VENABLE® LLP

750 E. PRATT STREET SUITE 900 BALTIMORE, MD 21202
T 410.244.7400 F 410.244.7742 www.Venable.com

Marta D. Harting (410) 244-7542 mdharting@venable.com

February 3, 2016

VIA HAND DELIVERY

Ruby Potter, Administrator
Maryland Health Care Commission
Center for Health Care Facilities
Planning & Development
4160 Patterson Avenue
Baltimore, MD 21215

Re: In the Matter of Recovery Centers of America Earleville
Docket No. 15-16-2363

Dear Ms. Potter:

Enclosed are an original and six copies of Interested Party Comments of Pathways on Corrected Modified Application for filing in the above-referenced case.

Should you have any questions, please let me know. Thank you for your attention to this matter.

Sincerely,

Marta D. Harting

Marta D. Harting

MDH:rlh
Enclosure
cc: Tom Dame, Esquire
John C. Eller, Esquire

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF *

RECOVERY CENTERS OF AMERICA *
EARLEVILLE **Docket No. 15-16-2363**
* * * * * * * * * * * *

INTERESTED PARTY COMMENTS OF PATHWAYS ON CORRECTED MODIFIED CERTIFICATE OF NEE APPLICATION

Pursuant to COMAR 10.24.01.08E(3)(a)(ii), Anne Arundel General Treatment Services, Inc., d/b/a/ Pathways ("Pathways") provides these comments regarding the Corrected Modified Certificate of Need Application (the "Modified Application") filed by Recovery Centers of America ("RCA") to establish an alcohol and drug abuse intermediate care facility ("ICF") in Earleville, Maryland.

In the Modified Application, RCA maintains its request to establish a new ICF in Earleville in Cecil County (Eastern Shore planning region) with 21 adult detox/assessment beds (licensed as ASAM level III.7D – Medically Monitored Inpatient Detoxification) ("Detox Beds"), and increases the number of adult residential beds (licensed as ASAM level III.5 – Clinically-Managed High-Intensity Residential Treatment) ("Residential Beds") at the project from 28 to 87. Under a revised construction plan, before being granted a CON, RCA plans to renovate an existing building to house 39 Residential Beds, and then it proposes to construct a three story addition to house the 21 Detox Beds and the remaining Residential Beds after obtaining a CON. The revised proposed capital cost of the entire project is $30.8 million of which $7.4 million RCA allocates to the detox/assessment beds.

The proposed Earleville facility is in addition to the two new ICFs in the Southern Maryland planning region (Waldorf and Upper Marlboro) that RCA seeks to establish pursuant

to the applications in Docket Nos. 15-08-2362 and 2364. Through all three applications (which are not couched in the alternative), RCA seeks to establish 140 new Detox Beds and 259 new Residential Beds in the State.

The proposed service area for proposed project has not changed, and would encompass Annapolis (and all of Anne Arundel County) within a 60 mile radius, while Annapolis is within a 30 mile radius of the proposed Upper Marlboro project and just outside of a 30 mile radius of the proposed Waldorf facility. RCA has defined overlapping and expansive service areas for each proposed new facility that extend as far as 110 miles from each proposed project as part of a "large regional market strategy." Modified Application at 32.

While RCA continues to highlight the expansion of Medicaid eligibility in Maryland under the Affordable Care Act ("ACA") in the Modified Application in support of the project (see Modified Application at 41), RCA maintains its business strategy of serving only the privately insured market and refusing to accept Medicaid, while at the same time requesting a sharply lower charity care requirement than imposed required in the State Health Plan for Facilities and Services – Alcoholism and Drug Treatment Intermediate Care Facility Treatment Services, COMAR 10.24.14 (the "SHP Chapter").

ARGUMENT

As set for the below, the Modified Application does not cure any of the failures of RCA's prior Application to comply with all SHP Chapter standards requirements and review criteria contained in COMAR 10.24.01.08G. In particular, the Modified Application continues to be inconsistent with the following standards and review criteria:

1. COMAR 10.24.14.05B and .07B (Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need and Bed Need Projection Methodologies)

2. COMAR 10.24.14.05D (Provision of Service to Indigent and Gray Area Patients)

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

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

5. COMAR 10.24.01.08G(3)(d) (Viability of the Proposal)

6. COMAR 10.24.01.08G(3)(f) (Impact on Existing Providers

Pathways is entitled to be an interested party in this matter for the reasons set forth in its Interested Party Comments and attachments filed on November 16, 2015. Additionally, Pathways incorporates its November 16, 2015 Interested Party Comments by reference as if fully set forth herein.

1.

Need

The Modified Application continues to fail to comply with the need projection methodology required by SHP Chapter Standard .05B (as set forth in Standard .07B(7)) as well the need requirement under COMAR 10.24.0108G(3)(b). In the Modified Application, RCA revised its projection of net need downward from its prior projection. Specifically, where it previously projected net need in the Eastern Shore region to be between 25 and 81 beds (as modified in RCA's August 31, 2015 completeness question responses), it now projects net need in this region to be between 10 and 51 beds. Modified Application at 35. Likewise, where RCA's prior Application projected statewide net need to be between 449 and 602 beds, it now projects state-net need to be between 307 and 419. Modified Application at 39.

RCA's lower net need projections still fail to comply with the need projection methodology in the SHP Chapter and overstates net need in the Eastern Shore region and

statewide.[1] Most significantly, in calculating net need, RCA continues to make an unauthorized downward adjustment to the number of existing ICF beds in the Eastern Shore region by reducing the inventory of beds at Hudson Center and Warrick Manor by 60%, from 75 beds to 31 beds taking the position that only 41% of the beds in an ICF are "true" detox beds. Modified Application at 35. There is no basis for this adjustment. Under the State Health Plan methodology, the adjusted inventory of beds is calculated by subtracting only the number of funded beds. The Commission most recently applied this methodology in its 2013 decision on the Father Martin's Ashley CON application (Docket No. 13-12-2340) (the "FMA Decision"), in which the Commission calculated the total number of beds in the inventory excluding only funded beds. See FMA Decision at 9.

Pathways has 32 adult ICF beds, all of which are licensed Detox beds (ASAM Level III.7D). No portion of Pathways beds are reserved or set aside as its "true" detox beds. All of Pathways 32 adult beds are made available for Detox treatment.

Accordingly, there is no basis for this adjustment, and it causes RCA's need projection in the Eastern Shore region to be overstated for this reason alone by 44 beds. Likewise, as shown in Corrected Modified Table 9 (at page 37), RCA inappropriately reduced the state-wide inventory on this basis, in addition to inappropriately failed to count the 32 adult beds at Pathways. Existing ICF inventory becomes 259 rather than 92 as calculated by RCA a difference of 167 beds.

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[1]RCA continues to apply the adult prevalence rate of 0.0864 in standard .07B(7)(b) only to the commercially insured population only, not the overall population as required by the standard. These prevalence rate would be expected to be lower among the commercially insured population only, so applying this rate to that population overstates prevalence amongst the population that RCA proposes to exclusively serve.

Correcting for RCA's undercounting of existing inventory produces the following net need projections:

RCA Net Private Bed Need Projections 2019 (Corrected)		
	Eastern Shore	**Statewide**
Min	(34)	140
Max	7	252

Accordingly, RCA's request for 21 Detox beds in the Eastern Shore region is inconsistent with the need methodology in the SHP Chapter and significantly exceeds the maximum net need produced by that methodology.[2]

RCA maintains its suggestion that only 6 of the 21 Detox Beds it requests would be used for Maryland residents by 2019. Modified Application at 36. There is no basis in the SHP Chapter to approve more ICF beds than the need methodology in the SHP Chapter produces based on an applicant's suggestion that it will not use the excess beds for Maryland residents. If it was, the Commission's need projection methodology and its need projections would become meaningless. For example, using RCA's approach, a nursing home applicant could establish beds in excess of the Commission's need projection by the simple expedient of defining for itself a large service area that extends beyond Maryland's borders (exceeding the need projection

[2] This assumes for the sake of argument only (without conceding) that RCA's need methodology complies with the State Health Plan methodology in all respects other than the understatement of existing beds.

based on the percentage that out of state residents represent within the service area population), but not be restricted to serving only out of state residents in those extra beds.

In the FMA Decision, the Commission found that on average seven of the fifteen new beds that FMA sought would be used for Maryland residents. See FMA Decision at 22. However, this does not provide precedent for RCA's approach here. First, FMA did not request approval of beds in excess of the net need projection generated by applying the need methodology in the SHP Chapter. Here, RCA seeks three times the maximum net need in the Eastern Shore region under that methodology. Second, the calculation in the FMA Decision was based on FMA's actual historical data on the origin of its patients. Here, RCA has no track record, and simply bases its number of "Maryland beds" on the percentage of Maryland residents within the total population in its proposed service area.

Further, RCA's argument is self-fulfilling. Its request for beds in excess of the net need projection produced by the methodology in the SHP Chapter is based on its self-defined multi-state service area and speculation that it will draw patients from these other states. RCA does not operate any ICFs currently anywhere, thus has no experience or data of its own from which to predict that its "large regional market strategy" will actually attract patients from other states. The Modified Application includes a list of providers in neighboring states with information about bed counts, rates, services and distances for each (see Table 12), but provides no waiting list data or other information to demonstrate that these facilities are not meeting the need for services in those states such that their residents would travel out of state to receive care. If RCA's hoped-for influx of patients from other states does not materialize, there is nothing to prevent it from seeking – and every reason to expect that it would seek -- to fill the excess beds with Maryland residents (who are not Medicaid recipients). This would be at the expense of

existing providers like Pathways that, under the Federal "IMD exclusion" described in Pathways' November 16, 2015 Comments, depend more heavily than ever on being able to care for that same population in order to remain financially viable.

Finally, for these reasons, and for the reasons set forth in Pathways' November 16, 2015 Comments, RCA has also not met its burden of demonstrating need under COMAR 10.24.10.08G(b).

2.

Provision of Service to Indigent and Gray Area Patients

RCA continues to request a waiver from the requirement in Standard .05D of the SHP Chapter to commit to providing 15% of its bed days to indigent and gray area patients. Specifically, it seeks a 6.15% charity care requirement, a margin that would allow RCA to generate a 10.2% margin in 2018 rather than the 5.3% margin it would generate under a 15% charity care requirement. See Modified Tables 16 and 17 to RCA's Responses to Additional Information Questions dated July 17, 2015. For all the reasons set forth in Pathways' November 16, 2015 Comments in this matter, RCA is inconsistent with this standard because it has not demonstrated that it would not be financially feasible to comply with the standard as written

In the Modified Application, RCA states that it is willing to extend charity care to the entire course of Detox and Residential treatment, up to its proposed level of b 6.15%. RCA suggests that extending charity care to the entire course of treatment up to this level generates a level of charity care that exceeds the level generated by a 15% requirement applied to Detox care only.

This is not a basis upon which to waive the 15% charity care requirement in the SHP Chapter. The public policy embodied in SHP Chapter Standard .05D is to ensure access to Detox Beds for indigent and gray area patients. That requirement can be reduced, as the Commission approved in the FMA Decision, but only if the applicant can demonstrate that a 15% requirement is not financially feasible, a demonstration that RCA has not made.

RCA suggests that allowing it to have a lower charity care percentage in return for its commitment to extend this level of charity care through the course of residential treatment is fair because it would not otherwise be required to provide charity care for residential services. At the same time, however, RCA acknowledges that it would not be clinically appropriate for it to release a charity care patient once Detox care is complete but before the course of treatment is complete because the patient cannot afford to pay for Residential treatment. Accordingly, RCA is not committing to do something that it would not already be required to do by clinical standards of care.

Moreover, RCA's statement that it will extend charity care to residential services unenforceable because the Commission does not regulate RCA's Residential Beds. An agency is not permitted to regulate a matter outside of its statutory jurisdiction even if it does so in aid of regulating a matter within its jurisdiction. For example, in *Holy Cross Hospital v. Health Services Cost Review Commission*, 283 Md. 677 (1978), the Court of Appeals rejected the HSCRC's attempt to set the rates charged by physicians, which the HSCRC argued was necessary in order to carry out its statutory charge to assure the public that total hospital costs are reasonably related to the total services provided. *See also Consumer Protection Division v. George*, 383 Md. 505 (2004).

Accordingly, RCA not demonstrated a basis to waive the 15% charity care requirement in the Modified Application.

3.

Availability of More Cost Effective Alternatives

The Modified Application is inconsistent with this standard. It assumes that existing providers are unable to provide the necessary inpatient detox service to meet the need, but has failed to provide any quantitative analysis to demonstrate this. 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 had a waiting list only on approximately 5% of the last 90 days, and the average wait time in rare those instances was only 24 to 48 hours.

Further, the Modified Application does not demonstrate that it would be a more cost effective alternative than existing providers. To the contrary, as stated in Pathways November 16, 2015 Comments in this matter, RCA's assumed daily rate for detox beds is approximately 40 percent higher than Pathways average rate from commercial payors.

4.

Viability of the Proposal

The Modified Application does not demonstrate the viability of the proposal as required by COMAR 10.24.10.08G(3)(d). RCA assumes the same unrealistic and unreasonable length of

stay in the Detox Beds of 14 days as it did in the prior Application. Pathways' average inpatient length of detox stay was only 3.92 days in FY 15 and 4.039 in the first half of FY16.

Likewise, RCA continues to assume unrealistic and unreasonable daily rates. RCA's assumed daily rate for detox beds of $860 is approximately 40 percent higher than Pathways average rate from commercial payors. RCA's assumed daily rate for the Residential Beds of $724 is approximately 33 percent higher than Pathways average rate from commercial payors for Pathways' rehab beds (ASAM level III.7) that represent a higher level of care.

Finally, the Modified Application fails to demonstrate how RCA will attract and retain the staffing levels shown on Table L to support the beds it seeks the midst of the critical shortage of qualified addictions professionals in Maryland. In its November 16, 2015 Comments in this matter, Pathways described the significant challenges it faces in finding and retaining qualified staff, and the shortage of professionals in this area is rapidly getting worse. Since July, 2015, Pathways has paid approximately $80,000 in staffing agency fees in order to hire qualified counselors, where it had no staffing agency charges in the prior year. The Modified Application does not acknowledge, let alone address, how RCA 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. [3]

[3] Further, almost a year after this application was filed, RCA has few referral agreements in place. Other than the two hospitals, the remaining referral agreements are with an 8 bed halfway house and an entity called Community Behavioral Health an Internet search of which indicates that it is a professional association, not a provider of services. It has also documented limited community support.

5.

Impact on Existing Providers and Health Care Delivery System

The Modified Application does not demonstrate that the project will not adversely impact existing providers like Pathways. RCA asserts, without analysis, that it will not have a material adverse impact on existing ICFs in the State because it only seeks 21 detox beds of which 6 will be used for Maryland residents. As discussed above, RCA's suggestion that only 6 of the detox beds will be used for Maryland residents is unfounded and there is no basis to analyze the Modified Application as one seeking anything less than 21 new Detox Beds. Further, this proposed project cannot be considered in isolation from the other two projects RCA proposes in Maryland which, when combined, represent the proposed addition of 140 new inpatient detox beds, all within 60 miles of Pathways. Pathways service area is well within the 90 to 110 mile radius "neighborhood" from which RCA would draw its patients"[4]

As shown on page 62 of the Modified Application, there is combined total of nearly 1,100 beds, all within RCA's 90 to 110 mile-radius "neighborhood."[5] Thus, there is a wealth of providers that are already providing inpatient detox services in RCA's expansive "neighborhood" with which RCA will compete, and RCA has presented no analysis of its impact on these providers, nor shown that any of them have long waiting lists or are turning away the commercially insured patients RCA proposes to serve.

[4] As described in Pathways' November 16, 2015 Comments, Pathways patients are primarily Anne Arundel County residents, but its extended service area includes the Eastern Shore, Prince George's County and Southern Maryland

[5] 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).

Further, taking into account the IMD exclusion, the likely adverse impact on existing providers like Pathways is clear.[6] As described in Pathways' November 16, 2015 Comments, Pathways payor mix has been dramatically altered by the IMD exclusion, and with Pathways' new payor mix under the IMD exclusion, a loss of only 20 percent of its commercial inpatient volume would have caused Pathways to operate at a loss in 2015 Surrounded by the three new Maryland facilities proposed by RCA that would serve the commercially insured market almost exclusively, a loss of 20 percent of Pathways' commercial inpatient volume is reasonably foreseeable.

Additionally, as described above and in Pathways' November 16, 2015 Comments in this matter incorporated herein by reference, the increased demand for qualified addictions treatment staff that RCA would generate would adversely impact Pathways by exacerbating the already critical shortage of these professionals in Maryland The increased demand for staff from RCA would increase Pathways' staffing costs and, if Pathways is unable to fill positions necessary to provide quality care as a result of the additional pressure on the labor market created by RCA, it will adversely impact access to care.

Finally, the Modified Application would have an adverse impact on costs to the health care delivery system. The daily rate assumed by RCA for its detox beds is approximately 40 percent higher than Pathways average rate from commercial payors

[6]As described in Pathways' November 16, 2015 Comments, Medicaid reimbursement is no longer available for residential or outpatient services provided to adults admitted to residential care at an IMD (including Pathways).

CONCLUSION

For the reasons stated above and in Pathways' November 16. 2015 Comments in this matter, the Modified Application should be denied. Pursuant to COMAR 10.24.09.01A(3), Pathways requests oral argument before a recommended decision is prepared.

Respectfully submitted,

Marta D. Harting

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

Counsel for Pathways

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Interested Party Comments on Corrected Modified Application filed by Pathways are true and correct to the best of my knowledge, information and belief.

Helen Reines

Helen Reines, Executive Director