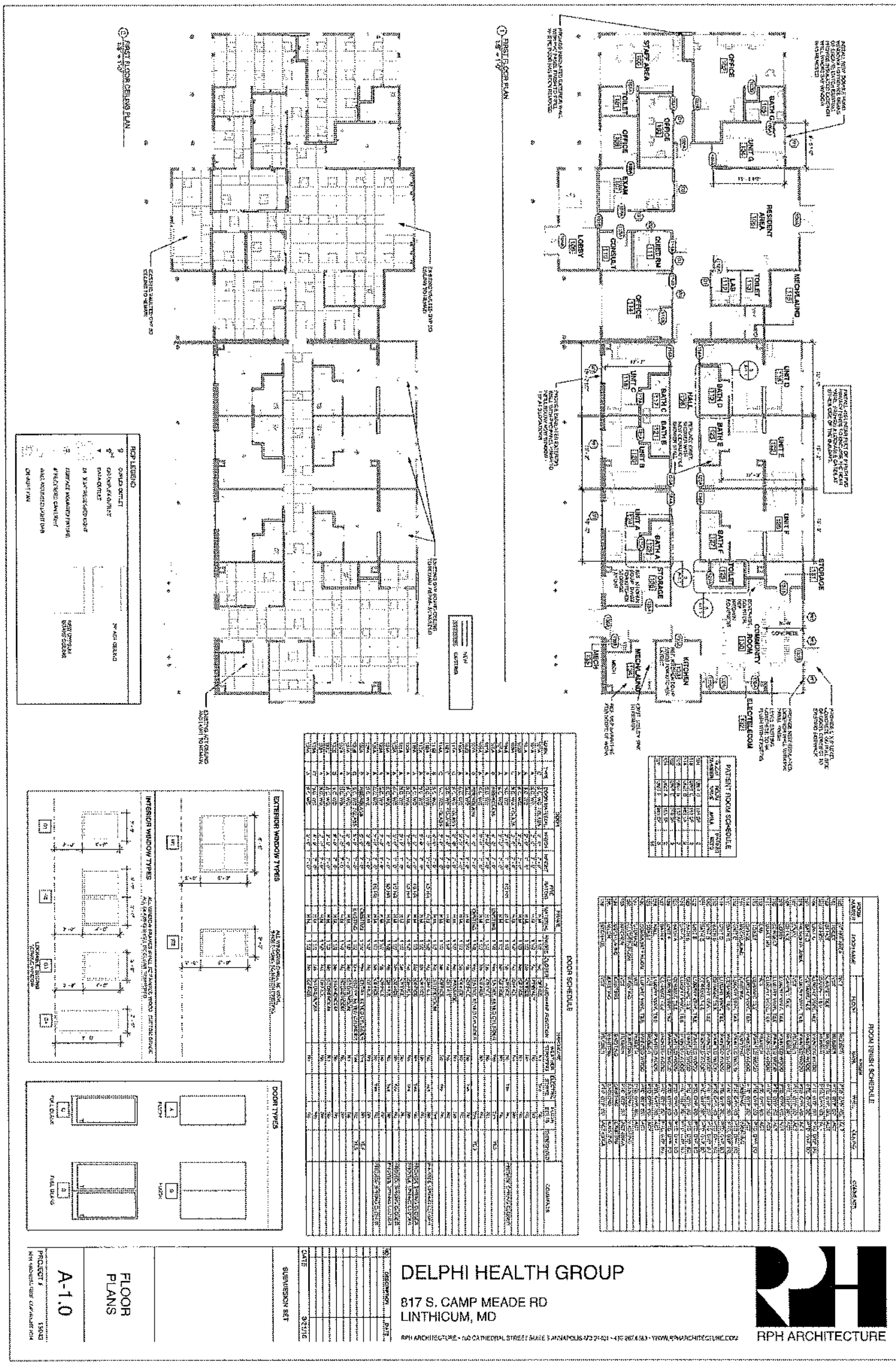
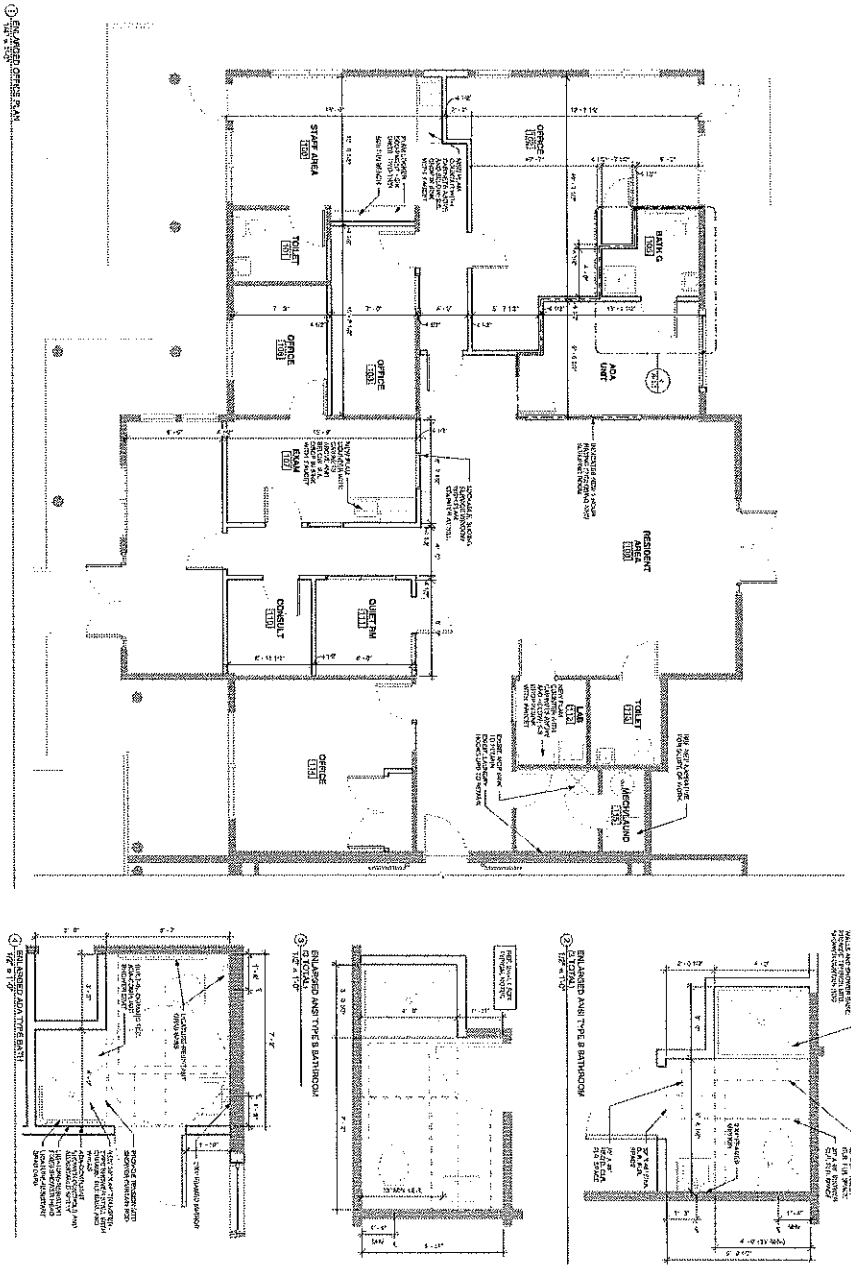

RPH ARCHITECTURE
DELPHI HEALTH GROUP
817 S. CAMP MEADE RD
LINTHICUM, MD
SUBMISSION SET
FLOOR PLANS
A-1.0



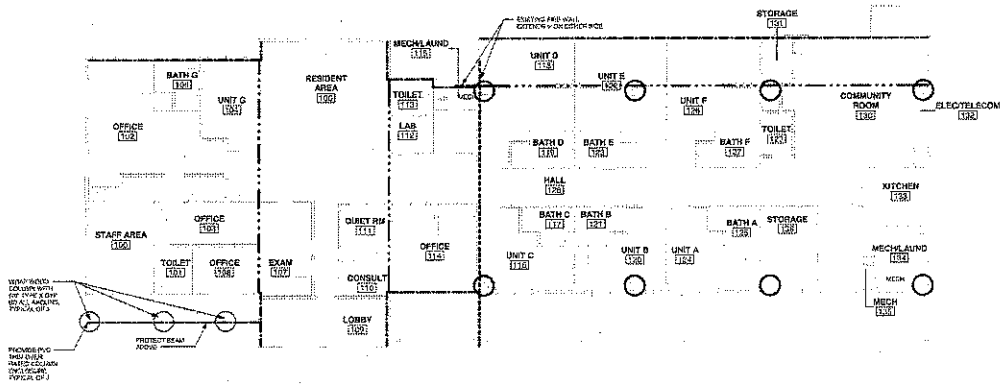
DELPHI HEALTH GROUP

817 S. CAMP MEADE RD
LINTHICUM, MD

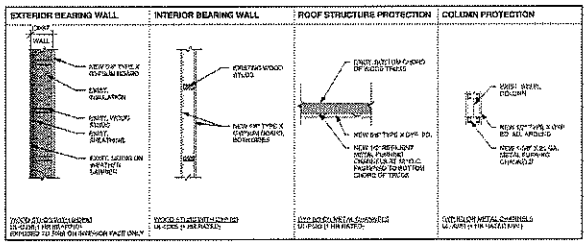
RPH ARCHITECTURE

ENLARGED PLANS

A-1.1



1 FIRST FLOOR PLAN
1/8" = 1'-0"



RPH ARCHITECTURE

DELPHI HEALTH GROUP
817 S. CAMP MEADE RD
LINTHICUM, MD

NO.	DESCRIPTION	DATE

DATE 3/21/18

SUBMISSION SET

FIRE RATING PLAN AND DETAILS

A-1.2

PROJECT # 15043

APX #4-4