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October 24, 2016

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

VIA EMAIL and HAND DELIVERY

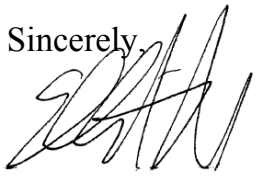
Re: Recovery Centers of America – Earleville
314 Grove Neck Road OPCO, LLC
Matter No. 15-07-2363

Dear Ms. Potter:

On behalf of applicant 314 Grove Neck Road OPCO, LLC, we are submitting six copies of their Response to 10/17/16 Comments Submitted by Interested Party in the above-referenced matter. I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

In light of the devastating substance use disorder crisis in Maryland, as described throughout Applicant's filings and recognized by the highest levels of leadership in this state, Applicant respectfully requests that a recommended decision issue as soon as practicable, and that such decision be presented at the next possible meeting of the Maryland Health Care Commission.

Sincerely,



Ella R. Aiken

ERA:blr
Enclosures
cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Joel Riklin, Program Manager
William Chan, Health Policy Analyst, HSP&P/CON
Suellen Wideman, Esq., Assistant Attorney General, MHCC

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013522-0004

Suellen Wideman, Esq., Assistant Attorney General, MHCC
Stephanie Garrity, Health Officer, Cecil County (w/ enclosures)
Marta D. Harting, Esq.
John J. Eller, Esq.
JP Christen, Chief Operating Officer, Recovery Centers of America
Edmund J. Campbell, Jr., Esq.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Thomas C. Dame, Esq.

IN THE MATTER OF RECOVERY CENTERS OF AMERICA – EARLEVILLE Docket No. 15-07-2363	* * * * * *	BEFORE THE MARYLAND HEALTH CARE COMMISSION

* * * * * * * * * * * *

RESPONSE OF 314 GROVE NECK ROAD OPCO, LLC TO COMMENTS SUBMITTED BY INTERESTED PARTY ASHLEY, INC.

314 Grove Neck Road OPCO, LLC ("Applicant"), a subsidiary of Recovery Centers of America, by its undersigned counsel, submits this response to the comments filed by interested party Ashley, Inc., *d/b/a* Ashley Addiction Treatment (*f/k/a* Father Martin's Ashley) ("Ashley") addressing Applicant's October 7, 2016 Modification in Response to the September 20, 2016 Project Status Conference. For the reasons set forth below and throughout the Applicant's filings in this review, Applicant respectfully requests that the Reviewer recommend approval of the pending application for Certificate of Need.

ARGUMENT

APPLICANT'S CHARITY CARE COMMITMENT COMPLIES WITH THE REVIEWER'S RECOMMENDATION AND WITH COMAR § 10.24.14.05D

COMAR § 10.24.14.05D governs the provision of charity care. The standard provides, in relevant part:

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

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

COMAR § 10.24.14.05D (emphasis added). During the September 20, 2016 Project Status Conference, the Reviewer directed Applicant, pursuant to this standard, to "make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days" in response to COMAR § 10.24.14.05D. September 20, 2016 Letter from Reviewer summarizing the Project Status Conference (the "September 20, 2016 Letter"), Exhibit 19. Applicant did just that. October 7, 2016 Modification, Exhibit, Tables G, H J, and K. Consistent with the Reviewer's comments during the Project Status Conference, and with Applicant's commitment to provide a continuum of care across residential and detox services to its patients, Applicant distributed the resulting amount of charity care across detox and residential services.

Ashley does not dispute that Applicant complied with the Reviewer's directive concerning charity care. Instead, it suggests that Applicant's charity care commitment does not comply with COMAR § 10.24.14.05D. Ashley's arguments are misguided.

A. COMAR § 10.24.14.05D applies to detox services only.

Standard .05D requires a charity care commitment with respect to detox services only. The text of that standard applies the 15% charity care requirement to "annual adult intermediate care facility bed days." *Id.* The Maryland Health Care Commission ("MHCC") has confirmed that the term "intermediate care facility," includes only detox services. In an August 3, 2015 determination of non-coverage, 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 [("ASAM")]. This would include Level III.7, medically-monitored intensive inpatient treatment and Level III.7- D, medically-monitored inpatient detoxification services."[1] August 3, 2015 Letter, Exhibit 20. Thus, an "intermediate care facility" does not encompass residential services. Indeed, the August 3, 2015 Letter confirms that the establishment of residential treatment services "does not require CON review and approval." *Id.*

The August 3, 2015 Letter is consistent with the applicable State Health Plan ("SHP") definition of an intermediate care facility, which applies to medically monitored intensive inpatient sub-acute detoxification services, but not to clinically managed residential treatment services. As Ashley states, COMAR § 10.24.14.08B(13) defines an intermediate care facility as:

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

[1] Such services are referred to in this filing and throughout this review as "detox" services.

Id. Notably, this definition includes the provision of "medical services." This is consistent with the definition of Level III.7.D services under state regulations, and with Level III.7 services as defined by ASAM.[2]

By contrast, both state regulations and ASAM define residential services to include "clinically managed services" rather than medically monitored intensive inpatient services.[3] Also notable is that the SHP includes definitions of "detoxification" and "sub-acute detoxification," but does not define residential treatment services or a category of

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[2] COMAR § 10.47.02.09 defines a level III.7.D program as "[a] medically monitored intensive inpatient treatment program" that shall: (1) [o]ffer a planned regimen of 24-hour professionally directed evaluation, care, and treatment in an inpatient setting; (2) [a]ct as an Intermediate Care Facility Type C/D; and (3) [m]eet the certification requirements for detoxification services as described in COMAR 10.47.02.10E." *Id.* at .09(A). Patients appropriate for this level of care "(1) Meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.7, or its equivalent as approved by the Administration; and (2) [r]equire 24-hour monitoring and care for subacute biomedical and emotional or behavioral conditions severe enough to warrant inpatient treatment." *Id.* at .09(B).

ASAM defines Level III.7 Services as "Medically Monitored High-Intensity Inpatient Services," and described as "24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counsel ability." The ASAM Criteria: Treatment for Addictive, Substance-related, and Co-occurring Conditions, Third ed., Ch. 3, Ed. David Mee-Lee, American Society of Addiction Medicine, 2013. Dimension 1 is defined as "Acute Intoxication and/or Withdrawal Potential;" Dimension 2 is defined as "Biomedical Conditions and Complications"; Dimension 3 is defined as "Emotional, Behavioral or Cognitive Conditions and Complications." *Id.*, Ch. 7.

[3] COMAR § 10.47.02.08 defines a level III.5 program as "[a] clinically managed high intensity residential program" that shall "(1) [p]rovide a highly structured environment in combination with moderate to high intensity treatment and ancillary services to support and promote recovery; and (2) [b]e characterized by its reliance on the treatment community as a therapeutic agent." *Id.* at .08(A). Patients appropriate for this level of care "meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level III.5, or its equivalent as approved by the Administration." The ASAM Criteria, Ch. 3.

ASAM defines Level III.5 Services as "Clinically Managed High Intensity Residential Services," described as "24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community." *Id.*, Ch. 7.

services consistent with ASAM Level III.5, further confirming that such services are not within the purview of the SHP for intermediate care facilities.

Ashley's suggestion that the mere fact that Applicant will provide residential treatment services on the same campus brings the services within CON regulation is misplaced. There is no such requirement in the SHP, and the SHP does not purport to regulate residential treatment services.

B. Applicant's calculation of charity care in terms of net revenue is appropriate.

Ashley's argument that Applicant's charity care commitment does not meet Standard .05D because it is calculated in terms of net revenue instead of patient bed days has no merit. As an initial matter, as described above, the Standard expressly allows modification for good cause, and Applicant's projections comply with the Reviewer's directive at the Project Status Conference. Furthermore, while Applicant states its commitment in terms of net revenue, it can just as easily be translated into detox bed days by reviewing the financial projection tables.

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

paid for with the charity care commitment. $939,378 divided by $860 equals 1,092 bed days. Thus, Applicant's charity care commitment can easily be stated in terms of bed days or net revenue using the statistical and financial projections.

Expressing charity care in terms of bed days, however, only would only result in a lower amount of charity care to patients. Applicant's detox rates are higher than its residential rates. The average daily reimbursement rate for detox services is $860, before charity care is factored into net revenue. The average daily rate reimbursement rate for residential services, before charity care, is $724.[4] Thus, if Applicant committed to provide 1,092 bed days to charity care patients across its detox and residential services, instead of $939,378 in net revenue, it would actually provide less charity care than if Applicant used net revenue as its means of measurement. However, Applicant's actual commitment in terms of detox and residential bed days can be ascertained from the projections as well. In FY 2018, Applicant commits $478,755 in net revenue to detox charity care, or 557 detox bed days ($478,755 / $860). *Id.*, Table J. Applicant commits $460,623 in net revenue to residential charity care ($939,378 - $478,755), or 636 residential bed days ($460,623 / $724). *Id.*, Table G. This is the equivalent to detox and residential course of treatment for 40 charity care patients (557/14 detox ALOS = 40; 636/16 residential ALOS = 40).

[4] *See* October 7, 2016 Modification, Exhibit 39, Tables F, G, H, I, J, and K. This number is stated the other filings in this review, but can also be calculated, for any year, by subtracting outpatient services revenue and detox net revenue, before charity care, from the entire facility net revenue, before charity care, and dividing that amount by the number of residential days in that year.

C. Applicant demonstrated that a modification to Standard .05D is appropriate based on its commitment to provide a continuum of charity care services.

Ashley incorrectly states that Applicant's calculation of charity care results from confusion or misunderstanding of the Standard .05D. Applicant agrees that Standard .05D requires Applicant to provide 15 percent or more of its detox patient bed days to charity care patients, unless Applicant demonstrates why the standard should not apply. Applicant also agrees that it has not provided 15 percent or more of its detox patient bed days to charity care for detox treatment, choosing instead to provide charity care in amount consistent with 15% of the net revenue associated with detox services, and distributing that amount across detox and residential care. Standard .05D expressly gives an applicant the flexibility to demonstrate that the charity care requirement should be modified, and Applicant has done that in this review.

Applicant's prior filings contain lengthy argument and discussion as to why a modification of the charity care requirement is appropriate. Applicant highlighted, in part, that it would be clinically inappropriate to provide charity care to patients at the detox level only, and that, while Standard .05D does not require a charity care commitment for residential treatment services, Applicant would make the commitment to provide charity care patients with a continuum of care. Thus, imposing a 15% charity care requirement on Applicant would have the effect of almost doubling the net revenue that the standard intended applicants to contribute to charity care. Applicant also noted that the percentage of Marylanders falling within the indigent and gray area population is

significantly decreasing as a result of the Affordable Care Act. Lastly, Applicant discussed that the requirement of 15% charity care would result in Applicant providing more than twice the charity care commitment of Ashley, which, as far as Applicant has been able to discover, is the only applicant to apply for intermediate care facility beds in the last 20 years. Imposing the requirement on Applicant simply because its projections indicate it would be able to absorb greater loss would hinder the development of these services by for profit entities at a time when Maryland is suffering from a substance abuse epidemic and there is a considerable deficit of beds.

The plain intent of Standard .05D also supports the modification. Not only does the Standard itself expressly allow modification, but the State Health Plan Chapter confirms that the Commission's intent is to "increase access to care for indigent and gray area populations" COMAR § 10.24.14.02B, and avoid "a two-tier system of care based upon the individual's ability to pay." COMAR § 10.24.14.03B(1). Applicant's modification to Standard .05D increases access to substance use disorder treatment by providing charity care services in the residential setting, which are often provided in a private pay setting, and avoids incentivizing two tiers of service where only full-pay patients receive both levels of care.

The Reviewer concluded, as the Standard allows, that Applicant provided a basis for modification of Standard .05D. The September 20, 2016 Letter states, "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." September 20, 2016 Letter.

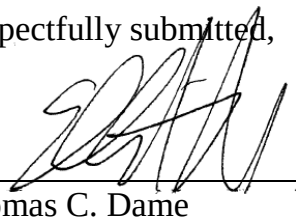
D. Ashley's additional arguments lack merit.

This is not a comparative review, and nothing in the SHP requires Applicant's proposal to be compared to Ashley's facility or its charity care commitment. Furthermore, Ashley and Applicant's applications are distinguishable. Ashley chose to seek CON approval and licensure for all of its beds, and to use its beds flexibly to provide detox and residential treatment. In contrast, Applicant is seeking to license only 21 of its 108 beds as detox beds. Those beds will be located in a distinct patient unit serving only detox patients. Ashley may regret seeking to license all of its beds as detox beds, and the resultant charity care level agreed to by Ashley in its CON review. However, Ashley's decision does not impose any obligation upon Applicant or the Reviewer to treat Applicant's beds similarly.

CONCLUSION

For the reasons set forth above and throughout Applicant's filings in this review, Applicant respectfully requests that the Reviewer recommend approval of the pending application for Certificates of Need. In addition, in light of the devastating substance use disorder crisis in Maryland, as described throughout Applicant's filings and recognized by the highest levels of leadership in this state, Applicant further respectfully requests that such a recommendation be presented at the next possible meeting consistent with the regulations governing this review.

Respectfully submitted,



Thomas C. Dame
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Gallagher Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore MD 21201
(410) 727-7702

Attorneys for
314 Grove Neck Road OPCO, LLC

Date: October 24, 2016

* * * * *

TABLE OF EXHIBITS

Exhibit	Description
19	September 20, 2016 Letter from Reviewer summarizing the Project Status Conference
20	August 3, 2015 determination of coverage

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 24th day of October, 2016, a copy of the Response of 314 Grove Neck Road OPCO, LLC to 10/17/16 Comments Submitted by Interested Party was served by email and first-class mail on:

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mdharting@venable.com

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Stephanie Garrity, MS
Health Officer
Cecil County
401 Bow Street
Elkton MD 21921
stephanie.garrity@maryland.gov

Ella R. Aiken

EXHIBIT 19

STATE OF MARYLAND

Craig Tanio, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

September 20, 2016

By E-Mail and U.S. Mail

Thomas C. Dame, Esquire
Ella R. Aiken, Esquire
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

John J. Eller, Esquire
Ober, Kaler, Grimes & Shriver
100 Light Street
Baltimore, Maryland 21202

Marta D. Harting, Esquire
Venable LLP
750 Pratt Street, Suite 900
Baltimore, Maryland 21202

Re: Project Status Conference
324 Grove Neck Road OPCO, LLC (RCA-Earleville; Docket No. 15-07-2363)
4620 Melwood Road OPCO, LLC (RCA-Upper Marlboro; Docket No. 15-16-2364)
11100 Billingsley Road LLC (RCA-Waldorf; Docket No. 15-08-2362)

Dear Counsel:

I am writing this letter to summarize the project status conference held today regarding applications filed by the above-referenced applicants, each associated with Recovery Centers of America Holdings, LLC (RCA), that seek Certificate of Need approval for intermediate care facility beds that are regulated by the Maryland Health Care Commission.

Present at the project status conference were the following representatives of the parties in this review:

Applicants:
Thomas C. Dame, Esquire
Ella R. Aiken, Esquire
J.P. Christen, RCA

Interested Party Anne Arundel General Treatment Services, Inc. d/b/a Pathways (all three reviews):
Marta D. Harting, Esquire
Helen Reines, Executive Director, Pathways

Interested Party Ashley, Inc. (RCA-Earleville only):
John J. Eller, Esquire
Steve Kendrick, COO, Ashley, Inc.
Al Germann, CFO, Ashley, Inc.

At the project status conference, I discussed the following areas for which modification is needed before I can make a positive recommendation to the Commission. I also requested additional information that will assist me in these reviews.

Project Costs

Each RCA applicant must submit revised cost estimates and supporting tables A through L. I request that each applicant pay close attention to these matters so that no additional filings or corrections will be needed.

COMAR 10.24.14.05D: Providing Care to Indigent and Gray Area Patients

As I noted at project status conference, regarding RCA's proposal for meeting charity care requirements, I am pleased that each applicant has committed charity care dollars to provide the full range of needed care to indigent and gray area patients, both in detoxification and residential care. From a public policy perspective, the proposed 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.

Each applicant m ust 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). While the 2015 modified applications' proposed charity care figures for RCA-Earleville and RCA-Waldorf appear to meet the standard, the amount of funds proposed by RCA-Upper Marlboro for charity care to such patients does not appear to be equivalent to the 15% of the net revenue for its detox bed days. As I noted, the applicants should determine whether new cost estimates and tables necessitate the need for changes from the 2015 modified applications.

COMAR 10.24.14.05J: Transfer and Referral Agreements

Each applicant must update information regarding its executed transfer and referral

agreements with or acknowledgement from agencies or facilities who have capabilities for managing cases that "exceed, extend, or complement" the applicant's capabilities. For each applicant, please provide documentation of transfer and referral agreements, and an updated list of the providers and agencies (categorized by provider type). If it is not possible to obtain executed agreements, please provide letters that express the provider's (or agency's) intent to enter a referral agreement after CON approval of the facility. Under those circumstances, issuance of first use (pre-licensure) approval will be conditioned on receipt of the documentation.

COMAR 10.24.14.05K: Referral Sources

Each applicant must document that it has established agreements that assure that it will provide the required level of services to indigent or gray area populations. As I pointed out, I do not know whether the applicants will be able to obtain referral agreements from the Behavioral Health Administration (successor to the Alcohol and Drug Abuse Administration) or other agencies that are named in COMAR 10.24.14.07K, since none of the applicants has received CON approval or is an existing provider. If it is not possible to enter referral agreements under these circumstances, I will accept letters that express an agency's intent to refer patients to the facility after CON approval of the facility. Again, first use approval will be conditioned on the receipt of such agreements.

Project Drawings

I request updated project descriptions and current architectural drawings for each project.

Other

Please verify the continued funding commitment by the Deerfield private equity fund for the updated estimate of each project's cost.

On or before September 27, 2016, each applicant should advise me whether or not it will modify its application as requested at the project status conference, and, if so, provide me with the estimated date by which the requested modifications to each application will be filed. As I noted, the filing date for the modifications to each application may differ. As provided in COMAR 10.24.01.09A(2)(d), the interested parties will have seven days after receipt of the modifications to file comments on the proposed changes. The applicant will have five days to respond to comments. If a date falls on a holiday or weekend, the filing is due on the next business day.

I want to remind all parties that this is a contested case and that the ex parte prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply to this proceeding until the Commission issues a final decision.

Sincerely yours,

Randolph S. Sergent
Commissioner/Reviewer

cc: Stephanie Garrity, MS, Cecil County Health Officer (RCA-Earleville application)
Pamela Brown-Creekmur, RN, Prince George's County Health Officer (RCA-Upper Marlboro application)
Dianna E. Abney, M.D., Charles County Health Officer (RCA-Waldorf application)
Paul E. Parker
Kevin McDonald
Karen Rezabek
Suellen Wideman, AAG

EXHIBIT 20

STATE OF MARYLAND

Craig P. Tanio, M.D
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

August 3, 2015

Ella R. Aiken, Esquire
Thomas C. Dame, Esquire
Gallagher, Evelius, and Jones, LLP
218 North Charles Street, Suite 400
Baltimore, MD 21201

Re: Requests for Determination of Coverage
Capital Expenditures for Establishment of Alcoholism and Drug Abuse Intermediate Care Facilities
Recovery Centers of America
Matter No.: 15-08-2362 and Matter No.: 15-07-2363

Dear Ms. Aiken and Mr. Dame:

I write in response to your letters of June 17 and July 15, 2015 requesting, on behalf of Recovery Centers of America ("RCA"), a determination of coverage for two capital projects that are, in whole or in part, the subject of the above-referenced Certificate of Need ("CON") applications.. Each of these applications proposes the establishment of alcoholism and drug abuse intermediate care facilities ("ICFs"). Matter No. 15-08-2362 involves the development of an ICF campus in Charles County and Matter No. 15-07-2363 involves the development of an ICF campus in Cecil County, both of which are proposed to provide facilities for inpatient detoxification and residential treatment.

Alcoholism and drug abuse ICFs are defined, in COMAR 10.24.14, as facilities "designed to facilitate the subacute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide." The Maryland Health Care Commission has determined that this definition corresponds to the subacute "inpatient" level of care and service 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.[1]

[1] It would not correspond to Level IV, medically-managed intensive inpatient treatment or Level IV-D, medically-managed inpatient detoxification. These levels of care fall under COMAR 10.24.17's definition of "acute alcohol and drug abuse services" defined as "emergency and detoxification services provided to individuals requiring 24-hour medical or psychiatric care as a result of life-threatening or serious acute or chronic alcohol or drug abuse, or medical psychiatric illness associated with substance abuse, provided in licensed acute general hospitals defined in Health General Article §19-301(f)-(g), Annotated Code of Maryland."

The development plan proposed by RCA for these two projects involves establishment of facilities that will be used to provide Level III.7-D medically-monitored inpatient detoxification services and Level III.5 clinically managed high-intensity residential treatment. RCA requests a determination with respect to the regulatory requirements associated with two project initiation scenarios that would proceed without issuance of a Certificate of Need. Under the first scenario, RCA would proceed with full development of both the Charles and Cecil County facilities even if a CON is not issued, but would limit itself to operation of the Level III.5 facilities for clinically managed high-intensity residential treatment, withholding operation of the detoxification facilities until issuance of a CON. Mr. Dame's letter of July 15, 2015 states that, "RCA is willing to accept the business risk that, if the CON Applications are denied, the facilities could not be used for purposes that would require a CON."

Under the second scenario, RCA would limit initial development of the two campuses that would proceed without CON authorization, to the facilities intended to house the Level III.5 facilities for clinically managed high-intensity residential treatment, withholding expenditures for development of the facilities intended to house the Level III-D medically-monitored inpatient detoxification services until such time as establishment of those facilities may obtain CON authorization.

I have determined that RCA may proceed to execute binding obligations to develop and incur expenditures for construction/renovation expenditures to develop those parts of the proposed Charles and Cecil County projects related to the provision of Level III.5 facilities for clinically managed high-intensity residential treatment, the second scenario outlined in the July 15, 2015 request for a determination of coverage. Establishment of such facilities does not require CON review and approval

I have determined that RCA may not proceed with initial development of these campuses as described in the first scenario, given that this would involve obligating RCA to expenditures and the incurrence of expenditures for establishment of facilities that require CON authorization.

Finally, a word of caution. As RCA contemplates the potential for substantive expenditures for facilities development prior to a decision on its CON applications, I would urge RCA to strongly reconsider the position it has taken with respect to the patient population it will serve and the implications of this position on RCA's ability to operate ICF campuses in the configuration it desires. The number of Maryland citizens without health insurance coverage has shrunk since the implementation of the Affordable Care Act but, at an estimated 400,000, it is still significant. Since last year, the Maryland Medicaid population has grown to over 1.2 million and more than 780,000 Maryland residents are enrolled in the Medicare program. Together, these two public programs provide health benefits to approximately one-third of Maryland's population. It is difficult to imagine the Maryland Health Care Commission approving new health care facilities that completely ignore these populations.

If you have any questions concerning this determination, please contact Kevin McDonald, Chief of the CON Division at 410-764-5982.

Sincerely,

Ben Steffen
Executive Director

cc: Kevin McDonald, Chief, Certificate of Need
Suellen Wideman, Assistant Attorney General
Gayle M. Jordan-Randolph, M.D., Deputy Secretary for Behavioral Health
Stephanie Garrity, Health Office, Cecil County
Dianna E. Abney, M.D., Health Office, Charles County