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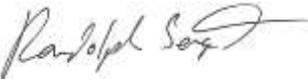
MARYLAND HEALTH CARE COMMISSION

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MEMORANDUM

TO: Commissioners

314 Grove Neck Road OPCO L.L.C
Ashley, Inc. d/b/a Ashley Addiction Treatment
Anne Arundel General Treatment Services, Inc. d/b/a Pathways

FROM: Randolph S. Sergent 
Commissioner/Reviewer

RE: Recommended Decision
Application for Certificate of Need
314 Grove Neck Road OPCO L.L.C
(Recovery Centers of America-Earleville)
Docket No. 15-07-2363

DATE: December 2, 2016

Enclosed is my Recommended Decision in my review of a Certificate of Need (“CON”) application by 314 Grove Neck Road OPCO L.L.C. to develop an intermediate care facility for the treatment of alcoholism and drug abuse on a 530-acre site in Earleville, in Cecil County. The applicant is owned by Recovery Centers of America Holdings LLC (“RCA”). I refer to this proposed project and the applicant as “RCA-Earleville.” RCA is a new entrant into addiction treatment services, and has two other pending CON applications in Maryland. I intend to have recommendations on the other two applications for consideration by the Commission at the January 2017 meeting.

Over a lengthy review process culminating in the applicant’s October 2016 modified application filed in response to a September 20, 2016 project status conference, the applicant ultimately submitted a proposal that complies with applicable standards in the State Health Plan for Facilities and Services (“State Health Plan”) and CON review criteria. Having considered the record in this review, I recommend that the Commission **APPROVE** the application for this project, as modified, with conditions.

Interested Parties

The interested parties in this review are Ashley, Inc. d/b/a Ashley Addiction Treatment, previously known as Father Martin's Ashley, ("Ashley") and Anne Arundel General Treatment Services, Inc. d/b/a Pathways ("Pathways").

Background

The CON application for this project was initially filed on March 27, 2015. A first modified application was filed on May 18, 2015. On July 15, 2015 RCA-Earleville requested a determination that it could proceed with the part of its planned project that is not regulated under CON.¹ MHCC staff issued a determination of non-coverage by Certificate of Need review on August 3, 2015 confirming that RCA could proceed with that part of the project. The modified application was docketed on October 16, 2015. Ashley and Pathways filed comments seeking interested party status, which I granted. Subsequently, the applicant filed a letter seeking to modify the project to change the number of beds, and, on December 21, 2015, filed a Corrected Modified Application. On June 15, 2016, the applicant filed notice that the cost of the project would be increasing due to design changes necessary to comply with fire codes. This increase necessitated RCA-Earleville's updating its application to reflect the increased cost, and it submitted revised information on July 28, 2016. RCA-Earleville subsequently requested that I hold a project status conference regarding the cost increase.

Project Description

After accounting for the changes to the plan and modifications to its application, RCA-Earleville seeks CON approval for a facility that will accommodate 21 beds classified as American Society of Addiction Medicine ("ASAM") Level III.7D – Medically Monitored Inpatient Detoxification). Only detoxification and treatment services provided at the "inpatient" level of care are regulated as ICF services. Thus, only the 21-bed detoxification beds require CON review and approval. As previously noted, it received a determination of non-coverage for 87 Level III.5 – Clinically Managed High-Intensity Residential Treatment beds that do not require CON approval that are part of the facility. RCA began operation of the residential beds at the Earleville site on October 5, 2016.

The total project cost estimate is \$32,581,335, with \$5,595,384 of that total estimated as the cost of the CON-regulated detoxification beds. Project costs are anticipated to come from equity funding of \$4,561,387 and a mortgage loan of \$28,019,948. Deerfield Management Company is identified as providing the senior debt for the entire project.

Project Status Conference and Modification in Response to Status Conference

¹ Commission staff had previously determined: that the State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services (COMAR 10.24.14) only regulates beds classified as Level III.7 and III.7D (detox); and that beds certified as III.5 (residential treatment) are not regulated under the Chapter. It is the inclusion of the 21 Level III.7D beds at RCA-Earleville that requires a CON for this project.

Because of changes that RCA was making to the other two RCA projects under review and RCA-Earleville's request that I hold a project status conference regarding this project, I held a project status conference on September 20, 2016. At the project status conference, I addressed certain issues, including those that stood in the way of my making a positive recommendation on this project and the two other RCA projects.

At the project status conference, I noted that COMAR 10.24.14.05D, the standard regarding provision of care to indigent and gray area patients, requires an applicant to commit that it will provide 15 percent or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients. The applicant had proposed providing both Level III.7D (detox) and III.5 (residential treatment) care to indigent or gray area patients in order to provide the entire regimen of care, which I found to be a valuable and holistic approach. RCA proposed measuring the gray area commitment as a proportion of the net revenue associated with total detox patient days (i.e., for the Level III.7-D patient beds for which CON approval is sought), rather than as a proportion of total bed days. I agreed to this approach.

I requested that RCA submit an updated project description, drawings, as well as updated financial and other tables in the application. I also pointed out RCA-Earleville's lack of compliance with COMAR 10.24.14.05J regarding documented transfer and referral agreements with agencies or facilities that have capabilities for managing cases that "exceed, extend, or complement" the applicant's capabilities. I instructed the applicant to correct this deficiency.

At the project status conference, I pointed out that RCA-Earleville must comply with COMAR 10.24.14.05K, which requires an applicant to document agreements with referral sources to assure that it will provide the percentage of care to indigent and gray area populations required by Regulation .05D, discussed above. While the applicant stated in its December 2015 second modified application that it "fully expects to engage in relationships with organizations that will refer patients in need of charity care," no such agreements had been produced.

The modifications submitted by RCA-Earleville on October 7, 2016 remedied each of the shortcomings of its earlier modified application.

Review Criteria and Standards

My recommendation that the Commission approve, with conditions, RCA-Earleville's application, as recently modified, is based on my findings that the proposed project is consistent with applicable State Health Plan standards and with Certificate of Need review criteria. The applicant has demonstrated that the project is needed, based on the bed need analysis in the State Health Plan Chapter for Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services. RCA-Earleville has shown that its project is a viable and cost-effective alternative for meeting that need.

In addition, I conclude that the facility's impact on existing providers will not be overly adverse or beyond the scope of what can be expected to occur in a normally competitive market. The proposed project is a "Track One" facility that is predominantly aimed at serving insured or

private paying consumers. Competition is to be expected and encouraged in such a situation. The primary impact of this project will be positive because it will improve access to this type of inpatient treatment, including more availability and accessibility for the lower income population. There is a growing consensus that additional resources are needed to battle substance abuse and addiction, which has emerged as a critical public health issue in recent years because of the sharp increase in drug overdose deaths that have occurred in Maryland and throughout the nation.

Review Schedule and Further Proceedings.

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on December 15, 2016, beginning at 1:00 p.m. at 4160 Patterson Avenue in Baltimore. The Commission will issue a final decision based on the record of the proceeding. As provided under COMAR 10.24.01.09B, the applicant and interested parties may submit written exceptions to the enclosed Recommended Decision. As noted below, exceptions must be filed no later than 2:00 p.m. on December 9, 2016. Written exceptions must specifically identify those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. Responses to exceptions must be filed no later than 2:00 p.m. on Monday, December 12, 2016. Copies of exceptions and responses must be sent in pdf format by email to the MHCC and all parties by these deadlines. The interested parties must also file 30 copies of written exceptions by noon of the business day following the deadline. The applicant must file 30 copies of its responses to exceptions by 4:00 p.m. on the date responses to exceptions are due.

In its November 29, 2016 letter, RCA stated its willingness to waive the five-day response period provided in Commission regulations if that would enable this matter to be considered by the Commission at its December 15, 2016 meeting. If the time frame given in this memorandum is not acceptable to RCA, it should notify all parties by email by 5:00 p.m. today, and this matter will be placed on the Commission's January 2017 agenda, with revised time frames for the filing of exceptions and RCA's response to exceptions.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes per interested party and 15 minutes for the applicant, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and response is as follows:

Submission of exceptions	December 9, 2016 No later than 2:00 p.m.
Submission of response	December 12, 2016 No later than 2:00 p.m.
Exceptions hearing	December 15, 2016 1:00 p.m.

IN THE MATTER OF
314 GROVE NECK ROAD
OPCO LLC

*** BEFORE THE**
*** MARYLAND HEALTH**
*** CARE COMMISSION**

Docket No. 15-07-2363

Reviewer's Recommended Decision

(Released December 2, 2016)

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I. INTRODUCTION

A. The applicant

The applicant in this matter is 314 Grove Neck Road OPCO LLC. The owner of the facility is 314 Grove Neck Road LLC. Both of these entities are owned by Recovery Centers of America Holdings LLC (“RCA”). RCA will provide corporate administrative staff, policies, and funding for both implementation and ongoing operations.. RCA will be the operator of the facility, under an arrangement with the applicant, the proposed licensee. (DI #44, p. 7).¹ The applicant states that the facility will be known as Recovery Centers of America Grove Neck Road Facility (RCA-related entities in this application are referred to collectively herein as “RCA-Earleville”).

The application states that RCA is a privately held company that will provide services for individuals with substance use disorder and their families. RCA states that members of its Executive Team represent an average of 22 years of experience in managing facilities and having expertise in the fields of Residential and Outpatient Treatment Facilities, Acute Care Hospitals, Behavioral Health Services, Academic Research, and Governmental Drug Policy Initiatives.

RCA is a new entrant into the addiction treatment market. It has two other projects under review in Maryland, in Upper Marlboro (Prince George’s County) and in Waldorf (Charles County). RCA also has treatment centers that are either operating or soon will be in: Westminster, Massachusetts; Danvers, Massachusetts; Blackwood, New Jersey; Mays Landing, New Jersey; and Paoli, Pennsylvania.

RCA states that it has developed a continuum of care model that is tailored to the needs of each patient and family situation, and espouses a mission to provide “world class treatment with immediate solutions and a commitment to supporting lifelong recovery.” (DI #44, p. 8).

The home page of RCA’s website (<http://www.recoverycentersofamerica.com/>) makes the following statement about its vision and approach to service delivery:

RCA’s unique, full-service **Neighborhood Model** sets it apart from all other treatment programs and facilities. RCA is pioneering a comprehensive, full-service treatment system across multiple levels of care closer to home. RCA’s network of neighborhood-based Recovery Campuses will become beacons of learning and change within the communities they serve. They will be centers of sobriety, treatment, spiritual life and healthy sober living for both individuals and families in recovery.

¹ See App. 2 for an organization/ownership chart for the RCA-Earleville facility and the roles of the involved entities. (DI #44, Exh. 3).

B. The Project

The applicant proposes to establish an exclusively inpatient alcohol and drug abuse treatment facility in Earleville, Cecil County, Maryland in a renovated manor house that sits on approximately 530 acres and has more than a mile of water frontage on Chesapeake Bay. The proposed project will include 21 detoxification/assessment beds that are regulated by Certificate of Need. RCA-Earleville expects to license the 21 beds as American Society of Addiction Medicine (“ASAM”) level III.7D – Medically Monitored Inpatient Detoxification (“detox”). The project will also feature 87 residential beds that the applicant expects to license as ASAM level III.5 – Clinically Managed High-Intensity Residential Treatment that are not subject to CON review.

Patients in the detox program proposed by RCA-Earleville will undergo a comprehensive medical and psychosocial evaluation and will receive detoxification services, including medications, to ensure a medically safe withdrawal. Patients will be closely monitored 24 hours a day by medical and nursing staff. Patients in the residential program will receive intensive, structured, multi-disciplinary treatment 24 hours a day provided by clinical, nursing, and medical staff. The diagram that follows illustrates a continuum of various levels of care within addiction medicine.



Source: The ASAM Criteria - American Society of Addiction Medicine
<http://asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>

Because it’s planned Level III-5 residential treatment beds do not require CON approval, the applicant requested and was granted determination of non-coverage by CON review in the summer of 2015 to proceed with its plans to renovate the Manor House to contain residential beds and to open a residential treatment facility while awaiting CON approval for the detox/assessment beds. The applicant has identified this work as Phase I of its project.

RCA-Earleville reports having renovated the Manor House to accommodate 31 residential beds, and has also added a terrace addition of eight residential beds. Phase I opened on October 5, 2016 with these 39 residential treatment beds. The applicant has stated that, prior to Commission action on its CON application, it will accept patients who require and have received detox level care elsewhere. Even after the facility opens its detox/assessment beds with CON approval, the applicant will continue to accept patients into its residential program who utilize detox services at elsewhere, or those who require only residential level of care. (DI #44, p.7).

If RCA receives CON approval for its detox beds, it plans to add a two-story addition to the Manor House that will hold a 21-bed detox unit (first floor) and 48 more residential treatment beds (a 20-bed unit on the first floor and a 2- bed unit on the second floor). Construction on the addition will begin immediately once the CON is approved and all permits are received, and is anticipated to take eight months (Phase II).

RCA has also renovated structures other than the Manor House to support its residential treatment facility during Phase I. Two gatehouses at the entrance to the Manor House area are renovated to house admissions, family programming, and meeting space. Two of three freestanding buildings ranging from 6,000-10,000 square feet, the “car barns,” have been renovated. One will include a gymnasium and fitness center, while the other will hold two offices for the personal trainer and recreation/adventure staff. The bulk of that building will house the new water treatment plant. The total square footage of affected by the proposed project, including both the Manor House and additional structures, is 76,695. (DI #71).

The total project cost is estimated at \$32,581,335, with \$5,595,384 as the estimated cost allocated for the CON-regulated detox beds. The application lists “equity funding” of \$4,561,387 and a mortgage of \$28,019,948 as the source of funds, and states that Deerfield Management Company will provide the senior debt for the entire transaction. (DI #44, p. 57). In the applicant’s modification responding to a project status conference held on September 20, 2016, RCA-Earleville attached a letter from Deerfield in which it reiterated its financing support for the project – as well as two other RCA ventures in Maryland. (DI #69, Exh. 44).

Table I-1, which follows, details the Project Budget.

Table I-1: Project Budget			
	Detox	Residential	Total
USE OF FUNDS			
CAPITAL COSTS			
Land Purchase	\$1,477,778	\$6,122,222	\$7,600,000
New Construction			
Building	\$1,287,825	3,863,475	5,161,300
Site and Infrastructure	\$588,131	2,404,901	2,993,032
Architect/Engineering Fees	\$17,465	53,302	70,767
Permits	\$12,305	\$37,552	\$49,857
Subtotal	\$1,905,726	6,359,230	\$8,264,956
Renovations			
Building		\$7,403,144	\$7,403,144
Architect/Engineering Fees		\$73,378	\$73,378
Permits (Building, Utilities, Etc.)		\$51,696	\$51,696
Subtotal	\$0	\$7,528,218	\$7,528,218
Other Capital Costs			
Movable Equipment	\$184,800	\$2,010,638	\$2,195,438
Contingency Allowance	\$167,798	\$587,159	\$754,957
Gross interest during construction period	\$0	\$0	\$0
Legal Fees	\$107,143	\$142,857	\$250,000
Property Due Diligence	\$21,429	\$28,571	\$50,000
Subtotal	\$481,170	\$2,769,225	\$3,250,395
Total Capital Costs	\$3,864,674	\$22,778,895	\$26,643,569
FINANCING COST AND OTHER CASH REQUIREMENTS			
Transaction Costs	\$754,424	\$2,210,204	\$2,964,628
Acquisition Costs	\$162,857	\$217,143	\$380,000
Due Diligence Costs	\$64,286	\$85,714	\$150,000
Subtotal	\$981,567	\$2,513,061	\$3,494,628
Working Capital Startup Costs	\$749,143	\$1,693,995	\$2,443,138
Total Uses of Funds	\$5,595,384	\$26,985,951	\$32,581,335
Sources of Funds			
Equity funding	\$783,354	\$3,778,033	\$4,561,387
Mortgage	\$4,812,030	\$23,207,918	\$28,019,948
Total Sources of Funds	\$5,595,384	\$26,985,951	\$32,581,335

Source: DI #69, Table E.

C. Summary of Reviewer's Recommendation

I recommend that the Maryland Health Care Commission approve this project because additional resources are needed to battle the epidemic of substance abuse that has invaded our society in Maryland and the nation. Through a long review process, RCA-Earleville has submitted a proposal that complies with the applicable State Health Plan standards. It has also demonstrated that the project is needed, that it is a cost-effective alternative, and that it is viable. In addition, I believe that its impact on existing providers will not be overly negative, especially in the longer term, while it will have a positive impact on consumers' access to services, especially the population that will benefit from the required charity care that will be offered. I summarize my key findings below.

Need and Capacity

Using the bed need formula in the State Health Plan chapter, I found that the need for additional beds to serve Eastern Shore residents exceeds the number of beds proposed by the applicant. In addition, the findings of the Heroin & Opioid Emergency Task Force chaired by Lieutenant Governor Boyd Rutherford were compelling, even if somewhat anecdotal.

Costs and Effectiveness

The question I considered in this criterion is 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. I found that the applicant has met this criterion by showing that need surpasses the capacity of existing providers. Further, I am satisfied that the applicant would provide services at a cost comparable to that of other providers.

Financial Feasibility and Viability

RCA-Earleville has demonstrated that the resources to launch this project are available, and in fact has already begun accepting patients to the levels of service that do not require regulatory approval. And despite the shortage of qualified addictions treatment specialists, RCA appears to have committed significant resources to this challenge and put together a robust recruitment operation. The applicant's ability to sustain the project will depend on its ability to fill its facility and obtain the reimbursement rates that it has projected. My need analysis indicates that need exists for the detox beds being proposed. The ICF Chapter does not offer guidance on projecting need for the residential treatment beds. Reaching target occupancies for both the detox and residential beds will depend on the applicant's ability to cultivate referral sources and a positive reputation.

Impact on Other Providers and the Health Care System

After careful analysis of the need for these services and the capabilities of existing providers to meet that need I find that approval of this application will not have an unduly detrimental impact on existing health care providers, and that it will improve geographic and demographic access to services.

Thus I recommend approval with conditions requiring the applicant – prior to First Use Approval – related to Joint Commission accreditation, provide executed transfer and referral agreements with all categories of providers mentioned at COMAR 10.24.14.05J, and document additional referral agreements with sources likely to refer indigent or gray area populations for treatment at RCA-Earleville, consistent with COMAR 10.24.14.05K. 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

Tari Moore, County Executive for Cecil County, Maryland, wrote a letter in support of the RCA-Earleville project in March of 2015. Clifford I. Houston, Cecil County Zoning Administrator, conveyed the November 25, 2014 Cecil County Board of Appeals' approval of a special exception to operate RCA's facility on its proposed site to Dr. Deni Carise in March of 2015. (DI #44, Exh. 26).

John Bennett, Chair of the Cecil County Drug and Alcohol Abuse Council, submitted a letter in support of the application and requested that the Commission require that the applicant dedicate two beds as "charity care" beds available only to Cecil County residents. (DI #47). Daniel Coulter, MPH, and Jean-Marie Donahoo, MPH, co-chairs of the Cecil County Community Health Advisory Committee, also wrote a letter in support of the modified application and made a similar request that the Commission require that the applicant dedicate two beds as "charity care" beds available only to Cecil County residents. (DI #49). On behalf of the Town of Cecilton, Mayor Joseph A. Zang, III wrote a letter supporting the modified application and also requested that the Commission require that the applicant dedicate two beds as "charity care" beds available only to Cecil County residents. (DI #52).

C. Interested Parties in the Review

I recognized two Maryland providers of alcohol and drug treatment facilities as interested parties in this review. They are Ashley, Inc. d/b/a Ashley Addiction Treatment (previously d/b/a Father Martin's Ashley) ("Ashley")² and Anne Arundel General Treatment Services, Inc. d/b/a Pathways ("Pathways"), a subsidiary of Anne Arundel Medical Center. Pathways is a not-for-profit alcohol and drug treatment center with 40 beds (32 adult and eight adolescent) located in Annapolis, Maryland. Pathways is licensed to provide ASAM level III.7D -- Medically Monitored Inpatient Detoxification, and ASAM level III.7 -- Medically Monitored Intensive Inpatient Treatment, among other levels of care. Ashley is a not-for-profit intermediate care

² At the time of its recognition as an interested party in this review Ashley, Inc. was doing business as Father Martin's Ashley. It has since changed its d/b/a name to Ashley Addiction Treatment. (DI #67).

facility offering the care and treatment of patients with alcoholism and drug addiction located in Havre de Grace in Harford County. Ashley is licensed to provide three levels of care: clinically managed high-intensity residential treatment, medically monitored intensive inpatient treatment, and medically monitored intensive inpatient treatment-detoxification.

The interested parties have filed comments on the application challenging the RCA-Earleville's need forecasts, financial viability, commitment to meeting the "gray area" requirements in the State Health Plan for Facilities and Services ("SHP"), and the applicant's assessment of impact on existing providers.

D. Community Support

Jennifer Tuerke wrote a letter in support of the modified application on behalf of Voices of Hope for Cecil County (an advocacy and outreach group for addicts, their families and friends) and also requested that the Commission require that the applicant dedicate two beds as "charity care" beds available only to Cecil County residents. (DI #53).

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" or "Chapter"). This Chapter, at Regulation .05, includes the following sixteen Certificate 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.

Applicant's Response

The applicant states that this standard is not applicable. (DI #44, p 25).

Reviewer's Analysis and Findings

The applicant has applied for 21 detox treatment beds subject to review in this matter and 87 residential beds for a total of 108 ICF beds. I find that the applicant is consistent with 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*.

Applicant's Response

RCA-Earleville cited statistics from a variety of sources and news accounts in supporting its position that “[t]housands of Maryland residents who are suffering from addiction need treatment today,” and that “Maryland’s existing portfolio of treatment facilities cannot begin to solve this problem.” See Appendix 3 for a sampling of statistics taken from the 2013 National Survey on Drug Use and Health, and an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).³ (DI #44, p.26). The applicant also pointed out that the Staff Report resulting in the most recently approved CON for ICF bed expansion (at Ashley), dated September 20, 2013, identified need for 107 to 152 private ICF beds for the Central Maryland Region alone.

As required by this standard, the applicant projected bed need by modifying the projection methodology outlined in COMAR 10.24.14.07B(7). These projections show a need for 10 to 51 new treatment beds to serve the Eastern Shore by 2019 and an additional 307 to 419 beds to serve portions of the Maryland population beyond the Eastern Shore that RCA anticipates serving, (DI #44, pp. 35, 39).

RCA defined its service area as going well beyond the Eastern Shore to include the area within a 90-mile radius of the proposed facility and also to include clusters of large populations areas bordering on this 90-mile radius extending the service area to 110 miles in some places. The result is a service area encompassing: the entire Delmarva Peninsula; to the east including Atlantic City, New Jersey; to the north beyond Trenton, New Jersey and Allentown and Harrisburg, Pennsylvania; to the west beyond Frederick, Maryland; and to the south beyond

³ The survey is available at:

<http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>.

Fredericksburg, Virginia. RCA used population data from the Maryland Department of Planning and the Environmental Systems Research Institute, Inc. (“ESRI”) to estimate 2014 population and project the 2019 populations aged 18 years and older for its defined service area, for the entire State of Maryland within this service area, and the Eastern Shore region. RCA then adjusted these populations to arrive at an estimate for the privately insured population.⁴ (DI #44, pp. 27-28, 32-33).

RCA estimates that six of the 21 detox beds will serve Maryland residents and 15 beds will serve residents of other states and the District of Columbia. It arrived at this conclusion because the Maryland portion of its expected service area (4,584,056) is 28% of its entire service area (16,470,407). RCA allocated the 21 beds accordingly, resulting in an expectation that six of the 21 beds would typically be occupied by Marylanders. (DI #44, p. 36).

Interested Party Comments

Ashley

Ashley states that the modified application is not currently approvable because it has failed to justify that the 21 beds proposed will be needed to provide subacute detox services. Ashley asserts that a more realistic projection would show a need for seven detox beds. Ashley bases its calculation on a shorter length of stay in detox (four days) than the 14 days RCA projects. Ashley states that RCA’s average length of stay assumption is inconsistent with the State Health Plan Intermediate Care Private Bed Need Average Length of Stay standard found at COMAR 10.24.14.07B(7)(g), and inconsistent with the actual number of subacute detox days of care provided at Ashley. (DI # 51, p. 5).

Ashley raises concern about what it characterizes as the changing and unfounded estimates made by RCA with respect to the percentage of beds used by existing providers for detox. It points out that this estimate has ranged from 15% to the latest estimate of 41%. Ashley states that it had provided a precise accounting of the number of its beds that are used for detox, 17 out of a total of 100. In conclusion, Ashley states, that the changing inventory of detox beds RCA has provided is not based on reasonable assumptions and should be disregarded with respect to the need for the 108-bed Earleville treatment center. (DI #51, pp. 5-8).

Pathways

Pathways states that RCA’s need projection methodology fails to comply with the SHP methodology. Pathways maintains that RCA applied the prevalence rates set forth in the ICF Chapter against the commercially insured population instead of the overall population as called for in the Chapter’s methodology. Pathways also states that RCA-Earleville incorrectly reduced the count of the existing ICF beds in the Eastern Shore region by reducing the inventory of “true” detox beds at Hudson Center and Warrick Manor from 75 beds to 31 beds, thereby showing greater need for the applicant’s 21 detox beds. Pathways states that this adjustment is

⁴ The ICF Chapter’s methodology adjusts service area population to deduct for the indigent population, which is defined as persons who qualify for services under the Maryland Medical Assistance Program regardless of whether the program will reimburse the facility for alcohol and drug abuse treatment.

inconsistent with the SHP's methodology that only subtracts the number of funded beds from the inventory. Pathways points out that the Commission most recently applied this methodology in its 2013 decision on the Ashley's CON application (Docket No. 13-12-2340) (the "Ashley Decision"), in which the total number of beds in the inventory were calculated by excluding only funded beds. Pathways' recalculation of RCA's projection for the Eastern Shore based on the 75-bed inventory shows a surplus of 34 beds at minimum need and a maximum need for seven beds. (DI #33, pp. 8-10; DI #50, pp. 3-5).

Pathways states that RCA made the same inconsistent adjustment to the statewide inventory in its projection of statewide bed need. Specifically, Pathways cites RCA's failure to account for any of Pathways' 32 adult ICF beds, all of which are licensed detox beds (ASAM Level III, 7D and Medically Monitored Intensive Inpatient Treatment, ASAM level III.7) and which Pathways states are not funded. Pathways maintains that the correction of the inventory results in a projected statewide need of 140 to 252 beds using RCA's methodology and correcting for RCA's undercounting of existing inventory. (DI #33 pp. 3 and 9-10 and DI #50 pp. 4-5).

Pathways states that RCA's accounting for out-of-state utilization is not consistent with the Chapter's methodology, which treats such utilization by excluding out-of-state discharges in the base year. (DI #33, p. 12). Pathways further challenges the appropriateness of RCA's estimate that just six of the Earleville detox beds would be used by Maryland residents, stating that there is no basis in the Chapter to approve more ICF beds than projected by the need methodology based on the applicant's suggestion that it will not use the excess beds for Maryland residents. (DI #50, p. 5). Further, Pathways contends that the beds sought by RCA to serve out-of-state residents (15 of the 21 beds) would not be restricted to non-Marylanders and that RCA has not demonstrated the out-of-state demand for those beds. (DI # 33, p. 12).

Finally, Pathways states that RCA does not currently operate any ICFs and, therefore, has no experience or data of its own from which to predict it will actually attract patients from other states. Pathways notes that, while RCA provided a list of providers in other states, it provided no information to demonstrate that these facilities are not meeting the needs of the residents of those states. (DI #50, p. 6).

Applicant's Response to Comments

RCA-Earleville states that the interested parties "have not advanced any persuasive reason to disregard Applicant's bed need analysis, which demonstrates a need for far more beds in the Eastern Shore Region than Applicant seeks to establish." (DI #54, p. 7). RCA-Earleville goes on to state that both interested parties' attempts to discredit its projections based on the application of the 41% ratio of ICF to residential beds is contradictory because applying a lower ratio would result in a projection of greater need. Conversely, counting all existing beds as ICF beds at facilities that provide both ICF and residential care would underestimate the need for ICF care because such beds at some facilities are used for different levels of care at different times (DI #37 pp.8-9; DI #54, p. 8).

Regarding Pathways' comments on the proportion of the beds that will serve Maryland residents (six of 21), RCA-Earleville points out that it projects sufficient need on the Eastern Shore to support the proposed 21 ICF beds, notwithstanding the probability that many patients will be out-of-state residents. RCA also notes that information on the use of existing beds by out-of-state residents is not publicly available. (DI #54, p. 10).

Reviewer's Analysis and Findings

This standard specifically relates to the need for the number of ICF beds proposed at Track One facilities, i.e., facilities whose admissions are primarily privately funded. RCA-Earleville prepared its own bed need projection that modified the methodology in the Chapter. The applicant's projection for the Eastern Shore region and portions of the state beyond the Eastern Shore that it expects to serve, generally following the methodology set forth in the ICF Chapter. Its projection for the Eastern Shore region showed a need for from 10 to 51 additional beds.

As Pathways noted, RCA's bed need projections are not completely consistent with the methodology set forth in the ICF Chapter. Specifically, Pathways is correct that RCA's adjustment of service area populations to account for only the privately insured population varies from the approach prescribed by the SHP methodology, which instead calls for adjusting the service area population to exclude the population that receives Medicaid from the need projection for Track One programs.

While I understand why RCA adjusted the population to reflect its target market (privately insured individuals), it is not consistent with the Chapter's need methodology and it is not consistent with standard .05D that contemplates that Track One programs will provide a percentage of service to indigent and gray area patients. Practically speaking, however, the ICF Chapter's methodology results in a higher base population than RCA's methodology of including only those with private insurance and would project a higher bed need than the approach taken by RCA.

The applicant and Ashley also disagree on the appropriate average length of stay to assume in making the projections. While RCA assumes a 14-day length of stay, Ashley reports that its average length of stay for the detoxification stage of treatment is four days. However, it is important to recognize that the Commission has determined that the definition of intermediate care facilities corresponds to the subacute inpatient level of care and services in the American Society of Addiction Medicine's Patient Placement Criteria. This would include Level III.7, medically-monitored intensive inpatient treatment, and Level III.7-D, medically-monitored inpatient detoxification services. Therefore, while RCA's use of a 14-day average length of stay,⁵ may be too long for the purely medical detoxification stage of treatment as pointed out by Ashley, it certainly is not too long for the combination of detox and medically monitored intensive inpatient treatment and the Chapter provides no bright-line distinction between these two "types" of care within the same "level" of care. Moreover, the 14-day average length stay is specified for adults in the SHP bed need methodology.

⁵ Use of a 14-day average length of stay is specified in the SHP bed need methodology.

The applicant and both interested parties disagree over the existing inventory of Track One beds. RCA calculated the number of existing beds by identifying the number of beds at each identified Track One facility and assumed that 41% of those beds would be classified as detox beds. Ashley states that this percentage is too high based on its own experience. Again, the ICF Chapter's bed need projection methodology at the heart of this standard does not make the type of distinction being argued here by RCA and Ashley is not meaningful in evaluating compliance of the project with this standard.

I agree with Pathways' that it is not appropriate to make an across-the-board assumption that 41% of all facilities' beds are detox beds when attempting to determine the existing regulated ICF bed inventory. While RCA is correct that counting all beds in alcohol and drug treatment facilities as available to meet the needs of patients for levels III.7D and III.7 care would underestimate the need, it is critical to know the level of inpatient care provided at each location and how each provider uses its beds before making any adjustment. In this regard, my research supports Pathways in its statement that all 75 beds at Hudson Center and Warwick Manor should be counted in the inventory. The only inpatient levels of care provided by Warwick Manor and Hudson Center are levels III.7 and III.7D. Therefore, all of its 75 beds should be included in the inventory. I oversaw MHCC staff's preparation of updated projections for the Eastern Shore and other regions, including a statewide projection.

The updated projected bed need for the Eastern Shore Region as of 2020 adjusted the population projections by subtracting the Medicaid population, resulting in an existing Track One inventory of 75 beds. Table III-1, below, compares this projection to those prepared by the applicant and also reflects a difference in the total projected population age 18 and older, which is attributable to using differing sources for population projections.

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

	RCA Projected 2019	MHCC Projected 2020
Projected Population for 18 years and older⁽¹⁾	418,847	386,194
RCA Estimate of the Number of Privately Insured (64.2% of Total)	268,900	
Indigent Population- Eastern Shore⁽²⁾		50,504
(a) Target Market Population (For RCA-Privately Insured; For MHCC-Non-Indigent Population)	268,900	335,690
(b) Estimated Number of Substance Abusers (a*8.64%⁽³⁾)	23,233	29,004
(c1) Estimated Annual Target Population (b*25%)	5,808	7,251
(c2) Estimated Number Requiring Treatment (c1*95%)	5,518	6,888
(d) Estimated Population requiring ICF (15%-30%)		
(d1) Minimum (c2*0.15)	828	1,033
(d2) Maximum (c2*0.30)	1,655	2,066
(e) Estimated Range requiring Readmission (10%)		
(e1) Minimum (d1*0.1)	83	103
(e2) Maximum (d2*0.1)	166	207
Total Discharges from out-of-state	N/A	N/A
(f) Range of Adults Requiring ICF Care		
Minimum (d1+e1+out of state)	910	1,137
Maximum (d2+e2+out of state)	,1821	2,273
(g) Gross Number of Adult ICF Beds Needed		
(g1) Minimum = ((f*14 ALOS)/365)/0.85	41	51
(g2) Maximum = ((f*14 ALOS)/365)/0.85	82	103
(h) Existing Track One Inventory ICF beds⁽⁴⁾	31	75
(i) Net Private ICF Bed Need		
Minimum (g1-h)	10	-24
Maximum (g2-h)	51	28

Sources: RCA projections as set forth in December 21, 2015 Corrected Modified Application (DI #44, p. 35).

⁽¹⁾ Population projections –RCA population projections based on ESRI data; MHCC projections 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⁾ ICF beds at Hudson Center and Warwick Manor – For RCA as set forth in December 21, 2015 Corrected Modified Application (DI #44, p.37); For MHCC from MHCC records including 200 inventory in SHP chapter and Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) from Behavioral Health Administration, DHMH Resource Directory as of August 2016.

As shown in Table III-1, above, RCA’s proposal for 21 ICF beds is at the high end of the projected need for the Eastern Shore Region. Pathways arrived at its projection of a bed need range of minus 34 to plus 7 by correcting the inventory of existing beds, but did not correct the projections for RCA’s inconsistent use of only the privately insured population instead of the correct use of the non-indigent population.

In addition to addressing the need for beds at the maximum range for the Eastern Shore, RCA-Earleville expects that its proposed facility will serve a large portion of the rest of Maryland and the state of Delaware as well as portions of Virginia, Pennsylvania, and New Jersey. While Pathways is correct that there is no vehicle to limit Marylanders' use or to reserve a proportion of the beds for out-of-state clients and that there is no basis in the Chapter upon which to approve more ICF beds than projected by the need methodology, the methodology does include a specific step to account for out-of-state discharges. Unfortunately, this data is not readily available for existing facilities and RCA did not include this step in its projections. Instead of including this step in its methodology, RCA projected that only a small portion of the beds would be used by Maryland residents. While I find that RCA-Earleville's method of estimating the number of beds that will serve Maryland residents – which is simply based on the proportion of Marylanders to their total projected service area population (27.6%) – is overly simplistic, it is reasonable to expect that the proposed facility will serve Maryland populations beyond the Eastern Shore, as well as from other states.

I am doubtful about the accuracy of the small percentage of beds that RCA-Earleville projects will be used by Maryland residents. As Pathways points out, RCA has no track record to support such a projection. To better understand this, I looked at the experience of Ashley, a facility that I conclude is somewhat similar to what RCA envisions for Earleville. At the time the Commission considered Ashley's application (Docket #13-12-2340) to expand and modernize Ashley reported that, in FY2013, 26% of its patients originated from the Central Maryland region and 48% from the State as a whole. If RCA-Earleville is as successful as Ashley in attracting patients from beyond its region and the State of Maryland, an average of five-to-six ICF beds would be used for residents of the Eastern Shore Region and ten of the 21 beds would be used by residents of Maryland. The five-to-six beds that would be used for Eastern Shore residents are well within the maximum projected need for 28 additional beds by 2020 for the region and the total of ten that would be used by residents of the State would only make a small dent in the ICF bed need for the State, which I have projected to be a minimum of 349 and a maximum of 503.

In summary, I find that the projected maximum need for additional beds to serve Eastern Shore residents is greater than the number of beds proposed by the applicant. Furthermore, I find that it is inevitable that the proposed facility will serve residents beyond the Eastern Shore region. My projected statewide need for additional beds *at the minimum range* is more than 16 times greater than the number of beds proposed at Earleville and more than double the total number of ICF comparable beds proposed for the three RCA facilities.

Therefore, I find that RCA-Earleville's proposal to construct and operate 21 ICF beds at Earleville 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.

RCA-Earleville states that its proposed facility will utilize a sliding fee scale for gray area patients, as shown below. The percentages shown represent the discount from the standard billing rate that is charged to insurance carriers for each service. (DI #44, Ex. 12).

<100% of Federal Poverty Level	75%
<150% but >100% of Federal Poverty Level	50%
<200% but >150% of Federal Poverty Level	25%

Reviewer’s Analysis and Findings

I find that the applicant’s policy is consistent with this standard.

D. 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 or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.**

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse treatment to indigent or gray area patients in its health planning region.

(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).

(4) An existing Track One intermediate care facility that seeks to increase beds shall provide information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, or gray area patients, including publicly-funded patients.

Introduction

The purpose of this standard is to require an applicant for new or expanded Track One ICFs to serve a minimum percentage of indigent and gray area patients. The standard does this

by requiring an applicant to establish a sliding fee scale for gray area patients consistent with the patient's ability to pay and by requiring that the applicant 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. It also allows an applicant 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.

At the September 20, 2016 Project Status Conference, I instructed RCA that, in its pending applications, each applicant must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is sought). (DI #66). The reasons for this instruction are set out in my analysis below. In reaching my conclusion, I was guided by MHCC staff's August 3, 2015 determination that intermediate care facility beds that require CON approval are those alcohol and drug abuse treatment beds that deliver Level III.7, medically-monitored intensive inpatient treatment, and Level III.7-D, medically-monitored inpatient detoxification services. (DI #21). Thus, in this review, the standard applies to the 21 beds that RCA-Earleville seeks to license as Level III.7-D beds.

Applicant's Response

In its October 2016 Modified Application, RCA-Earleville referred to Tables F through K of its Exhibit 39 as evidence that it has complied with my recommendation at the project status conference regarding provision of care to indigent and gray area patients and charity care, and stated a commitment to providing charity care in an amount equal to 15% of the net revenue associated with its detox bed days. RCA-Earleville stated that its operating projections show charity care for each calendar year to be equal to 15% of Gross Detox Revenue less Detox Allowance for Bad Debt, less Detox Contractual Allowance. The applicant states that the resulting dollar amount of charity care will be distributed across detox and residential services so that patients receiving care under the charity care policy will receive both detox and residential treatment at the facility. (DI #69, p. 1).

Interested Party Comments

Ashley

Ashley opened its comments by stating that it is not opposed to the entry of new providers of substance abuse treatment services in Maryland, but that it did seek to assure that there is "a level playing field," and that any such new providers should be required to meet all requirements of the ICF Chapter, as Ashley was required to do when it received CON approval to expand its facility in 2013.

Ashley states that RCA-Earleville's proposal to provide services to indigent and gray area patients at a level equal to 15% of the net revenue associated with detox patients does not meet the requirements of the ICF Chapter because this commitment is "based upon a misinterpretation

of what constitutes an intermediate care facility under the Chapter.” (DI #71, p. 2). Ashley notes (emphasis added) that the Chapter defines an ICF as

a facility designed to facilitate the sub-acute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide.

Ashley believes that the Chapter provides that “an ICF is a facility that not only provides sub-acute detoxification, but also provides rehabilitation, all within ‘a residential setting,’” and does not state that the beds in an ICF are limited to those providing detoxification services. (DI #71, pp. 2-3)

Ashley elaborates further, stating its view that the misinterpretation is rooted in “viewing the charity care requirements ... as being applicable only to patient days associated with detoxification occurring in that portion of its ICF containing beds for which CON approval is required, rather than [applying to] the full period in which both detoxification and rehabilitation substance abuse treatment services are provided in an ICF setting.” (DI #71, p. 3).

Consequently, Ashley states that,

[g]iven that the SHP defines intermediate care facility to include both sub-acute detoxification as well as the post-detoxification rehabilitation of patients, rather than defining an ICF solely in terms of detoxification as RCA-E has done, it is evident that the SHP requires that the Standard be applied to the entire 30 day ALOS of RCA-E patients irrespective of the bed designation within the facility, or whether CON review is required for some or all of the beds providing the full range of ICF detoxification and rehabilitation services. (DI #71, p. 3).

Ashley notes that: (a) the Standard requires that an applicant provide at least 15% of its proposed annual adult intermediate care facility bed days for charity care cases; (b) the SHP defines intermediate care facility to include both sub-acute detoxification as well as the post-detoxification rehabilitation of patients, rather than defining an ICF solely in terms of detoxification as RCA-E has done; and concludes that “the SHP requires that the Standard be applied to the entire 30 day ALOS ... irrespective of the bed designation within the facility, or whether CON review is required for some or all of the beds providing the full range of ICF detoxification and rehabilitation services.” (DI #71, p. 3).

Ashley acknowledges that RCA-Earleville’s commitment meets the 15% standard, but only when measured solely against the detox patient-days. It states, however, that the commitment is seriously deficient when compared to a patient’s total stay (i.e., detoxification and rehabilitation). Ashley states that there is some confusion regarding how to judge compliance with this standard “because of an apparent inconsistency in SHP requirements and the request for project modifications in the September 20, 2016 summary of the project status conference” (DI #71, p. 4).

Ashley points out that the project status conference summary stated that each applicant: “must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is sought).” It questions why the charity care commitments are being defined in terms of 15% of the net revenue associated with the total number of detoxification patient days, rather than in terms of the intermediate care facility bed days as it states is defined in the SHP. Ashley reiterates that the standard does not require an applicant to make a charity care commitment in terms of the net revenue associated with 15% of patient days, but instead requires allocation of 15% of bed days. Ashley further maintains that the requirement is 15% of ICF bed days, rather than 15% of detox (Level 3.7-D) bed days. Summarizing these points, Ashley states that “[n]o exceptions are provided in the Standard related to particular levels of care, or that that the Standard is met by an equivalent net revenue commitment”

Ashley states that the applicant has not shown why it should be granted an exception to the 15% standard, pointing out that its application proposed an indigent and gray area commitment of 6.15%, based on its assertion that the coverage extended by the Affordable Care Act (“ACA”) would effectively accomplish the same effect as the 15% commitment did when it was instituted. Ashley acknowledges that the number of uninsured Marylanders has in fact declined, but not nearly as much as the estimate upon which RCA-Earleville based its rationale for a 6.15% commitment (The Henry J. Kaiser Family Foundation January 2014 Fact Sheet “How Will the Uninsured in Maryland Fare Under the Affordable Care Act?”). Thus, Ashley states that RCA-Earleville’s request for an exemption from the standard is unwarranted, positing that

[d]espite the reduction in the number of uninsured Marylanders ... there remain hundreds of thousands who still lack health coverage ... many of whom are indigent adults who could benefit from the services to be provided by the proposed RCA-E facility, but lack the insurance coverage or private means to pay for these services. It would be pure speculation to assume that by 2018, the reduction in uninsured Marylanders will reach the Kaiser target, and that indigent and gray area Marylanders will be able to obtain the services proposed by RCA-E at other ICF facilities.” (DI #71, p. 8).

Finally, Ashley contrasts the indigent and gray area commitment required of it in its 2013 CON, noting that it “projected 4,015 charity care days, and charity care costs of \$3,584,821, representing a commitment at a 6.3% level which results in operating income at essentially a break-even level” with RCA-Earleville’s proposed commitment, stating that the result would be “that RCA-E would be required to provide far less charity care to Maryland residents than what the SHP requires, and far less than half of Ashley’s commitment, while still realizing enormous profits.” (DI #71, p. 11).

Applicant’s Response to Comments

RCA-Earleville points out that I directed it to “make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days” in response to this standard, and that was what it did. (DI #72, p.2). The applicant goes on to say that Ashley does not dispute that it has complied with my directive, but instead maintains that the applicant’s charity care commitment does not comply with COMAR 10.24.14.05D.

RCA-Earleville states that Standard .05D requires a charity care commitment for detox services only, noting that the standard applies the 15% charity care requirement to “annual adult intermediate care facility bed days,” and that the Commission has confirmed that the term “intermediate care facility” refers only to detox services. RCA-Earleville cites an August 3, 2015 determination of non-coverage in which Executive Director Ben Steffen confirmed that:

[t]he Maryland Health Care Commission has determined that this definition [of intermediate care facilities] corresponds to the subacute ‘inpatient’ level of care and services in the American Society of Addiction Medicine’s Patient Placement Criteria. This would include Level III.7, medically-monitored intensive inpatient treatment and Level III.7-D, medically-monitored inpatient detoxification services.

The determination confirms that the establishment of residential alcohol and drug abuse treatment services “does not require CON review and approval.” From this, the applicant draws the conclusion that “an ‘intermediate care facility’ does not encompass residential services.” (DI #72, p. 3).

The applicant points out that COMAR 10.24.14.08B(13) defines an intermediate care facility as a “‘facility designed to facilitate the subacute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide’ [and notes that] this definition includes the provision of ‘medical services.’” In contrast, according to the applicant, both State regulations and ASAM define residential services to include “clinically managed services” rather than medically monitored intensive inpatient services. RCA-Earleville concludes that the ICF Chapter does not regulate residential treatment services.

Next the applicant addresses Ashley’s argument that RCA-Earleville’s charity care commitment does not comply with the standard because it is calculated in terms of net revenue rather than in patient bed days. First, RCA-Earleville states that the standard expressly permits modification for good cause, and points out that its projections comply with the project status conference directive to make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days. The applicant also points out that its commitment made in terms of net revenue can easily be translated into detox bed days by reviewing the financial projection tables, explaining as follows:

Applicant’s statistical and financial projections contain both patient bed day data and revenue data. In FY 2018, for example, Earleville is projected to have 7,282 detox patient days. October 7, 2016 Modification, Exhibit 39, Table I. Fifteen percent of those days is equal to 1,092 days. Detox net revenue for the same year, before charity care, is \$6,262,521, for an average detox daily rate of \$860. Id., Table J. The total FY 2018 charity care commitment is \$939,378. Id, Table G. That amount divided by the average daily rate of \$860 would demonstrate the total number of detox bed days that could be paid for with the charity care commitment. \$939,378 divided by \$860 equals 1,092 bed days. Thus,

Applicant's charity care commitment can easily be stated in terms of bed days or net revenue using the statistical and financial projections. (DI #72, p. 5).

RCA-Earleville states that expressing its commitment in terms of bed days instead of dollars would actually have the effect of reducing the number of bed days such a commitment would finance, because the projected average daily reimbursement rate for detox services is \$860, while the average daily rate reimbursement rate for residential services is \$724 (before charity care is factored into net revenue for both). (DI #72, pp. 5-6).

Finally, RCA-Earleville essentially dismisses Ashley's comparison of the commitment in Ashley's CON with the commitment the applicant should have to make. The applicant notes, first, that the current review is not a comparative review with Ashley's completed project, and, second, that there is a substantive difference in the applications. The applicant points out that Ashley sought CON approval and licensure for all of its beds, giving it the ability to use its beds flexibly to provide detox and residential treatment in any bed, while RCA-Earleville seeks to license only 21 of its 108 beds as detox beds, locating them in a distinct part of the facility.

Reviewer's Analysis and Findings

At the September 20, 2016 project status conference, I stated that RCA-Earleville must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is required and sought). As previously noted, I was guided by MHCC staff's August 3, 2015 determination that intermediate care facility beds that require CON approval are those beds that deliver services classified as ASAM Level III.7, medically-monitored intensive inpatient treatment, and Level III.7-D, medically-monitored inpatient detoxification. In this review, the standard applies to the 21 beds that RCA-Earleville seeks to license as Level III.7-D beds.

I do not accept Ashley's contention that the indigent and gray area commitment extends to the remaining 87 residential treatment beds. For that reason, it is not necessary to address whether the Commission even would have the authority to impose charity care requirements on non-regulated beds, absent the agreement of an applicant. RCA-Earleville's commitment will be calculated based only on the 21 detox beds subject to CON review.

In implementing that commitment, it is appropriate and in accordance with the intent of the charity care standard to permit the applicant to pay that commitment across the entire continuum of care offered at the facility (i.e., the residential treatment component as well as the detox component). RCA-Earleville's proposal regarding charity care will provide the full range of needed care at the facility, both in detoxification and residential care. From a public policy perspective, RCA-Earleville's proposal to provide a full range of care is much more desirable than the situation where an indigent or low income patient would receive detox services at RCA-Earleville and then be released to others for additional needed care. As I stated at the project status conference, it is my understanding that patients are most often "lost to treatment" when they are sent to another provider for follow-up care after completion of detox. RCA-Earleville's proposal to provide charity care as both detox and residential treatment better satisfies the Commission's intent in this standard, to require a proposed facility that will admit primarily private pay patients (a "Track One" facility) to provide a requisite amount of needed alcohol and drug abuse treatment to indigent and gray area patients.

In addition, modifying the standard in terms of net revenue rather than bed days makes sense because detoxification beds are more expensive than residential beds. If RCA-Earleville were permitted to provide residential bed-stays on an equivalent basis with detoxification bed stays, it could avoid some of the charity care required by the regulation. Expressing RCA-Earleville's obligation in terms of dollars (net revenue associated with detox patient days) rather than in bed days actually increases the benefit to indigent and gray area patients because the net revenue from a detox day exceeds that of a residential treatment day a larger obligation and subsidy pool. As RCA-Earleville points out, the standard allows for a modification, and it makes sense to state the charity care standard in terms of net revenue in this instance. I persuaded that my directive to the applicant to make its commitment in terms of the net revenue associated with 15% of detox patient days rather than requiring a literal compliance with the complies with the standard.

In order to determine if the applicant's proposed level of charity care meets the 15% standard, I constructed Table III-2, below, using information submitted by RCA-Earleville in its Modification in Response to September 20, 2016 Project Status Conference. (DI #69, Exh. 39).

Table III-2: Analysis of RCA – Earleville Charity Care Commitment

	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
	Gross Revenue	Contractual Allowance	Allowance For Bad Debt	Net Revenue	Expenses	Income From Operations	15% Of Detox Net Revenue	"Pledged"
2017	\$26,173,350	\$19,220,738	\$521,446	\$6,431,166	\$3,810,665	\$2,620,501	\$964,675	\$964,675
2018	\$28,099,418	\$20,635,171	\$559,819	\$6,904,428	\$4,104,625	\$2,799,803	\$1,035,664	\$1,035,664

Source: Columns 1,2, 3, 5 are from Table K, and Column 8 is from Table H of RCA's Modification in Response to the September 20, 2016 Project Status Conference (DI #69, Exh. 39). Columns 4, 6, and 7 are calculations made from the information provided in those two tables.

As Table III-2 shows, the applicant's projected operating budget shows charity care to be at the level prescribed. I find that the applicant has met this standard.

.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.

Applicant's Response

The applicant stated that it will post charges for services, and the range and types of services provided, in a conspicuous place, to make it available to the public. (DI #44, p. 48).

Reviewer's Analysis and Findings

I find that 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.

Applicant's Response

The facility is within 30 minutes driving time from Union Hospital, 106 Bow Street, in Elkton (Cecil County). The applicant states that, according to Google Maps, the facility is within 26 minutes without traffic and 28 minutes with traffic. (DI #44, p 48).

Reviewer's Analysis and Findings

I note that my Google Maps search yielded differing results than the applicant's – showing a travel time of 27 minutes without traffic and 30 minutes with traffic. I find that, under either search, the applicant 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.

Applicant's Response

The applicant is applying for 21 adult detox treatment beds. The project will include 87 other adult residential beds for a total of 108 alcohol and drug abuse treatment beds. (DI # 44, p. 49).

Reviewer's Analysis and Findings

I find that the applicant 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.

(a) An applicant seeking to expand an existing ICF must document that its accreditation continues in good standing, and an applicant seeking to establish an ICF must agree to apply for, and obtain, accreditation prior to the first use review required under COMAR 10.24.01.18; and

(b) An ICF that loses its accreditation must notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.

(c) An ICF that loses its accreditation may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

Applicant's Response

The applicant states that it will apply for accreditation from the Joint Commission once the facility is licensed and operational, and that it has requested the Early Survey Option from the Joint Commission. If the CON is granted, this survey will occur one month before opening and will grant preliminary accreditation status prior to opening. (DI #44, p. 49).

Reviewer's Analysis and Findings

I find that the applicant is consistent with this part of the Quality Assurance standard.. However, I recommend that, if the project is approved by the Commission, the Certificate of Need should contain the following condition:

RCA-Earleville 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) 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.

(a) An applicant seeking to expand an existing ICF must document that its certification continues in good standing, and an applicant seeking to establish an ICF must agree to apply for certification by the time it requests that Commission staff perform the first use review required under COMAR 10.24.01.18.

(b) An ICF that loses its State certification must notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and must cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.

(c) Effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

Applicant's Response

RCA-Earleville states that it will seek licensure from the Department of Health and Mental Hygiene for its detox and residential programs. (DI #44, p. 50).

Reviewer's Analysis and Findings

I find that the applicant is consistent with this standard.

.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.

(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.

Applicant's Response

In response to subsection (1), RCA-Earleville states that objective monitoring and evaluation processes will assure that resources are utilized to provide quality patient care as well as "efficiency of financial and personal resources." (DI #44, pp. 45-46). The applicant states that its utilization review will include: evaluation of the utilization of services provided, as related to over/under-utilization of services; periodic evaluation of documentation; ongoing review of clinical appropriateness for admission, continued stay and discharge, in accordance with the RCA Policy and Procedures Manual.

In its response to subparagraph (2), the applicant commits to include at least one year of aftercare following treatment in each patient's treatment plan. RCA-Earleville states that patient aftercare planning begins at the time of admission, and discharge planning includes: clinical issues to be addressed in continuing care; a description of the services to be provided which will assist the patient in maintaining long-term sobriety; a specific point of contact to facilitate the patient in obtaining the needed services; dates, times and address of continuing care appointments; and re-entry criteria. (DI #44, pp. 45-46).

Reviewer's Analysis and Findings

I find that RCA-Earleville is consistent with this standard.

J. 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.**

Applicant's Response

RCA-Earleville referred to five referral agreements between RCA and other providers that had been submitted in its May 18, 2015 modified application, as well as to its August 31, 2015 response to additional information questions. (DI #15, Exh. 17; DI #23, Exh. 28). These agreements were with: Community Behavioral Health; Homecoming Project, Inc.; Union Hospital in Elkton, for emergency medical services; UM Harford Memorial Hospital in Havre de Grace, for emergency medical services; Addictions Recovery, Inc. dba Hope House for referrals for detoxification.

The applicant also submitted a newly-arranged referral agreement with Sheppard Pratt Health System for "services provided by Sheppard Pratt, including inpatient co-occurring care and outpatient co-occurring partial-hospitalization care." RCA stated that it is actively seeking additional referral relationships and will send any additional agreements to the Commission as they are executed. (DI #69, p.2).

Interested Party Comments

Neither Ashley nor Pathways commented on this standard.

Reviewer's Analysis and Findings

At the September 20, 2016 project status conference, I stated that RCA must update information regarding its executed transfer and referral agreements with or provide acknowledgement from agencies or facilities that have capabilities for managing cases that "exceed, extend, or complement" the applicant's capabilities. RCA was asked to provide documentation of transfer and referral agreements, and an updated list of the providers and agencies (categorized by provider type). Understanding that these providers and agencies might not be willing to execute agreements with a facility that was not yet operational, I said that the applicant could provide letters that expressed the provider's (or agency's) intent to enter a referral agreement after CON approval of the RCA facility, and that, in such circumstances, issuance of first use (pre-licensure) approval would be conditioned on receipt of the agreements.

RCA-Earleville was asked to provide copies of these agreements categorized by the

provider types identified in the standard. It did not list the providers with whom it has executed agreements by category, making it more difficult to assess the adequacy and breadth of these arrangements. It appears that the applicant has not definitively provided agreements with several categories of providers identified in this standard, including: (c) the 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; or (f) the jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services.

However, RCA-Earleville has provided transfer and referral agreements with with an outpatient mental health and substance abuse clinic on the Eastern Shore with locations in Salisbury, Centreville, and Cambridge; and an eight-bed halfway house for women located in Bel Air. Given this documentation, I find that the applicant can meet this standard with an appropriate condition. I recommend that, if the project is approved by the Commission, the Certificate of Need should contain the following condition:

Prior to first use approval, RCA-Earleville must provide executed transfer and referral agreements with the remaining categories of providers in standard .05J, for which it has not provided the agreements clearly identifying the category each provider or agency occupies, prior to receiving first use approval.

.05K. Sources of Referral;

K. Sources of Referral.

(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.

Applicant's Response

The applicant states in its December 2015 modified application that it “fully expects to engage in relationships with organizations that will refer patients in need of charity care,” and “has identified several potential referral sources” to whom it “will reach out to at least some of these organizations to secure referral agreements as the CON process moves forward.” (DI #44, p.48 and Exh. 18).

In its modification filed in response to the September 20, 2016 project status conference, RCA stated that it is actively seeking a referral agreement from the Maryland Department of Health, Behavioral Health Administration, and the Cecil County Health Departments informing it of RCA's commitment to provide charity care. (DI #69, p. 2). On October 31, 2016, RCA-Earleville filed a transmittal with signed referral agreements between the Cecil County Health Department and the applicant.

Reviewer's Analysis and Findings

At the September 20, 2016 project status conference, I stated that RCA must document that it has established agreements that assure that it will provide the required level of services to indigent or gray area populations. Similar to my instructions regarding transfer agreements, I said that if the applicants were unable to obtain referral agreements from the Behavioral Health Administration (successor to the Alcohol and Drug Abuse Administration) or other agencies that are named in this standard because such agencies might not be willing to execute agreements with a facility that was not yet either operational or in possession of CON approval, I would accept letters that express an agency's intent to refer patients to the facility after CON approval of the facility.

The applicant has produced one referral agreement with the Cecil County Health Department, a likely source of referrals of indigent and gray area patients. RCA-Earleville stated that it had solicited one with such an agreement with the Behavioral Health Administration. Given that, I find that the applicant has met this standard, although I will recommend that any approval of this project carry the condition that:

Prior to first use approval, the applicant must document additional referral agreements with sources likely to refer indigent or gray area populations for treatment at RCA-Earleville, consistent with COMAR 10.24.14.05K.

.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.

Applicant's Response

The applicant states that its policy is to ensure that the mission of the organization and each affiliated facility is met by providing appropriately qualified staff to deliver services to patients and by ensuring that ongoing education and training needs are identified and provided. The RCA Human Resources Department oversees orientation and the RCA Training Institute oversees the Clinical Core Trainings for clinical supervisors, primary therapists, case managers, and recovery support staff. Additional staff training and educational opportunities are offered throughout the year, as well as ongoing supervision, support and social gatherings. The RCA Human Resources Department is responsible for tracking attendance at in-service education sessions and ensuring that continuing education units are awarded when possible. (DI #44, Exhibit 19)

Reviewer's Analysis and Findings

I find that the applicant 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.

Applicant's Response

RCA states that it has developed an Admissions Criteria policy and procedure as well as Detoxification Treatment Protocols for the evaluation, treatment and detoxification for patients under its care. A physician or physician's assistant will assess each patient on the detoxification unit within 24 hours of admission, and will also provide on-site monitoring and evaluation of patients in the detoxification unit on a daily basis, if medically necessary. All patients in the detoxification program will be provided treatment for coexisting medical, emotional, or behavioral problems. The Detoxification unit will be a separate unit staffed 24 hours a day, 7 days a week by nursing personnel. (DI #44, p. 49 and Exh. 34).

Reviewer's Analysis and Findings

I find that the applicant 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.

Applicant's Response

The applicant states that RCA's Safety and Infection Control Committee will ensure that all staff receive training in infection control. RCA staff will be trained on RCA's Infection Control policy upon hire and annually thereafter. In addition, RCA will offer HIV testing and counseling, with patient consent, per RCA's policy on HIV Testing and Counseling. (DI # 44, p.49 and Exh. 21).

Reviewer's Analysis and Findings

I find that the applicant 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.**

Applicant's Response

The applicant states that aftercare planning begins at the time of admission, and details a commitment to providing a continuum of care. Accordingly, it notes that each patient that receives treatment at the Earleville location will receive an individualized aftercare plan upon discharge and will be referred to outpatient treatment. RCA will operate eight outpatient facilities within its broader catchment area: two in Blackwood, NJ; two in Waldorf, Maryland; and two in Paoli, Pennsylvania.

RCA points out that the outpatient services available at the above RCA facilities will include Partial Hospitalization, Intensive Outpatient, and Outpatient Programs. RCA's Partial Hospitalization program will provide treatment five days a week for four hours each day and will be offered Monday through Friday. The program will provide education, group therapy, and individual therapy to patients. RCA's Intensive Outpatient Program will offer group therapy three days a week for three hours per session. The Outpatient Program will offer group therapy two times per week for two hours per session. Both the Intensive Outpatient Program and the Outpatient Program will be offered during daytime hours, evening hours, and on weekends. In addition, all patients in the outpatient programs will receive an assessment upon admission, participate in a psychosocial evaluation process, and receive an individualized treatment plan from his/her primary therapist. Individual and family sessions will also be provided to all patients as clinically indicated. (DI #44, Exh. 22).

In addition to the other RCA facilities, the applicant also documented a referral agreement with the Homecoming Project, which provides outpatient services in Bel Air, Maryland. (DI #44, Exh. 17)

Reviewer's Analysis and Findings

I find that the applicant 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.

Applicant's Response

The applicant states that it will report utilization data and required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program on a monthly basis. The applicant will also participate in the comparable data collection program specified by the Department of Health and Mental Hygiene ("DHMH"). (DI # 44, p. 56).

Reviewer's Analysis and Findings

The SAMIS program has been discontinued and replaced by the Behavioral Health Administration's ("BHA") annual publication *Outlook and Outcomes*, which presents data from the Statewide Maryland Automated Tracking System ("SMART") to which all Maryland DHMH- certified or Joint Committee-accredited alcohol and drug abuse treatment programs are required to report. DHMH's website regarding the program⁷ states that

[t]he data in *Outlook and Outcomes* reflects the status of substance treatment, intervention, and prevention programs in Maryland, the services they deliver, and the populations that they serve. Data collected through the tracking of patients who have entered the treatment system provides a rich repository of information on activity and treatment outcomes in the statewide treatment network. The data are an essential indicator of the trends and patterns of alcohol and drug abuse in the state. Through the identification of these trends and patterns, sound long-term planning to meet the population needs can occur, and outcome measures that insure quality treatment and fiscal accountability are established and met.

I find that the applicant is consistent with this standard.

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.

Applicant's Response

The applicant referenced its response to Section 10.24.01.05B, above. Interested party comments related to need are discussed there as well.

Reviewer's Analysis and Findings

When I previously discussed the need for these beds earlier in this Recommended Decision at COMAR 10.24.14.05B, I found that the projected maximum need for additional beds to serve Eastern Shore residents is greater than the number of beds proposed by the applicant. Furthermore, I find that, particularly given the crisis in Maryland and elsewhere regarding opioid and other addictions, it is inevitable that the proposed facility will serve residents beyond the Eastern Shore region. The projected statewide need for additional beds *at the minimum range* is more than 16 times greater than the number of beds proposed at Earleville and more than double the total number of ICF comparable beds proposed for the three RCA facilities. Consistent with that finding, I find that the application meets this criterion.

⁷ See the following link: <http://bha.dhmf.maryland.gov/SitePages/Outlook%20and%20Outcomes.aspx>

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.

Applicant's Response

RCA reiterated the perceived scope of the problem of alcohol and drug abuse and the current lack of capacity to meet what it calls a growing need, stating that its “bed need calculations demonstrate that existing providers do not have enough capacity to meet the growing need and RCA brings a solution to a massive problem.” (DI #44, p. 53). Thus, RCA concludes that the alternative of entering the treatment market by acquiring an existing provider would not address the need for incremental new beds and would produce no net benefit to Maryland residents. The applicant also dismisses the alternative of adding beds to existing facilities because “that does not provide the necessary breadth of coverage residents of Maryland require to address the growing population suffering from addiction.” (DI #44, p.53).

The applicant states that, therefore, it “determined to build new treatment facilities of a scope that could begin to address the dire need in the State of Maryland.” In seeking sites RCA states that it reviewed many different sites across the Maryland, considering factors, such as site size, zoning, access to major roadways and interchanges, and targeting locations with dense populations and commensurate bed need. It also hoped to repurpose existing structures in order to minimize environmental impacts.

Ultimately the applicant selected the property at 314 Grove Neck Road, in Earleville for the project that is the subject of this review. It also selected two other Maryland sites on which to develop programs, in Waldorf and Upper Marlboro. In vetting a prospective location vis a vis the adequacy of demand to support a program, the applicant states that it considers its catchment area to be essentially a 90-mile radius and analyzes population and income statistics to assess whether “the site was viable on the basis of being able to capture a patient who is able to afford Applicant services.” (DI #44, p. 54). The applicant concluded that the Earleville site was viable from this perspective.

Given that this project is one of three proposed by the applicant, during the application process RCA was asked why it chose to develop several sites around the State rather than selecting one central location with a larger number of beds that would offer the ability to realize economies of scale. RCA stated that having three sites strategically located across the State will enable it to provide treatment that is readily available to patients near where they live and work, stating that most of the population would be within 60 miles of their treatment facility, and asserting that a single large facility in a centralized location would hinder patients’ access to care. (DI #44, pp 52-54, Exh. 24).

Interested Party Comments

Pathways

Pathways states that the applicant has failed to provide any quantitative analysis to demonstrate that existing providers are unable to provide the necessary inpatient detox services to meet the need. The Modified Application does not present 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. Pathways' waiting list occurred only on approximately 5% of the last 90 days, and the average wait time in those rare instances was only 24 to 48 hours. (DI #33, p. 18 and DI #50, p.9). Pathways sought to downplay the relevance of applicant's references to the findings of the Interim Report of the Heroin & Opioid Emergency Task Force, stating: "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." (DI #33, p. 18).

Pathways also asserts that RCA's proposal does not demonstrate that it would be a more cost effective alternative than existing providers, and in fact, assumed a daily rate for detox beds is approximately 40 percent higher than Pathways average rate from commercial payors. (DI#33, p.19 and DI#50, p.9)

Applicant's Response to Comments

The applicant calls the interested party's comments that it has failed to show that existing providers cannot meet the existing need for services "misguided," citing the Interim Report of the Heroin & Opioid Emergency Task Force chaired by Lieutenant Governor Boyd Rutherford and stating that Maryland "has already recognized the significant wait times and lack of services across the state," which is "especially true in rural areas of the state, where two of the applicant's facilities will be located."⁸ (DI#37, p.20)

The applicant points out that data regarding wait times are not publicly reported, and that "anecdotal statements from both area providers and Maryland residents in fact point to significant wait times across the State. The Interim Task Force Report states there is 'an average wait time of four weeks' for admission to the Eastern Shore's Whitsitt Center." (DI#37, p.20) The applicant submitted a Baltimore Sun article of August 25, 2015 (DI#37, Exhibit 13) which quoted John Herron, director of Tuerk House, a treatment program based in the West Baltimore community of Sandtown-Winchester, stated that it was turning "about four people a week away."

Finally, applicant points out that in connection with its 2012 CON application, FMA indicated it had an average wait time of 3.26 days for residential (ASAM level III.5) care, 4.96 days for monitored intensive inpatient (ASAM level III.7) care, and 3.55 days for detox (ASAM level III.7-D) care. (DI#37, p.21 and Exhibit 11 at p. 13)

⁸ "Families consistently reported experiencing multiple and repeated barriers, such as excessively long waiting periods...." Heroin and Opioid Emergency Task Force, *Interim Task Force Report*, pp. 3-4. (DI #44, Exh. 30).

Reviewer's Analysis and Findings

This review criterion requires the Commission to compare the cost effectiveness of the proposed project with the cost effectiveness of providing the services through alternative existing service providers or through an alternative facility that has submitted a competitive application as part of a comparative review. There is no competing application in this case. However, two existing providers of this service are contesting the application. The purpose of this regulation is to avoid issuing a CON to a facility that is cost-ineffective in light of alternatives. This regulation is not intended to shield existing providers from any competition so long as they can contend that they also are cost effective.

RCA's perspective on this criterion is that adding detox (and residential treatment) capacity is the only alternative that would contribute to what it perceives as a serious undersupply of services, as evidenced by its need analysis as well as the findings of the Heroin & Opioid Emergency Task Force ("Task Force"). While Pathways argues that RCA did not adequately document that other facilities were turning people away or had lengthy waiting lists and wait times, but there is no need for RCA to make any such showing. The requirement that the Commission consider whether a facility is cost effective should not be read as a guarantee that current providers will be insulated from competition unless they have waiting lists. In any event, as RCA notes, data regarding wait times is not publicly reported and the Task Force found that the wait for admission to the Eastern Shore's Whitsitt Center is four weeks.

As discussed earlier in this report, the need for a greater supply of detoxification services has been shown. 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. The applicant has met this criterion by showing a need that surpasses the capacity of existing providers. Further, I am satisfied that the applicant has adequately explained its site selection process.

Pathways also asserted that the applicant's pricing made it less than a cost-effective alternative, claiming that RCA's projected daily rate for detox beds is approximately 40 percent higher than Pathways average rate. That may or may not prove to be the case. Insurers will have the option of negotiating with the applicant and/or not including it as a covered provider.

I find that the applicant has met this criterion.

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.

Applicant's Response

Availability of Financial Resources

The applicant describes its funding plan as equity funding of \$ 4,561,387 and a mortgage of \$28,019,948. RCA states that it has raised all equity required for this project from Deerfield Management Company through its Deerfield Private Design Fund III, L.P., which has agreed to provide financing to RCA for all three of its proposed projects. Of the total project cost, \$5,595,384 is allocated to the detoxification treatment component requiring CON approval. (DI #44, p.57; DI #69, Exh. 44).

A letter from Deerfield Management stated its continued commitment to financing the project, also stating that it “remain[s] excited by the opportunity to help address what we believe to be a shortage of addiction treatment beds within the state of Maryland.” (DI #69, Exh. 44).

The applicant also provided the ADV form⁹ on file with the Securities Exchange Commission for Deerfield Management, and states that “the relevant part of the financial information for the RCA funding is the current gross asset value of the ‘Private Design III’ fund from which the transactions will be funded [noting that] page 38 of the ADV form it shows a fund valuation of \$1,667,124,016.” (DI #44, p.57 and Exhibit 25, pp. 282-287)

Projected Financial Performance

RCA-Earleville projects positive financial performance beginning in year 2. Its projections are based on maintaining occupancy rates of 66.3%, 80.1%, and 85.1% respectively in its 87 residential treatment beds in 2016-2018, and 92.9% and 95.0% respectively in its 21 detox beds in 2017 and 2018. The applicant projects a positive bottom line beginning in the first full year of operation.

⁹ An explanation of an ADV form can be found at <https://www.sec.gov/answers/formadv.htm>

Table III-3: Financial Projections

	2016	2017	2018
REVENUE			
Inpatient Services	\$18,374,400	\$103,624,762	\$ 4,457,140
Gross Patient Service Revenues	18,374,400	103,624,762	14,457,140
Allowance For Bad Debt	509,696	2,089,241	2,307,898
Contractual Allowance	13,277,440	75,768,209	83,685,161
Charity Care		\$964,675	1,035,664
Net Operating Revenue	\$4,587,264	\$24,802,637	\$27,428,417
EXPENSES			
Salaries & Wages (including benefits)	\$ 2,966,587	8,391,622	9,177,524
Contractual Services	254,509	609,478	680,342
Supplies	9,897	33,467	37,358
Administrative/office expenses	1,081,078	3544207	3863670
Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities)	1,088,423	4,200,299	4,235,521
Food	321,109	1,717,979	1,917,731
Marketing expense	178,141	953,082	1,063,898
Liability insurance	32,620	137,425	153,404
Other Expenses: Licensing & legal expenses	17,250	92,290	103,021
Total Operating Expenses	\$ 5949614	\$ 19679849	\$ 21,232,469
Income From Operations	(\$1,362,350)	\$ 5,122,788	\$ 6,195,948

Source: DI #69, Table H.

During the completeness review process, staff questioned the applicant regarding its projected charges and reimbursement levels. RCA-Earleville responded that it “conducted extensive research ... in determining its standard billing rates. The rates discussed in the Modified Application are standard rates from insurance carriers.” It provided the information in Table III-4, below, which compared its proposed rates to those paid in Maryland and neighboring states.

**Table III-4: Daily Reimbursement Rate –
RCA, Maryland, and Neighboring State Providers**

Rhode Island (2013)	\$1,326
Massachusetts (2013)	\$1,128
New Jersey (2013)	\$1,001
Pennsylvania (2013)	\$956
Maryland (2013)	\$872
Neighboring State Avg (2013)	\$1,057
RCA – I/P Residential	\$724
RCA – Detox / ICF Rate	\$860
RCA - Blended Rate	\$787

Source: TruVen Health Analytics (DI #23, p.3).

Community Support for the Proposed Project

As previously noted, the applicant has received letters of support from: John Bennett, the Chair of the Cecil County Drug and Alcohol Abuse Council; Daniel Coulter and Jean-Marie Donahoo, the co-chairs of the Cecil County Community Health Advisory Committee; Joseph Zang III, the Mayor of Cecilton; and Jennifer Tuerke, Executive Director of Voices of Hope for Cecil County, a non-profit Recovery Community Organization. Each of these letters included the request “that the Commission require the applicant to dedicate two beds as a ‘charity care’ bed available only to Cecil County residents.”

Interested Party Comments

Pathways

Pathways states that the application does not demonstrate the viability of the proposal, basing that statement on the four points that follow.

First, Pathways states that RCA’s assumption of a 14-day average length of stay (ALOS) in the detox beds is unrealistic and unreasonable, especially when compared to Pathways’ detox ALOS was only 3.92 days in FY 15 and 4.039 in the first half of FY16.

Second, Pathways states that RCA’s assumed daily rates are also “unrealistic and unreasonable,” claiming that RCA’s assumed daily rate for both detox beds (\$860) and residential beds (\$724) are approximately 40% and 33%, respectively, higher than the average rate Pathways receives from commercial payors, even though Pathways’ rehab beds (ASAM level III.7) represent a higher level of care than RCA’s (ASAM III.5). (DI #33, pp.19, 20).

Third, Pathways asserts that the application fails to demonstrate how RCA will attract and retain the staffing levels it shows on Table L to support the beds it seeks when “there is a very limited supply of qualified addictions professionals in Maryland.” Pathways described the challenges it has recently faced in finding and retaining qualified staff,¹⁰ and cites a statement from p. 3 of the Task Force Interim Report that there is “a critical shortage of qualified treatment professionals in the State.” Pathways concludes that “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.” (DI #33, p. 20).

¹⁰ “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.” (Pathways Comments, DI #33, p.20).

Finally, (in its initial November 2015 comments) Pathways commented 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,” and noted that one of those agreements was with Hope House, which it characterized as being “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.” (DI #33, p 19).

Applicant’s Response to Comments

Responding to Pathways’ comments regarding detox length of stay, the applicant pointed out that the State Health Plan chapter for Alcohol and Drug Abuse ICFs (COMAR § 10.24.14.07) requires that the need for private beds be calculated using a 14-day average length of stay for adults. The applicant also noted that it will utilize several patient centered assessment tools such as the Clinical Institute Withdrawal Assessment for Alcohol and the Clinical Opiate Withdrawal Scale to create a patient-focused detoxification plan for each patient that “will allow the clinical team the ability to titrate the medication being utilized during the detoxification process to alleviate specific withdrawal symptoms the client may be experiencing.” (DI #37, p.10).

Responding to Pathways’ comments regarding reimbursement projections, RCA-Earleville reiterated the information (shown in Table III-4, above) that it submitted in response to staff completeness questions, and stated that RCA “completed extensive research based on various external resources in determining its rack billing rate, analyzing rates in neighboring states, the State of Maryland, and Medicare,” and that its Detoxification and Inpatient Rehabilitation reimbursement projections compare favorably with its findings. RCA went on to state that “[w]hile Pathways may experience lower rates, a single, 32 combined ICF and residential bed facility is not comparable to the facilities RCA proposes. Applicant’s rates are achievable based on the Maryland market. Furthermore, these rates are similar to those experienced by [Ashley].” (DI # 37, pp. 21-23)

Responding to Pathways’ assertion that RCA failed to demonstrate its ability to hire qualified staff by acknowledging the challenge but also expressing confidence in its ability to do so, RCA cited its mission “to get 1,000,000 Americans into recovery,” RCA stated its belief “treatment professionals will be excited to become a part of RCA’s mission, and [that RCA] will devote significant effort to the hiring process in order to create a positive and collaborative work environment.” RCA stated that is conducting searches for employees on a national basis, has an internal recruiter assigned to each RCA facility, and has hired a physician recruiting firm with experience in the Mid-Atlantic region to recruit top quality psychiatrists and primary care physicians. It is also using a national recruiting company to find and screen all other candidates (e.g., primary therapists and nurses).

RCA claims that it has had substantial success thus far, having recruited senior leaders in addiction, behavioral healthcare, and a variety of other industries from across the nation to build the foundation of the company. Further, RCA states that these leaders will be able to tap into “far-ranging networks they will utilize to recruit skilled professionals committed to RCA’s vision.” For example, it notes that Deni Carise, Ph.D., RCA’s Chief Clinical Officer, is one of

the foremost researchers and teachers in the substance use disorders field today. Dr. Carise is one of the early developers of the Addiction Severity Index (“ASI”), which remains one of the foremost assessment tools for addictions and is used worldwide. Dr. Carise and her staff are building the company’s clinical programs and state of the art initiatives to make RCA one of the premier treatment providers in the country.

Reviewer’s Analysis and Findings

The applicant has demonstrated that the resources needed to launch this project are available, and in fact has already begun accepting patients to the levels of service that do not require regulatory approval. Despite the shortage of qualified addictions treatment specialists, RCA appears to have committed significant resources to this challenge and put together a robust recruitment operation.

RCA-Earleville’s ability to sustain the project will depend on its ability to fill its facility and obtain the reimbursement rates that it has projected. My need analysis indicates that need exists for the detox beds being proposed. The Chapter does not offer guidance on projecting need for the residential treatment beds. Reaching target occupancies for both the detox and residential beds will depend on the applicant’s ability to cultivate referral sources and a positive reputation. As for reimbursement levels, the applicant has presented information that shows it to be within the bounds of what other facilities are being paid.

I find that the applicant has met this criterion.

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.

Applicant’s Response

Not applicable.

Reviewer’s Analysis and Findings

The applicant has not applied for Certificate of Need in Maryland before. This criterion is not applicable.

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.

Applicant's Response

RCA-Earleville opened its discussion of impact on existing providers by referring to its need analysis, in which it has projected that as many as 1,821 adult Marylanders residing in the Eastern Shore Region will require ICF care in 2019. The applicant also referred to its estimate that only six of its 21 proposed beds would be occupied by Marylanders, with out-of-state clients filling the remainder. RCA pointed out that the Eastern Shore Region has only two Track One facilities: Hudson Health Services in Salisbury; and Warwick Manor Behavioral Health in East New Market. RCA concludes that the demand for beds exceeds the current supply, and the addition of the six beds expected to be occupied by Maryland residents will not adversely impact other providers in any significant way. (DI #44, pp. 60-61).

The applicant asserts that the proposed project will improve access to “urgently needed alcohol and drug abuse treatment services in the Eastern Shore Region and throughout the projected service area,” and points out that the commitment it has made to provide care to indigent and gray area patients will improve access for patients with limited financial resources.

Interested Party Comments

Ashley

Ashley asserts that the application, if approved, would cause it to suffer two adverse impacts: its volume and revenues would suffer; and the scale of the proposed project “will seriously challenge [Ashley] and other Maryland facilities to maintain their existing staffing levels to meet the current demand for services, and maintain their accessibility to the gray area and indigent patients.”¹¹

Speaking to the alleged impact on its volume, Ashley stated that the proposed RCA-Earleville facility “would result in fewer admissions to FMA.” (DI #32, p. 2). FMA primarily bases its assessment of the likelihood that its volumes will be negatively affected on its critique of the applicant’s assessment of bed need. As discussed earlier in the bed need standard, COMAR 10.24.14.05.B, Ashley argues that the applicant is overestimating the average length of stay (ALOS) in the detox phase of care as well as understating the number of beds in the current supply. Ashley presents an alternative bed need projection that reflects its view of an appropriate

¹¹Ashley states that it appears the proposed Earleville facility “will be staffed with 124.54 FTEs when fully utilized.” (DI #51, p.9).

ALOS in both the detox and residential phases of treatment, which is illustrated in the following table.

Table III-5: FMA Projection of Appropriate RCA-E Bed Complement

Calendar Year	Projected ICF Patients		ALOS: Detox	ALOS: Residential	Total Days		Beds Needed (@85% Occupancy)	
	Detox	Residential			Detox	Residential	Detox	Residential
2016	377	377	4 days	16 days	1,508	6,032	5	20
2017	507	507	4 days	16 days	2,028	8,112	7	27
2018	507	507	4 days	16 days	2,028	8,112	7	27

Source: DI #32, p. 13.

Ashley concludes its comments on this aspect of impact by stating that it “will surely be impacted to the point where it will be unable to meet its CON commitments, and will need to seek MHCC approval to lower the level of patient days to be provided to indigent and gray area patients.”¹² (DI #32, p. 18).

With regard to the impact on staffing, Ashley stated that RCA’s recruiting efforts have caused its existing staff to “consider the employment opportunities at the proposed RCA-E facility.” (DI #51, p. 9).

Pathways

Pathways states that the Modified Application does not demonstrate that the project will not adversely impact existing providers like Pathways for essentially two reasons: first, it implies that this RCA project will create an excess supply of beds in the region, negatively affecting its financial standing. It also states that RCA's project will adversely impact Pathways' ability to attract and retain qualified addictions staff.

With regard to the impact on supply of beds and thus the financial standing of existing providers, Pathways states that the proposed project, which it states “cannot be considered in isolation from the other two projects RCA proposes in Maryland,” will “represent the proposed addition of 140 new inpatient detox beds, all within 60 miles of Pathways.” (DI #33, p. 6)

Pathways contends that the adverse impact from RCA's proposed project will be exacerbated by the IMD exclusion.¹³ Pathways explains that under the IMD exclusion Medicaid

¹²Ashley’s CON application to add 15 beds was approved in 2013 with a condition that it “provide a minimum of 6.3% of patient days of care to indigent and gray area patients ... commencing with the first full year of operation following completion of the approved project [and] shall document the provision of such charity care by submitting annual reports”

¹³The federal IMD exclusion prohibits Medicaid reimbursement for adults between the ages of 21 and 64 who are receiving services provided in “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and treatment of individuals with mental diseases.” Because of this non-payment policy, many Medicaid enrollees with acute

reimbursement is no longer available for residential or outpatient services provided to adults admitted to residential care at an IMD (which includes Pathways), and that Pathways has experienced a substantial reduction in Medicaid length of stay and reimbursement for those services. Pathways states that its payor mix is now 85% commercial payors and only 13% Medicaid (as compared to 62% commercial and 36% Medicaid in calendar year 2014). Pathways stated that if the proposed RCA facilities “were to deprive Pathways” of even 20 percent of its commercial inpatient volume (equating to approximately \$266,877 in revenues). Pathways states that such a scenario would have caused it to operate at a loss in 2015.

Pathways also asserted that there is not a lack of providers, citing not only the inventory of

nearly 1,100 beds, all within RCA's 90-mile-radius [and that] 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).

Pathways states that there is a “wealth of providers” of inpatient detox services in RCA's projected market area, and that 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. (DI #33, p. 17).

Applicant’s Response to Comments

In its initial response to the interested parties’ comments, RCA-Earleville states that neither interested party presented a quantitative impact analysis demonstrating that it will lose patients and revenue as a result of the proposed project, instead simply stating that it may lose private patients as a result of the proposed project, and that such a loss will harm it financially. RCA states that, in the face of what it calls “the overwhelming need for ICF beds in Maryland, these unsupported assumptions are insufficient and without merit.” Further, the applicant states that the interested parties will likely benefit from the “substantial investment” it intends to make in its catchment area to create awareness of treatment services, thus increasing the number of people seeking treatment.

RCA also references a need analysis it had done that showed Maryland’s Central Region, in which both interested parties are located, to have an existing maximum private bed need of

psychiatric and addiction treatment needs are referred to hospital emergency departments and general acute care inpatient units, rather than smaller, community-based specialized providers with expertise to care for these individuals. Until August of 2015 Maryland had a waiver of this exclusion, and it is currently pursuing its renewal.

<http://dhmh.maryland.gov/docs/IMD%20Exclusion%20Waiver%20Fact%20Sheet%20and%20Public%20Notice%20v2.pdf>

253 beds.¹⁴ It states that, even if all of the RCA projects in Maryland are approved and completed, there would still be an existing private bed need in Maryland. (DI #37, p. 25 and Exh. 5).

In response to a second round of comments triggered by its submission of a modified application, RCA-Earleville opined that Pathways was possibly overstating the impact that the IMD exclusion would have on it. RCA speculated that Pathways could very well be eligible for Medicaid reimbursement through 2019.¹⁵ RCA states that, if so, “Pathways’ arguments that RCA’s facilities will too greatly impact Pathways in light of the loss of the IMD waiver should be excluded” from this review. (DI #54, pp. 13-16).

RCA also discounted suggestions that existing providers can meet the current need in Maryland, saying such a suggestion is contradicted by the findings of the Interim and Final Report of the Heroin and Opioid Emergency Task Force as well as the applicant’s need projection.

In response to Ashley’s and Pathways’ complaints that the proposed project will increase the difficulty of finding qualified staff for existing ICF facilities, RCA stated that CON regulations do not require an applicant to show that there will not be competition for the needed workforce when new services are added, saying that

[s]uch a requirement would stunt needed growth and give existing providers a monopoly in the field. It could also artificially freeze wage growth for staff at health care facilities. The staffing requirements for a RCA’s 21 bed facility in Earleville...may be similar to the staffing needs of the proposed special psychiatric hospital that AAMC proposes to build on the Pathways campus.

RCA-Earleville concludes that the possibility that the proposed facility may cause some competition for staffing cannot outweigh the significant need for these services in Maryland. (DI #54, pp. 13-16).

Reviewer’s Analysis and Findings

The interested parties complain that the proposed project would threaten their respective occupancies, but they fail to present any solid quantitative analysis that their financial stability would be under threat. This criterion should not be interpreted as a guarantee to existing

¹⁴ While RCA’s projection differs from mine due to its variance from the methodology prescribed in the Chapter, the direction of RCA’s comment is correct: the Central Region shows a maximum bed need of 160 and a minimum of 113.

¹⁵ RCA-Earleville stated that, “[o]n December 11, 2015, Senate Bill 599, Improving Access to Emergency Psychiatric Care Act became Public Law No. 114-97, extending the Maryland IMD Waiver through September 30, 2016. The law further allows extension of the waiver through the end of 2019 if Maryland’s continued participation is not projected to increase net program spending under Title XIX of the Social Security Act, and if Medicaid’s actuarial calculations determine that the program is cost-neutral.” (DI #54, p. 13).

providers that they will be insulated from any adverse impact from new competition. For all of the reasons stated above, the current need in Maryland for ASAM Level III.7D and III.7 services outstrips the supply. There is no evidence that existing providers are likely to be significantly harmed by RCA's proposal to increase the supply of ASAM Level III.7D beds.

The same reasoning applies with respect to the interested parties' complaints about staffing. This criterion does not insulate an existing provider from having to compete appropriately for staff. As RCA-Earleville stated, "the possibility that the proposed facility may cause some competition for staffing cannot outweigh the significant need for these services in Maryland." Existing providers may see a short-term impact, and they may have to sharpen up their recruitment efforts, but I do not see this as a reason to find against the applicant. Indeed, over the longer term, the increased availability of jobs may attract new skilled professionals to the field.

I find that approval of this application will not have an inappropriate detrimental impact on existing health care providers, and that it will improve geographic and demographic access to alcohol and drug abuse treatment services.

IV. REVIEWER'S RECOMMENDATION

Based on my review and analysis of the application and the record in this review, I find that RCA-Earleville's proposed project 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. In addition, I believe that its impact on existing providers will not overly negative, especially in the longer term, while it will have a positive impact on consumers' access to services, especially the population that will benefit from the required charity care that will be offered.

Accordingly I recommend that 314 Grove Neck Road OPCO LLC be awarded a Certificate of Need to establish an Alcoholism and Drug Abuse Intermediate Care Facility in Earleville in Cecil County, Maryland, subject to the following conditions.

1. Prior to first use approval, RCA-Earleville must receive preliminary accreditation by the Joint Commission and must timely receive final accreditation by the Joint Commission;
2. Prior to first use approval, RCA-Earleville must provide executed transfer and referral agreements with the remaining categories of providers in standard .05J, for which it has not provided the agreements clearly identifying the category each provider or agency occupies; and
3. Prior to first use approval, RCA-Earleville must document additional referral agreements with sources likely to refer indigent or gray area populations for treatment at RCA-Earleville, consistent with COMAR 10.24.14.05K.

IN THE MATTER OF
314 GROVE NECK ROAD
OPCO LLC

*** BEFORE THE**
*** MARYLAND HEALTH**
*** CARE COMMISSION**

Docket No. 15-07-2363

FINAL ORDER

Based on the analysis and findings in the Reviewer’s Recommended Decision, it is this 15th day of December, 2016, **ORDERED:**

That the application of 314 Grove Neck Road OPCO, LLC for a Certificate of Need to establish an alcohol and drug abuse treatment facility with 21 Intermediate Care Facility beds to be licensed as American Society of Addiction Medicine (“ASAM”) level III.7D – Medically Monitored Inpatient Detoxification (“detox”), and containing 87 inpatient residential beds that the applicant expects to license as ASAM level III.5 – Clinically Managed High-Intensity Residential Treatment that are not subject to CON review, at a total project cost estimated at \$32,581,335, with \$5,595,384 as the estimated cost allocated for the CON-regulated detox beds, and with equity funding of \$4,561,387 and a mortgage of \$28,019,948, be and hereby is APPROVED, subject to the following conditions:

1. Prior to first use approval, RCA-Earleville must receive preliminary accreditation by the Joint Commission and must timely receive final accreditation by the Joint Commission;
2. Prior to first use approval, RCA-Earleville must provide executed transfer and referral agreements with the remaining categories of providers in standard .05J, for which it has not provided the agreements clearly identifying the category each provider or agency occupies;
3. Prior to first use approval, RCA-Earleville must document additional referral agreements with sources likely to refer indigent or gray area populations for treatment at RCA-Earleville, consistent with COMAR 10.24.14.05K.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

RECORD OF THE REVIEW

APPENDIX 1: Record of the Review

314 Grove Neck Road OPCO, LLC (Recovery Centers of America-Earleville)
Docket No. 15-07-2363

Docket Item #	Description	Date
1	Commission staff acknowledged receipt of the LOI.	2/27/2015
2	Staff published notice in the Maryland Register requesting additional letters of intent for ICF services in Maryland.	3/6/2015
3	Thomas Dame, counsel for the applicant, requested waiver of the 60-day waiting period to file the Certificate of Need (CON) application	3/10/2015
4	Mr. Dame filed a revised request for waiver of the 60-day waiting period to file the Certificate of Need (CON) application	3/20/2015
5	Ben Steffen, Executive Director of MHCC, granted applicant's request for waiver of the 60-day waiting period to file the CON application.	3/25/2015
6	Mr. Dame, submitted a Certificate of Need (CON) application with large format plans on behalf of the applicant for its ICF project.	3/25/2015
7	Staff acknowledged receipt of the application for completeness review by letter.	3/30/2015
8	Staff requested that the Cecil Whig publish notice of receipt of the CON application.	3/30/2015
9	Staff requested that the Maryland Register publish notice of receipt of the CON application.	3/30/2015
10	Following completeness review, staff requested additional information before a formal review of the CON application could begin.	4/15/2015
11	Mr. Dame requested an extension of time to file responses to completeness questions, which was granted until May 4, 2015 by Commission staff.	4/29/2015

12	Staff granted an additional extension to file responses to completeness questions until May 13, 2015.	5/4/2015
13	Staff granted another extension to file responses to completeness questions until May 18, 2015.	5/12/2015
14	Ella Aiken, counsel for the applicant, filed answers to completeness questions and additional information.	5/18/2015
15	Ms. Aiken filed a Modified Application on behalf of the applicant.	5/18/2015
16	Ms. Aiken filed Corrected Exhibits 1 and 2 to the Modified Application.	5/26/2015
17	Staff acknowledged a request to receive copies of all notices and other correspondence in this matter from Marta Harting, of Venable, LLP.	6/29/2015
18	Staff acknowledged a request to receive copies of all notices and other correspondence in this matter from Richard J. Coughlan on behalf of Steven Kendrick, COO of Farther Martins Ashley and John J. Eller, Esq.	6/29/2015
19	Following completeness review, staff requested additional information before a formal review of the Modified CON application can begin.	7/17/2015
20	Staff granted an extension of time to file responses to completeness questions until August 7, 2015.	7/31/2015
21	By letter to applicant's counsel, Ben Steffen, Executive Director of MHCC, granted authorization for the capital project for the substance abuse component that does not require CON review.	8/3/2015
22	Staff granted an additional extension of time to file responses to completeness questions until August 31, 2015.	8/14/2015
23	Ms. Aiken filed answers to completeness questions and additional information.	8/31/2015
24	Staff notified the applicant, via email from Kevin McDonald, Chief of CON to Mr. Dame, that Exhibit 25 was not included in its Modified Application.	9/18/2015

25	Mr. Dame filed Exhibit 25 to the Modified CON Application.	9/22/2015
26	Staff notified the applicant that the formal start of the review of the application would be October 16, 2015 and requested additional information.	9/29/2015
27	Staff requested that the Cecil Whig publish notice of formal start of the review of the Modified CON application.	9/29/2015
28	Staff requested publication in the Maryland Register of notice of the formal start of the review.	9/29/2015
29	Staff requested Local Health Planning Comments on the Modified CON Application.	9/30/2015
30	Notice of formal start of the review was published in the Cecil Whig.	10/7/2015
31	The applicant filed Responses to Additional Information Questions Dated September 29, 2015	10/14/2015
32	John J. Eller, Esq. filed Interested Party Comments on behalf of Father Martin's Ashley.	11/16/2015
33	Marta Harting, Esq. filed Interested Party Comments of Pathways	11/16/2015
34	Ms. Harting filed an Errata to Interested Party Comments of Pathways.	11/19/2015
35	Ms. Aiken filed a request to modify by letter the pending CON application.	11/30/2015
36	Ms. Aiken filed a request to modify the August 3, 2015 Determination of Coverage to reflect proposed changes to RCA's construction plans.	11/30/2015
37	Mr. Dame filed the applicant's response to Interested Party Comments	12/1/2015
38	Email correspondence among staff, the applicant, the Cecil County health officer, and counsel for the applicant and proposed interested parties requesting confirmation of the proposed residential and detox beds.	12/1/2015
39	Email correspondence from Suellen Wideman, Assistant Attorney General for the Commission, among staff, the applicant, the Cecil	12/1/2015

	County health officer, and counsel for the applicant and proposed interested parties requesting that the applicant file a complete application containing all of the modifications included in the November 30, 2015 filing.	
40	Ms. Aiken filed a letter regarding the number of beds sought by the applicant in this matter and notified the staff and representatives of the interested parties that a replacement application incorporating all proposed modifications would be forthcoming.	12/3/2015
41	The Cecil County Health Department provided notice of the date, time, and location for a meeting of the Drug and Alcohol Abuse Council at which representatives of the applicant and Commission staff would discuss the application for Certificate of Need in this matter.	12/2/2015
42	Staff requested additional information from the applicant on the Modified Application.	12/7/2015
43	Email correspondence from Ms. Wideman to staff, the Cecil County Health Officer, and counsel for the applicant and proposed interested parties regarding the December 10th Cecil County Drug and Alcohol Abuse Council meeting.	12/9/2015
44	Ms. Aiken filed the Completed Corrected Modified CON Application, Volume 1 & 2 on behalf of RCA	12/21/2015
45	Ms. Aiken filed a Redlined Version of the Corrected Modified CON application.	12/21/2015
46	Ms. Aiken also filed the applicant's Response to Additional Information Requested Dated December 7, 2015.	12/21/2015
47	John Bennett, Chair of the Cecil County Drug and Alcohol Abuse Council, filed a letter in support of the application and requested that the Commission require that the applicant dedicate two beds as "charity care" beds available only to Cecil County residents.	1/7/2016
48	The Commission posted notice on its website regarding the modification of the CON application in this matter and announced that persons desiring to provide comments should submit them no later than 4:30 p.m. on February 3, 2016.	1/20/2016

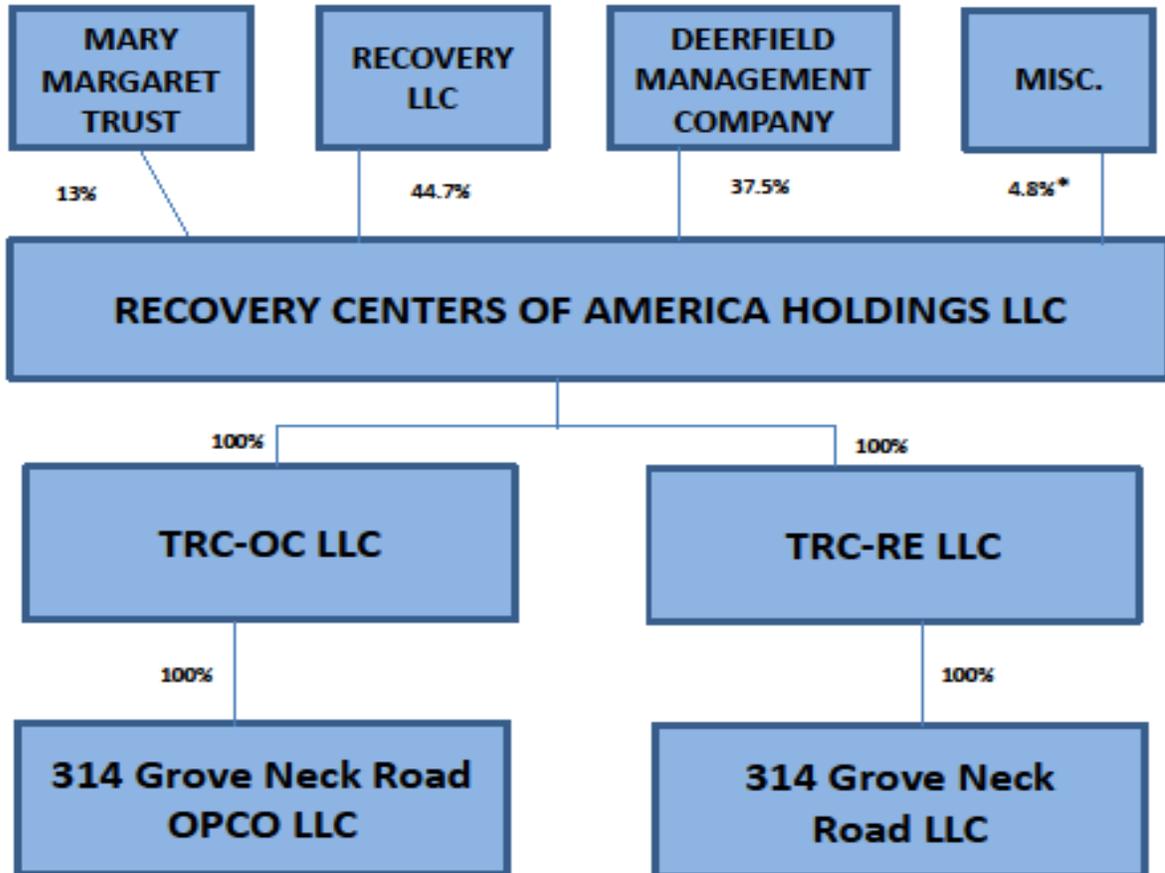
49	Daniel Coulter, MPH and Jean-Marie Donahoo, MPH, co-chairs of the Cecil County Community Health Advisory Committee, wrote a letter in support of the modified application and also requested that the Commission require that the applicant dedicate two beds as “charity care” beds available only to Cecil County residents.	1/25/2016
50	Ms. Harting filed Interested Party Comments of Pathways on the Corrected Modified Application.	2/3/2016
51	Richard Coughlan filed Interested Party Comments of Father Martin’s Ashley on the Corrected Modified Application.	2/3/2016
52	Joseph A. Zang, III, Mayor, wrote a letter on behalf of the Town of Cecilton in support of the modified application and also requested that the Commission require that the applicant dedicate two beds as “charity care” beds available only to Cecil County residents.	2/12/2016
53	Jennifer Tuerke wrote a letter in support of the modified application on behalf of Voices of Hope for Cecil County and also requested that the Commission require that the applicant dedicate two beds as “charity care” beds available only to Cecil County residents.	2/17/2016
54	Ms. Aiken filed Response to Comments Submitted by Interested Parties on the December 21, 2015 Corrected Modified Application on behalf of the applicant.	2/18/2016
55	Ms. Aiken submitted Exhibits 35 and 36 in pdf format.	3/10/2016
56	Ms. Aiken requested staff to provide a status update on the pending review of this matter.	3/30/16
57	Commissioner Randolph S. Sergent, appointed Reviewer in this matter, notified the parties that Interested Party status was granted to Father Martin’s Ashley and Pathways in this review.	5/27/2016
58	Mr. John Paul Christen, Chief Operating Office of Recovery Centers of America, notified Commissioner Sergent that due to the fire code in Maryland, construction plans from a 3-story to a 2-story wood addition had been made, increasing total project costs by approximately \$26,150.00	6/15/2016
59	Via email, staff thanked Mr. Christen for notice of the increased cost estimates and requested that RCA provide revised Tables A through	6/24/2016

	L, reflecting the changes on behalf of Commissioner Sergent.	
60	Ms. Aiken to Commissioner Sergent – Revised tables A-L for cost increase of project	7/28/2016
61	Email correspondence among Suellen Wideman, staff, the applicant, the Cecil County health officer, and counsel for the applicant and interested parties regarding the deadlines for interested party comments	8/2/2016
62	Ms. Aiken made a request for a project status conference on behalf of the applicant.	8/15/2016
63	Email correspondence among the parties regarding availability for a Project Status Conference to be held on September 20, 2016.	9/7/2016
64	Email correspondence among the parties regarding additional attendees for the Project Status Conference.	9/15/2016
65	Email correspondence among the parties regarding guidance on the Project Status Conference and what to expect	9/19/2016
66	Correspondence from Commissioner Sergent to Dame/Eller/Harting summarizing the Project Status Conference.	9/20/2016
67	Mr. Eller filed a notice of change in trade name for Father Martin’s Ashley to “Ashley Addiction Treatment.”	9/26/2016
68	Mr. Dame and Ms. Aiken filed notice that the applicant will modify the application as a result of the project status conference, by letter to Commissioner Sergent.	9/27/2016
69	Ms. Aiken filed the Modification in Response to September 20, 2016 Project Status Conference and two sets of full-size project drawings on behalf of the applicant.	10/7/2016
70	Email correspondence among the parties requesting clarification of the deadline for responses to the October 7 th Modification.	10/12/2016
71	Mr. Eller filed comments on the Modification on behalf of Ashley.	10/17/2016
72	Ms. Aiken filed Response to the 10/17/16 Comments Submitted by Interested Party on behalf of the applicant.	10/24/2016

73	Ms. Aiken submitted Agreements to Refer Indigent/Gray Area Patients with the county health department on behalf of the applicant.	10312016
74	Ms. Aiken wrote to Commissioner Sergent requesting that the Commission bring consideration of the project to the November Commission meeting	10/31/2016
75	Ms. Aiken filed a request that the Commission waive a portion of the 15 days between the filing of exceptions and a Commission meeting and issue a recommended decision in time for consideration at the December 15, 2016 meeting of the Commission.	11/29/2016

APPENDIX 2
ORGANIZATION / OWNERSHIP CHART

ORGANIZATIONAL CHART
Grove Neck Road Facility



* The ownership of the remaining 4.8% interest in Recovery Centers of America Holdings LLC is divided among over twenty persons.

The entities identified in the preceding table have the following roles in the proposed project.

- 314 Grove Neck Road OPCO LLC: Applicant. Will be the licensee and operator of the facility, providing facility level staff.
- 314 Grove Neck Road LLC: Property owner. Will lease the facility to 314 Grove Neck Road OPCO LLC.
- TRC-OC LLC: Sole member of 314 Grove Neck Road OPCO LLC. Passive holding entity; will have no role in day to day operations, or the treatment and care provided at the facility.
- TRC-RE LLC: Sole member of 314 Grove Neck Road LLC. Passive holding entity; will have no role in day to day operations, or the treatment and care provided at the facility.
- Recovery Centers of America Holdings LLC: Serves as the holding company and sole member of TRC-OC LLC and TRC-RE LLC. Will provide corporate administrative staff, policies, and funding for both implementation and ongoing operations.
- Recovery LLC: Investor, no role in day to day operations, or the treatment and care provided at the facility.
- Deerfield: Investor, no role in day to day operations, or the treatment and care provided at the facility.
- Mary Margaret Trust: Investor, no role in day to day operations, or the treatment and care provided at the facility.

APPENDIX 3

Key Statistics:

2013 National Survey on Drug Use and Health

The applicant cited the following statistics which it characterized as key results of the 2013 National Survey on Drug Use and Health:

A. Illicit Drug Use

- In 2013, an estimated 24.6 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 9.4 percent of the population aged 12 or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used nonmedically.
- The rate of current illicit drug use among persons aged 12 or older in 2013 (9.4 percent) was similar to the rates in 2010 (8.9 percent) and 2012 (9.2 percent), but it was higher than the rates in 2002 to 2009 and in 2011 (ranging from 7.9 to 8.7 percent), showing significant increase in use over the past several years.
- Marijuana was the most commonly used illicit drug in 2013. There were 19.8 million current (past month) users in 2013 (7.5 percent of those aged 12 or older), which was similar to the number and rate in 2012 (18.9 million or 7.3 percent). The 2013 rate was higher than the rates in 2002 to 2011 (ranging from 5.8 to 7.0 percent). Marijuana was used by 80.6 percent of current illicit drug users in 2013.
- Daily or almost daily use of marijuana (used on 20 or more days in the past month) increased from 5.1 million persons in 2005 to 2007 to 8.1 million persons in 2013.
- In 2013, there were 1.5 million current cocaine users aged 12 or older, or 0.6 percent of the population. These estimates were similar to the numbers and rates in 2009 to 2012 (ranging from 1.4 million to 1.7 million or from 0.5 to 0.7 percent), but they were lower than those in 2002 to 2007 (ranging from 2.0 million to 2.4 million or from 0.8 to 1.0 percent).
- The number of past year heroin users in 2013 (681,000) was similar to the numbers in 2009 to 2012 (ranging from 582,000 to 669,000) and was higher than the numbers in 2002 to 2005, 2007, and 2008 (ranging from 314,000 to 455,000).
- An estimated 1.3 million persons aged 12 or older in 2013 (0.5 percent) used hallucinogens in the past month. The number of users in 2013 was similar to that in 2012 (1.1 million), but it was higher than in 2011 (1.0 million).
- The percentage of persons aged 12 or older who used prescription-type psychotherapeutic drugs non-medically in the past month in 2013 (2.5 percent) was similar to the percentages in 2010 to 2012 (ranging from 2.4 to 2.7 percent).
- The number and percentage of past month methamphetamine users in 2013 (595,000 or 0.2 percent) were similar to those in 2012 (440,000 or 0.2 percent) and 2011

(439,000 or 0.2 percent), but they were higher than the estimates in 2010 (353,000 or 0.1 percent).

- Among youths aged 12 to 17, the rate of current illicit drug use was lower in 2013 (8.8 percent) than in 2002 to 2007 (ranging from 9.6 to 11.6 percent) and in 2009 to 2012 (ranging from 9.5 to 10.1 percent).
- The rate of current marijuana use among youths aged 12 to 17 in 2013 (7.1 percent) was similar to the 2012 rate (7.2 percent) and the rates in 2004 to 2010 (ranging from 6.7 to 7.6 percent); however, it was lower than the rates in 2002, 2003, and 2011 (ranging from 7.9 to 8.2 percent).
- Among youths aged 12 to 17, the rate of current nonmedical use of prescription-type drugs declined from 4.0 percent in 2002 and 2003 to 2.2 percent in 2013. The rate of nonmedical pain reliever use among youths also declined from 3.2 percent in 2002 and 2003 to 1.7 percent in 2013.
- The rate of current use of illicit drugs among young adults aged 18 to 25 in 2013 (21.5 percent) was similar to the rates in 2009 to 2012 (ranging from 21.3 to 21.6 percent), which was consistent with the steady rate of current marijuana use in this age group during this time (19.1 percent in 2013 and ranging from 18.2 to 19.0 percent in 2009 to 2012).
- Among young adults aged 18 to 25, the rate of current nonmedical use of prescription-type drugs in 2013 was 4.8 percent, which was similar to the rates in 2011 (5.0 percent) and 2012 (5.3 percent), but it was lower than the rates in the years from 2002 to 2010 (ranging from 5.5 to 6.5 percent).
- The rate of current cocaine use in 2013 among young adults aged 18 to 25 was 1.1 percent, which was similar to the rates in 2009, 2011, and 2012, but it was lower than the rates from 2002 to 2008 and in 2010.
- Among adults aged 26 or older, the rate of current illicit drug use in 2013 (7.3 percent) was similar to the rate in 2012 (7.0 percent), but it was higher than the rates in 2002 to 2011 (ranging from 5.5 to 6.6 percent). This was driven by rates of current marijuana use, which also remained steady between 2013 and 2012 (5.6 and 5.3 percent, respectively). However, the rate of current marijuana use in 2013 was higher than the rates in 2002 to 2011 (ranging from 3.9 to 4.8 percent).
- Among adults aged 50 to 64, the rate of current illicit drug use increased from 2.7 percent in 2002 to 6.0 percent in 2013. For adults aged 50 to 54, the rate increased from 3.4 percent in 2002 to 7.9 percent in 2013. Among those aged 55 to 59, the rate of current illicit drug use increased from 1.9 percent in 2002 to 5.7 percent in 2013. Among those aged 60 to 64, the rate of current illicit drug use increased from 1.1 percent in 2003 and 2004 to 3.9 percent in 2013.

- Among unemployed adults aged 18 or older in 2013, 18.2 percent were current illicit drug users, which was higher than the rates of 9.1 percent for those who were employed full time and 13.7 percent for those who were employed part time. However, most illicit drug users were employed. Of the 22.4 million current illicit drug users aged 18 or older in 2013, 15.4 million (68.9 percent) were employed either full or part time.
- In 2013, 9.9 million persons (3.8 percent of those aged 12 or older) reported driving under the influence of illicit drugs during the past year, which was similar to the rate in 2012 (3.9 percent). In 2013, the rate was highest among young adults aged 18 to 25 (10.6 percent), although this rate was lower than the rate in 2012 for this age group (11.9 percent).
- Among persons aged 12 or older in 2012-2013 who used pain relievers nonmedically in the past 12 months, 53.0 percent got the drug they used most recently from a friend or relative for free, and 10.6 percent bought the drug from a friend or relative. Another 21.2 percent reported that they got the drug through a prescription from one doctor. An annual average of 4.3 percent got pain relievers from a drug dealer or other stranger, and 0.1 percent bought them on the Internet.

B. Alcohol Use

- Slightly more than half (52.2 percent) of Americans aged 12 or older reported being current drinkers of alcohol in the 2013 survey, which was similar to the rate in 2012 (52.1 percent). This translates to an estimated 136.9 million current drinkers in 2013.
- In 2013, nearly one quarter (22.9 percent) of persons aged 12 or older were binge alcohol users in the past 30 days. This translates to about 60.1 million people. The rate in 2013 was similar to the estimate in 2012 (23.0 percent). Binge drinking is defined as having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey.
- In 2013, heavy drinking was reported by 6.3 percent of the population aged 12 or older, or 16.5 million people. This rate was similar to the rate of heavy drinking in 2012 (6.5 percent). Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.
- Among young adults aged 18 to 25 in 2013, the rate of binge drinking was 37.9 percent, and the rate of heavy drinking was 11.3 percent. These rates were lower than the corresponding rates in 2012 (39.5 and 12.7 percent, respectively).
- The rate of current alcohol use among youths aged 12 to 17 was 11.6 percent in 2013. Youth binge and heavy drinking rates in 2013 were 6.2 and 1.2 percent, respectively. The rates for current and binge alcohol use were lower than those reported in 2012 (12.9 and 7.2 percent, respectively).

- In 2013, an estimated 10.9 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage was lower than in 2002 (14.2 percent), but it was similar to the rate in 2012 (11.2 percent). The rate was highest among persons aged 21 to 25 and persons aged 26 to 29 (19.7 and 20.7 percent, respectively). Among persons aged 12 to 20 and those aged 21 to 25, the rates of driving under the influence of alcohol were lower in 2013 (4.7 and 19.7 percent, respectively) than in 2012 (5.7 and 21.9 percent, respectively).
- An estimated 8.7 million underage persons (aged 12 to 20) were current drinkers in 2013, including 5.4 million binge drinkers and 1.4 million heavy drinkers. Corresponding percentages of underage persons in 2013 were 22.7 percent for current alcohol use, 14.2 percent for binge alcohol use, and 3.7 percent for heavy use. All of these percentages were lower than those in 2012. 4
- Past month, binge, and heavy drinking rates among underage persons declined between 2002 and 2013. Past month alcohol use declined from 28.8 to 22.7 percent, binge drinking declined from 19.3 to 14.2 percent, and heavy drinking declined from 6.2 to 3.7 percent.
- In 2013, 52.2 percent of current underage drinkers reported that their last use of alcohol occurred in someone else's home, and 34.2 percent reported that it had occurred in their own home. Most current drinkers aged 12 to 20 (77.6 percent) were with two or more other people the last time they drank alcohol. The rate of drinking alone the last time that underage persons drank alcohol was highest among youths aged 12 to 14 (14.5 percent).
- Among current underage drinkers, 28.7 percent paid for the alcohol the last time they drank, including 7.8 percent who purchased the alcohol themselves and 20.5 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 36.6 percent got it from an unrelated person aged 21 or older; 24.5 percent got it from a parent, guardian, or other adult family member; and 16.4 percent got it from another person younger than 21 years old.
- In 2013, underage current drinkers were more likely than current alcohol users aged 21 or older to use illicit drugs within 2 hours of alcohol use on their last reported drinking occasion (19.9 vs. 5.7 percent, respectively). The most commonly reported illicit drug used by underage drinkers in combination with alcohol was marijuana.