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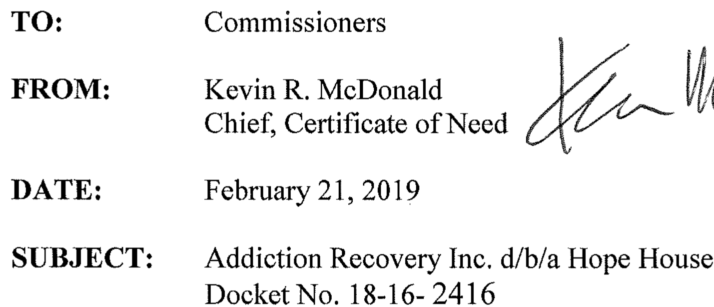
MEMORANDUM



TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: February 21, 2019

SUBJECT: Addiction Recovery Inc. d/b/a Hope House
Docket No. 18-16- 2416

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by Addiction Recovery Inc. d/b/a Hope House.

Hope House seeks a CON to convert its existing residential beds at 429 Main Street to ICF beds, ASAM Levels 3.7 and 3.7WM ("withdrawal management") and add four additional beds, to establish a 22-bed ICF. The applicant reports that this project requires no construction or renovation of 429 Main Street in Laurel. Thus, there is no capital expenditure required to implement the project.

Commission staff analyzed the proposed project's compliance with the CON review criteria at COMAR 10.24.01.08G(3) and the State Health Plan standards at COMAR 10.24.14.05, State Health Plan: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services. Staff recommends that the project be **APPROVED.**

IN THE MATTER OF	*	BEFORE THE
	*	
ADDICTION RECOVERY INC. d/b/a	*	MARYLAND HEALTH
HOPE HOUSE	*	
	*	CARE COMMISSION
Docket No. 18-16-2416	*	
	*	

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Staff Report and Recommendation

February 21, 2019

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I. INTRODUCTION

A. The Applicant

The applicant in this matter is Addiction Recovery Inc. d/b/a Hope House. Addiction Recovery Inc. ("Hope House") is a private, non-profit provider of non-hospital inpatient detoxification ("detox" or "withdrawal management") services, inpatient treatment services, residential treatment services, and partial hospitalization for adults struggling with alcoholism and drug addiction. It also provides counseling services for certain persons charged with or convicted of driving under the influence of intoxicants.

Hope House has been in operation since 1983 and is accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") and licensed by the Maryland Department of Health ("MDH"). It is Medicaid-certified. It operates inpatient programs for addiction at three locations. At Crownsville (Anne Arundel County), it operates a detox and inpatient treatment program with 49 beds. In Laurel (Prince George's County) Hope House provides services out of two adjacent facilities: at 419 Main Street, it provides detox and inpatient rehabilitation with 18 beds; and at the adjacent 429 Main Street, it currently operates 16 residential treatment beds.[1]

B. Background

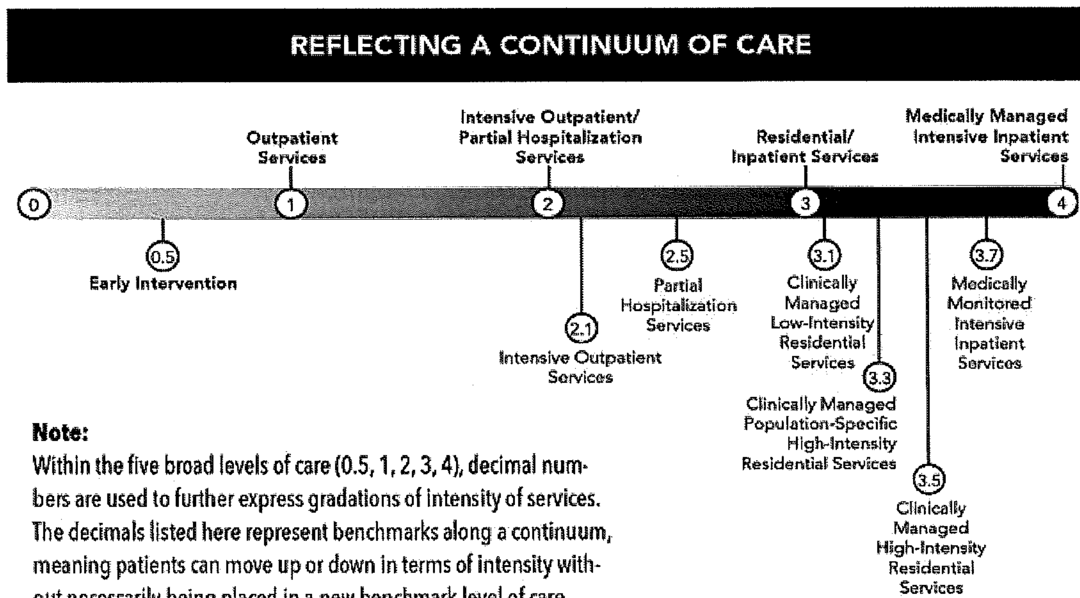
The American Society of Addiction Medicine ("ASAM") developed a a taxonomic scheme for classifying a continuum of levels of addictions treatment, that is illustrated in Figure 1, on the following page. It is used to classify levels of treatment in Maryland. The Laurel Hope House facility at 429 Main Street is classified as a Level 3.3 in Figure 1, providing a program of clinically managed, population-specific, high intensity residential service. It wants to raise the level of care at this facility to Level 3.7, i.e., medically monitored, intensive inpatient service. This is not hospital-level inpatient addictions withdrawal management or treatment (Level 4 in the ASAM schema).

ASAM Level 3.7 corresponds with the term "intermediate care facility" ("ICF"), a regulated category of health care facility in Maryland's Certificate of Need ("CON") law. In recent years, Maryland's CON program has regulated the supply and distribution of Levels 3.7 and 4 alcohol and drug abuse treatment ICFs and hospitals, but not lower levels of addictions treatment, such as early intervention, outpatient, partial hospitalization, or residential services.

The other Laurel Hope House facility, at 419 Main Street, and the Crownsville facility provide medically monitored, intensive inpatient services, both withdrawal management and treatment (ASAM Level 3.7). Thus, the proposed project would result in all three ARI facilities in Maryland having the capability to provide Level 3.7 inpatient services.

[1] This facility is licensed for 18 beds and has the physical capacity to set up and staff 18 beds.

Figure 1



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

C. The Project

Hope House seeks a CON to convert its existing residential beds at 429 Main Street to ICF beds, ASAM Levels 3.7 and 3.7WM ("withdrawal management") and add space for four additional beds, to establish a 22-bed ICF.

The applicant reports that this project requires no construction or renovation of 429 Main Street in Laurel. Thus, there is no capital expenditure required to implement the project. (DI#11, p. 4 and DI #12, App. 1, Table B-Project Budget).

D. Summary of Staff Recommendation

Staff recommends approval of the project based on its conclusion that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff concludes that the impact of the project is positive, primarily because it will improve the availability and accessibility of intensive inpatient alcohol and drug treatment services that will be broadly available to patients across the full range of income levels. This is a feature that has not been present in the last five ICF projects considered by the Commission, which provided only limited services to low income or Medicaid patients.

II. PROCEDURAL HISTORY

A. Record of the Review

Hope House filed its original application on March 7, 2018. Staff concluded that the applicant had failed to respond to several standards and criteria in its initial filing. In response to extensive staff completeness questions, Hope House filed a replacement application on July 31, 2018. It, too, required significant follow-up questioning to arrive at a complete application. The application was docketed for review in December 2018.

Please see Appendix 1, Record of the Review.

B. Local Government Review and Comment

No comments on this project were received from the Department of Health or local government entities in the service area.

C. Interested Parties in Review

There are no interested parties in the review.

D. Community Support

Hope House provided a letter of support from Maryland House Detox, a recently-established ICF in Linthicum (Anne Arundel County), which stated that Hope House "serves a large portion of indigent and gray area patients that Maryland House cannot serve," making it "crucial that Hope House … have access to additional detox beds to serve a traditionally underserved population." Hope House also submitted a letter of support from Serenity Sistas' Inc., which describes itself as a "recovery residence" program that provides alcohol-free and illicit drug-free housing to individuals with substance-related disorders, addictive disorders or co-occurring mental health and substance-related disorders or addictive disorders, but does not provide clinical treatment. This organization, with residences in Annapolis, also cited a need for detox bed capacity.

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 State Health Plan for Facilities and Services ("State Health Plan"), at COMAR 10.24.14: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services ("ICF Chapter") is the relevant State Health Plan chapter in this review. The ICF Chapter, at Regulation .05, includes the following sixteen CON approval rules and review standards for new substance abuse treatment facilities and for expansion 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.

The proposed project fits within the specifications outlined in 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.*

The applicant is a Track Two facility, i.e., it is an ICF that provides over half of its patient days to indigent or gray area patients.[2] Thus, Paragraph (1)(a) of this standard is not applicable.

(b) For Track Two, as defined at Regulation .08, an applicant who proposes to provide 50 percent or more of its patient days annually to indigent and gray area patients may apply for:

(i) Publicly-funded beds, as defined in Regulation .08 of this Chapter, consistent with the level of funding provided by the Maryland

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[2] The ICF Chapter, at COMAR 10. defines the "indigent population" as those "persons who qualify for services under the Maryland Medical Assistance Program (more commonly known as Medicaid), regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment." The "gray area population" is defined as those "persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any source is no more than 180 percent of the most current Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment.

Medical Assistance Programs (MMAP), Alcohol and Drug Abuse Administration, or a local jurisdiction or jurisdictions; and

Subparagraph (b)(i) applies to this Track Two facility; however, its language is outdated. As of July 1, 2017, Maryland reimburses ICFs through a fee-for-service arrangement using an Administrative Services Organization ("ASO"). According to Kathleen Rebbert-Franklin, Director of Health Promotion and Prevention at the Behavioral Health Administration of MDH, the fee-for-service arrangement is

> a contract held by Medicaid with significant input from the Behavioral Health Administration ('BHA'). This means that if a provider is willing to serve those with Medicaid, then they can admit to their facility as authorized and submit bills for reimbursement. There's no pre-determined amount of funding for any particular facility. This…is a significant change from the previous system where funds were given to specific ICFs through grants from BHA to the local jurisdiction. The previous payment method only allowed a limited number of ICFs to receive funding, and there was limited to no ability to manage utilization. Under our new reimbursement structure, the ASO, Beacon, authorizes admission for everyone admitted to this level of care. Patients must meet medical necessity criteria to receive that approval.

(ii) A number of beds to be used for private-pay patients in accordance with Regulation .08, in addition to the number of beds projected to be needed in Regulation .07 of this Chapter.

Subparagraph (b)(ii) is not applicable because Hope House is not seeking beds to be used exclusively for private-pay patients, but is seeking beds that are "substantially funded by ... the State," which, as noted earlier, occurs primarily through the Medicaid program.

(2) To establish or to expand a Track Two intermediate care facility, an applicant must:

(a) Document the need for the number and types of beds being applied for;

In its initial application, Hope House cited a "big waiting list … a heroin epidemic … and the Governor['s declaration of] a State of Emergency" in response to this standard. (DI #4, p.14). In its replacement application, Hope House provided information on its waiting list for the first six months of 2018. It reported that, in an average month during this six-month period, it had 146 persons on the list and this monthly average increased from 120 persons in the first three months of 2018 to 172 persons in April through June of 2018. It stated that "[i]n January 2018, Hope House Treatment Centers joined an initiative with the local health department to communicate waitlist numbers for data tracking purposes. For that reason, waitlist numbers are only available from January 2018 ...."

As previously noted, Hope House received letters of support from Maryland House Detox, a Track One ICF in Anne Arundel County and Serenity Sistas' Inc., an Annapolis-based provider of recovery residences.

Staff concludes that ARI has documented the need for the proposed project.

(b) Agree to co-mingle publicly-funded and private-pay patients within the facility;

(c) Assure that indigents, including court-referrals, will receive preference for admission, and

(d) Agree that, if either the Alcohol and Drug Abuse Administration, or a local jurisdiction terminates the contractual agreement and funding for the facility's clients, the facility will notify the Commission and the Office of Health Care Quality within 15 days that that the facility is relinquishing its certification to operate, and will not use either its publicly- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

Hope House affirmed that:

- It will co-mingle publically-funded and private-pay patients within the facility;
- Indigent persons, including court-referrals, will receive preference for admission;
- If the contractual agreement and funding is terminated, it will notify the Commission and the Office of Health Care Quality within 15 days to relinquish its certification to operate and that it will not use any of its beds for private-pay patients without obtaining a new Certificate of Need.

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

The applicant stated that its "self-pay rates are based off minimum operating costs for treatment. Therefore, the self-pay rates are the lowest possible rates for any given service." (DI #12, p.14). When staff requested clarification, Hope House stated that it contracts with most major private insurance plans and Maryland Medicaid, and stated that for the "small portion of patients that do not have insurance...[Hope House] has the ability to get an 'uninsured authorization' for coverage of benefits while the patient waits the application approval for Medicaid." (DI#18, p.3).[3]

When pressed for a clear, concise summary of its practice regarding patients who are uninsured, Hope House stated that, "Addiction Recovery, Inc. d.b.a. Hope House Treatment Centers self-pay rates are based off minimum operations costs for services rendered. Individuals [i.e., individuals above 138% of the Federal Poverty line] pay the minimum operating costs for each service rendered regardless of income level."

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[3] Hope House notes that Maryland Medicaid covers all individuals with incomes up to 138% of the federal Poverty Line. (DI#20).

After further discussion with the applicant concerning the necessity for taking a more straight forward approach to complying with this standard, the sliding fee scale table that follows was provided on February 1, 2019.

Table 3-1: Sliding Fee Scale - Hope House

Household Income	One-Person Household [2018 FPL: $12,140]							
	Detox Fee per Diem	Inpatient Fee per Diem	Assessment Fee	Screening/ Processing Fee	Intensive Outpatient Fee per Session	Outpatient Fee per Session	Individual Outpatient Fee per Session	DUI/DWI Course Fee
$23,000 or less (up to 189% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$23,001 - $39,000 (189% - 321% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$39,001 - $55,000 (321% - 453% of FPL)	$425	$400	$185	$150	$85	$65	$85	$625
$55,001 or more (more than 453% of FPL)	$475	$450	$210	$175	$110	$90	$110	$650

Household Income	Two-Person Household [2018 FPL: $16,460]							
	Detox Fee per Diem	Inpatient Fee per Diem	Assessment Fee	Screening/ Processing Fee	Intensive Outpatient Fee per Session	Outpatient Fee per Session	Individual Outpatient Fee per Session	DUI/DWI Course Fee
$29,000 or less (up to 176% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$29,001 - $45,000 (176% - 273% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$45,001 - $61,000 (273% - 371% of FPL)	$425	$400	$185	$150	$85	$65	$85	$625
$61,001 or more (more than 371% of FPL)	$475	$450	$210	$175	$110	$90	$110	$650

Household Income	Three-Person Household [2018 FPL: $20,780]							
	Detox Fee per Diem	Inpatient Fee per Diem	Assessment Fee	Screening/ Processing Fee	Intensive Outpatient Fee per Session	Outpatient Fee per Session	Individual Outpatient Fee per Session	DUI/DWI Course Fee
$35,000 or less (up to 168% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$35,001 - $51,000 (168% - 245% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600

$51,001 - $67,000 (245% - 322% of FPL)	$425	$400	$185	$150	$85	$65	$85	$625
$67,001 or more (more than 322% of FPL)	$475	$450	$210	$175	$110	$90	$110	$650

Household Income	Four-Person Household [2018 FPL: $25,100]							
	Detox Fee per Diem	Inpatient Fee per Diem	Assessment Fee	Screening/ Processing Fee	Intensive Outpatient Fee per Session	Outpatient Fee per Session	Individual Outpatient Fee per Session	DUI/DWI Course Fee
$40,000 or less (up to 159% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$40,001 - $56,000 (159% - 223% of FPL)	$375	$350	$160	$125	$60	$40	$60	$600
$56,001 - $70,000 (223% - 279% of FPL)	$425	$400	$185	$150	$85	$65	$85	$625
$70,001 or more (more than 279% of FPL)	$475	$450	$210	$175	$110	$90	$110	$650

Source: Based on information provided by the applicant, February 1, 2019

The applicant has established a sliding fee scale for gray area patients consistent with the client's ability to pay, consistent with this standard.

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

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:

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

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

(c) Commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) An 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.

This standard is not applicable to this project. Hope House is seeking to establish a Track Two ICF. Hope House states that most of the patients it will serve will be eligible for participation in the Medicaid program.

.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.

The applicant has committed to posting information concerning charges for services, and the range and types of services provided, in a conspicuous place, and that this information is available to the public upon request. (DI #12, p. 15).

Based on Hope House's commitment, the proposed project 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.

The applicant states that the facility is within 15 minutes driving time of both Howard County General Hospital and University of Maryland Laurel Regional Hospital. This latter hospital converted its general hospital operation to a freestanding medical facility ("FMF") on the same site earlier this year. A relocated Adventist HealthCare general hospital (Washington Adventist) will be opening in 2020 or 2021 at a Silver Spring location that is approximately six miles from the Laurel FMF.

Staff confirmed that the proposed Hope House ICF is within 30 minutes driving time of an acute care hospital, 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.

Hope House states that all beds are designated for adults 18 years of age and older. (DI #12, p.16). The proposed project 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.

Hope House documented that it is currently accredited by CARF in good standing, with its accreditation renewal scheduled for September 30, 2019. Hope House committed that it will comply with the notification provision of Paragraph (b) and with any determination made by the Office of Health Care Quality under Paragraph (c). (DI #12, p. 18).

(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.

Hope House documented that it is currently certified by the Office of Health Care Quality and committed that it will comply with the provisions in Paragraphs (b) and (c). (DI#12, p. 18).

.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.

Hope House documented that it has policies governing utilization review and control programs, and has treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral, and aftercare. (DI #11, App. G re Utilization Review, App. D re Treatment Protocols, App. H re Admission Protocols, App. I re Length of Stay, and App. J re Discharge Planning and Referral).

The proposed project 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.

Hope House has secured transfer and referral agreements as required by this standard. The details are summarized in Table III-2, below.

Table III-2 Hope House Transfer and Referral Agreements

Provider Category	Agreement(s) with:
Acute care hospitals	Doctors Community Hospital, Lanham
Halfway houses, therapeutic communities, long-term care facilities	A+ Counseling Center, Fort Washington QCI Behavioral Health, LLC, Largo Precision Recovery, Laurel
Local alcohol and drug abuse intensive and other outpatient programs	A+ Counseling Center, Fort Washington QCI Behavioral Health, LLC, Largo Precision Recovery, Laurel
Local community mental health center or center(s)	A+ Counseling Center, Fort Washington QCI Behavioral Health, LLC, Largo
The jurisdiction's mental health and alcohol and drug abuse authorities	Behavioral Health Services-Prince George's County (Drug Court System)
The Behavioral Health Administration of MDH (formerly the Mental Hygiene Administration with its division of Alcohol and Drug Abuse)	Behavioral Health Services-Prince George's County (Health Department) Anne Arundel County Mental Health Agency, Inc. (Provides stabilization services to the Hope House Laurel location)
The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services	A+ Counseling Center, Fort Washington QCI Behavioral Health, LLC, Largo Precision Recovery, Laurel

Source: (DI-18, p.3)

.05K. Sources of Referral.

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

(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.

Hope House provided documentation of the income distribution of its patients, noting that 83% of the patients it served over the last four years (2015-2018) "are on Medicaid and are considered indigent or gray area population." (DI #12, p.20 and App. L).

Subsection (2) is not applicable. The project seeks to establish a Track Two ICF.

.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.

Hope House states that it requires that all staff to complete onboarding training at orientation. It also provided a listing of continuing education and training modules that it uses for in-service education of its staff. (DI #12, p.20 and App. M). The proposed project is consistent with this standard.

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

The applicant provided copies of its admission standards, treatment protocols, staffing standards, and floor plans as a demonstration of its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification. (DI #12, p. 20 and App. H, D, N, and A, respectively).

The applicant demonstrated compliance 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.

Hope House provided copies of its policies for Infection Control and Blood Borne Pathogen Training, which detailed its methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients. (DI #12, p. 21 and App. O and P).

The proposed project 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.

Hope House submitted its Outpatient Policy/Procedure, documenting that it meets all of the specifications in this standard. (DI #12, App. Q).

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

The applicant states its commitment to report utilization data and any other required information to the SAMIS program on a monthly basis, and will also participate in any comparable data collection program specified by the Department of Health. (DI #12, p. 21). Based on this commitment, Hope House meets this standard.

B. NEED

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

The ICF Chapter has a need analysis standard a regional ICF bed need projection, but that bed need projection does not apply to this project but only to proposals for the development of Track One ICF bed capacity. As outlined earlier in this report, with respect to Standard *.05B. Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need,* at COMAR 10.24.14.05B.2(a), the applicant has demonstrated need for the 22 Track Two ICF beds it proposes to develop, based on the information provided on its waiting list in the first half of 2018 (a monthly average of 145.8 persons). As also noted, the Governor of Maryland declared a State of Emergency (which has since expired) with respect to the "crisis" of heroin, opioid, and fentanyl overdoses in 2017 and treatment of heroin and opioid addiction is one dimension of the needed response identified to this emergency, along with prevention and enforcement of laws aimed at controlling the supply and use of these substances. As additional background, staff notes that, in the 2018 session of the General Assembly, the Commission supported proposed legislation that would have eliminated CON regulation of the supply and distribution of alcoholism and drug abuse treatment ICFs. That legislation did not make it out of committee. In its CON Modernization Report that the Commission adopted at its December 2018 meeting, it recommended that the addition of ICF beds by existing providers of Level 3.7 services be deregulated and that the Commission undertake further study of the necessity for CON regulation of this service as a mechanism for barring entry into Maryland of undesirable service providers.

Staff recommends that the Commission find that the applicant demonstrated a need for this proposed project.

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.

This project converts a facility providing a lower level of addictions treatment, i.e., a clinically managed, high-intensity residential program, to a medically monitored intensive inpatient program with withdrawal management capabilities under medical supervision, with no capital investment required. Hope House states that it is the only inpatient addiction treatment program in Prince George's County with the ability to provide ASAM Level 3.7WM and 3.7 treatment services. Hope House states that the alternative treatment approach is for patients to receive detoxification treatment in a local hospital setting and that the cost of hospital treatment far exceeds the cost of withdrawal management at an ICF. (DI #12, pp. 24, 25). The only other CON for new bed capacity for Level 3.7WM that MHCC has authorized in recent years is operated or planned for operation in Track One ICFs that do not participate in the Medicaid program. Staff recommends that the Commission find that the proposed project is a cost-effective alternative for expanding the availability and accessibility of Track Two ICF beds.

D. VIABILITY OF THE PROPOSAL

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

Availability of Financial Resources

There is no capital cost associated with implementation of this project. The additional resources required will be for qualified staff. Hope House projects that the project will require an increase of approximately $287,000 (FY 2018 dollars) in annual salary expenses. This projection is, based on an additional three full time-equivalent ("FTE") nursing staff, three FTE treatment aides, 0.2 FTE physicians, 0.5 FTE nurse practitioners, and 0.4 FTE psychiatric nurse practitioners, with the latter three staffing categories being contract staff. These 7.1 additional FTEs represent an increase of 6.9% in the applicant's total staff FTEs (employed and contracted) across its two ICFs and one residential program.

Projected Financial Performance

Table III-3: Financial Projections-Uninflated (Select Line Items Only)

	Actual		Projected		
	2016	**2017**	**2018**	**2019**	**2020**
REVENUE					
Inpatient services	$4,558,924	$4,959,339	$6,727,889	$7,106,238	$7,106,238
Outpatient services	122,061	95,994	109,195	158,909	158,909
Net patient services revenue	$4,350,639	$4772413	$6,631,808	$7,218,032	$7,218,032
Other revenue (grants and contributions)	224,954	119,987	127,673	95,873	95,873
Net Operating Revenue	$4,575,593	$4,892,400	$6,759,481	$7,313905	$7,313905
EXPENSES					
Salaries & wages (including benefits)	$3,286,182	$3,738,534	$4,662,284	$5,152,603	$5,410,233
Depreciation	128,658	148,347	135,091	155,659	163,442
Total Operating Expenses	$4,311,506	$4,847,387	$5,957,775	$6,691,785	$7,026,274
Net Income	$ 264,087	$ 45,013	$ 801,706	$ 622,120	$ 287,631

Source: DI #18, Table D

Table III-3 reflects two years of actual and three years of projected financial performance for all three Hope House facilities. As can be seen, the bulk of Hope House's business is concentrated in the delivery of institutional care rather than outpatient services, which reportedly contributed only 2.4% of net patient service revenue in 2016 and 2017, combined. ARI reports that it generated net income in 2016 and 2017. The substantial revenue increase in 2018 is indicative of the enhanced Medicaid funding initiated in 2017 for Level 3.7 services, provided by two of Hope House's three facilities and the growth in both revenue and profitability projected for 2018 and 2019 reflects the proposal under review, which will convert Hope House's third facility to a higher revenue-generating ICF. The applicant projects a return to more modest levels of profitability by 2020, after two years of strong net income performance.

Community Support for the Proposed Project

Hope House reported that it received grants and contributions in 2016 and 2017 that totaled $345,000, about 3.6% of reported net operating revenue for those years. This type of support is projected to decline substantially in the out years of 2018 to 2020, projected to be equivalent to only 1.5% of net revenue over that period. The two letters of support received for this project have been previously noted.

Staff recommends that the Commission find that the proposed project is viable, as modeled by the applicant. While staff does not view the applicant's supporting analysis with respect to the availability of staff resources at the salaries projected as rigorous or thorough, there is a reasonable basis for believing that demand for expanded ICF bed capacity by low income households will be strong. Hope House is an experienced provider of Level 3.7 inpatient services.

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.

Hope House noted that its only previous CON, to establish the facility at Crownsville, was granted more than 15 years ago (the outer limit established in the application instructions), but states that it fully complied with the terms and conditions of that CON. Staff confirmed that the last Certificate of Need was granted to Hope House more than thirty years ago, and found no evidence of non-compliance with any terms or conditions of that CON.

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

COMAR 10.24.01.08G(3)(f)Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

The applicant is the only provider of inpatient withdrawal management and addictions treatment in Prince George's County. For a jurisdiction of this size, the 22 additional ICF beds resulting from this project are modest. Hope House describes the current situation with respect to detoxification, stabilization, and treatment resources in its service area as one of gridlock. Hope House states that the additional withdrawal management bed capacity resulting from this project will allow individuals to receive this medical service in a much lower cost setting than the general hospital and also noted that the new ICF will be a resource to which hospitals will be able to more quickly transfer patients for treatment. Hope House also states that the greater ability to accommodate referrals from drug-court, parole, and probation offices that this proposed project will provide will allow patients "to receive treatment vs. the cost incurred from incarceration." (DI #12, p. 27).

Staff believes that Maryland lacks sufficient ICF capacity for low income persons and that this deficit is substantial. The ICF Chapter rests on an assumption that this dearth of needed resources for the indigent and gray area population is a long-standing condition of the health care delivery system in Maryland that is likely to persist. For that reason, the proposed project will not have a negative impact on existing addictions treatment providers, on ICF bed occupancy, on costs and charges of other providers, or on costs to the health care delivery system. All indicators suggest that the impact of this project will be positive because it will make ICF services for low income persons marginally more available and accessible.

IV. STAFF RECOMMENDATION

Staff recommends that the Commission **APPROVE** Hope House's application to establish a 22-bed ASAM Levels 3.7 and 3.7WM alcoholism and drug treatment ICF in Laurel. This recommendation is based on staff's conclusion that the proposed project complies with the applicable State Health Plan standards and that the applicant has demonstrated the need for the project, its cost effectiveness, and its viability. Staff also concludes that the impact of the project is positive, primarily because it will improve access to intensive, medically-monitored inpatient

alcohol and drug treatment services and that these services will primarily be used by low income households, who are currently underserved with respect to Level 3.7 care.

There is no capital expenditure associated with the project. The ICF will be implemented in an existing residential facility operated by Hope House.

IN THE MATTER OF	*	BEFORE THE
	*	
ADDICTION RECOVERY INC. d/b/a HOPE HOUSE	* *	MARYLAND HEALTH
	*	CARE COMMISSION
Docket No. 18-16-2416	* *	

* *

FINAL ORDER

Based on Commission Staff's analysis and recommendation, it is this 21st day of February, 2019, **ORDERED:**

That the application of Addiction Recovery, Inc. d/b/a Hope House to establish an alcoholism and drug abuse treatment intermediate care facility with 22 ASAM Levels 3.7 and 3.7WM beds at 419 Main Street in Laurel (Prince George's County), Maryland is **APPROVED.**

MARYLAND HEALTH CARE COMMISSION

APPENDIX:
RECORD OF THE REVIEW

Addiction Recovery Inc. d/b/a Hope House
Docket No. 18-16-2416

Docket Item #	Description	Date
1	D'Souza to McDonald – Letter of Intent	11/15/17
2	Maryland Register Notice – Request for additional letters of Intent Triggering Comparative Review	11/16/17
3	Potter to D'Souza – No additional LOI's received for comparative review and acknowledgement of receipt of LOI	1/26/18
4	Certificate of Need Application	3/7/18
5	Potter to D'Souza – Acknowledge receipt of application for completeness review	3/12/18
6	Potter to Washington Times – Request to publish notice of receipt of application	3/12/18
7	Maryland Register – Request to publish notice of receipt of application	3/12/18
8	Notice of receipt as published in the Washington Times	3/19/18
9	McDonald to D'Souza – Request for completeness and additional information	6/18/18
10	E-Mail – Dsouza to McDonald – Request Extension to file completeness until 7/31/18	7/26/18
11	Dsouza to McDonald – Completeness Response	7/31/18
12	Revised Certificate of Need Application	7/31/18
13	E-Mail – Attestation for Revised CON Application	8/1/18

14	E-Mail – Klemmer to McDonald – Amended documents for Revised CON Application	8/1/18
15	Completeness Information	9/21/18
16	McDonald to D-Souza – Second Round request for completeness information	10/19/18
17	E-Mail – Extension to file additional completeness until 11/6/18	10/29/18
18	Completeness Information	11/7/18
19	McDonald to D-Souza – Commission requires information on sliding fee scale	11/20/18
20	E-Mail – Klemmer to McDonald – Required Sliding Fee Scale	11/20/18
21	Potter to D-Souza – Formal start of review of application will be 12/7/18	11/20/18
22	Potter to Washington Times – Request to publish notice of formal start of review	11/20/18
23	Maryland Register – Request to publish notice of formal start of review	11/20/18
24	FORM – Request LHP Comments	11/20/18
25	Notice of formal start of review as published in the Washington Times	11/29/18
26	Applicant submits additional information	2/5/19
27	Applicant submits revision to sliding fee scale policy signed by Board chair	2/14/19