STATE OF MARYLAND

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MEMORANDUM

TO: Commissioners

4620 Melwood Road OPCO L.L.C. (Recovery Centers of America-Upper Marlboro)
Anne Arundel General Treatment Services, Inc. d/b/a Pathways

FROM: Randolph S. Sergent
Commissioner/Reviewer

RE: Recommended Decision
Application for Certificate of Need
4620 Melwood Road OPCO L.L.C.
(Recovery Centers of America-Upper Marlboro)
Docket No. 15-16-2364

DATE: January 9, 2016

Enclosed is my Recommended Decision in my review of a Certificate of Need ("CON") application by 4620 Melwood Road OPCO L.L.C. to develop an intermediate care facility for the treatment of alcoholism and drug abuse. The 4620 Melwood Road OPCO L.L.C. facility would involve new construction and renovation on a 68 acre site in Upper Marlboro (Prince George's County). The applicant is owned by Recovery Centers of America Holdings LLC ("RCA"), a recent entrant into addiction treatment services. I refer to this proposed project and the applicant as "RCA-Upper Marlboro."

A lengthy review process culminated in the applicant filing a modified application in October 2016, in response to a project status conference that I held on September 20, 2016. With this modification, the applicant ultimately submitted a proposal that complied 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** this application, as modified, with conditions.

Interested Parties

Anne Arundel General Treatment Services, Inc. d/b/a Pathways ("Pathways") is an interested party in this review.

Background

The CON application for this project was initially filed on March 27, 2015. A first modified application was filed on May 18, 2015. The modified application was docketed on October 16, 2015. Pathways filed comments seeking interested party status, which I granted. 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-Upper Marlboro to update its application to reflect the increased cost, and it submitted revised information on July 28, 2016. After comments were filed by Pathways on August 9, 2016, noting that the modification to increase costs was not permitted by COMAR 10.24.01.08E(2), I held a project status conference on September 20, 2016 that addressed all three pending applications by the Recovery Centers of America. RCA-Upper Marlboro subsequently modified its application.

Project Description

After accounting for the changes to the plan and modifications to its application, RCA-Upper Marlboro seeks CON approval for a facility that will accommodate 55 detoxification/assessment 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 55-bed detoxification beds require CON review and approval. The project will also include 70 Level III.5 – Clinically Managed High-Intensity Residential Treatment beds for which CON approval is not required.

The total project is estimated to cost $27,816,407, with $12,239,219 as the estimated cost allocated for the CON-regulated detox beds. The application lists "equity funding" of $3,894,297 and a mortgage of $23,922,110 as the source of funds, and states that Deerfield Management Company will provide the equity senior debt for the entire project.

Project Status Conference and Modification in Response to Status Conference

Because of changes that RCA was making to its three proposed projects under review and RCA-Earleville's request that I hold a project status conference regarding its 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-Upper Marlboro'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.

Finally, I also pointed out that RCA-Upper Marlboro 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 May 18, 2015 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-Upper Marlboro on October 7, 2016 remedied each of the shortcomings of its earlier modified application.

Review Criteria and Standards

I recommend that the Commission approve, with conditions, RCA-Upper Marlboro's application, as recently modified, because 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-Upper Marlboro has shown that its project is a viable and cost-effective alternative for meeting that need.

In addition, I conclude that the proposed 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 January 26, 2017, 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 the interested party may submit written exceptions to the enclosed Recommended Decision. As noted below, exceptions must be filed electronically no later than 1:00 p.m. on Tuesday, January 17, 2017, with 25 paper copies of the exceptions submitted at the Commission's offices by noon on January 18, the day following the filing deadline. 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 1:00 p.m. on Friday, January 20, 2017. Copies of exceptions and responses must be sent in pdf format by email to the MHCC and all parties by the filing deadlines. Twenty-five paper copies of the response to exceptions must be submitted at the Commission's offices by 3:00 p.m. on Friday, January 20, 2016.

In its January 5, 2017 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 January 26, 2017 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 February 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 any response to exceptions is as follows:

Submission of exceptions	January 17, 2017 No later than 1:00 p.m.
Submission of response	January 20, 2017 No later than 1:00 p.m.
Exceptions hearing	January 26, 2017 1:00 p.m.

IN THE MATTER OF	*	**BEFORE THE**
	*	
4620 MELWOOD ROAD OPCO LLC	*	**MARYLAND HEALTH**
	*	
Docket No. 15-16-2364	*	**CARE COMMISSION**

*** ***

Reviewer's Recommended Decision

January 9, 2017

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I. INTRODUCTION

A. The Applicant

The applicant in this matter that will be licensed to operate the proposed facility is 4620 Melwood Road LLC. The owner of the real assets that will constitute the facility, the land and improvements, is 4620 Melwood Road OPCO LLC. Each 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 #15, Exh.3).[1] The applicant states that the facility will be known as Recovery Centers of America Upper Marlboro.

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 have expertise in the fields of residential and outpatient treatment facilities, acute care hospitals, behavioral health services, academic research, and governmental drug policy initiatives.

B. The Project

RCA is a relatively new entrant into the addiction treatment market. It has recently opened (October, 2016) a residential treatment facility in Earleville, in Cecil County, and has been authorized to establish an inpatient detoxification facility that will operate in conjunction with that residential program. In addition to the Prince George's County project that is the subject of this Recommended Decision, it has one other project under review in Maryland, located in Waldorf (Charles County). RCA opened treatment centers in Mays Landing, New Jersey and Westminster, Massachusetts, in 2016. It has projects under development in Danvers, Massachusetts, Blackwood, 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

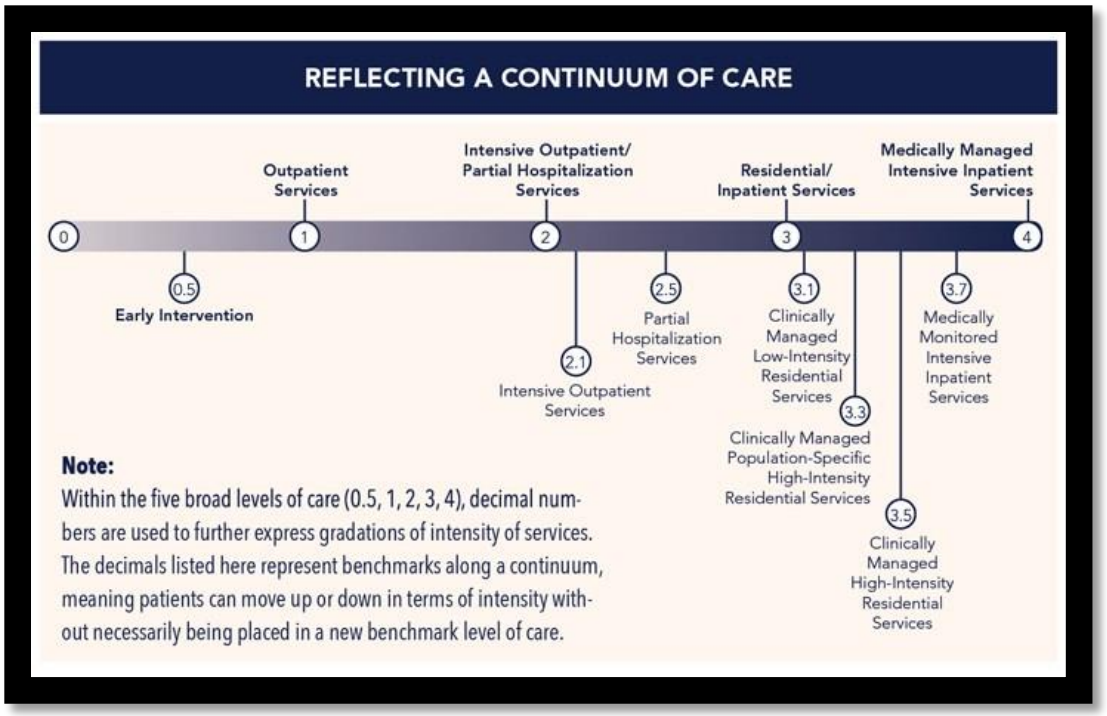
[1] See App. 2 for an organization/ownership chart for the RCA-Upper Marlboro facility and the roles of the involved entities. (DI #15, Exh. 3).

> 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.

The proposed RCA-Upper Marlboro facility will operate exclusively as an inpatient alcohol and drug abuse treatment facility at 4620 Melwood Road in Upper Marlboro (Prince George's County). It would be constructed on a 68-acre site that housed the German Protestant Orphan Asylum Association of the District of Columbia between 1965 and 1978. At some point thereafter, Second Genesis ran an addiction recovery operation at the site. The existing main building is considered functionally obsolete and would be razed and replaced by a three-story building of approximately 74,000 square feet which will house 125 beds. The ancillary building that exists on the site was constructed as a gym and will be used by the applicant as a fitness center and will also be used from time to time for various self-help groups. (DI#47).

The proposed project will include 55 detoxification/assessment beds that require Certificate of Need review and approval and will be licensed to provide "medically monitored inpatient detoxification, American Society of Addiction Medicine ("ASAM") Level III.7D. Inpatient care of this type falls within the State Health Plan's definition of alcoholism and drug abuse intermediate care facility ("ICF") treatment services. The project will also include 70 residential treatment beds that the applicant expects to license for ASAM Level III.5 – Clinically Managed High-Intensity Residential Treatment. This level of care is not subject to CON regulation.

Patients in the detoxification ("detox") program 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 as defined by ASAM. These levels of care are used by Maryland's Behavioral Health Administration, a division of the Department of Health and Mental Hygiene, to license alcohol and drug treatment programs.



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

The total project cost is estimated at $27,816,407, with $12,239,219 as the estimated cost allocated for the CON-regulated detox beds. The application lists "equity funding" of $3,894,297 and a mortgage of $23,922,110 as the source of funds, and states that Deerfield Management Company will provide the equity senior debt for the transaction. (DI #15, p. 57). In the applicant's modification responding to a project status conference held on September 20, 2016, RCA-Upper Marlboro attached a letter from Deerfield in which it reiterated its financing support for the project and the other two RCA ventures in Maryland. (DI #47, Exh. 38).

Appendix 2 details the Project Budget.

C. Summary of Reviewer's Recommendation

I recommend that the Maryland Health Care Commission approve this project because it complies with the applicable criteria and standards. It has demonstrated that the project is needed, that it is a cost-effective alternative, and that it is viable. The project complies with the applicable standards of the State Health Plan. I find that its impact on existing providers of treatment at the same care levels will be consistent with that expected when new competitors enter an existing market with few current providers. Over the long-term, it will have a positive impact on consumers' access to services, including some lower income consumers it has committed to serve at discounted charges or as charitable cases. I summarize my key findings as follows:

Need and Capacity

Using the bed need formula in the State Health Plan chapter for alcohol and drug abuse ICF services, I find that the need for additional beds to serve Southern Maryland 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 indicates a need for more drug abuse treatment resources.

Costs and Effectiveness

I find that the applicant will provide services at a cost comparable to that of similar providers and has demonstrated that its development plan has the potential for providing care that is as effective as those of similar providers.

Financial Feasibility and Viability

RCA-Upper Marlboro has demonstrated that the resources needed to launch this project are available. RCA has demonstrated a commitment to the challenge of recruiting qualified addictions treatment specialists. Reaching target occupancies for both the detox and residential beds will depend on the applicant's ability to cultivate referral sources and the maintenance of a positive reputation.

Impact on Other Providers and the Health Care System

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.

Based on these finding, I recommend approval of the proposed project with several conditions. These concern accreditation by the Commission on Accreditation of Rehabilitation Facilities, reporting on fulfillment of the applicant's commitment to serve lower income individuals, executing transfer and referral agreements, and measuring the effectiveness of its program. 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

State Senator Douglas Peters of Prince George's County wrote a letter in support of the RCA-Upper Marlboro project in January 2016. A letter of support dated February 1, 2016 was also received from County Council Chairman Derrick Leon Davis. ((DI #s 32 and 33 respectively)

C. Interested Party in the Review

I recognized Anne Arundel General Treatment Services, Inc. d/b/a Pathways ("Pathways"), a subsidiary of Anne Arundel Medical Center, as an interested party in this review. 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 1eve1 III.7 -- Medically Monitored Intensive Inpatient Treatment. As such, it functions as an alcoholism and drug abuse ICF.

Pathways filed comments on the application challenging the need for the RCA-Upper Marlboro project. Its comments question the project's financial viability and state that its impact on existing providers is such that approval is not warranted. It also questions the applicant's commitment to serving low-income patients as required by the State Health Plan for Facilities and Services ("SHP") and the proposed project's cost and effectiveness.

D. Community Support

As noted above under Local Government Review and Comment, letters of support were received from a State Senator and County Council Chairman. No other letters of support were filed.

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 conceded that the proposed new adult intermediate care beds exceed the standard of 50 noted in subpart (2), but offered the following rationales in an implied attempt to explain why the standard limiting size should not apply.

Need for treatment beds

Citing the bed need projections it calculated using a variation on the need projection methodology in the SHP chapter, RCA posited that:

> [the] project size is also reasonable in light of the extreme need for treatment beds in Maryland. Applicant's calculations indicate a need for new ICF treatment beds in the range of 450 to 598, using 2014 population data, and 471 to 624 using projected 2019 population data. The Southern Maryland Region has a net bed need of 99 to 120 using 2014 population data, and 104 to 126 using 2019 projected population. Furthermore, based on the facility catchment area, Applicant expects that only 25 of its detox / assessment beds will be used to serve Maryland patients by year 2019. (DI# 15, p.22)

Economies of scale allowing greater investment in care

RCA stated:

> …{a}…facility of this size has the patient volume and revenue stream…{to}support additional that staff [sic] would be difficult to attract and fund at smaller sites. For example, the facility's expected patient volume will enable Applicant to more easily attract and support a full-time Site Medical Director, who would be more difficult to find, financially support and provide enough clinical need for a smaller site. This is a crucial component of care…as it creates a position for someone who will take ownership of all medical services and direct the team in this delivery of care…{and}also allows Applicant to offer additional clinical programming and enhanced clinical staff coverage, which has a high labor cost, than Applicant could offer at a smaller scale facility…the size of the proposed project also allows Applicant to have one or more full-time Psychiatrists, creating capability of having extended psychiatry coverage for all patients as well as the assurance that when a psychiatrist takes vacation, there will be others to work with patients. (DI# 15,p.22)

Interested Party Comments

Pathways commented that the application is inconsistent with this standard. It asserts that RCA's contention that the maximum size standard should not apply because the beds it seeks are needed does not make sense because need is a given, and the maximum size standard is a separate consideration. Pathways stated:

If the existence of need is a basis to exempt an applicant from this standard, there would be no reason to have a maximum size standard, and the standard would be deprived of any meaning or effect. Need is a separate and distinct requirement for CON approval. In applying the maximum size standard, it must be assumed that there is a need for the beds. This standard concerns not the existence of need, but how need is to be met under the State Health Plan, and reflects a preference for smaller facilities over large facilities. (DI#30, p.8).

Pathways also points out an inconsistency in RCA's contention that the larger scale it is proposing will enable it to provide a greater level of service. Pathways points out that RCA "suggests that the additional beds will allow it to have a full time Medical Director, as well as 'one or more' full time psychiatrists," but that the work force information in its application (Table L), however, "does not include a full time Medical Director, and reflects only a 1.1 FTE psychiatrist."

Pathways also asserts that RCA has not identified examples of clinical programming it could not afford without the additional beds, nor has it "presented any quantitative analysis to demonstrate that without the additional beds it could not support these positions." Pathways also observes that RCA's projection of a healthy profit margin makes its claim to need this number of beds to support its programming lack credibility. (DI#30, p.8 and 9).

Applicant's Response to Comments

RCA responded by stating that Marylanders are suffering through a substance use disorder crisis, and that existing providers do not have enough beds to address the problem. RCA cites passages from the Interim Report of the Heroin and Opioid Emergency Task Force Task which identify conditions such as "excessively long wait periods" and "insufficient capacity at both inpatient and outpatient treatment facilities" that are barriers to care. RCA decries what it describes as Pathways' contention that "the size limitation standards of Standard .05A should limit the number of Intermediate Care Facility ("ICF") beds Applicants may establish, based on a purported lack of need," and points out that Standard .05A allows for an applicant demonstrate why the facility size standard should not apply to a proposed project. RCA reasserts its position that the "extreme need in Maryland and the recognized lack of resources to address this problem alone support setting aside the size limitation." (DI #31, pp.3 and 4).

RCA went on to address Pathways' comments questioning the need for such scale to promote better programming. RCA pointed out that the "default" bed count set forth in this standard has not been updated to respond to the "growing substance use disorder epidemic," and repeated the assertion that larger scale facilities that can spread fixed costs over a greater patient population (which enables greater revenue), "making the operation more cost efficient and the organization, which is a for-profit entity dependent on investor financing, more financially secure." (DI #31, p.4).

Reviewer's Analysis and Findings

Only subsection (2) of Standard .05A – limiting an ICF to 50 adult beds -- applies to the proposed facility in this review. COMAR 10.24.14, the State Health Plan for Facilities and Services: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services, does not state or otherwise make apparent the rationale for this size limitation.

Pathways characterized it as "a preference for smaller facilities over large facilities," Certainly, that is one possibility. But, there are no data or explicit statements to identify the strength of such a preference, or the policy justifications for it. Given the dramatic changes in health

technology and care delivery that continue to take place, which affect the efficiency of care delivery and economies of scale, it would not make sense to always prefer a smaller over a larger facility as an inflexible rule - I believe a rule of reason should be applied. When balanced against the level of crisis we see today in Maryland and around the country, I am sympathetic to the applicant's argument that the extent of the addiction crisis is a compelling reason to reconsider the applicability of this standard in the current situation.

On the issue of economies of scale, RCA's explanation that scale brings the ability to maximize investment in staffing and programming rings true to me, and is another reason to reconsider this standard's applicability. I took note of Pathways' comments that the staffing table (Table L) presented by the applicant was not consistent with RCA's statement that "the facility's expected patient volume will enable Applicant to more easily attract and support a full-time Site Medical Director…{and} also allows Applicant to have one or more full-time Psychiatrists." However, I will point out that the FTE numbers from the applicant's Table L cited by Pathways appears to be the number of FTEs that were allocated to the detox beds, not the total staffing complement serving the total number of beds at the facility. I expect Pathways to staff this facility in accord with its representations to this Commission.

I find that there is a sound rationale – based in the level of need for these services and allowing an applicant to improve services through economies of scale – for finding the 50 bed limit should not apply in this case, and that RCA meets 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' Response

The applicant cited a raft of statistics from a variety of sources and news accounts in supporting its thesis that: "Thousands 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 those statistics taken from the 2013 National Survey on Drug Use and Health, an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).[2] (DI #15, pp. 23-27 and DI #21, pp. 7-9) The applicant also pointed out that the Staff Report resulting in the most recently approved CON for ICF bed expansion of Ashley Addiction Services (formerly Father Martin's Ashley), dated

[2] The survey is available at http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf .

September 19, 2013, which identified the need for 107 to 152 Private ICF beds for the Central Maryland Region alone. (DI #15, p. 27)

In response to this standard, the applicant projected bed need by modifying the projection methodology outlined in COMAR 10.24.14.07B(7). These projections showed a need for 73 to 89 new treatment beds to serve the privately insure population of Southern Maryland and for 102 to 124 new treatment beds to serve the total over 18 population of Southern Maryland by 2019. (DI #21, Exhibit 29).

RCA defined its service area as extending well beyond the Southern Maryland region. It defined that service area as essentially a 90 mile radius of the proposed facility as well as several large population centers bordering on this 90 mile radius to extend the service area to about 110 miles in some places. The result is a service area encompassing the entire Delmarva Peninsula and extending northeast almost to Wilmington, Delaware; northwest to Chambersburg, Pennsylvania; westward beyond Martinsburg, West Virginia; and beyond Richmond, Virginia to the south. RCA used population data from Maryland Department of Planning and the Environmental Systems Research Institute, Inc. ("ESRI") to estimate 2014 population and project 2019 populations 18 years and older for its defined service area, for the entire State of Maryland, for the portion of Maryland within this service area, and for the Southern Maryland region. RCA then adjusted these populations to arrive at an estimate for the privately insured population and then added back the non-privately insured population.[3] (DI #15, pp. 33-40, and DI #21, Exhibit 29).

RCA estimated that 25 of the 55 detox/assessment beds (45.5%) will serve Maryland residents and 34 beds will serve residents of other states and the District of Columbia. It arrived at this estimate by dividing the 2019 projected population of the Maryland portion of its expected service area (4,689,719) by the projected population of its expected service area (10,371,320). (DI #15, p. 38).

Interested Party Comments

Pathways stated that RCA's need projection methodology fails to comply with the SHP methodology. Pathways maintained that RCA applied the prevalence rates set forth in the SHP against the commercially insured population instead of the overall population as called for in the SHP methodology. Pathways also maintained that the applicant incorrectly reduced the count of the existing ICF beds in the Southern Maryland region by reducing the inventory of "true" detox beds at Anchor/Walden Sierra[4] by 60% from 20 beds to 8 beds assuming that only 41% of the existing ICF beds are true detox beds. Pathways stated that this adjustment is inconsistent with the SHP methodology that only subtracts the number of funded beds from the inventory. Pathways pointed out that the Commission most recently applied this methodology in its 2013 decision on

[3] The State Health Plan 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 for alcohol and drug abuse treatment.
[4] Anchor/Walden Sierra is the only existing Track one ICF in the Southern Maryland region

the Father Martin's Ashley CON application (Docket No. 13-12-2340), in which the Commission calculated the inventory excluding only funded beds.

Pathways' recalculation of the beds needed to serve RCA's estimate of the privately insured population of the region incorporating those 20 beds into the Southern Maryland inventory showed a need ranging from 61 beds at minimum need to 77 beds at the maximum need. Pathways observed that this level of projected need for the region is far below the total of 119 beds proposed by RCA for the two facilities that are currently in the CON review process, i.e., the 55 beds that are the subject of this review of the proposed Upper Marlboro facility, and a proposed 64 beds at RCA-Waldorf. (DI #30, pp. 9-11).

Pathways stated 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 beds (ASAM level III.7) and which Pathways states are not funded (i.e., are Track One beds). Pathways maintained that correcting the inventory results in a projected statewide need in the range of 226 to 379 beds (using RCA's methodology but correcting for RCA's undercounting of existing inventory). (DI #30 pp. 10-11).

Pathways stated that RCA's accounting for out-of-state utilization is not consistent with the SHP methodology which treats such utilization by excluding out-of-state discharges in the base year. (DI #30, p. 12) Pathways further challenged the appropriateness of RCA's estimate that just 25 of the Upper Marlboro detox beds and 30 of the Waldorf detox beds would be used by Maryland residents, stating that there is no provision in the SHP chapter to approve more ICF beds than the need methodology would project based on an applicant's contention that it will not use the excess beds for Maryland residents. Furthermore, Pathways contended that the beds sought by RCA to serve out-of-state residents (30 at Upper Marlboro and 34 at Waldorf) would not be restricted to non-Marylanders and that RCA has not demonstrated the out-of-state demand for those beds. (DI # 30, pp. 11-13).

Finally, Pathways pointed out 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 points out 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 #30, p. 12).

Applicant's Response to Comments

RCA stated that it adjusted the need methodology in order to present what it thought would be the most accurate picture of the need in the population that the proposed facility would serve. The applicant called Pathways' objections to the adjustments it made to the projection methodology "without merit," because a strict application of the SHP private bed need methodology results in a projection of greater private bed need than that identified in Applicants' Modified Applications, and because RCA's requested beds are within the maximum need for the target year. (DI #31, pp. 4-5).

However in response to Pathways' comments, RCA completed an alternative need analysis that made no adjustments to the methodology set forth in COMAR § 10.24.14.07 other than updating the existing bed capacity. In this alternative analysis the projected population 18 and over was adjusted to remove the indigent population defined as the population enrolled in Medicaid consistent with the methodology in the SHP. The projected population was not adjusted so that need would only be projected for the privately insured population. The applicant estimated the Medicaid population as 15.6% of the projected population based on the statewide percentage of Medicaid enrollees in 2014. RCA followed the remaining steps as outlined in the methodology to project a gross need for 106 to 128 beds. RCA continued to assume that eight of the 20 beds at Anchor of Walden (41%) are equivalent to what had previously been classified as ICF. Thus the applicant determined that the projected net need is a minimum of 98 and a maximum of 120 beds and the proposals to construct two facilities with a total of 119 beds complies with the bed need standard. The applicant also prepared an alternative projection for the remainder of the state following SHP methodology and the same assumption as used for the Southern Maryland projections. The results is a projected net need of from 512 to 642 beds. (DI #31, pp. 5 -6, and Exhibit 5)

The applicant goes on to state that the interested parties' attempt 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. The applicant pointed out that data concerning the percentage of beds that existing facilities use for ICF level care is not readily available. (DI #31 pp.7-8)

Regarding Pathways comments on the proportion of the beds that will serve Maryland residents, 25 of the 55 beds proposed for Upper Marlboro, RCA pointed out that it projects sufficient need in the Southern Maryland region to support the proposed the 55 ICF/CD beds at Upper Marlboro and the proposed 64 ICF/CD beds at Waldorf, notwithstanding the probability that many patients will be out-of-state residents. RCA also pointed out that the Commission in its' approval of the CON application of Father Martin Ashley's, now Ashley Addiction Services, (Docket No. 13-12-2340)) recognized that an ICF can serve a multi-state area. (DI #31, p. 6)

Reviewer's Analysis and Findings

In making its bed need projections, RCA adjusted the methodology prescribed in the ICF Chapter. Its projection for the Southern Maryland region – which encompasses the locations of both of its proposed Waldorf and Upper Marlboro facilities -- showed a need for 73 to 89 new treatment beds to serve the privately insured adult population of the region. This level of bed need would not be sufficient to support the 119 Level III.7D beds proposed by RCA at the two new facilities proposed for the region (64 beds at Waldorf and 55 beds at Upper Marlboro).

RCA then increased its bed need projection by adding the number of beds required to serve the portion of the regional population that is estimated to lack private insurance. After this adjustment the projected bed need increased to 102 to 124 new treatment beds.[5]

Pathways is correct in its statement that RCA-Waldorf's original bed need projection, adjusting the service area population to account for only the privately insured population, varies from the approach prescribed by the SHP methodology. The ICF Chapter's methodology instead calls for adjusting the service area population to exclude the population that receives Medicaid from the need projection for Track One programs. The step RCA added to its calculation – adding back the beds needed to serve the population not privately insured – is inappropriate because it does not exclude the Medicaid population as called for in the methodology. Thus, RCA's need projection produces a higher level of need than would be produced by following the methodology, all other steps being equal.

The applicant and Pathways also disagree over the existing inventory of Track One ICF beds. RCA calculated the number of existing beds by identifying the number of beds at each Track One facility it identified and assumed that 41% of those beds would be classified as detoxification beds. I agree with Pathways' assertion that it is not appropriate to make an across-the-board assumption that 41% of all facilities' beds are detoxification beds when attempting to define the existing ICF bed inventory. I note that the beds that are licensed as ICF beds and subject to CON review include not only the medical detoxification stage of treatment (now classified as III.7D Level of Care and referred to herein as "detox" beds) but also Level III.7 beds that are used for medically monitored intensive inpatient treatment.

RCA is correct in its assertion that counting all alcohol and drug treatment beds as available to meet the needs of patients for Levels III.7D and III.7 care could underestimate the need. I note that arriving at an accurate count requires knowing: (1) the level of inpatient care and residential care provided at each location; and (2) how each provider uses its beds. In the case of the 20 beds at Anchor of Walden my research supports Pathways' statement that all 20 should be counted in the inventory because the only levels of care provided by Anchor at Walden are inpatient levels III.7 and III.7D.

In response to Pathways' comments regarding the adjustment of the population projections to project need for the privately insured population, RCA completed an alternative bed need analysis that adjusted the regional population for an estimate of population enrolled in Medicaid as called for by the methodology in the SHP. RCA's alternative methodology was faulty in two ways. First, RCA's calculation of Medicaid enrollees was based on the percentage of Medicaid enrollees statewide as opposed to the number for the specific region in question. Second, RCA

[5] I note that RCA did not make this last adjustment in its bed need projection for Earleville on the Eastern Shore where its bed need projection for the privately insured population appeared to support the number of beds proposed. I also note that the applicant's projection of a bed need of from 449 to 602 beds to serve the Maryland population beyond the Southern Maryland region is incorrect because RCA-Waldorf subtracted the population for the Eastern Shore from the State total instead of the Southern Maryland population.

continued to assume that only eight of Anchor of Walden's 20 Track One beds[6] are equivalent to what had previously been classified as ICF, understating the supply and thus arriving at an inflated bed need. Thus the applicant determined that the projected net need is a minimum of 98 and a maximum of 120 beds and the proposals to construct two facilities with a total of 119 beds complies with the need standard. (DI #31, pp. 5 -6, and Exhibit 5).

Meanwhile Pathways' projection of a bed need range of 61 to 77 beds resulted from its correction of the inventory of existing beds. However, since Pathways did not correct for RCA's use of only the privately insured population (instead of using the non-indigent population as prescribed in the SHP methodology), its need projection is too low, because the privately insured population is a sub-set of, and thus less than, the non-indigent population.

Faced with the facts that: the Commission has not updated the bed need projections for some time; the applicant and interested party differ in their calculation of bed need; and the methodologies employed by both vary somewhat from the methodology set forth in the SHP, I assigned and oversaw Commission staff preparation of updated projections for the Southern Maryland planning region. The updated projected bed need for Southern Maryland adjusted the population projections by subtracting the Medicaid enrollment for the region as of July 31, 2015, and considered the existing Track One inventory to be 20 beds.

Table III-1 below compares my updated projection to the projections prepared by the applicant, both its original projections and the alternative projections prepared in response to interested party comments. The table also contains differing 18-and-over population projections, which is attributable to the use of different sources for population projections and the one year difference in time frame. This calculation results in a projected need of 96 to 120 beds for the region. I note that, for the entire State, the projection shows a need of 312 to 466 beds, taking into account the recently approved beds for the RCA-Earlville and Maryland House Detox projects.

[6] The only existing Track One beds in the region.

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

	RCA Projected 2019	RCA Alternative 2019 Projection	MHCC Projected 2020
Projected Population for 18 years and older[(1)]	989,712	989,712	1,015,278
RCA Estimate of the Number of Privately Insured (64.2% of Total)	635,395		
Indigent Population- RCA at 15.6%, MHCC –Southern Maryland[(2)]		154,395	100,316
(a) **Target Market Population (For RCA-Privately Insured; For RCA Alt. & MHCC-Non-Indigent Population)**	635,395	835,317	914,962
(b) **Estimated Number of Substance Abusers (a*8.64%[(3)])**	54,898	72,171	79,053
(c1) **Estimated Annual Target Population (b*25%)**	13,725	18,043	19,763
(c2) **Estimated Number Requiring Treatment (c1*95%)**	13,038	17,141	18,775
(d) **Estimated Population requiring ICF/CD (12.5%-15%)**			
(d1) Minimum (c2*0.125)	828	2,143	2,347
(d2) Maximum (c2*0.15)	1,655	2,571	2,816
(e) **Estimated Range requiring Readmission (10%)**			
(e1) Minimum (d1*0.1)	83	214	235
(e2) Maximum (d2*0.1)	166	257	282
Total Discharges from out-of-state	N/A	N/A	N/A
(f) Range of Adults Requiring ICF/CD Care			
Minimum (d1+e1+out of state)	910	2,357	2,584
Maximum (d2+e2+out of state)	1,821	2,828	3,098
(g) **Gross Number of Adult ICF Beds Needed**			
(g1) Minimum = ((f*14 ALOS)/365)/0.85	81	106	116
(g2) Maximum = ((f*14 ALOS)/365)/0.85	97	128	140
(h) **Existing Track One Inventory ICF beds[(4)]**	8	8	20
(i) Net Non-Indigent ICF Bed Need			
Minimum (g1-h)	**73**	**98**	**96**
Maximum (g2-h)	**89**	**120**	**120**

Sources: RCA-Waldorf projections as set forth in August 31, 2015 Response to completeness questions (DI # 23, Exh. 29) and RCA- Waldorf response to Interested Party comments (DI #35,Exh. 5)

(1) Population projections –RCA population projections based on Environmental Systems Research Institute, Inc.. 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) For MHCC: 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 Anchor of Walden – For RCA as set forth in August 31, 2015 Response to completeness questions (DI # 23, Exh.29); For MHCC from MHCC records including 2002 inventory in SHP chapter and Medically Monitored Intensive Inpatient & Detox Facilities (non-forensic) from Behavioral Health Administration, DHMH Resource Directory as of August 2016.

RCA's proposal for a total of 119 new ICF beds at the two facilities is at the high end of – but within -- the range of the updated bed need that I project for Southern Maryland. This calculation of net need does not take into account the step in the methodology to account for out-of-state discharges, which effectively means that the projected bed need is somewhat understated. Since this data is not readily available for existing facilities, RCA did not include this step in its projections, despite the fact that it is expecting the proposed facility to serve a large portion of the rest of Maryland, the entire state of Delaware, as well as portions of Virginia and Pennsylvania.

RCA attempted to compensate for this missing step by calculating the proportion of beds it expected to be used by Maryland residents, basing that projection on the proportion of Marylanders to the total projected service area population for the facility (45.9%). While I find its method of estimating the number of beds that will serve Maryland residents to be overly simplistic, I do expect that the proposed facility will draw a not insignificant number of clients from other parts of Maryland and from other states.

Based on my analysis, I find that the projected maximum need for additional beds to serve Southern Maryland 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 Southern Maryland region. In addition, the projected statewide need for additional beds *at the minimum range* is more than twice the total of 140 ICF beds proposed by RCA at the three locations, Waldorf and Upper Marlboro in Southern Maryland and Earlville on the Eastern Shore. Therefore, I find the proposal to operate 64 ICF beds at RCA-Upper Marlboro 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-Upper Marlboro 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 #15, p.41 and 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 of 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 #45). 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 in the RCA-Upper Marlboro file). Thus, in this review, the standard applies to the 55 beds that RCA-Upper Marlboro seeks to license as Level III.7-D beds.

Applicant's Response

In its October 2016 Modified Application, RCA-Upper Marlboro referred to Tables F through K of its Exhibit 33 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-Upper Marlboro 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 #47, p. 1).

Interested Party Comments

In its comments on RCA's initial modified application, Pathways asserted that RCA's argument in support of a reduced indigent and gray area bed days' percentage actually fosters the opposite result. The "indigent population" is defined in the State Health Plan as "those persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment." Thus, the standard is designed to ensure access to services on the part of Medicaid recipients (whether Medicaid reimburses for the services or not). Accordingly, Medicaid expansion and the fact that more previously uninsured Marylanders now have access to Medicaid demonstrates why the 15% standard should not be reduced, not why it should be reduced. Pathways also asserted that RCA puts misplaced reliance on the Father Martin's Ashley (FMA) decision as precedent for its request. FMA, a non-profit ICF in operation for more than twenty years that does not participate in Medicaid, sought, and the Commission approved, a lower charity care requirement of 6.3%. This was based on a showing by FMA that a 15% requirement was not financially feasible and would have resulted in a significant operating loss. If RCA were to provide 15% of its annual adult intermediate care facilities bed days to Indigent or Gray Area patients at the proposed Upper Marlboro facility, the total profit margin would still be 12.2%. (DI # 30, p. 16).

Commenting later on RCA's modified application in response to the project status conference, Pathways summarized its view of RCA's proposal as amounting to offering to provide charity care at a level of 7.6% of detox revenues and 7.6% of total inpatient revenues, and "stat{ing} that the amount of its charity care commitment across all inpatient and outpatient services is equivalent to 15% of detox revenues after bad debt and contractual allowance." (DI#49, p.1) Pathways contends that

> Standard .05D cannot reasonably be interpreted to limit the indigent/gray area obligation to detox bed days, but allow an applicant to satisfy that obligation based on charity care provided in residential beds and other services. Either the obligation applies only to the detox beds, in which case it is satisfied based only on care provided in the detox beds, or it

applies to all beds, in which case it is satisfied based on care provided in total beds. [7] In either case, RCA does not comply.

Pathways also asserts that the applicant's indigent and gray area proposal is inconsistent with Standard .05D because it has not stated its charity care commitment in bed days – as the standard calls for -- but rather in gross revenues after bad debt and contractual allowances. (DI#49, p.2,3)

Applicant's Response to Comments

RCA-Upper Marlboro 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 #41, p.2). The applicant goes on to say that Pathways does not dispute that RCA has complied with my directive, but instead maintains that RCA's charity care commitment does not comply with COMAR 10.24.14.05D.

RCA-Upper Marlboro 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-Upper Marlboro 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 #50, p. 3,4).

Next the applicant addresses Pathways' argument that RCA-Upper Marlboro'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-Upper Marlboro states that the standard expressly permits modification for good cause, and points out that its projections comply with the project status conference directive I gave to make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days. In addition RCA pointed out that my September

[7] Pathways claims that this interpretation is supported by the language of the standard, which refers to "intermediate care facility bed days", not limited to detox bed days. Further, the definition of "intermediate care facility" in the State Health Plan refers to the entire facility, not just the detox beds in a facility.

20 letter (DI#46, Project Status Conference Summary) stated approval of an approach that would allow the charity care to be allocated across the continuum of care.[8]

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 that the applicant's statistical and financial projections contain both patient bed day data and revenue data, allowing for easy calculation. RCA stated:

> In FY 2019, for example, Billingsley[9] is projected to have 23,313 detox patient days. (October 7, 2016 Modification, Exhibit 34, Table I.) Fifteen percent of those days is equal to 3,497 days. Detox net revenue for the same year, before charity care, is $20,046,600, for an average detox daily rate of $860. (Id, Table J.) The total FY 2019 charity care commitment is $3,006,990. (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. $3,006,990 divided by $860 equals 3,497 days. Thus, Applicants' charity care commitment can easily be stated in terms of bed days or net revenue using the statistical and financial projections. (DI#50, p.5,6)

Finally RCA-Upper Marlboro 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 #50, p.6).

Reviewer's Analysis and Findings

At the September 20, 2016 project status conference, I stated that RCA-Upper Marlboro 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 55 beds that RCA-Upper Marlboro seeks to license as Level III.7-D beds. The standard does not apply to the other residential treatment beds.

I reject Pathways' assertion that RCA's offer to allocate 15% of the net revenues associated

[8] That letter stated "From a public policy perspective, the provision of a full range of care is much more desirable than the situation where an indigent or low income patient would receive detox services and then be released to others for additional needed care."

[9] Reviewer's note: "Billingsley" is the third of this applicant's CON applications. It is not clear if the applicant mistakenly cited this information for that facility rather than for this Upper Marlboro application. Nevertheless, the same point applies.

with detox services to cover the full treatment regimen means that RCA is not proposing to meet its 15% obligation to indigent and gray area patients.

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-Upper Marlboro'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-Upper Marlboro'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-Upper Marlboro 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-Upper Marlboro's proposal to provide charity care as both detox and residential treatment better satisfies the Commission's intent in this standard, i.e., 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 bed days makes sense because detoxification beds are more expensive than residential beds. If RCA-Upper Marlboro 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-Upper Marlboro'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-Upper Marlboro 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 believe 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 standard meets the intent of the standard and will yield a better result.

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-Upper Marlboro in its Modification in Response to September 20, 2016 Project Status Conference. (DI #47, Exh. 33).

Table III-2: Analysis of RCA – Upper Marlboro 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	$66,352,125	$48,726,541	$1,321,919	$16,303,665	$9,220,257	$7,083,408	$2,445,550	$2,445,550
2018	$69,835,658	$51,284,718	$1,391,320	$17,159,620	$9,714,095	$7,445,525	$2,573,943	$2,573,943

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 #47, Exh. 33). 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 meet

the level prescribed. I find that the applicant has met this standard. However, I recommend that, if the project is approved by the Commission, the Certificate of Need should contain the following condition:

> RCA-Upper Marlboro shall provide a charity care commitment to indigent and gray area patients that is equivalent to 15% of the net revenue associated with total detox patient days (i.e., patient days in Level 3.7-D beds). RCA-Upper Marlboro shall document its provision of care to indigent and gray area patients on an annual basis by submitting an annual report completed by an independent firm of Certified Public Accountants using Agreed-Upon Procedures documents: its total net revenue; its net revenue from total detox patient days; the value of the charity care provided to indigent and gray area patients; and details the procedures used in the analysis. Each audited annual report shall be submitted to the Commission within 120 days of the end of RCA-Upper Marlboro's fiscal year, from the project's inception and continuing for five years thereafter.

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

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 #15, p. 43).

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 applicant responded that the facility is within 30 minutes driving time of MedStar Southern Maryland Hospital Center, 7503 Surratts Road, Clinton, MD 20735 (10 minutes without traffic/11 minutes with traffic, according to Google Maps). (DI #15, p 44).

Reviewer's Analysis and Findings

I note that my Google Maps search yielded slightly different results from the applicant's, but yielded a travel time well within the 30 minute standard. I find that 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 only for adult treatment beds -- 55 adult detox treatment beds and 70 other adult residential beds for a total of 125 alcohol and drug abuse treatment beds. (DI # 15, p. 44).

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.

(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

The applicant states that it will apply for accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) once the facility is licensed and operational, and will also seek licensure from the Department of Health and Mental Hygiene for its detox and residential programs (DI #15, p. 45).

Reviewer's Analysis and Findings

I find that the applicant is consistent with 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-Upper Marlboro must receive accreditation by the Commission on Accreditation of Rehabilitation Facilities prior to receipt of First Use Approval.

.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-Upper Marlboro 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 #15, 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-Upper Marlboro 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-Upper Marlboro is consistent with this standard.

.05J. Transfer and Referral Agreements.

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

(a) Acute care hospitals;
(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;
(c) Local community mental health center or center(s);
(d) The jurisdiction's mental health and alcohol and drug abuse authorities;
(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;
(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services; and,
(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

Applicant's Response

In its application RCA-Upper Marlboro included a referral agreement it had executed with CARE Consultants Treatment Center (http://treatment-facilities.healthgrove.com/l/5279/CARE-Consultants-LLC), a provider of outpatient, partial hospitalization and day treatment programs in Clinton Maryland, and stated that it had contacted two hospitals, the local community health center, the County Health Department, and several halfway houses and therapeutic communities seeking transfer and referral agreements. (DI#15, p.48) Applicant also submitted a referral agreement with Addictions Recovery Inc., d/b/a Hope House, a treatment facility in Crownsville.

Subsequent to the Project Status Conference RCA 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 #47, p.2, Exh.34).

Interested Party Comments

Pathways commented that RCA was not in compliance with this standard, nor with the directive I gave at the Project Status Conference, stating that

> "almost a year and a half {after stating that it was seeking transfer and referral agreements in its Modified Application filed in May, 2015}…RCA has only produced three executed transfer and referral agreements, and those agreements do not meet the State Health Plan Standard. RCA has not established referral relationships with any local acute care hospital, local or State health department or agencies, or community mental health centers. Nor has it even provided letters of intent to enter into such a relationship as stated in the Reviewer's letter." (DI#49, p.4)

Pathways also pointed out that at the Status Conference I indicated a willingness to accept letters from organizations and agencies that might be unwilling to fully execute such an agreement until a potential provider acquired a CON that stated an interest in executing such an agreement with RCA once it was successful in acquiring a CON – and that no such letters were produced. Further, Pathways pointed out that my direction to provide an updated list of providers and agencies – categorized by provider type -- with whom RCA has executed transfer and referral agreements has not occurred.

Applicant's Response to Comments

RCA disagreed with Pathways, referencing the three transfer agreements that it has in place, and stating that it has reached out to many providers and agencies for referral agreements "on several occasions," but that it has "encountered reluctance…to confirm any agreement or intent until Applicants receive CON approval {by}...third parties…{each of whom has} their own internal policies and practices." (DI#50, p.9)

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-Upper Marlboro has provided transfer and referral agreements with just three other providers, though it claims to have contacted many more and found some reluctance on their part to strike an agreement with a provider which as yet is not in place. Anticipating that, I stated a willingness to accept letters stating an intent to establish such a relationship; no such letters were received.

This dearth of referral agreements or letters of intent to establish same, and RCA's failure to comply with the directive to provide a chart listing these agreements categorized by the provider types identified in the standard, makes 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: (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) 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, since RCA-Upper Marlboro has provided transfer and referral agreements with two Prince George's County treatment facilities as well as a psychiatric hospital 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-Upper Marlboro 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;

(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 stated in its initial, May 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 #15, 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" referral agreements from the Maryland Department of Health, Behavioral Health Administration, and the county Health Departments for Cecil, Charles, and Prince George's Counties informing them of RCA's commitment to provide charity care, and stated that RCA "is sending, on the same date of this filing {October 7, 2016}, letters to those agencies informing them of this review and RCA's commitment to provide charity care." (DI #47, p. 2).

On November 17, 2016 applicant submitted a document signed by the Prince Georges County Health Officer acknowledging its awareness of the proposed project and indicating an interest in developing a referral process for gray area patients should the applicant acquire a Certificate of Need. (DI#52).

Interested Party Comments

Pathways asserted that RCA does not comply with this standard because it has not produced any letter from an agency expressing its intent to refer indigent or gray area patients to RCA, nor has it made any outreach to the Medical Assistance program.

Pathways pointed out that RCA's May 2015 application said "it 'fully expects' to engage in these relationships and would reach out to these organizations to secure referral agreements," yet in its October 7, 2016 modification it was still only " 'actively seeking' agreements with these State and local agencies," and that "More than a year and a half {after its Modified Application filed in May, 2015}, it has produced no such agreement." (DI#49, p.5).

Applicant's Response to Comments

RCA acknowledged that it is obligated to enter into referral agreements for the provision of indigent and gray area care as a means of ensuring that such care is provided, and reiterated that it is "actively seeking referral agreements from the Maryland Department of Health, Behavioral Health Administration, and county Health Departments for Charles and Prince George's Counties."

RCA again claimed to have encountered reluctance by some third parties to "confirm any agreement or intent until Applicants receive CON approval," and stated that since "Applicants previously expressed their willingness to accept a CON conditioned on the execution of additional agreements, there is no legitimate health policy reason to delay a decision on the basis of this issue alone." (DI#50, p.9)

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.

In its modification in response to the project status conference submitted on October 7, 2016 the applicant documented its contact with the Maryland Department of Health, Behavioral

Health Administration, and the county Health Departments for Cecil, Charles, and Prince George's Counties, each of whom are likely sources of referrals of indigent and gray area patients. However, as of this writing MHCC has not received any documentation that agreements or the intent to execute agreements are in place. (DI#47, Exh.35) Despite the applicant's stated intent to seek such agreements going back at least to May of 2015, contacts with the above-named agencies seem to only have been initiated on October 7, 2016, the same day the applicant submitted its modification.

Nevertheless, I have some assurance that RCA will follow through on executing these agreements. It has already received a letter of interest in developing a referral process with the Prince Georges County Health Department, and it will need more such referral sources to meet its 15% indigent/gray area requirement and the associated condition that I have recommended.

Therefore, I will find that the applicant has met this standard, as long as 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-Upper Marlboro, 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 #15, p.49 and 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 #15, p. 50 and Exh. 20).

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 # 15, p.50 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 it will offer outpatient services including Partial Hospitalization, Intensive Outpatient and Outpatient Programs. Its Partial Hospitalization program will provide be offered Monday through Friday for four hours each day, and will provide education, group therapy, and individual therapy to patients. The Intensive Outpatient Program will offer group therapy three days a week for three hours per session, while the Outpatient Program will offer group therapy two times per week for two hours each session. Both the Intensive Outpatient Program and the Outpatient Program will be offered during the day, evening hours, and on weekends. RCA states that all patients in the outpatient programs will receive assessment upon admission, participate in a psychosocial evaluation process, and receive an individualized treatment plan from their primary therapist. Individual and family sessions will also be provided to all patients as clinically indicated

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 # 15, p. 51).

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 program[10] 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

[10] See the following link: http://bha.dhmh.maryland.gov/SitePages/Outlook%20and%20Outcomes.aspx

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.

The applicant has agreed to participate in this reporting. In addition, the MHCC has conditioned previous CON applicants for a drug and alcohol treatment facility that provides a range of services up to and including Level III.7 care to participate in a program to measure their effectiveness. I find that the applicant is consistent with this standard, but recommend that if this application is approved it should also contain the following condition.

> At the end of the fifth year of full operation following completion of the approved project, RCA-Upper Marlboro will provide a report to the Commission on its program effectiveness using measures, drawn from recognized organizations that develop and promote the use of quality measures from other sources, that are approved by Commission staff within 120 days from the grant of first use approval. The evaluation of program effectiveness shall include, at a minimum, evaluation of treatment success through follow-up of discharged patients and collaborative efforts with similar treatment programs in Maryland and other states to initiate standardized peer review for study and improvement of program effectiveness.

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 10.24.14.05B, 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 Southern Maryland residents is greater than the number of beds proposed by the applicant, and the projected statewide need for additional beds *at the minimum range* is more than twice the total of 140 ICF beds proposed by RCA at the three locations. 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 Southern Maryland region.

Therefore, I find the proposal to operate 55 ICF beds at RCA-Upper Marlboro is consistent with this criterion.

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 #15, 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 #15, 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 Upper Marlboro property 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 Earleville. 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 #15, p. 54). The applicant concluded that the Upper Marlboro 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 #15, pp 53-55).

Interested Party Comments

Pathways asserts that "RCA is inconsistent with this standard," contending 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. Pathways claims that

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' states that it had a waiting list on only 5% of the last 90 days {comments are dated November 16, 2015}, and the average wait time in those rare instances was only 24 to 48 hours. (DI #30, p. 18). 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 #30, p. 18).

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."[11] (DI#31, 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#31, p.20) The applicant submitted a Baltimore Sun article of August 25, 2015 (DI#31, 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#31, p.21 and Exhibit 11 at p. 13)

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.

[11] "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).

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"). 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.

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 $3.9 million and a mortgage of $23.92 million. 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, $12.2 million is allocated to the detoxification treatment component requiring CON approval. (DI #47, Exh.33, Table H).

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 #47, Exh. 38).

The applicant also provided the ADV form[12] 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

[12] An explanation of an ADV form can be found at https://www.sec.gov/answers/formadv.htm

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 #15, p.57 and Exhibit 25)

Projected Financial Performance

RCA-Upper Marlboro projects positive financial performance beginning in year 2, the first full year of operation. Its projections are based on maintaining occupancy rates of 45.5%, 80.8%, and 81% in its 70 residential treatment beds over the first three years of operation, and 45.5%, 89.9% and 90.2% over the same period. The applicant projects a positive bottom line beginning in year 2, its first full year of operation.

Table III-3: Financial Projections

	2015	2016	2017	2018
REVENUE				
Inpatient Services	0	$52,250,700	$129,185,700	$135,964,379
Outpatient Services		743,707	3,536,114	3,712,920
Gross Patient Service Revenues	0	$52,994,407	$132,721,814	$139,677,299
Allowance For Bad Debt		1,437,655	2,593,816	2,729,919
Contractual Allowance		37,874,153	94,601,492	99,565,465
Charity Care		989,172	2,445,550	2,573,943
Net Operating Revenue	**0**	**$12,693,427**	**$33,080,956**	**$34,807,972**
EXPENSES				
Salaries & Wages (including benefits)	$576,991	$5,593,508	$10,858,398	$11,428,756
Contractual Services		354,123	1,010,897	1,076,575
Supplies		29,939	81,803	86,705
Administrative/office expenses	1,673,596	3,010,255	3,564,965	3,824,607
Facilities expenses (repairs & maintenance, rent, real estate taxes, utilities		2,523,499	2,707,090	2,737,885
Food		690,188	2,014,233	2,143,449
Marketing expense		531,562	1,488,142	1,581,525
Liability insurance		178,741	185,443	194,716
Other Expenses: Licensing & legal expenses		78,656	212,604	225,071
Total Operating Expenses	**$2,250,587**	**$12,990,471**	**$22,123,575**	**$23,299,289**
Income From Operations	**$(2,250,587)**	**$(297,044)**	**$10,957,381**	**$11,508,683**

Source: DI #47, Table H.

During the completeness review process, staff questioned the applicant regarding its projected charges and reimbursement levels. RCA-Upper Marlboro 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 #21, p.19).

Community Support for the Proposed Project

As previously noted, State Senator Douglas Peters of Prince George's County wrote a letter in support of the project in January 2016. A letter of support dated February 1, 2016 was also received from County Council Chairman Derrick Leon Davis. ((DI #s 32 and 33 respectively)

Interested Party Comments

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 #30, 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,[13] and cites a statement from

[13] "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).

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 #30, 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 #30, 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-Upper Marlboro 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.. 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-Upper Marlboro'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-Upper Marlboro opened its discussion of impact on existing providers by referring to its need analysis, in which it has projected that as many as 2,151 adult Marylanders residing in the Southern Maryland Region will require ICF care in 2019. The applicant also referred to its estimate that only 25 of its 55 proposed beds would be occupied by Marylanders, with out-of-state clients filling the remainder. RCA pointed out that the Southern Maryland Region has only one Track One facility, with 20 beds. RCA concludes that the demand for beds exceeds the current supply, and the addition of the 25 beds expected to be occupied by Maryland residents will not adversely impact other providers in any significant way. (DI #15, pp. 60-61).

The applicant asserts that the proposed project will improve access to "urgently needed alcohol and drug abuse treatment services in the Southern Maryland 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

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 #30, p.23)

Pathways contends that the adverse impact from RCA's proposed project will be exacerbated by the IMD exclusion.[14] Pathways explains that under the IMD exclusion Medicaid

[14]The 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 psychiatric and addiction treatment needs are referred to hospital emergency departments and general acute care inpatient units, rather than smaller,

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), such a scenario would have caused it to operate at a loss in 2015, and that "(s)urrounded by the three new Maryland facilities proposed by RCA that would exclusively serve the commercially market, a loss of 20 percent of Pathways' commercial inpatient volume is reasonably foreseeable." (DI#30, p.23)

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Pathways also asserted that there is not a lack of providers, but instead 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. Pathways cites an 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). (DI#30, p.24)

Pathways also commented that the RCA projects would "adversely impact Pathways' ability to attract and retain qualified addictions staff," citing the 79 FTEs associated with the Waldorf project and a total of 187 FTEs over RCA's three proposed projects. Pathways stated that "there is a very limited supply of qualified addictions professionals already in Maryland, and RCA's proposed projects will only exacerbate the problem to the detriment of Pathways and other existing providers" who will find it more difficult to fill positions and provide quality care to patients. (DI#30, p.24)

Applicant's Response to Comments

In its initial response to Pathways' comments, RCA-Upper Marlboro 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

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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

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 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. (DI#37, p. 21)

RCA also referenced 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 253 beds.[15] 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).

Reviewer's Analysis and Findings

Pathways has not presented a solid quantitative analysis that its financial stability would be under threat. This criterion should not be interpreted as a guarantee to existing 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-Upper Marlboro 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-Upper Marlboro'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 be overly negative, especially in the longer term, while it will have a positive impact on consumers'

[15] 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.

access to services, especially the population that will benefit from the required charity care that will be offered.

Accordingly I recommend that 4620 Melwood Road OPCO LLC be awarded a Certificate of Need to establish an Alcoholism and Drug Abuse Intermediate Care Facility in Upper Marlboro in Prince George's County, Maryland, subject to the following conditions.

1. RCA-Upper Marlboro shall provide a charity care commitment to indigent and gray area patients that is equivalent to 15% of the net revenue associated with total detox patient days (i.e., patient days in Level 3.7-D beds). RCA-Upper Marlboro shall document its provision of care to indigent and gray area patients on an annual basis by submitting an annual report completed by an independent firm of Certified Public Accountants using Agreed-Upon Procedures documents: its total net revenue; its net revenue from total detox patient days; the value of the charity care provided to indigent and gray area patients; and details the procedures used in the analysis. Each audited annual report shall be submitted to the Commission within 120 days of the end of RCA- Upper Marlboro's fiscal year, from the project's inception and continuing for five years thereafter.

2. RCA-Upper Marlboro must receive accreditation by the Commission on Accreditation of Rehabilitation Facilities prior to receipt of First Use Approval.

3. Prior to first use approval, RCA-Upper Marlboro 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.

4. 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- Upper Marlboro, consistent with COMAR 10.24.14.05K.

5. At the end of the fifth year of full operation following completion of the approved project, RCA-Upper Marlboro will provide a report to the Commission on its program effectiveness using measures, drawn from recognized organizations that develop and promote the use of quality measures from other sources, that are approved by Commission staff within 120 days from the grant of first use approval. The evaluation of program effectiveness shall include, at a minimum, evaluation of treatment success through follow-up of discharged patients and collaborative efforts with similar treatment programs in Maryland and other states to initiate standardized peer review for study and improvement of program effectiveness.

IN THE MATTER OF	*	**BEFORE THE**
	*	
	*	**MARYLAND HEALTH**
4620 MELWOOD ROAD OPCO LLC.	*	
	*	**CARE COMMISSION**
	*	
DOCKET NO. 15-16-2364	*	

*** ***

FINAL ORDER

Based on the analysis and findings in the Reviewer's Recommended Decision, it is this 26th day of January, 2017, **ORDERED:**

That the application of 4620 Melwood Road OPCO LLC ("RCA-Upper Marlboro") for a Certificate of Need to establish an alcohol and drug abuse treatment facility with 55 Intermediate Care Facility beds to be licensed as American Society of Addiction Medicine ("ASAM") level III.7D – Medically Monitored Inpatient Detoxification ("detox"), and containing 70 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 $27,816,407, with $12,239,219 as the estimated cost allocated for the CON-regulated detox beds, and funded with equity funding of $3,894,297 and a mortgage of $23,922,110, be and hereby is APPROVED, subject to the following conditions:

1. RCA-Upper Marlboro shall provide a charity care commitment to indigent and gray area patients that is equivalent to 15% of the net revenue associated with total detox patient days (i.e., patient days in Level 3.7-D beds). RCA-Upper Marlboro shall document its provision of care to indigent and gray area patients on an annual basis by submitting an annual report completed by an independent firm of Certified Public Accountants using Agreed-Upon Procedures documents: its total net revenue; its net revenue from total detox patient days; the value of the charity care provided to indigent and gray area patients; and details the procedures used in the analysis. Each audited annual report shall be submitted to the Commission within 120 days of the end of RCA-Upper Marlboro's fiscal year, from the project's inception and continuing for five years thereafter.

2. RCA-Upper Marlboro must receive accreditation by the Commission on Accreditation of Rehabilitation Facilities prior to receipt of First Use Approval.

3. Prior to first use approval, RCA-Upper Marlboro 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.

4. 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-Upper Marlboro, consistent with COMAR 10.24.14.05K.

5. At the end of the fifth year of full operation following completion of the approved project, RCA-Upper Marlboro will provide a report to the Commission on its program effectiveness using measures, drawn from recognized organizations that develop and promote the use of quality measures from other sources, that are approved by Commission staff within 120 days from the grant of first use approval. The evaluation of program effectiveness shall include, at a minimum, evaluation of treatment success through follow-up of discharged patients and collaborative efforts with similar treatment programs in Maryland and other states to initiate standardized peer review for study and improvement of program effectiveness.

APPENDIX 1

RECORD OF THE REVIEW

APPENDIX 1: RECORD OF THE REVIEW

4620 MELWOOD ROAD OPCO LLC (Recovery Centers of America-Upper Marlboro)
Docket No. 15-16-2364

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 Washington Times publish notice of receipt of the CON application.	3/20/2015
9	Staff requested that the Maryland Register publish notice of receipt of the CON application.	3/30/2015
10	Staff received notice of receipt of the application as published in the Washington Times.	4/8/2015
11	Following completeness review, staff requested additional information before a formal review of the CON application could begin.	4/29/2015
12	Mr. Dame requested an extension of time to file responses to completeness questions, which was granted until May 13, 2015 by Commission staff.	5/4/2015
13	Ella Aiken, counsel for the applicant, requested an additional extension of time to file until May 18, which was granted by staff	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	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
17	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
18	Following completeness review, staff requested additional information before a formal review of the Modified CON application can begin.	7/17/2015
19	Staff granted an extension of time to file responses to completeness questions until August 7, 2015.	7/31/2015
20	Staff granted an extension of time to file responses to completeness questions until August 31, 2015.	8/11/2015
21	Ms. Aiken filed answers to completeness questions and additional information.	8/31/2015
22	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
23	Mr. Dame filed Exhibit 25 to the Modified CON Application.	9/22/2015
24	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
25	Staff requested that the Washington Times publish notice of formal start of the review of the Modified CON application.	9/29/2015
26	Staff requested publication in the Maryland Register of notice of the formal start of the review.	9/29/2015
27	Staff requested Local Health Planning Comments on the Modified CON Application.	9/30/2015
28	Notice of formal start of the review was published in the Washington Times	10/9/2015
29	The applicant filed Responses to Additional Information Questions Dated September 29, 2015	10/14/2015
30	Marta Harting, Esq. filed Interested Party Comments of Pathways	11/16/2015
31	Mr. Dame filed a Response to Interested Party Comments on behalf of the applicant.	12/1/2015
32	Letter of support from Senator Douglas J Peters, Legislative District 23.	1/29/2016

33	Letter of Support from Derrick Leon Davis, Prince George's County Council Chairman	2/11/2016
34	Ms. Aiken requested an update on the status of the pending review.	3/30/2016
35	Commissioner Randolph S. Sergent, appointed Reviewer in this matter, notified the parties that Interested Party status was granted to Pathways in this review.	5/27/2016
36	Mr. Christen filed revised costs for the proposed project.	6/24/2016
37	Mr. McDonald requested that the applicant submit revised tables for the cost increase by email to Mr. Christen.	6/15/2016
38	Ms. Aiken filed revised tables for the project's cost increase.	7/28/2016
39	Ms. Wideman notified Ms. Harting, Mr. Eller, and Ms. Aiken of the deadlines for interested party comments by email.	8/2/2016
40	Ms. Harting filed Comments of Pathways on the Applicant's July 28, 2016 filing.	8/9/2016
41	Ms. Aiken filed the applicant's Response to Comments Submitted by the Interested Party	8/15/2016
42	Email correspondence among the parties regarding availability for a Project Status Conference to be held on September 20, 2016.	9/7/2016
43	Email correspondence among the parties regarding additional attendees for the Project Status Conference.	9/15/2016
44	Email correspondence among the parties regarding guidance on the Project Status Conference and what to expect	9/19/2016
45	Letter from Commissioner Sergent to Dame/Eller/Harting conveying the Project Status Conference Summary	9/20/2016
46	Mr. Dame to Commissioner Sergent notice that the applicant will modify the application as a result of the project status conference	9/27/2016
47	Ms. Aiken filed the applicants Modified Application.	10/7/2016
48	Email correspondence with counsel that responses to the modified application would be due on October 17, 2016.	10/12/2016
49	Ms. Harting filed Comments on the Modified Application on behalf of Pathways	10/17/2016
50	Mr. Dame filed the applicant's response to Pathways' comments.	10/24/2016
51	Ms. Aiken wrote to Commissioner Sergent requesting that the Commission bring consideration of the project to the November Commission meeting	10/31/16
52	Ms. Aiken filed the applicant's agreements to refer indigent gray area patients	11/17/2016
53	Ms. Aiken filed a request that the Commission waive a portion of the 15 days between the filing if exceptions and a Commission meeting	11/29/2016

	and issue a recommended decision in time for consideration at the December 15, 2016 meeting of the Commission.	

APPENDIX 2:

PROJECT BUDGET

Appendix 2, Estimated Project Budget, RCA-Upper Marlboro

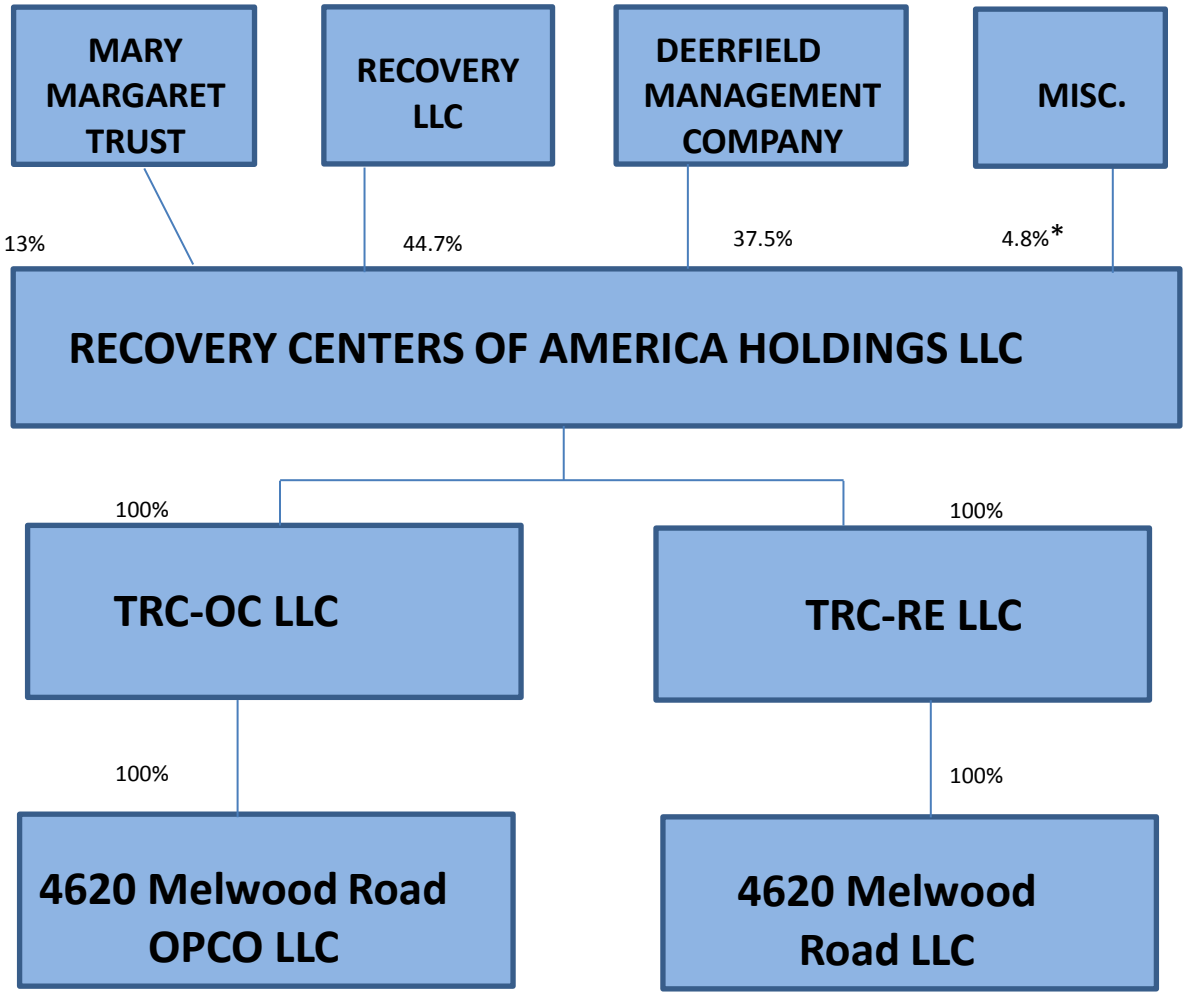
	Detox	Residential	Total
USE OF FUNDS			
CAPITAL COSTS			
Land Purchase	$1,430,000	$1,820,000	$3,250,000
New Construction			
Building	6,593,205	8,391,352	14,984,557
Site and Infrastructure	652,565	830,538	1,483,103
Architect/Engineering Fees	143,258	182,328	325,586
Permits	87,759	111,694	199,453
Subtotal	**$7,476,787**	**$9,515,912**	**$16,992,699**
Other Capital Costs			
Movable Equipment	$464,640	$591,360	$1,056,000
Contingency Allowance	511,023	650,392	1,161,415
Gross interest during construction period	0	0	0
Legal Fees	110,000	140,000	250,000
Property Due Diligence	22,000	28,000	50,000
Subtotal	**$1,107,663**	**$1,409,752**	**$2,517,415**
Total Capital Costs	**$10,014,450**	**$12,745,664**	**$22,760,114**
FINANCING COST AND OTHER CASH REQUIREMENTS0			
Transaction Costs	$331,219	$421,551	$752,770
Acquisition Costs	71,500	91,000	162,500
Due Diligence Costs	66,000	84,000	150,000
Subtotal	**$468,719**	**$596,551**	**$1,065,270**
Working Capital Startup Costs	$1,756,050	$2,234,973	$3,991,023
Total Uses of Funds	**$12,239,219**	**$15,577,188**	**$27,816,407**
SOURCES OF FUNDS			
Equity	$1,713,491	$2,180,806	$3,894,297
Mortgage	10,525,728	13,396,382	23,922,110
Total Sources of Funds	**$12,239,219**	**$15,577,188**	**$27,816,407**

Source: DI #47, Table E.

APPENDIX 3

ORGANIZATION / OWNERSHIP CHART

ORGANIZATIONAL CHART
Melwood 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.

- 11100 Billingsley Road OPCO LLC: Applicant: Will be the licensee and operator of the facility, providing facility level staff.

- 11100 Billingsley Road LLC: Property owner. Will lease the facility to 11100 Billingsley Road OPCO LLC.

- TRC-OC LLC: Sole member of 11100 Billingsley 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 11100 Billingsley 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 4

Key Statistics:

2013 National Survey on Drug Use and Health

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 nonmedically 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.