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

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RESPONSE OF 314 GROVE NECK ROAD OPCO, LLC
TO COMMENTS SUBMITTED BY INTERESTED PARTIES
ON THE DECEMBER 21, 2015 CORRECTED MODIFIED APPLICATION

February 18, 2016

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314 Grove Neck Road OPCO, LLC ("Applicant"), a subsidiary of Recovery Centers of America ("RCA"), by its undersigned counsel and pursuant to COMAR § 10.24.01.08F(3), submits this response to the comments filed by Anne Arundel General Treatment Services, Inc. d/b/a Pathways ("Pathways") and Father Martin's Ashley ("FMA," together with Pathways, the "Interested Parties") addressing Applicant's December 21, 2015 Corrected Modified Certificate of Need Application (the "12/21 Application").

INTRODUCTION

As recognized by the State's highest leadership, Maryland is in the midst of a substance use disorder crisis. In 2014 there were 1,039 drug and alcohol related deaths in the State, a 21% increase from the number of such deaths in 2013, and a 60% increase since 2010. *See* **Exhibit 1**, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE ("DHMH"), Annual Death Report 2014: Drug and Alcohol Related Intoxication Deaths in Maryland, 2014 (May, 2015).[1] Although counts for 2015 are still preliminary, initial data indicates that 599 unintentional intoxication deaths occurred in Maryland from January through June – 71 deaths more than that same period in 2014. *See* **Exhibit 2**, DHMH, Quarterly Death Report Q2-2015 (Sept. 25, 2015). If the trend continues at a flat rate for the second half of 2015, the total number of unintentional intoxication deaths in 2015 will be 1198, a 15.3% increase from 2014, or 3.28 a day. At this rate, 193 people will have died in Maryland from substance use disorder between submission of the Corrected Modified Application on December 21, 2015 and the date of this filing.

The Interim Report of the Heroin and Opioid Emergency Task Force created by Governor Larry Hogan recognizes a lack of sufficient resources to address the heroin and opioid

[1] Exhibits 1 through 13 are attached to Applicant's December 1, 2015 Response to Interested Party Comments.

epidemic, as well as significant barriers to care including the availability of and access to treatment providers. **Exhibit 3** at pp. 3-4. These findings are echoed in the Final Report, available at https://governor.maryland.gov.[2] Letters of support submitted in this and other RCA projects also confirm the need for services RCA proposes establishing in Maryland. *See* **Exhibit 14** to this response and **Exhibit 26** to the 12/21 Application. Applicant, together with two other proposed RCA facilities, proposes to commit $67,613,105 to developing three substance use disorder facilities in Maryland. The capital for these projects has already been raised, and comes at no cost to the State or its taxpayers.

At a time when people are dying in Maryland every day from substance intoxication, and Maryland leadership is acknowledging the lack of available beds and resources to address the problem, the Interested Parties continue to oppose Applicant's proposed project in an apparent effort to avoid competition for these much needed services.

Indeed, the Interested Parties have recognized the need to devote additional resources to substance use disorder treatment. On December 10, 2015, the Cecil County Health Department, Cecil County Drug and Alcohol Abuse Council held a meeting in Cecilton, Maryland. Representatives of RCA and the Commission appeared at that meeting to discuss Applicant's proposed facility. FMA Chief Operating Officer Stephen Kendrick spoke and recognized the extreme need for beds in Cecil County, stating that he is not opposed to more treatment providers "because there is so much demand and people are dying." Mr. Kendrick also expressed

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[2] The direct link to the report, available on the website of the Office of Governor Larry Hogan, is https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf.

confidence in RCA's management team and that RCA will provide good treatment. Affidavit of J.P. Christen, paragraph 5.

On January 29, 2015 Anne Arundel Medical Center Inc. ("AAMC") submitted a Letter of Intent to "establish a new psychiatric special hospital on the site of Pathways, AAMC's longstanding substance use and co-occurring disorders treatment facility." *See* **Exhibit 15**. The letter further indicates that AAMC will be adding a partial hospitalization program to the Pathways campus. According that letter, the addition of these mental health beds "will be a critical part of a continuum of inpatient and outpatient mental health and substance use services on this campus, along with a partial hospitalization day mental health program to be located on the Pathways Campus." *Id.* AAMC has indicated it is committing $17 million dollars to this development of additional mental health and substance abuse services on the Pathways campus.[3]

Given the undeniable public health crisis and the recognition by even the Interested Parties that additional resources are needed, the Interested Parties' position that there is no need for Applicant's project must be viewed as no more than an effort to avoid competition and protect their status as two of the few private providers of these much needed services.

Summary of Application Timeline

March 27, 2015 Application. Applicant filed an application for a Certificate of Need ("CON") for the proposed project on March 27, 2015. At that time, Applicant's proposed project included "17 Detox / Assessment beds subject to a Certificate of Need review, and an additional 32 residential beds for services that Applicant expects to certify at level III.5 or lower

[3] *See* Gantz, S. (Feb. 4, 2016). "Anne Arundel Medical Center plans $17M investment in behavioral and mental health," BALTIMORE BUSINESS JOURNAL. *Retrieved from* http://www.bizjournals.com/baltimore/news/2016/02/04/anne-arundel-medical-center-plans-17m-investment.html.

according under the American Society of Addiction Medicine (ASAM) Patient Placement Criteria." March 27, 2015 Application, pp. 4-5. Thus, the proposed project had a total of 49 beds. *Id.*, pp. 4, 32, and Exh. 1.[4]

May 18, 2015 Modification Application. On May 18, 2015, Applicant modified its application. In the Modified Application, Applicant's proposed facility included "21 Detox / Assessment beds subject to a Certificate of Need review" and "28 residential beds that Applicant expects to license as ASAM level III.5." Modified Appl., p. 5. The Project Description and need analysis referred to the project's 21 ICF beds, (*see* Mod. Appl. at pp. 5, 37). The project drawings also showed a total of 21 ICF beds and 28 Residential beds. *Id.*, Exh. 8.[5]

October 16, 2015 Docketing Notice. The May 18, 2015 Application was docketed on October 16, 2015. MARYLAND REGISTER, Vol. 42 (21), p. 1364 (October 16, 2015).

November 16, 2015 Interested Party Comments. On November 16, 2015, the Interested Parties submitted comments opposing Applicant's project.

November 30, 2015 Letter Modification of Application. On November 30, 2015, Applicant modified its application by letter to comport to revised plans to develop additional

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[4] See the December 1, 2015 Response to Interested Party Comments, n. 2 for description of Detox / Assessment beds and residential beds. Detox / Assessment beds are sometimes referred in this response as "ICF" (Intermediate Care Facility) beds. Residential treatment beds are sometimes referred to as "Residential" beds.

[5] Table A in that submission contained an error. However, as described more fully in the December 3, 2015 letter attached as **Exhibit 16**, all other aspects of Applicant's May 18 Modified Application, and the responses to completeness questions that followed, confirmed that Applicant sought 21 ICF beds. Furthermore, the Docketing Notice and the Interested Parties' comments demonstrate that both the Maryland Health Care Commission and the Interested Parties understood that Applicant sought 21 ICF beds. *Id.*

Residential beds on the site. That letter modified the application to include 21 ICF beds and 87 Residential beds, and updated the financial tables to be consistent with this change.

December 1, 2015 Response to Interested Party Comments. On December 1, 2015, Applicant filed responses to the comments of Pathways and FMA.

December 3, 2015 MHCC Request to Provide Replacement Application. On December 3, 2015, Suellen Wideman, Esq., counsel for the Commission, requested that Applicant provide a replacement application with all the modification information incorporated into a complete application.

December 21, 2015 Corrected Modified Application. Prior to docketing, Applicant had made several corrections and changes to its Application through its Responses to Completeness Questions. Thus, in order to create a single source of information, Applicant provided a corrected, modified application that incorporated all updates and corrections identified in responses to completeness questions and the November 30, 2015 modifications. Applicant also revised its Responses to Completeness Questions that were impacted by the November 30, 2015 modification, and appended them to the December 21, 2015 Corrected Modified Application.

January 20, 2016 Notice to Provide Comments on Modified Application. On January 20, 2016, the Commission published a notice advising that comments on the 12/21 Application were due by February 3, 2016.

February 3, 2016 Interested Party Comments. On February 3, 2016, Pathways and FMA filed comments on the 12/21 Application.

ARGUMENT

I. THE INTERESTED PARTIES' COMMENTS ARE OUTSIDE THE SCOPE OF PERMISSIBLE COMMENTS ON THE MODIFICATION TO THE APPLICATION

The majority of the Interested Party comments are beyond the scope of comments permissible at this time. Pursuant to COMAR § 10.24.01.08.E, within 10 business days of the posting of a modified application on the Commission's website, an interested party may submit "comments on the changes." *Id.* at .08.E(3)(a)(ii). The majority of comments made by Pathways and FMA are not responses to changes to the project. Instead, Pathways and FMA respond to information set forth in Applicant's May 18, 2015 Application and subsequent responses to completeness questions submitted prior to docketing. These comments are untimely, as the proper time to raise them was in the November 16, 2015 comments. The Interested Party comments also reply to Applicant's December 1, 2015 Response to the November 16, 2015 Interested Party Comments. Such replies are not permitted by the MHCC's regulations. The Commissioner appointed as Reviewer in this matter should not consider comments that were not properly made.

II. PATHWAYS' CRITICISMS BASED ON APPLICANT'S "FAILURE" TO REPORT THE NONPUBLIC PROPRIETARY DATA OF THIRD PARTIES ARE ILLOGICAL.

Throughout its comments, Pathways criticizes Applicant for not having provided the Commission with data regarding existing providers that are not publically reported, and may be confidential and/or proprietary. Pathways criticizes Applicant for not accurately stating existing providers' ratio of ICF and Residential beds or waitlist information. It also criticizes Applicant for using an alternative means of incorporating out-of-state demand for services into its analysis since the Commission has not updated the relevant need projections since 2005. Lastly,

Pathways comments about the impact the project will have on Pathways without supporting those statements with any data that would subject Pathways' claims to verification, and again criticizes Applicant for not conducting a data driven analysis of impact.

The data Applicant would require to respond to Pathways' concerns is not publically reported. Pathways' suggestion that Applicant should provide the Commission with nonpublic and potentially confidential or proprietary data of third parties is not possible.

III. APPLICANT HAS SUFFICIENTLY IDENTIFIED BED NEED FOR ITS PROPOSED PROJECT – STANDARD .05B; REVIEW CRITERIA 10.24.01.08G(3)(b)

As set forth in Section I, above, the Interested Parties' supplemental comments on need are untimely. Applicant did not change the number of ICF beds it is seeking in the 12/21 Application, which is consistent with the May 18 Application. Nor did Applicant change its assumption that most existing facilities use 41% of their ICF and Residential beds for ICF care, an assumption that was updated in the August 31 Response to Completeness Questions, which was available to the Interested Parties during the first comment period. Thus, Pathways and FMA are impermissibly using the opportunity to comment on project changes to address matters that have not changed and are not open to comment at this time.

Even if these comments were permissible, FMA and Pathways have not advanced any persuasive reason to disregard Applicant's need analysis, which demonstrates a need for far more beds in the Eastern Shore Region than Applicant seeks to establish.

A. FMA's Comments on Need are Inconsistent with the ICF State Health Plan and FMA's Own Recognition of Need.

FMA's renewed comments that Applicant has not demonstrated need are in direct contradiction of statements made by FMA COO Stephen Kendrick, and are an attempt by FMA

to avoid competition in the market. At a time when leadership in Maryland, and FMA's own COO, are acknowledging a substance use disorder crisis and a lack of sufficient providers, FMA's comment that only 7 ICF beds are needed in the Eastern Shore Region is unsound. FMA's comments should be seen as no more than an attempt to protect its status as the largest private ICF facility in Maryland.

FMA's need analysis also disregards the ICF chapter of the State Health Plan (the "SHP"). The SHP requires that need be calculated based on a 14 day length of stay, yet FMA projects need based on its own experience of a 4 day length of stay. COMAR § 10.24.14.07(g). Applicant is neither permitted nor authorized by the SHP to project need based on a 4 day length of stay, nor must Applicant conform its treatment to the experience of FMA.

B. Applicant Properly Assumed That Existing Joint ICF and Residential Providers Used Only a Portion of Beds for ICF Care.

The attempts by FMA and Pathways to discredit Applicant's analysis based on its application of a ratio of ICF and Residential beds are contradictory. FMA and Pathways both recognize that the percentage of true ICF beds at existing facilities is far lower than the 41% Applicant applied. FMA's own submission demonstrates that its percentage of ICF treatment is, as Applicant stated, 20% (4 of 20 days). FMA February 3 Comments, p. 5. The application of this percentage to the existing inventory of the total number of beds at existing facilities that render both ICF and residential care would result in even greater need than Applicant projected.

In addition, as discussed more fully in Applicant's December 1 Response to Comments, counting all existing beds at facilities that provide both ICF and Residential care would greatly underestimate the need for ICF beds. *See* December 1 Response to Comments, pp. 8-10. The existing Maryland ICF providers either preexisted CON regulation, or improperly sought CON

approval for their entire complement of beds, even though they are not providing ICF services in all of those beds. At the pre-application conference in this matter, Commission Staff indicated that it disproves of the flexible use of ICF beds and that Applicant must break out the number of ICF beds from its total complement; Applicant complied. That other facilities license their entire complement of ICF and Residential beds at the ICF level of care, when all parties to this review agree that not all of those beds are used for ICF care, is not a valid justification for calculating existing need based on the licensed rather than actual ICF bed capacity in Maryland. Calculating the existing inventory in this manner would incorrectly assume that existing providers staff all of their beds for ICF care, which would impose unnecessary costs on the healthcare system, and that they would only allow ICF patients to transfer into Residential care if there were no wait list or demand for ICF care.

Furthermore, the suggestion by Pathways and FMA that Applicant's inability to know the exact number of beds existing providers use for ICF versus Residential care demonstrates inexperience is unreasonable. These data are not publically reported and may be confidential and/or proprietary, and there is no standard of care that requires a certain ratio of beds. FMA and Pathways, however, could provide their own data on both this and other factors in this review. That they have deliberately chosen not to do so while at the same time chastising Applicant for not having access to such unreported data demonstrates the unreasonableness of their positions. The Commission should reject these arguments. To the extent the Commission desires to review the data, it should require FMA and Pathways to report their data.

C. Pathways' Additional Comments on Need are Inconsistent with the ICF State Health Plan Chapter.

Pathways continues to rely on the unsupported assumption that the substance use disorder prevalence rate in the commercially insured population is below that of the indigent population to argue that Applicant's need analysis overstates private bed need.[6] Pathways' position directly contradicts the SHP. As explained in Applicant's December 1 Response to Comments, the SHP need methodology defines a prevalence rate for the adult population of 8.64%. COMAR § 10.24.14.07(B)(4)(c)(i). COMAR § 10.24.14.07(B)(7), *Method of Calculation for Private Beds* (emphasis added), assumes a prevalence rate of .0864 for the private adult population.[7]

Pathways also attacks Applicant's projection of the number of beds it will use for out-of-state patients. Applicant's need analysis projects more than enough need in the Eastern Shore to support 21 additional ICF beds. That Applicant also demonstrates the percentage of these beds that it believes will be used for out of state patients does not negate this need analysis. Furthermore, the SHP need methodology recognizes out-out-state discharges. COMAR § 10.24.14.07(5)(e). The Commission has not updated the ICF need projection for the Eastern Shore since 2005, and that projection was based on data from 2000. *See* SHP Table 2. Because discharge data is not publically reported, Applicant instead used an alternative method of demonstrating the number of its own beds that it expects will service out of state patients. While RCA believes its alternative approach is reasonable, if the Commission does not accept this method, it should require all existing providers to release their out of state discharge

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[6] *See* Applicant's December 1, 2015 Response, pp. 11-12 for a more in depth discussion of Pathway's incorrect assumption.

[7] In calculating private bed need, the Commission applies this prevalence rate directly to the non-indigent population. *See* COMAR 10.24.14, Table 4.

numbers. It would be unfair and improper to penalize Applicant's methodology based on an outdated SHP need projection and the failure to have data which is not within its control.

IV. APPLICANT HAS SUFFICIENTLY DEMONSTRATED THE REASONABLENESS OF ITS CHARITY CARE COMMITMENT – STANDARD .05D

The Interested Parties' comments on Applicant's charity care commitment are inappropriate at this late stage. FMA and Pathways do not comment on any changes in the specific dollar amounts of charity set forth Applicant's financial tables, but on the 6.15% level of charity care, which has not changed. Instead, they simply used the additional comment period as an opportunity to reply to RCA's December 1 Response to Comments, although the Commission's regulations do not permit a reply. Furthermore, the Interested Parties fail to raise a meaningful challenge to Applicant's demonstration pursuant to standard .05D that Applicant should not be required to commit 15% of its patient bed days to indigent and gray area patients. Standard .05D is not a mandate, and allows an applicant to show why it should not be required to make this commitment (as FMA did in connection with its recent bed expansion project). Applicant has done that in both its 12/21 Application and its December 1, 2015 Response to Comments. Furthermore, Standard .05D does not restrict the reasons supporting a waiver solely to financial feasibility issues.

The SHP need methodology was designed to "increase access to care for indigent patients and reduce competition among those facilities that take predominantly private patients." SHP, p. 7. Applicant is making a significant commitment to providing care to indigent and gray area patients in its service area. The Interested Parties' insistence that Applicant commit 15% of its beds to Charity Care is an obvious effort to prevent competition for their services.

Standard .05D was promulgated under a much different treatment landscape. At the time, private facilities had occupancy rates of 40%-75% while there was a shortage of services for the indigent and gray area community. *See* SHP pp. 6-7. There are currently more funded beds in Maryland than non-funded beds. *See* 12/21 Application Table 9. As discussed in Applicant's 12/21 Application, the Affordable Care Act has also increased access to care for the indigent and gray area population. Lastly, Maryland leadership has recognized a public health crisis and lack of providers and the SHP methodology reveals significant need for private beds in Maryland.

In addition, Standard .05D sets forth an ambitious goal, and it does not appear that any current ICF Track One providers are required to provide 15% charity care. To impose this requirement only on Applicant would unreasonably interfere with the ability of new providers to enter the marketplace.

There is no support for FMA and Pathways' argument that the Commission should not consider the substantial charity care that Applicant is committing to the community through its Residential services simply because those services fall outside of Commission's regulatory power. There is in fact evidence that such commitments are proper in a Certificate of Need review. For example, in the 2013 Decision on FMA's expansion, it appears that the Commission conditioned approval on FMA providing a certain percentage of charity care across all services, not only for ICF care. **Exhibit 1**, pp. 11-14. In connection with the review concerning the relocation of Washington Adventist Hospital by Adventist HealthCare, Inc. ("AHC"), AHC's commitment to a 24/7 urgent care center, which is not subject to regulatation by the Commission, at the site of its existing facility played a substantial role in the Commission's decision that AHC had satisfied the impact standard. **Exhibit 17**, pp. 163-4, 167. That the

Commission cannot enforce a commitment to provide charity care in services outside of its regulatory authority does not mean such commitments are not relevant to evaluating whether Applicant has complied with Standard .05D.

V. THE INTERESTED PARTIES HAVE NOT RAISED MEANINGFUL CHALLENGES UNDER STANDARDS 10.24.01.08G(3)(c) - IMPACT

The Interested Parties make several overlapping comments concerning the viability and cost effectiveness of the project, and its impact on existing providers. As set forth below, these comments are without merit.

A. Pathways May Be Overstating the Impact of the IMD Exclusion.

Pathways' argument that it will be adversely impacted by the proposed project focuses largely on the exclusion for Medicaid reimbursement for institutions for mental diseases ("IMD") and the phase out of the Medicaid Emergency Psychiatric Demonstration project, which waived this exclusion in Maryland (the "IMD Waiver"). Pathways November 16, 2015 Comments at pp. 5, 21, -22; Pathways February 3, 2016 Comments at p. 12.

On December 11, 2015, Senate Bill 599, Improving Access to Emergency Psychiatric Care Act became Public Law No. 114-97, extending the Maryland IMD Waiver through September 30, 2016. The law further allows extension of the waiver through the end of 2019 if Maryland's continued participation is not projected to increase net program spending under Title XIX of the Social Security Act, and if Medicaid's actuarial calculations determine that the program is cost-neutral.

While Applicant is not familiar with the specifics of Pathways' Medicaid reimbursement, it appears that Pathways will be eligible for Medicaid reimbursement through at least September 20, 2016, and potential through 2019. If true, Pathways arguments that RCA's facilities will too

greatly impact Pathways in light of the loss of the IMD waiver should be excluded from this review.

B. Existing Providers Cannot Meet the Current Need.

Pathways' suggestion that existing providers can meet the current need in this State is directly contradicted by the findings set forth in the Interim and Final Report of the Heroin and Opioid Emergency Task Force and Applicant's need projection. Pathways also misleadingly suggests its wait list history for only the past 90 days is indicative of the overall need for services while at the same time stating that the loss of the IMD waiver (although it now appears resolved for a period of time) has had a dramatic impact on its payor mix during that time period, and criticizes Applicant for not providing the nonpublic and potentially confidential or proprietary wait list time of other Maryland providers. The experience of a single provider in the 90 days following the loss of a significant reimbursement source relied on by that provider is not indicative of need in the state of Maryland.

C. Applicant's Rates Are Reasonable.

As described in detail in the 12/21 Application, Responses to Completeness Questions, and December 1 Response to Comments, Applicant projects achievable reimbursement rates that are comparable to Maryland facilities and below the average rates in neighboring states. *See* 12/21 Application at pp. 64-66 and December 1 Response to Comments, p. 22-24. That Pathways, a single provider, uses lower rates does not make Applicant's project non-viable. Pathways comment that the project is not cost effective because Pathways offers lower rates is also impractical – Pathways operates 32 adult beds that are used mostly by patients of Anne Arundel County. Pathways February 3 Comments, p. 11 n. 4. Pathways cannot begin to meet the need that Applicant projects and proposes to address.

D. Applicant's Leadership Have Extensive Experience in the Field.

The Interested Parties each complain that Applicant does not have a "track record" for providing these services. Pathways February 3 Comments, 6; FMA February 3 Comments, 7. While this is true of the facility itself, it cannot be relevant to this review or no new provider could ever enter the market. FMA's comments also contradict FMA COO Steven Kendrick's statements during the December 10, 2015 meeting in Cecilton, Maryland, during which he expressed confidence in RCA's management team and that RCA will provide good treatment. Affidavit of J.P. Christen, paragraph 5.

Current RCA team members include senior leaders in addiction, behavioral healthcare, and a variety of other industries from across the nation to build the foundation of the company. For example, Deni Carise, Ph.D., RCA's Chief Clinical Officer, is one of the foremost researchers, teachers, and experts in the substance use disorders field today. Barbara Kistenmacher, Ph.D., Executive Director of the Earleville facility, is a Clinical Psychologist with 14 years of experience with experience in the private self-pay, commercial insurance, and public sectors of the mental health and addictions fields. Dr. Kistenmacher has served as executive director, director, supervisor, clinician, researcher, faculty member, and independent consultant across all levels of mental health and addictions care, including detoxification, residential, day treatment, intensive outpatient, non-intensive outpatient, and structured sober living. *See* **Exhibit 18**; 12/21/15 Application, Exhibit 5.

E. Applicant's Staffing is Reasonable.

FMA and Pathways complain that Applicant's proposed project will increase the difficulty of finding qualified staff for existing ICF facilities. The Certificate of Need regulations do not require a party to show no competition will exist for workforce when new

services are added. Such a requirement would stunt needed growth and give existing providers a monopoly in the field. It could also artificially freeze wage growth for staff at health care facilities. The staffing requirements for a RCA's 21 bed facility in Earleville will be far less than that of larger scale health projects to establish new acute care hospitals, and indeed may be similar to the staffing needs of the proposed special psychiatric hospital that AAMC proposes to build on the Pathways campus. *See* **Exhibit 15**. That Applicant's facility may cause some competition for staffing requirements cannot outweigh the significant need for these services in Maryland.

CONCLUSION

For the reasons set forth above, Applicant respectfully requests that the Commission approve Applicant's CON application.

Respectfully submitted,

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Attorneys for 314 Grove Neck Road OPCO, LLC

February 18, 2016

Table of Exhibits

Exhibit	Description
14	Additional Letters of Support
15	Anne Arundel Health System, Inc. Letter of Intent
16	December 3, 2015 Letter to Kevin McDonald
17	Excerpts from the Recommended Decision in the Matter of Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital
18	Curricula Vitae of Deni Carise, Ph.D, Barbara Kistenmacher, Ph.D

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 18th day of February, 2016, a copy of the Response of 314 Grove Neck Road OPCO, LLC to Comments Submitted by Interested Parties was served by email and first-class mail on:

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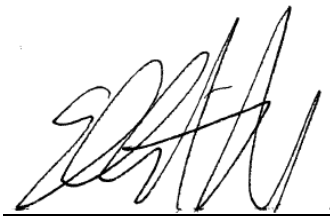

Ella R. Aiken

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

I, J.P. Christen, declare as follows:

1. I am more than 21 years of age and competent to give this Affidavit.

2. I am the Chief Operating Officer of Recovery Centers of America ("RCA").

3. On December 10, 2015, I attended a public meeting of the Cecil County Drug and Alcohol Abuse Council (the "Council") at the Cecilton Community Center in Cecilton, Maryland. The purpose of the meeting was to discuss RCA's proposal to establish an alcohol and drug treatment center in Earleville, Maryland and the Certificate of Need ("CON") approval process applicable to the project. I was accompanied by several other members of the RCA team. Kevin McDonald and Suellen Wideman attended on behalf of the Maryland Health Care Commission (the "Commission"). Also, several members of the Council and a number of citizens attended.

4. Mr. McDonald and Ms. Wideman provided information about the CON process. The RCA team then made a presentation about the proposed project. Several participants asked questions and made comments about RCA's proposed project.

5. Among those who offered public comment was Stephen Kendrick, who identified himself as the Chief Operating Officer of Father Martin's Ashley ("FMA"). Mr. Kendrick stated that FMA is seeking interested party status in the CON review. However, he said that FMA is not opposed to more treatment providers because "there is so much demand and people are dying." Mr. Kendrick expressed confidence in RCA's management team and that RCA will provide good treatment. He said that the question is how much charity care should be reserved for Cecil County residents, and he urged the Council to request that a portion of RCA's charity care be dedicated for Cecil County residents.

I hereby declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

This the 18th day of February, 2016.

J.P. Christen

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Interested Party Comments are true and correct to the best of my knowledge, information, and belief.

February 18, 2016
Date

J.P. Christen
Chief Operating Officer
Recovery Centers of America

#537072
013522-0001

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Interested Party Comments are true and correct to the best of my knowledge, information, and belief.

February 18, 2016
Date

Barbara Kistenmacher, Ph.D.
Chief Executive Officer
Bracebridge Hall (Earleville)
Recovery Centers of America

#552443
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EXHIBIT 14

Charles County Commissioners

CHARLES COUNTY COMMISSIONERS
Peter F. Murphy, *President*
Ken Robinson, *Vice President*
Debra M. Davis, Esq.
Amanda M. Stewart, M.Ed.
Bobby Rucci

Michael D. Mallinoff
County Administrator

October 22, 2015

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Recovery Centers of America's Center for Addiction Medicine – Letter of Support

Dear Mr. Steffen,

It is our pleasure to write a letter of support for Recovery Centers of America's (RCA) Center for Addiction Medicine in Waldorf. The Center will include residential services, Partial Hospital and Intensive Outpatient Services on one campus on Billingsley Road. RCA also has a Certificate of Need pending for Detoxification services on the Billingsley Road campus.

The Charles County Board of Commissioners is highly concerned about the rampant drug and alcohol problems in our county and state. RCA provides state of the art treatment including detox, residential, and a variety of outpatient services to those in our communities who are in great need of a local treatment center. There is an extreme shortage of substance abuse disorder treatment sources in our County. The Board of Commissioners highly respect the work of our local Jude House, however, the program always has a waiting list, and is just not large enough to provide the acute treatment our residents need. We do know that RCA plans to work closely with Jude House as they develop their treatment center, and are pleased that knowledge of addiction treatment and the community will be shared.

In conclusion, the Charles County Board of Commissioners fully support the efforts of RCA as they build and provide much needed treatments to addiction for Charles County and the State of Maryland.

Sincerely,

Peter F. Murphy, *President*

Ken Robinson, *Vice President*
District 1

Debra M. Davis, Esq.
District 2

Amanda M. Stewart, M.Ed.
District 3

Bobby Rucci
District 4

CECIL COUNTY
HEALTH
DEPARTMENT

STEPHANIE GARRITY M.S., HEALTH OFFICER

JOHN M. BYERS HEALTH CENTER • 401 BOW STREET • ELKTON, MD 21921

WWW.CECILCOUNTYHEALTH.ORG

January 7, 2016

Kevin McDonald
Chief - Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Health Care Commission
4160 Patterson Ave.
Baltimore, MD 21215

RE: Certificate of Need Application (CON) – Intermediate Care Facilities
Recovery Centers of America – Earleville
314 Grove Neck Road, OPCO, LLC
Matter No. 15-07-2363

Dear Mr. McDonald:

The Cecil County Drug and Alcohol Abuse Council (DAAC) supports the above-referenced CON application for 21 in-patient detoxification beds, but requests that the Commission require the applicant to dedicate **two** beds as "charity care" beds available only to Cecil County residents. We believe this meets the applicant's pledge of 4-6% of income available for charity care, and specifies how that charity care is to be used.

Members of the DAAC who have had past experience with other facilities and the charity care issue have advised that trying to access charity care has proven very difficult. It seems the pledge of charity care is honored in ways that do not appear obvious to those trying to find help. Requiring dedicated beds not only provides a much needed resource for Cecil County, but becomes a public relations advantage for the institution.

We further ask that the details of the dedicated beds be negotiated with the Cecil County Health Department to make sure there is a smooth transition and usage.

Thank you for your consideration.

Sincerely,

John Bennett

John Bennett, Chair
Cecil County Drug and Alcohol Abuse Council

Cc: Stephanie Garrity, Health Officer

THE PRINCE GEORGE'S COUNTY GOVERNMENT

Chairman
Derrick Leon Davis
Council Member, District 6

February 1, 2016

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Recovery Centers of America's Center for Addiction Medicine – Letter of Support

Dear Mr. Steffen:

It is a pleasure to write a letter of support for Recovery Centers of America's (RCA) Center for Addiction Medicine in Prince George's County. The Center will include residential services, partial hospital and intensive outpatient services at 4620 Melwood Road, Upper Marlboro, Maryland. RCA has a certificate of need pending for Detoxification Services on the Melwood campus.

Prince George's County is highly concerned about the rampant drug and alcohol problems in our County and State. RCA provides state of the art treatment including detox, residential and a variety of outpatient services to those in our communities who are in great need of a local treatment center. There is an extreme shortage of substance abuse disorder treatment sources in our County.

In conclusion, I fully support the efforts of RCA as they create and provide much needed treatments for addiction to residents of Prince George's County and the State of Maryland.

Sincerely,

Derrick Leon Davis
Council Chairman

County Administration Building – Upper Marlboro, Maryland 20772
Phone (301) 952-3426 Fax (301) 952-3238
E-mail: CouncilDistrict6@co.pg.md.us
www.princegeorgescountymd.gov

EXHIBIT 15

MARYLAND HEALTH CARE COMMISSION

Subject: Request for Additional Letters of Intent

Add'l. Info: Subject: Notice of Receipt of Letter of Intent to Establish a Psychiatric Hospital in Central Maryland (Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties and Baltimore City)

On January 29, 2016 the Maryland Health Care Commission received, from Anne Arundel Medical Center, Inc. (AAMC), a Letter of Intent to establish a special hospital psychiatric with 16 beds on the site of Pathways, an alcoholism and drug abuse intermediate care facility operated by AAMC's at 2620 Riva Road, in Annapolis.

Pursuant to COMAR 10.24.01.08A(3) the Commission hereby initiates a 30-day period in which additional Letters of Intent to apply for a Certificate of Need may be submitted to establish an acute psychiatric hospital or increase the acute psychiatric hospital capacity of an existing hospital in Central Maryland. Additional Letters of Intent should be submitted to the Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, Maryland, 21215 and are due by the close of business, March 21, 2016.

Contact: Ruby Potter (410) 764-3276

[16-04-18]

Agency/Department Sort Name: Maryland

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

January 29, 2016

CHS - 7814

VIA HAND DELIVERY

Ms. Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Potter:

Pursuant to COMAR 10.24.01.07C, Anne Arundel Medical Center, Inc. ("AAMC") hereby gives notice of its intent to file a certificate of need (CON) application to establish a new psychiatric special hospital on the site of Pathways, AAMC's longstanding substance use and co-occurring disorders treatment facility located approximately two miles from AAMC's hospital campus in Annapolis. With the location of a psychiatric special hospital on the same site as Pathways, the site can function as a comprehensive, integrated campus providing a continuum of inpatient and outpatient mental health and substance use services. Pathways provides inpatient and outpatient care for teens and adults who suffer from drug or alcohol dependence, as well as those suffering from a combination of substance use and mental health issues. The psychiatric special hospital will be a critical part of a continuum of inpatient and outpatient mental health and substance use services on this campus, along with a partial hospitalization day mental health program to be located on the Pathways campus.

AAMC provides the following information required by COMAR 10.24.01.07C:

(a) Name and address of person on whose behalf this letter is filed:

Anne Arundel Medical Center, Inc.
2001 Medical Parkway
Annapolis MD 21401

(b) Date entity was formed:

AAMC is a nonstock corporation formed under the laws of the State of Maryland in 1902.

(c) Identity and percentage of 5 percent owners:

AAMC's single member is Anne Arundel Health System, Inc.

(d) Description of proposed project:

AAMC will apply for a CON to establish a new psychiatric special hospital at the existing site of Pathways as part of a comprehensive campus providing a continuum of integrated, inpatient and outpatient mental health and substance use services. As part of this continuum, a building will be constructed on the Pathways site for the inpatient mental health unit and a partial hospitalization day mental health program, as well as administrative offices to support these programs. The building may also contain shell space for future expansion of the psychiatric special hospital.

The psychiatric special hospital will have 16 inpatient psychiatric beds and be licensed as a psychiatric special hospital.

(e) Quantity and types of beds or health services involved:

The health services involved with the project are inpatient psychiatric services that will be part of a continuum of integrated mental health and substance abuse inpatient and outpatient services on the site of Pathways, AAMC's longstanding substance use and co-occurring disorders treatment facility. The project involves 16 inpatient psychiatric beds.

(f) Location and Planning Jurisdiction

Location: 2620 Riva Road, Annapolis MD 21401
Planning Jurisdiction: Anne Arundel County (Central Maryland)

Should you have any questions, please contact me.

Very truly yours,

Marta D. Harting

Marta D. Harting

MDH:mdh

cc. Jinlene Chan, M.D., M.P.H., Anne Arundel County Health Officer

EXHIBIT 16

GALLAGHER
EVELIUS & JONES LLP
ATTORNEYS AT LAW

ELLA R. AIKEN
eaiken@gejlaw.com
direct dial: 410 951 1420
fax: 410 468 2786

December 3, 2015

VIA EMAIL and
HAND DELIVERY

Kevin McDonald
Certificate of Need, Chief
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

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

Dear Kevin:

I write on behalf of Recovery Centers of America and 314 Grove Neck Road, OPCO, LLC (collectively, "RCA") regarding the number of beds sought by RCA for its proposed project in Earleville, Maryland.

1. March 27, 2015 Application

RCA filed an application for a Certificate of Need ("CON") for the proposed project on March 27, 2015. At that time, RCA's proposed project included "17 Detox / Assessment beds subject to a Certificate of Need review, and an additional 32 residential beds for services that Applicant expects to certify at level III.5 or lower according under the American Society of Addiction Medicine (ASAM) Patient Placement Criteria." March 27, 2015 Application, pp. 4-5. Thus, the proposed project had a total of 49 beds. The project description, need analysis and Table A matched this bed count. *Id.*, pp. 4, 32, and Exh. 1.

2. May 18, 2015 Modification Application

On May 18, 2015, RCA modified its application. In the Modified Application, RCA's proposed facility included "21 Detox / Assessment beds subject to a Certificate of Need review" and "28 residential beds that Applicant expects to license as ASAM level III.5." Modified Appl., p. 5. The Project Description and need analysis referred to the project's 21 detox / assessment beds, (*see* Mod. Appl. at pp. 5, 37). The project drawings also showed a total of 21 detox / assessment beds and 28 residential beds. *Id.*, Exh. 8. Unfortunately, however, Table A contained an error. Although RCA updated its detox room count from 8 semi-private rooms to 10 semi-private rooms, and its residential room count from 5 private and 12 semi-private rooms to 5 private and 10 semi-private rooms, the final column of Table A – Physical Bed Count was not updated. After we submitted RCA's Modified Application, we noticed errors in Exhibit 1,

which included all MHCC form tables, and Exhibit 2, which included financial projections with alternative assumptions. These corrections were described in a May 19, 2015 letter as follows:

- Tables G, H, J, and K in Exhibits 1 and 2 have been exchanged and retitled. These tables were inadvertently placed in the wrong exhibit number in the earlier submission; no other changes were made to the tables.

- Table I was inadvertently omitted from Exhibit 1 in the earlier submission and is now included.

Unfortunately, we did not at that time correct the error in the final column on Table A.

We understand mistakes like these can create confusion, and require your staff to expend additional time reviewing and analyzing applications. We do our best to avoid these types of mistakes and will make every effort in the future to avoid them.

Fortunately, we believe that the Interested Parties understood the scope of the project as proposed in the text and project drawings of the May 18, 2015 Modified Application despite this error, and had an appropriate opportunity to comment on that scope. As an initial matter, the October 16, 2015 notice in the Maryland Register of the formal start of review for the project accurately described its scope. That notice stated:

> The Maryland Health Care Commission (MHCC) hereby gives notice of docketing of the following applications for Certificate of Need:
>
> ...
>
> Recovery Center [*stet*] of America — Earleville — Docket No. 15-07-2363; Establish an alcohol and drug abuse intermediate care facility which will include **21 detox/assessment beds** (subject to CON review) and an additional **28 residential beds** at level III.5 or lower to be located at 314 Grove Neck Road, Earleville, Cecil County; Proposed Cost: $17,370,227.

MARYLAND REGISTER, Vol. 42 (21), p. 1364 (October 16, 2015) (emphasis added). Furthermore, each of the Interested Parties referred in their comments to the number of beds proposed by the Modified Application in a manner consistent with the October 16, 2015 notice. *See* Comments of Father Martin's Ashley, p. 11 ("...21 beds are designated for detox and 28 are designated for residential"); Comments of Pathways, p. 6 ("...RCA seeks to establish a new ICF in Earleville...with 21 'detox/assessment' beds ...and 28 residential beds.")

3. November 30, 2015 Letter Modification of Application

On November 30, 2015, RCA modified its application by letter to comport to its revised plans to develop additional residential beds on the site. The revised project description, Table A, and project drawings all demonstrated that the site, as modified, will include 21 detox / assessment beds and 87 residential beds.

In light of the history of this application and its modifications, and despite the prior errors in Table A, we believe the beds requested at each stage should be viewed as follows:

	Residential Beds (III.5)	Detox / Assessment Beds (III.7 and III.7-D)	Total Beds
Original Application (March 27, 2015)	32	17	49
Modified Application (May 18, 2015)	28	21	49
Modified Application (Nov. 30, 2014)	87	21	108

As requested by Ms. Wideman, we will provide a replacement application that incorporates all of the correct information. Once again, we apologize for any confusion that these errors caused, and will make every effort to avoid such errors in the future. We appreciate your time and review of this matter.

Sincerely,

Ella R. Aiken

ERA:blr
cc: Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Joel Riklin, Health Policy Analyst, HSP&P/CON
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Stephanie Garrity, Health Officer, Cecil County
JP Christen, Chief Operating Officer, Recovery Centers of America
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Marta D. Harting, Esq.
John J. Eller, Esq.
Thomas C. Dame, Esq.

EXHIBIT 17

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

MEMORANDUM

TO: Commissioners

Adventist HealthCare, Inc.
Holy Cross Hospital of Silver Spring
Laurel Regional Hospital
MedStar Montgomery Medical Center
City of Takoma Park

FROM: Frances B. Phillips, RN, MHA
Commissioner/Reviewer

RE: Recommended Decision
Matter of Adventist HealthCare, Inc
d/b/a Washington Adventist Hospital
Docket No. 13-15-2349

DATE: November 18, 2015

Enclosed is my Recommended Decision in my review of the application of Adventist HealthCare, Inc. ("AHC") for a Certificate of Need to: (1) relocate Washington Adventist Hospital ("WAH") from Takoma Park (Montgomery County) and replace it with a 170-bed general hospital on a site in the White Oak area of the County; and (2) renovate the inpatient psychiatric facilities on the existing WAH campus and relicense those facilities as a special hospital-psychiatric. Having conducted site visits at the existing hospital and the proposed site, and having considered the entire record in this review,[1] I recommend that the Commission **APPROVE** the application of Adventist HealthCare, Inc. for a Certificate of Need, with conditions.

Background

The first Certificate of Need ("CON") application seeking to relocate Washington Adventist Hospital resulted in a September 2012 Recommended Decision by then-

[1] As is apparent from my issuance of this Recommended Decision, I have determined that an evidentiary hearing would not be helpful to me in this review. Accordingly, pending requests for an evidentiary hearing are denied.

Commissioner/Reviewer Barbara McLean, who "regretfully" recommended denial of the application while expressing her view that "the replacement and relocation of Washington Adventist Hospital may very well offer the best solution for revitalizing the hospital's performance and prospects for the future." Commissioner McLean's recommendation to deny the application was based on her finding that the earlier proposed project was unlikely to be viable. The earlier CON application involved the relocation of WAH to the same White Oak area site, but that proposed replacement hospital was designed for 249 beds, with 565,983 square feet of building space and had an estimated cost of $397,705,000.[2] Washington Adventist Hospital, Inc., the applicant entity, proposed taxable debt securities, Federal Housing Administration mortgage insured bonds, as a primary funding source, and stated that it would seek to raise $285.6 million. Commissioner McLean's Recommended Decision outlined a number of problems with the proposal, but noted that the primary basis for her recommendation lay in her "strong doubts with respect to the financial feasibility and viability of the specific proposal" presented in the application. She stated her "hope that AHC and WAH will seriously and constructively consider the issues raised" in her Recommended Decision and "promptly move to develop a new plan to achieve the important objectives addressed in this application so that the future of both WAH and AHC can be assured." The full Commission did not consider Commissioner McLean's Recommended Decision because the CON application was withdrawn after the issuance of her recommendation.

The Proposed Project

AHC returned with an alternative plan and a more solid financial position from which to launch its plans. AHC still proposes to relocate and replace the general acute care hospital but would leave its acute psychiatric inpatient facilities in Takoma Park, to be relicensed as a special hospital for psychiatric services that, administratively, will be operated by the Adventist Behavioral Health division of AHC. Currently, these psychiatric beds are part of the WAH general hospital facility. As with the original proposal, the already separately-licensed special hospital for medical rehabilitation operated on the Takoma Park campus will also stay in place.

Although Washington Adventist Hospital in Takoma Park is currently licensed for 230 beds, AHC proposes a smaller replacement hospital of 170 beds and 427,662 square feet of building space[3] in White Oak. It plans to reduce the capital cost requirements for the move to White Oak by buying power from a central utility plant built by a third party. The estimated project cost is $330.8 million for the relocation and replacement of the general hospital and $5.2 million for the renovation of the existing inpatient psychiatric unit for a total of $336.1 million, approximately $62 million less than the earlier proposal. AHC plans to finance the project with approximately $245 million[4] in borrowing, through the sale of its own tax-exempt bonds, assisted by the Maryland Health and Higher Educational Facilities Authority. It proposes to fund the balance of the project costs with $55.6 million in cash equity, $20 million from contributed gifts, $11 million in contributed land, and $4.5 million in interest income.

[2] In contrast, the current application proposes: 170 beds, plus 40 acute psychiatric beds that would remain in Takoma Park; 427,662 square feet of building space; and, a cost of $330.8 million for the replacement hospital and $5.2 million for the renovation of the acute psychiatric beds, for a total cost of $336.1 million
[3] Compared to the earlier proposal, this is a reduction of 24% in building space.
[4] This is slightly over $40 million less in debt financing than in the earlier application.

The White Oak site of approximately 49 acres is approximately 6.6 miles from the existing Takoma Park campus. AHC also proposes to provide a full-time (24/7/365) urgent care center[5] at the Takoma Park campus in renovated space currently occupied by the WAH Emergency Department immediately upon the opening of the replacement hospital in White Oak. On-campus laboratory and radiology services will support the urgent care center and special psychiatric and rehabilitation hospital operations. A Federally Qualified Health Center on the Takoma Park campus will continue to operate and is scheduled for expansion. Only the renovation of the behavioral health space is a component of this project and CON application. Additional investment by AHC in redevelopment of this campus, approximately $13.2 million, is proposed, which includes the cost of developing the urgent care capability. These are not CON-regulated expenditures but are directly related to the hospital facility changes under review.

Interested Parties and Participating Entities

The interested parties in this review are Holy Cross Hospital of Silver Spring, Laurel Regional Hospital, and MedStar Montgomery Medical Center. The City of Takoma Park is a participating entity in this review.

Review Criteria and Standards

As previously noted, I recommend that this CON application be approved, with conditions. My recommendation is based, in part, on my findings that the proposed project is consistent with the applicable State Health Plan standards and with Certificate of Need review criteria. The applicable State Health Plan ("SHP") standards include those for Acute Hospital Services, General Surgical Services, Psychiatric Services, and Obstetric Services. While this project involves the relocation of cardiac surgery and percutaneous coronary intervention services, these programs are both operating at volumes consistent with applicable SHP standards and the SHP chapter under which the application is considered[6] does not contain standards applicable to the relocation of such programs. I note that these programs will be subject to on-going performance review in the future, based on a new regime of regulatory oversight established in Maryland during the last three years.

I have found that the proposed relocation and replacement of the project is needed and is a more cost-effective approach to meeting the need for modernization of WAH than attempting to modernize the hospital on-site, given the need for replacement of the facilities in order to create a general hospital meeting contemporary standards of design, space, and life safety. The choice of site for this relocation and replacement is acceptable in terms of access to hospital services. It will increase the distance to a general hospital campus for the population living near the existing Takoma Park campus but this change will not leave this population at a great distance from alternative hospitals or the new WAH hospital site.

[5] I have recommended that a condition regarding the proposed urgent care center be placed on AHC's Certificate of Need to address concerns that I share with the City of Takoma Park.

[6] The Commission adopted a proposed replacement of COMAR 10.24.17, the Cardiac Surgery and PCI Services chapter of the State Health Plan, which became effective on November 9, 2015 and that replaces an earlier chapter adopted in 2014.

I also considered the need for the services and capacities proposed by AHC and found them to be reasonable and consistent with current trends in hospital use and the future environment for delivery and payment for hospital services under Maryland's program for regulation of hospital charges. My examination of the impact of this project on other hospital service providers and on cost and charges led me to find that this impact is acceptable, given the expected benefits of this project.

In addition, I found the proposed project to be financially feasible and likely to create a viable and sustainable general hospital in the Silver Spring area that will operate in conjunction with a special hospital and outpatient service campus operated by AHC in Takoma Park to serve most of the needs of the service area population historically served by WAH. My findings in this regard are supported by the Health Service Cost Review Commission ("HSCRC"), which provided a generally positive review of this project's financial prospects. Contingent on the issuance of a CON for the project, in October 2015, the HSCRC acted on an application for additional budgeted revenue to support the depreciation and interest expenses associated with this project. While HSCRC did not approve all of the additional revenue sought for this project, it approved an amount that AHC accepted as sufficient for implementation of the project. AHC has provided both MHCC and HSCRC with updated financial projections consistent with the HSCRC action.

Finally, I found that AHC has a good track record in meeting the terms and conditions of previously authorized CON applications.

Review Schedule and Further Proceedings

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on December 17, 2015, beginning at 1:00 p.m. at 4160 Patterson Avenue in Baltimore. The Commission will issue a final decision based on the record of the proceeding.

As provided under COMAR 10.24.01.09B, the applicant and interested parties may submit written exceptions to the enclosed Recommended Decision. As noted below, exceptions must be filed no later than noon on Wednesday, December 2, 2015. Written exceptions must specifically identify those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. Responses to exceptions must be filed no later than 4:30 p.m. on Thursday, December 10, 2015. Copies of exceptions and responses must be sent by email to the MHCC and all parties by these deadlines. The applicant and interested parties must also file 30 copies of written exceptions and responses to exceptions by noon of the day following the deadline.

I note that, because a participating entity does not have a right of judicial appeal, Commission regulations do not grant a participating entity the right to file exceptions to a Recommended Decision. Despite this, I would like the City of Takoma Park, a participating entity in this review, to file comments on my Recommended Decision, if it desires, as long as it does so by the deadline for interested parties to file exceptions. I want to point out that a participating entity may, in accordance with COMAR 10.24.01.09C, request that the Chair of the Commission permit it to make an oral presentation to the MHCC before action is taken on an application for Certificate of Need.

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

Submission of exceptions	December 2, 2015 No later than noon
Submission of responses	December 10, 2015 No later than 4:30 p.m.
Exceptions hearing	December 17, 2015 1:00 p.m.

cc: Montgomery County Department of Health and Human Services

IN THE MATTER OF	*	**BEFORE THE**
	*	
ADVENTIST HEALTHCARE, INC. d/b/a WASHINGTON ADVENTIST HOSPITAL	*	**MARYLAND HEALTH**
	*	
	*	**CARE COMMISSION**
	*	
Docket No.: 13-15-2349	*	
	*	

****

Reviewer's Recommended Decision

December 17, 2015

(Released November 18, 2015)

F. Impact on Existing Providers and the Health Care Delivery System

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

Applicant's Response

AHC: General Impact

AHC states that its plans to relocate WAH from Takoma Park to the White Oak sections of Montgomery County, while retaining the campus in Takoma Park for some health care services, will have a positive impact on the health care system. The general hospital's patients will benefit from private rooms, more efficient clinical space and improved access to outpatient services, improved public transportation, and improved parking, among other enhancements. Further, AHC says that the services that will remain on the Takoma Park campus will provide continued health care services to patients in the immediate area and that the project will have a positive impact on the health care delivery system through better aligning WAH's facilities and operations with the new realities of hospital care delivery and payment. Specifically, it notes that the project's downsizing of inpatient bed capacity and its ability to increase access to outpatient services will enhance the provision of population- based care. (DI #27, Vol. I, p. 133)

AHC: Impact on Existing Health Care Providers

AHC believes that the impact of WAH's relocation on existing hospitals will not be substantial and, in some cases, expects that the other hospitals may experience an increase in discharges related to the relocation. In arriving at this conclusion, AHC took into account a number of factors in projecting the impact on existing providers, including changes in population and use rates, and the reduced number of beds proposed for construction at the White Oak location. In its modified application, AHC provides an impact analysis of how medical/surgical and obstetric service volumes generated by the service area (expected to provide 85% of the WAH White Oak hospital's inpatients) are likely to change over the next few years and the first five years after the White Oak hospital campus is in operation. The applicant notes that two inpatient services will be provided at the replacement hospital. It quantifies the changes specifically resulting from the relocation and also makes predictions about how population changes and use of hospitals will combine with the relocation to produce a "net" forecast of volume changes at the region's Maryland hospitals. (DI #27, p.133-142)

AHC states that population projections[91] show that significant aging of the population will occur in what it foresees as the replacement hospital's White Oak Total Service Area (TSA) over a 10-year period from 2013 – 2023. While the 15-44 population is expected to decline in the TSA in that period, the population aged 65-74t is projected to grow by 44% (average annual growth of3.7%). AHC states that the increase in the elderly population will exert pressure for higher levels

[91] Nielsen Claritas is AHC's vendor of demographic estimates and projection.

of service that will result in net growth in demand for its replacement hospital's inpatient health care facilities, despite the decline in use rates likely to continue from the health care reforms currently being implemented with increased emphasis on alternatives to inpatient hospital services. AHC projects that WAH's inpatient discharges will grow about 6.3% from 53,908 in 2013 to 57,317 in 2023, a projection that assumes relocation to White Oak, and thus the White Oak TSA, in 2019. (DI #27, Vol. I, p. 133)

AHC states that its analysis shows that between now and CY2023 there is more than enough growth in demand for MSGA hospital admissions to offset volume reductions attributable to declining use rates or the relocation. If the replacement hospital were open today, Washington Adventist Hospital White Oak would gain MSGA cases from other area hospitals, such as Holy Cross of Silver Spring, MedStar Montgomery, Suburban and Laurel Regional. Other area general hospitals, such as Prince George's and Doctors Community, would gain cases from the move. There would be a total of 1,423 cases within the Washington Adventist Hospital/White Oak TSA that would move to the relocated hospital, with the majority of those cases coming from Holy Cross of Silver Spring. (DI #27, Vol. I, p. 137)

The applicant reports that Holy Cross of Silver Spring had a total of 10,947 MSGA discharges in CY 2013 that originated from the proposed White Oak TSA.[92] AHC states that, if it had operated in White Oak in CY 2013, Holy Cross would have had 1,102 fewer MSGA discharges, but with incremental growth (985 discharges), AHC projects that HCH will have 10,829 discharges in 2023, a decline in MSGA discharges of only 1.1% over the ten-year period. AHC states that MedStar Montgomery had 3,404 MSGA discharges from the White Oak TSA in CY 2013 and that WAH's relocation would have reduced this number by 91 (2.7%). However, using assumptions similar to those used in evaluating likely impact on Holy Cross of Silver Spring, the number of discharges at MMMC are projected to increase to 3,645 by 2023. AHC projects that Prince George's Hospital Center would see an increase in MSGA discharges of around 7.1% attributable to the relocation of WAH. (DI #27, Vol. I, p. 133)

[92] A description of how AHCs identified its proposed TSA (85% service area) can be found under the *Need* criterion, 10.24.01.08G(3)(b), *supra*, p-118.

Table IV-56: AHC's Projections of 2023 MSGA Discharges Originating from the White Oak TSA Defined by AHC Montgomery and Prince George's County Hospitals

Providers	CY2013 (1)		Adjustments		CY2023 Discharges (4)	
	Discharges	Market Share	Location Adj (2)	Incremental Growth (3)	Discharges	Market Share
Holy Cross	10,947	20.31%	(1,102)	985	10,829	18.89%
Montgomery General	3,404	6.31%	(91)	331	3,645	6.36%
Shady Grove Adventist	2,801	5.20%	0	280	3,081	5.38%
Suburban Hospital Center	2,739	5.08%	(79)	266	2,926	5.10%
Laurel Regional Hospital	2,857	5.30%	(95)	276	3,038	5.30%
Prince Georges Hospital Ctr	4,887	9.07%	63	495	5,445	9.50%
Southern Maryland	2,441	4.53%	0	244	2,685	4.68%
Fort Washington Hospital	148	0.27%	0	15	163	0.28%
Doctors Community Hospital	8,096	15.02%	63	816	8,975	15.66%
Other Providers	9,114	16.91%	(183)	893	9,824	17.14%
Washington Adventist	**6,474**	**12.01%**	**1,423**	**(1,193)**	**6,705**	**11.70%**
Total	53,908	100.00%	-	3,409	57,317	100.00%

Notes:
(1) Actual CY2013 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Incremental growth by provider indicates slight increases in market share for all providers due to actual projected discharges for WAH.
(4) CY2023 discharges = CY2013 discharges + location adj + calculated incremental growth.
Source: DI #27, p.137

AHC reports that it conducted an analysis of obstetric market shares by zip code area to understand the likely impact of the proposed relocation of WAH to White Oak. AHC estimates the changes in obstetric market share (at the zip code area level) that other hospitals in Montgomery and Prince George's County will experience as a result of the relocation of WAH. The applicant points out that, while the move of approximately six miles will result in some redistribution of cases among hospitals serving the TSA, its analysis shows that between now and CY2023, growth in demand for obstetric services will offset most of the volume lost as a result of the relocation. AHC states that its analysis shows that, if the replacement WAH had opened in 2013, the White Oak hospital would have gained obstetric cases from Holy Cross of Silver Spring, MedStar Montgomery, Adventist Shady Grove and Laurel Regional; Prince George's Hospital would have also gained obstetric cases. (DI #27, p. 141)

AHC bases its projection of growth in demand on the projected growth in the "newborn" population, provided by Nielsen Claritas. It notes that Nielson Claritas predicts a decline of about five percent in the primary child-bearing age group of 15 to 44 year old females in the White Oak TSA between 2013 and 2023. A similar increase in the newborn population is projected over the same time period. AHC projects that the number of obstetric discharges generated by the White Oak TSA population will grow by 5.4% between 2013 and 2023. (DI #27, p.180)

Based on its assumptions regarding growth in demand for obstetric services, AHC predicts that obstetric volume will grow over the ten-year period being forecast at four of the six hospitals that obtain substantial numbers of obstetric discharges from the White Oak TSA AHC's predictions of net reductions for MedStar Montgomery and Adventist Shady Grove are small (11

and 17 discharges), just from the limited proportion of total obstetric volume coming to these hospitals from the White Oak TSA. (DI #27, Vol. I, pp. 141-42)

Table IV-57: AHC's Projections of 2023 Obstetric Discharges Originating from the White Oak TSA Defined by AHC Montgomery and Prince George's County Hospitals

Providers	CY2013 (1)		Adjustments		CY2023 Discharges (4)	
	Discharges	Market Share	Location Adj (2)	Incremental Growth (3)	Discharges	Market Share
Holy Cross	4,026	54.31%	(143)	172	4,055	51.88%
Montgomery General	273	3.68%	(26)	11	258	3.30%
Shady Grove Adventist	403	5.44%	(30)	17	389	4.98%
Suburban Hospital Center	1	0.01%	-	0	1	0.01%
Laurel Regional Hospital	502	6.77%	(4)	22	521	6.66%
Prince Georges Hospital Ctr	381	5.14%	84	21	485	6.21%
Southern Maryland	15	0.20%	-	1	16	0.20%
Doctors Community Hospital	10	0.13%	-	0	10	0.13%
Fort Washington Hospital	1	0.01%	-	0	1	0.01%
Other Providers	532	7.18%	1	24	557	7.12%
Washington Adventist	1,269	**17.12%**	**118**	**137**	**1,523**	**19.49%**
Total	7,413	100.00%	-	404	7,817	100.00%

Notes:
(1) Actual CY2013 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Incremental growth by provider indicates slight increases in market share for all providers due to actual projected discharges for WAH.
(4) CY2023 discharges = CY2013 discharges + location adj + calculated incremental growth.
Source: DI #27, p.141

AHC: Impact on Costs and Charges of Existing Providers and on Costs to the Health Care Delivery System

AHC further states that it attempted to quantify potential gross revenue impacts, but since it is not assuming any increase in revenues attributable to increased market share, it is not projecting a negative impact on revenues of other area hospitals.[93] AHC adds that the $19.7 million rate increase it requested from HSCRC is estimated to be less than 0.11% of the statewide allowable increase of 3.58%, adjusted for population growth, that Maryland is committed to achieving under the new Medicare waiver model implemented in 2014. AHC states that this one-time permanent increase of just under $20 million is far less impactful to other hospitals than a scenario in which AHC was counting on large volume shifts to enable the project to cover the increase in capital spending caused by the project.[94] (DI #27, p. 142-143)

[93] I note that the payment model for hospitals in Maryland, which was initiated in 2014, recognizes market shifts in updating global budget revenues. System-wide, the model is evolving in a way that would make such recognized shifts revenue neutral (i.e., hospitals capturing market share from other hospitals will be able to make upward adjustments in their charges to gain approved revenue increases while the hospitals losing market share will have to reduce charges to stay within budgeted revenue totals adjusted downward. The volume changes AHC projects appear likely to result in such adjustments.

[94] On October 14, 2015, HSCRC acted on AHC's request for a rate adjustment for this proposed project

Interested Party and Participating Entity Comments

Before summarizing interested party and participating entity comments, I want to note that, in a motion filed on October 13, 2015, Laurel Regional Hospital gave formal notice in this review that,

> [o]n July 31, 2015, LRH announced that it will replace its acute inpatient hospital due to continued declines in inpatient; a decline of 20 percent since 2013, and a multi-year trend of unsustainable operating losses. … Accordingly, LRH will replace the hospital with an ambulatory medical center in order to focus its resources on community-based ambulatory care." (DI #110, p. 1)

LRH further stated that it "plans to have the Ambulatory Medical Center established by 2018" and that,

> [w]hile the regulatory approval process for the closure is undertaken, LRH has started the transition away from inpatient care by temporarily delicensing its obstetrics beds and a portion of its medical/surgical beds and plans to phase out all but 30 of its medical/surgical beds by the end of 2015. (DI #110, p. 2 & n.1)

Although I denied LRH's motion to file additional comments, I assured it that "in this review, I will consider its stated plans to cease the provision of inpatient services and to convert to an ambulatory medical center." For this reason, I will not address no-longer-relevant comments regarding the impact of AHC's proposed project on the inpatient services that LRH provided at the time it filed comments and that it either has ceased providing (obstetrics) or has stated that it will not continue to provide after 2017. However, I will discuss comments that LRH made about AHC's analysis and other still relevant matters.

Holy Cross Hospital of Silver Spring

Holy Cross of Silver Spring ("HCH") takes issue with AHC's claim that the impact of the relocation of WAH will not have a substantial impact on other providers. HCH states that the proposed partial relocation of WAH will increase HCH's Emergency Department volume and result in insufficient access for patients, particularly those with the greatest need for emergency care. HCH projects that its ED will experience a significant increase in volume as a result of the relocation. Based on a nine-month projection of actual ED utilization for CY 2014, HCH projects that the relocation will result in a total shift of approximately13,300 additional cases, or a 15% increase over its three-year ED case average of 88,000 cases, a shift that would bring its yearly volume of ED cases to more than 100,000. To accommodate more than 100,000 ED visits annually, HCH would need to expand ED capacity. However, HCH notes that it already expanded its ED several times and that, at this point, there is no space to expand beyond the existing footprint on the existing site. (DI #50, pp. 19-20)

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and, on a contingent basis, approved a budget adjustment of $15.3 million for the project, which AHC has accepted. (DI #111) AHC has since provided adjusted and updated projections of revenues and expenses to demonstrate feasibility and viability going forward, (DI #118).

HCH reports that over the first six months of FY 2015 ED visits increased 4.6% and that it expects volume to continue to grow despite steps to curb growth in inappropriate utilization. HCH believes that growth will continue for the following three reasons: (1) growth of the senior population; (2) patterns of care seeking by the newly insured that will skew toward use of the ED; and (3) substantial numbers of persons remaining uninsured who are ineligible for federal assistance. (DI #84, p. 2)

HCH states that it based its projection of the impact on ED volume on AHC's market share adjustments. HCH notes that it also considered other factors that affect ED volume such as changes in provider relationships, changes in market shares among other existing providers, and changes in travel distance to existing facilities and to the proposed WAH relocation site. (DI #50, pp.20-21) HCH used AHC's projection of MSGA market shift and applied this projection to the ED volumes to establish a low end of the projected impact because HCH believes that AHC's "analysis assumes dramatic shifts to WAH's ED which are not likely."[95] HCH cites WAH's assumed market share shift for zip code 20904, the zip code area of the proposed White Oak site, from 11% to 57%. HCH believes that a market share shift for this zip code area is not only unlikely, but implausible, given that the drive time difference advantage WAH would gain over HCH is only an average of four minutes and that HCH is currently the market leader with a market share of 66% compared to WAH's 18%. (DI #84, p. 6 and Att.) The following table provides examples of HCH's analysis.

Table IV-58: HCH: Analysis of the Impact of Washington Adventist Hospital Relocation on Emergency Department Visits at HCH

Zip Code	Area	WAH 2014 Market Share	Total Est. 2014 ED Visits(1)	Assumed WAH Market Share After Move	Annual Increase (WAH Loss) In HCH ED Visits
20783	Hyattsville	60.3%	14,073	3.0%	5,081
20912	Takoma Park	66.2%	8,121	3.3%	3,778
20782	Hyattsville	53.1%	7,216	2.7%	1,384
20903	Silver Spring	40.5%	7,829	2.0%	2,470
20904	Silver Spring	11.7%	17,432	28.3%	(1,974)
20910	Silver Spring	18.0%	9,709	0.9%	1,331

Source: DI #50, Exh. 5.
Note: Total estimated 2014 ED visits based on 9 months of actual data.

In addition to concern about crowding of the HCH Emergency Department as a result of a relocation-related shift in volume, HCH is concerned that there will be a negative impact on its payer mix. HCH states that 56% of the ED patients are either uninsured or under-insured in the eight zip code areas to which the relocation of WAH is projected to result in a shift of ED volume. HCH notes that, not only do these patients frequently use the ED for primary care, but they require more hospital resources than other patients. (DI #50, p. 22)

HCH questions whether AHC's urgent care center will be able to treat all the conditions treated at WAH's existing ED, and expects that patients who previously sought emergency care at

[95] HCH's May 29, 2015 response to my April 29, 2015 request for additional information (DI #84, p. 6).

WAH's existing ED will seek future treatment at neighboring EDs or will be transferred from the walk-in clinic. HCH notes that its ED will be the closest for a large portion of WAH's current primary service area; therefore, as detailed above, HCH expects to receive a significant percentage of patients who choose to visit an ED rather than the proposed Takoma Park walk-in clinic and almost all of the patients redirected from the walk-in clinic when the resources of a hospital ED are needed. (DI #98, pp. 5-6) In support of its feared results of the WAH relocation, HCH notes that the addition of 25 urgent care centers established in Montgomery County since 2012 (plus 15 existing centers) has not reduced hospital ED volume. HCH believes that, while convenient to patients, urgent care centers have a limited scope of services and limited hours of availability and for these reasons, the addition of urgent care centers do not significantly impact ED volume. HCH believes that the same is true of Federally Qualified Health Centers. Therefore, HCH concludes the FQHC operated by Community Clinic, Inc. on the Takoma Park campus will not reduce ED volume increases at HCH resulting from the WAH relocation. (DI #102, pp. 3-5)

Laurel Regional Hospital/MedStar Montgomery Medical Center

Laurel Regional Hospital[96] states that AHC's market share analysis does not provide a consistent methodology or a statistically-based analysis that correctly uses formulas to support its findings or conclusions. LRH believes that AHC's allocation of increases and decreases in WAH's market shares at a zip code area level were not formulated in a methodologically consistent manner. For example, LRH cites WAH's projection of a 5% increase in its market share in zip code area 20707 and associated market share decreases of 2% for HCH and 3% for LRH in spite of 2013 market shares of 43.9% for LRH and 8.0% for HCH. LRH points out it has a market share in this zip code area that is 5.5 times that of HCH but AHC is projecting that the impact on LRH would be 1.5 times the impact on HCH. (DI #92, pp. 2-3)

LRH states that the relocation of WAH to the White Oak/Fairland area will have an unwarranted negative impact on LRH and MedStar Montgomery Medical Center because the White Oak/Fairland area is a significant part of each hospital's primary service area. LRH and MMMC state that they jointly applied the methodology developed by the Reviewer in the prior CON review of a proposed relocation of WAH to the White Oak site (Docket No. 09-15-2295)[97] to estimate the impact of the relocation on patient volumes at the two hospitals. The analysis also estimated the impact on revenues of the two hospitals. (DI #51, pp. 1-2; DI #52, p. 24) This analysis was initially submitted in LRH's February 9, 2015 comments, in which LRH reported that its application of the methodology indicates that, after accounting for population growth heavily weighted to the population aged 65 and older, over and the declining hospital discharge rates (11.2% for MSGA patients and 2.0% for OB patients) between 2013 and 2023, MMMC would lose 284 patients (3.7% of its otherwise expected 2023 discharges) as a result of the WAH relocation. (DI #51, p. 2 and Exh. 4) LRH and MMMC also submitted their analysis of the impact of expected volume losses on revenues, expenses, and operating margins. MMMC included losses in outpatient revenue based on its expected losses in inpatient revenue based on the 2014 relationship of outpatient revenue to inpatient revenue at each hospital, 91% for MMMC.

[96] See my discussion page 154, *supra*, regarding LRH's announced intention to cease providing inpatient services by 2018.

[97] Note that the 2012 Reviewer's Recommended Decision did not result in a Commission decision since the applicant withdrew the application before MHCC action.

Applying the 50% HSCRC market share shift adjustment factor and each hospital's 2014 collection ratio, they concluded that MMMC would suffer a reduction in net revenue of $2.26 million.. They reached an estimated expense reduction of $1.3 million for MMMC by applying the expected collection ratio (86% for MMMC and variable expense reductions of 29% for MMMC). By subtracting the estimated expense reductions from the estimated revenue losses, MMMC calculated an estimated net impact on operating margin of $952,000 for MMMC. (DI #83, Excel Workbook #2)

Table IV-59: MMMC
Impact of Lost Volume Due to WAH Proposed Relocation
2014 Dollars (in $000's)

Line		MedStar MMC	Note
1	Projected Discharge Reduction	(284)	
2	FY 2014 Average Charge Per Discharge	$ 9,712	(1)
3	Inpatient Revenue Reduction (A)	$ (2,758,000)	(2)
4	Outpatient Revenue to Inpatient Revenue	91%	(3)
5	Outpatient Revenue Reduction (B)	$ (2,511,000)	(4)
6	Total Revenue Reduction (A + B)	$ (5,269,000)	(5)
7	Expected HSCRC Market Share Adjustment Factor	50%	
8	Expected Collection Ratio	86%	(6)
9	Net Revenue Impact (A)	$ (2,257,000)	
10	Projected Revenue Reduction	$ (5,269,000)	
11	Expected Collection Ratio (1)	86%	
12	Composite Variable Cost Assumption	29%	
13	Net Expense Change (B)	$ (1,305,000)	
14	Net impact on Operating Margin (A-B)	$ (952,000)	
15	Total FY 2014 Actual Revenue	$166,918,000	(7)
16	Net Revenue Impact as Percent of Total Revenue (Line 9/Line 15)	-1.35%	

Source: DI #83 Excel Workbook #2 (Sources and Notes as listed by LRH/MMMC)
Notes: (1) HSCRC Inpatient Abstract Data Set for the twelve months ended June 30, 2014 & computation is total inpatient charges divided by total actual discharges.
(2) Line 3 equals Line 1 (discharges) times Line 2 (average charge per discharge).
(3) HSCRC Inpatient and Outpatient Abstract Data Set for the twelve months ended June 30, 2014. Computation is Outpatient Revenue divided by Inpatient.
(4) Line 3 (Inpatient Revenue Reduction) times Line 4 (Outpatient revenue percentage) to compute the corresponding outpatient revenue impact of volume loss.
(5) Total Revenue Reduction (line 6) equals IP Revenue reduction (line 3) plus OP revenue reduction (line 5)
(6) FY 2014 HSCRC Annual Filing RE Schedule
(7) HSCRC Inpatient and Outpatient Abstract Data. The total inpatient and outpatient revenue for the twelve months ended June 30, 2014. Data excludes LRH's Specialty Unit revenue.

In separate comments, MedStar Montgomery Medical Center states that the proposed project should not be approved at the proposed location because it will unnecessarily duplicate existing health resources. Specifically, MMMC believes "that another hospital is not needed in the White Oak/Fairland area because there are three other hospitals already in the service area"[98] and another hospital will create excessive structural costs. MMMC also states that approval of the project will unnecessarily increase costs to the health care delivery system because it will shift

[98] MMMC comments on AHC application (DI #52, p. 25)

volume from a lower cost hospital, MMMC, to a higher cost hospital, WAH. (DI #52, p. 25)

City of Takoma Park

The City of Takoma Park states that relocating WAH to White Oak would leave 12,000 to 15,000 ED visits to be absorbed by other facilities. CTP believes that, given the travel time, the proposed shuttle bus service for patients, visitors, and employees from Takoma Park to the White Oak campus may not be an attractive option for ED patients, but that the planned 24/7 urgent care center could conceivably absorb many of these visits. (DI #54, p. 21 and 31)

Applicant's Response to Comments

AHC states that the relocation of WAH will enhance and strengthen the region's health care system, as the Commission's approvals of relocated, outmoded facilities for Harford County (Upper Chesapeake Medical Center), Allegany County (Western Maryland Regional Medical Center), Washington County (Meritus Medical Center), and Anne Arundel County (Anne Arundel Medical Center), similarly resulted in "an increased level of quality and patient care and, ultimately, a new equilibrium distribution of patients across those facilities, something that results in an obvious public benefit and a strengthened regional health care delivery system."[99] AHC states that the Commission must consider what the effect would be on the region's health care delivery system if this application were denied. (DI #59, p. 4)

Regarding the interested parties' claims that the relocation of WAH will have an unwarranted negative impact on their hospitals, AHC states that the methodologies relied upon by HCH, LRH, and MMMC in their claims of negative impact are flawed, unsupported, and wholly unreliable. Therefore, AHC believes the interested parties have failed to offer any basis for the Commission to conclude that the relocation of WAH would result in an unwarranted negative impact to any of them. (DI #95, p. 1)

AHC states that regardless of the impact of the relocation on LRH and MMMC discharges, there will be no adverse impact because any such decreases will be offset by increases resulting from population growth. (DI #59, p. 2) AHC also states that the relocation will not result in any unwarranted impact on the other hospitals' profitability. Specifically, AHC believes that the analysis of the impact on profitability prepared by LRH and MMMC is based on variable cost assumptions that are unreliable. AHC analyzed the recent experience of both LRH and MMC from FY 2013 to FY 2014 using annual filing data prepared by the Maryland Hospital Association. AHC observed that MMMC experienced a volume decrease of slightly more than 5% and reduced direct care expenses by a little more than 5% indicating a variable expense factor of 89%, which is also significantly more than the 50% used by MMMC. (DI #95, pp. 2-6) AHC then calculated an aggregate variable cost factor for each hospital to account for non-patient care direct expenses as well as direct patient care expenses using a direct care cost factor of 90% for Laurel because AHC felt that the 112% is unsustainable. AHC calculated variable expense factors of 51.8% for MMMC. AHC then calculated its own estimate of the impact on the profit margins of MMMC using the two hospitals' analysis of volume impact and projected that the decrease in operating margin would be $78,779 for MMMC. (DI #95, pp.6-7)

[99] AHC response to comments of interested parties and participating entity (DI #59, p. 4)

AHC takes issue with HCH's claim that HCH's emergency department volume will increase dramatically following WAH's relocation pointing to the fact that WAH's ED will be new with improved patient privacy. AHC states that HCH has failed to properly account for the planned urgent care center on the Takoma Park campus and the FQHC that is currently being expanded. AHC notes that HCH discounts the potential impact of the urgent care center on ED volumes while pointing to its own efforts to divert low level ED volume to alternative locations. AHC responds to HCH's claim that its ED is more accessible by public transportation by pointing to the small percentage of patients (1.7%) that arrive by public transportation. (DI #95, pp. 7-9)

AHC says that Holy Cross of Silver Spring's citation of proximity as a major reason why patients will flock to its ED contradicts the discounting of proximity by HCH as a reason why patients who currently go to HCH might shift to WAH, claiming that the WAH location will not be much closer than the HCH ED and that HCH ED patients have established travel habits and relationships. AHC also states, that "HCH applied unwarranted and extremely aggressive decreases in WAH market share without considering offsetting increases that would occur when it relocated into a redefined service area."[100] AHC cites the example of three zip code areas, two where WAH has market shares of over 60% and one for which it has a market share of 53%, where HCH ignored current market presence and estimated that WAH's market share after relocation would be reduced to 3%. AHC notes that in one of the zip code areas (20782), the drive time to HCH and WAH in White Oak would be the same. Another of the three zip code areas is 20912, WAH's current home zip code, where it will continue to have connections to the urgent care center and other services that will remain on the campus. In summary, AHC states that "HCH assumed an increase of 20% or greater in 10 zip codes but did not assume that WAH would realize an increase in market share of 20% or greater in any zip codes, not even its new home zip code 20904."[101] (DI #95, pp. 7-10)

Reviewer's Analysis and Findings

This criterion requires an applicant to provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area. The criterion requires that this information include 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. In considering this criterion, I want to first note that I have considered the impact of this project on geographic and demographic accessibility under the related Geographic Accessibility and Adverse Impact standards, COMAR 10.24.10.04B(1) and (4).[102] I concluded that the proposed relocation is consistent with the Geographic Accessibility standard and would not inappropriately diminish either access for the population in the primary service area or the availability or accessibility to care, including access for the indigent and uninsured because I found that other hospitals are reasonably accessible to these populations and that some services would likely continue to be available on the Takoma Park campus through the existing Federally Qualified Health Center and the establishment of an urgent care center. Thus, as is the case with other criteria established in regulation for CON project reviews, the State Health Plan standards,

[100] AHC June 29, 2015 response to data submitted by HCH, LRH and MMM (DI #95, p. 10).
[101] DI #95, p. 10.
[102] See discussions at pages 22 and 26, *supra.*

the subject of the first review criterion, includes applicable standards for this review that bear on the issue here, impact of the project. For this reason, this Recommended Decision must be read beyond this section to obtain a full review of this issue.

Regarding the impact on volume of other providers, the applicant projected relatively small decreases in volume at other hospitals as a result of this project and projects that, when coupled with gains attributable to population growth and aging, will not translate into actual reductions in volume for most hospitals during the ten year preceding 2023, by which time the relocation adjustments will have occurred. MMMC questions the methodology used by AHC to project the impact of the proposed relocation of WAH on market share and discharge volumes and state that the relocation will have an unwarranted negative impact on its general hospital operations. LRH and MMC jointly prepared their own projections using a methodology based on that used by an MHCC Reviewer in a prior review of a similar relocation of WAH to the same White Oak site (Docket No. 09-15-2295). LRH reports that MMMC would lose 284 (3.7% of its total) as a result of the relocation.

I have reviewed both the methodology used by the applicant and the methodology used by LRH and MMMC to project the impact of the proposed relocation on MSGA and obstetric discharges. As I pointed out in my analysis and findings under the *Need* criterion, I am concerned that AHC's determination of the expected service area was too conservative and resulted in an expected service area for the new location that is too small and not as different from the present service area as would seem likely. I share the interested parties' questions about the applicant's methodology, as well as the concerns expressed by the City of Takoma Park. I explained my concern with the statement that I cannot see a clear, consistent relationship between the rationale provided for the changes in zip code market share and the projected market shares. While I am more comfortable with the methodology used by MMMC because of its prior use, it was only used in a single Recommended Decision that was not acted on by the Commission because the application was withdrawn.

My review of the use by LRH and MMMC of an earlier Reviewer's methodology raises questions about the number of zip code areas included and the proximity rank of some them. I am also concerned with the projection of future volumes on a zip code area level by age group. I am concerned that projections for such small market segments is less reliable on a year-to-year basis. I recognize that the methodology used in the prior recommended decision also projected discharges at a zip code level; however, I have chosen to project discharges on a service area basis to minimize the year–to-year fluctuation that can occur when using smaller areas. While I have concerns about the earlier methodology, I do not agree with AHC's charge that the earlier analysis ignores the proximity of other hospitals to WAH's new location. My review indicates that there is an adjustment for the current market shares of other hospitals in each zip code area analyzed by LRH and MMC. I also disagree with AHC's statement that the shift in discharges to DC hospitals makes no sense. It appears reasonable to me that some discharges would shift from WAH to DC hospitals when WAH moves approximately six miles to the north, especially from DC zip code areas that are in WAH's current MSGA service area.

Given my questions and concerns with the competing approaches to projecting impact, I have performed my own analysis. While this analysis is based on the one used in the prior

Recommended Decision, I determined expected services areas as described under the *Need* criterion. My impact analysis used these service areas and the expected market shares for all relevant hospitals, the determination of which was also described under the *Need* criterion. To arrive at the discharge impact that one would have expected to occur in 2013, if WAH had been operating in White Oak, I multiplied the expected market share for each hospital for each zip code area by the total discharges from all Maryland and DC hospitals generated from that zip code area. I then subtracted each hospital's actual 2013 discharges originating in that zip code area to estimate the impact of the relocation. The result for MSGA discharges is an estimated loss of 291 discharges from MMMC (4.6% of discharges), and 773 from HHC (4.6% of discharges). For obstetrics my estimate of the loss that would have occurred in 2013 is 20 for MMC and 79 for HCH. Therefore, my estimate of the total loss of discharge volume attributable to the relocation of WAH is 311 discharges for MMMC and 852 for HCH.

I recognize that my estimates of likely market shifts and projected volume changes are much closer to those projected by MMMC than the changes projected by AHC. However, I cannot conclude that the impact is unwarranted. First, LRH has already terminated provision of obstetric and perinatal services, and has noted in this review that it will not be providing inpatient services after 2017. (DI #110) Second, MMMC's calculation of the impact of such decreases in volume is questionable. One question is whether outpatient volume would decrease in proportion to the projected decrease in inpatient volume. No basis for this assumption was submitted. Another question is the calculation of the impact of the estimated decreases on each hospital's profitability. Both AHC and HSCRC questioned these calculations and the variability assumptions used. HSCRC questioned the assumption of a 60% rate for supplies and drugs stating that these cost should be close to 100% variable with volume and that use of a higher variability factor would reduce the estimated project impact. (DI #131, p. 12). AHC did its own calculation of variable cost factors, as explained above, and determined that for MMMC, a more appropriate assumption is 51.8% rather than 29%. I have concluded that the impact on MMMC profitability, if any, is likely to be much less than MMMC has projected.

With respect to Holy Cross Hospital's comments on volume impacts, HCH is concerned that increases in the volume of ED visits will overwhelm its resources. It has not registered concerns with declining volume negatively affecting its profitability. While HCH projects a 15% increase in ED volume (13,302 additional visits) as a result of the relocation of WAH, AHC claims that HCH applied extremely aggressive assumptions with respect to decline in WAH market share in zip code areas close to Takoma Park, but did not assume similar increases in market share in zip code areas "moving closer" to WAH after it relocates. I reviewed HCH'S market share assumptions as summarized above and carefully considered AHC's response. Ultimately I determined it was necessary to conduct my own market share analysis to settle the conflicting claims. My analysis indicates that it can be reasonably predicted that HCH's Emergency Department may lose volume as a result of the relocation of WAH, rather than gain considerable visit volume, as it predicts.

I modeled this analysis on the analysis of MSGA market share shifts described earlier in this Recommended Decision under the *Need* criterion. One major difference is that market share shifts are only based on visits to Maryland hospitals, and not DC hospitals, because data of the same currency on outpatient visits to DC hospitals is not available. For that reason I only

considered the change in proximity rank among Maryland hospitals. As in the MSGA analysis, I included a large number of zip code areas in this analysis, including 80 Maryland zip code areas. I included all the zip code areas identified by AHC as being in WAH's current service area and the expected service area. I also determined the zip code areas that contributed to the first 85% of WAH's 2014 visit volume and any other zip code areas of comparable proximity rank to the existing WAH and the proposed WAH, which occurred with the zip code areas for which WAH is the sixth closest Maryland hospital.

I used the same rules for determining the target market share of Maryland zip code areas that I used for examining the need for MSGA bed capacity. For the DC zip code areas, WAH currently has a proximity ranking that ranges from one (WAH is the closest hospital) to 10 when considering both Maryland and District of Columbia hospitals. Following relocation of WAH to White Oak, its proximity ranking will range from ninth to fourteenth. Since WAH's current proximity ranking for these zip code areas is no higher than 10 and it is the tenth most proximate hospital ED to only one of these zip code areas, its average market share for the zip code areas for which it is ninth and tenth ranked hospital, which was 4.6% of all visits to Maryland hospitals, was used as a target market share assumption for all DC zip code areas. As for MD zip code areas, if a DC zip code area had a lower market share in 2014 than 4.6%, its 2014 market share was used as the expected market share.

The target market share for each hospital for each zip code area was then adjusted to account for the current relative strengths of the other hospitals based on their 2014 market share, in order to arrive at an expected market share. This was done by assuming that total market share of WAH-White Oak, the interested party hospitals and other hospitals would equal the total 2014 market shares of the same hospitals substituting WAH-Takoma Park for WAH-White Oak.[103] This step also adjusts each of the other hospital's expected market share in zip code areas where WAH's market share is expected to change as a result of the relocation. This part of market share adjustment process has the effect of reducing the expected market share changes that would have resulted from only relying on the change attributable to the change in proximity ranking.

In the last steps of my analysis, I calculated the expected impact of WAH's relocation by multiplying the expected market shares for each hospital for each zip code area times the total 2014 ED visits from that zip code area to all MD hospitals and subtracted the hospitals actual 2014 visits from that zip code area. I then summed the changes for each hospital for all the zip code areas. The result is that I would expect Holy Cross to lose approximately 2,700 ED visits, which would have been 3.1% of its 86,453 visits for 2014. The table below sets forth my finding regarding expected ED market shares for the relocated WAH and HCH in key zip code areas and the change in visits to HCH that would have resulted.

[103] No DC hospitals were included in this step because the number of outpatient ED visits to those hospitals is not available. All Maryland hospitals were included as opposed to those with over 3% market share that were used in the MSGA analysis. This was done for ease of data management and has no significant impact on the analysis because of the small market shares.

Table IV-60: Comparison of 2014 and Expected Emergency Department Visits Market Shares and Impact on Visits to Holy Cross Hospital Visit

Zip Code	Total 2014 ED Visits to MD Hospitals	2014 ED Market Shares		WAH Proximity Rank		Expected WAH ED Market Shares Per HCH	Expected WAH ED Market Shares Per MHCC	HCH Expected Increase (Decr.) In HCH ED Visits	Reviewer Expected Increase (Decr.) In HCH ED Visits
		WAH	HCH	TP	WO				
20705	7,737	12.5%	30.2%	4	1	12.9%	53.2%	0	(1,086)
20707	11,567	2.3%	5.8%	5	2	7.2%	19.7%	(34)	(120)
20782	7,507	52.4%	17.7%	1	4	2.7%	28.4%	1,384	672
20783	13,944	59.2%	25.2%	1	2	3.0%	43.2%	5,081	1,373
20866	3,599	5.6%	33.5%	4	1	20.5%	56.0%	(190)	(645)
20901	10,019	21.9%	64.7%	2	2	11.2%	21.9%	911	0
20903	8,092	40.5%	48.6%	2	2	2.0%	40.5%	2,470	0
20904	17,787	11.6%	59.0%	3	1	28.3%	53.5%	(1,974)	(4,970)
20905	4,392	4.3%	27.7%	4	1	NA	56.7%	NA.	(666)
20906	23,486	2.4%	38.2%	5	4	7.4%	2.4%	(455)	0
20910	9,880	17.6%	65.5%	2	3	0.9%	7.75%	1,331	785
20912	7,963	65.0%	25.5%	1	3	3.3%	44.2%	3,778	1,209

Source: Maryland Discharge Data Base, Maryland Outpatient Data Base, Spatial Insights Drive Time Matrix, HCH February 9, 2015 Comments on Application (DI #50, Exh. 5).

Based on the above analysis, I tend to agree with AHC that HCH applied extremely aggressive decreases in WAH's market shares. Specifically, as pointed out by AHC, the decreases in market share for zip code areas 20782, 20783, and 20912 from more than 50% to approximately 3.0% appear extreme. I also think that the projected decrease in WAH's market share from around 40% to 2.0% is extreme for a zip code area for which WAH's proximity ranking will not change. I also agree that HCH's treatment of what would be WAH's home zip code area is inconsistent with HCH's treatment of WAH's current home zip code area. In conclusion, I find that Holy Cross Hospital is unlikely to experience an increase in Emergency Department visits of the magnitude it predicts as a result of the relocation of Washington Adventist Hospital. This finding is bolstered by my conclusion regarding COMAR 10.24.10.04B(4), the *Adverse Impact* standard of the Acute Hospital Services Chapter, that the urgent care center that AHC plans to establish and operate on the Takoma Park campus is likely to be able to serve at least a quarter of the demand that would otherwise be handled by the WAH ED if that facility remained in place.

I also considered the impact of the relocation on LRH's ED volume. My analysis indicates that LRH would have lost approximately 4,098 of its 32,720 ED visits in 2014, a loss of 12.5%, if the replacement WAH had already been established in White Oak. I note that this analysis estimates the impact on LRH's ED volume as a part of an acute care hospital with inpatient services. I believe the impact on an alternative emergency care facility in Laurel, which is freestanding and not part of a general hospital ED, would not be as great. .LRH has announced that it will transition the LRH campus to one that is limited to providing outpatient services with a freestanding emergency service capability. The implementation of that plan could reduce visit volume in Laurel regardless of whether WAH relocates because the LRH campus will not be able to serve the highest acuity patients. However, low and mid-range acuity patients are a substantial portion of any hospital's ED visits, and, with appropriate public information and education, most such patients could be expected to use the LRH emergency care center if it is more convenient,

rather than opting to go further to a hospital ED that may not be necessary for the patients' needs and is likely to be less convenient, in terms of wait time.

I note that AHC indicates that 45% of the WAH ED visits could be treated at an urgent care center. I expect that the percentage for the facility proposed by Laurel would be higher. Freestanding emergency services at Laurel would have the same advantages as the establishment of the urgent care center by AHC in Takoma Park, in that Laurel is an established location with a patient population familiar with the location, which as an emergency center would have the added advantage of being able to treat mid-range acuity patients. While AHC's 45% estimate is based on treating level I and II patients and some level III patients, I considered the experience of existing Freestanding Medical Facilities, as reported in the Commission's February 1, 2015 report.[104] I note that for Germantown Emergency Center ("GEC"), in FY 2014, 57.7% of the visits were level III and 19.6% were level IV and that for Bowie Health Center ("BHC"), the percentages were 53% and 22.5% respectively. GEC was nine miles from the nearest hospital[105] and BHC is 9.2 miles from the nearest hospital. The relocated WAH will be seven miles from LRH. I further note that, in FY 2014, there were 37,247 visits to GEC and 35,344 visits to BHC. Based on the current utilization and the location of LRH in an area with population density similar to that of GEC and BHC, I believe that, after its transition, the emergency center and ambulatory medical campus located on the site of LRH will be able to maintain a high percentage of its current volume, given sufficient efforts to inform and educate the public, regardless of the relocation of WAH.

I have also considered MMMC's comments regarding the impact of the proposed relocation on the cost of the health care delivery system. MMMC asserts that the relocation to the White Oak/Fairland section of Montgomery County would duplicate existing resources and add unnecessary costs to the health care delivery system. MMMC claims that this area is already served by three other hospitals. Its comment appears to ignore the fact that WAH's proposed location is in zip code area 20904, which is already in WAH's primary service area. This claim is also misleading in that zip code area 20904 is in the primary service area of two other hospitals, not the three claimed by MMMC. While zip code area 20904 is in LRH's 85% service area, it is not in its primary service area. I also find that WAH is the second most important hospital for this zip code area in that it had the second most MSGA discharges from the zip code area in 2013.

Based on my findings under COMAR 10.24.10.04B(5),[106] the *Cost Effectiveness* standard, that the relocation of WAH is the most cost effective solution to its physical plant problems and that the proposed site, located within WAH's primary service, is reasonable, I do not agree that the proposal is an unnecessary duplication of hospital resources. Regarding MMMC's assertion that the relocation will unnecessarily increase health care delivery costs, I take special note of HSCRC's comments on WAH's charges relative to other hospitals, taking into account cost differences attributable to the relative socioeconomic status of its service area population. I note that HSCRC found that, while MMMC's charges for FY 2014 were 12.3% lower than WAH's, they were 10.4% higher when the estimated impact of these population differences on costs are factored into the comparison. (DI #131, pp.8-9)

[104] Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities
[105] GEC is now 1.7 miles from the nearest hospital with the opening of Holy Cross Germantown Hospital in October 2014.
[106] See discussion at p.43, *supra.*

In summary, WAH's relocation six miles to the north of its current site, to a site within its current primary service area, will not duplicate existing hospital resources. While I find that MMMC is likely to see fewer inpatients and less revenue than it would otherwise experience without the relocation of WAH, I find that the impact of any such decrease in volume on MMMC's profitability should be significantly less than it has projected. Moreover, it does not appear that any shift in volume from MMMC to the relocated WAH will increase health system costs as a result of the relative charge structure of the two institutions. While the relocation will add costs to the health care delivery system in the form of a capital cost increase to WAH's revenue budget, such an increase is necessary to modernize an obsolete and poorly functioning hospital resource that is still an important component of the regional health care delivery system. Therefore, I do not consider the likely impact of the relocation of WAH on other hospitals or the cost to the health care delivery system related to this relocation to be a factor that would justify denial of this application.

I conclude that, from a broad health care delivery system perspective, WAH plays a very important role in providing services to the residents of southeastern Montgomery County and western and northern portions of Prince George's County. Its current operation in an outdated physical plant, as discussed in detail under the *Cost-Effectiveness* standard,[107] makes its future survival and ability to perform well dependent on its relocation and replacement. Relocation in an urban area with competitive hospitals is inevitably going to have an impact on service areas and market share.

I find that the application is consistent with this criterion and that both the health care delivery system and the population in WAH's service area will benefit from having a modern hospital that can thrive and better serve the region.

V. SUMMARY OF RECOMMENDED DECISION

The basis for my recommendation that the MHCC approve AHS' application is summarized as follows:

A. COMPLIANCE WITH APPLICABLE STATE HEALTH PLAN STANDARDS

COMAR 10.24.10 – Acute Hospital Services

General Standards

(1) Information Regarding Charges
(2) Charity Care Policy
(3) Quality of Care

I found that the applicant has complied with these general standards.

Project Review Standards

[107]See my analysis regarding the cost effectiveness standard, COMAR 10.24.10.04B(5), *supra*, p.43.

(1) Geographic Accessibility

This standard requires me to evaluate whether the proposed project is located to optimize accessibility in terms of travel time for its likely service area population, and defines optimal travel time as being within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area. AHC's analysis found that just over 90% of the service area population of WAH, as operated at its current site, resides within a 30-minute travel time, under normal conditions; also that just over 95% of the service area population for the relocated hospital at White Oak, would reside within a 30-minute travel time of that site, under normal conditions. It concludes that aggregate drive time for the White Oak service area population would be lower (-4.9%) than that for the Takoma Park service area population.

While AHC's analysis was focused on its projected new service area, I was concerned about the effect that a relocation would have on the residents of the existing service area. My analysis showed that of the 13 zip code areas making up WAH's PSA, six would be at least 5 minutes farther away from WAH if it relocated as proposed; four others would experience less than a five minute increase in travel time; and three zip code areas would be closer to WAH at White Oak. Only one would experience an increase in travel time in excess of 20 minutes, but that zip code area has six closer hospital alternatives. In summary, all but one of the 13 zip code areas comprising WAH's current service area will remain within a 20 minute drive time of a hospital ED.

I find the proposed project meets this standard.

(2) Identification of Bed Need and Addition of Beds

The proposed replacement hospital will have 152 MSGA beds, 19 fewer MSGA beds than were licensed in FY 2015 and 17 fewer beds than are currently licensed. This number of beds represents a reduction in physical MSGA bed capacity for WAH of 87 beds. All of the 152 MSGA beds will be located in private rooms.

This standard provides that only beds identified as needed and/or currently licensed shall be developed at an acute care general hospital, and contains tests that apply to proposed additional beds. This application seeks to replace MSGA bed capacity that is currently licensed, and does not propose any additional bed capacity. WAH currently has a physical capacity for 239 MSGA beds and has allocated 169 beds within its overall acute care license to MSGA services in FY 2016. AHC is proposing to develop a physical bed capacity for only 152 MSGA beds at White Oak

I find that AHC has satisfied this standard.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit – Not applicable.

(4) Adverse Impact

This standard says that capital projects undertaken by hospitals shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. In October 2015, WAH obtained a decision from the Health Services Cost Review Commission, contingent on approval of the proposed relocation and replacement project that is the subject of this Recommended Decision, that it was eligible for an increase in its permanent rate base of $15.39 million on January 1, 2019. This approval, while substantially smaller than the $19.7 million increase requested, was accepted by WAH. The latest data compiled by HSCRC (covering 2013) shows that WAH had an adjusted charge level (based on HSCRC's Reasonableness of Charges comparison methodology) that was 7.01% lower than its peer group. For this reason, AHC does not need to demonstrate that its Debt to Capitalization ratio is below the average ratio for its peer group under this standard. The latest available data compiled by HSCRC also showed WAH to have an Average Age of Plant of 26.7 years in 2014, older than all hospitals in the state excepting Upper Chesapeake–Harford Memorial and Fort Washington. This information supports my conclusion that significant physical plant modernization and/or replacement of WAH is reasonable, and satisfies this portion of the standard.

The second part of this standard – its impact on the availability or accessibility to care for the population in the primary service area – drew much comment from the interested parties and the City of Takoma Park, a participating entity. Holy Cross Hospital also said that the move would inundate its ED with additional visits that it would struggle to accommodate. I performed an analysis at the census block-group (CBG) level to assess the likely impact of this project on that segment of the Takoma Park population who might be most negatively affected by the hospital's potential relocation. I found that none of these CBGs will be more than 15 minutes from an emergency room – and most will be much closer than 15 minutes, if the proposed project is implemented. In addition, since the applicant has committed to transforming its current ED into a 24/7/365 urgent care center if/when it moves to White Oak, my analysis shows that anywhere from 25% to 45% of the visits to its ED could be served in an urgent care setting, and thus could continue to access this facility.

Given the importance of this UCC to mitigating impact, as well as the concerns expressed by interested parties and Takoma Park, I am recommending a condition be attached to an approval of this project that obligates AHC to maintain 24/7/365 UCC access unless it receives approval from MHCC to reduce its hours of operation.

I found AHC met this standard.

(5) Cost-Effectiveness

In its evaluation, Adventist compared each of four options – two on-site renovation/expansions and two options at the White Oak location -- to a set of seven categories of objectives that would need to be satisfied to identify what it viewed as the optimal option that would meet both the needs of AHC and the needs of its service area population. The option chosen was to build a replacement hospital in White Oak, without replacement of the acute psychiatric beds, which will remain on the Takoma Park campus in expanded and renovated space, and operate

EXHIBIT 18

Barbara Kistenmacher, Ph.D.

As a Clinical Psychologist with 14 years of experience, I have worked in the private (self-pay), commercial insurance, and public sectors of the mental health and addictions fields. In this context, I have served as executive director, director, supervisor, clinician, researcher, faculty member, and independent consultant across all levels of mental health and addictions care, including detoxification, residential, day treatment, intensive outpatient, non-intensive outpatient, and structured sober living. As an executive leader, I bring a unique combination of administrative, financial, board development, fund-raising, clinical, and program development expertise to any organization.

Currently, I am the Executive Director of Hazelden, New York (HNY), part of the Hazelden Betty Ford Foundation. In this capacity, I oversee a multi-million dollar budget which includes multiple programs that are housed in two NYC neighborhoods. I have spent the past 4.5 years turning HNY into a financially viable operation through top line growth and cost management. In addition, I have also been rebuilding the New York board of directors, transforming the quality of clinical services provided, mentoring managers toward excellence using the evidence-based Studer approach, working closely with the Director of Philanthropy on fundraising initiatives, and increasing the visibility of HNY through marketing, sales, and public relations initiatives.

During my five-year tenure at Bronx-Lebanon Hospital, I transformed a 75 employee department that had been lacking a strong leader for nine years prior to my arrival. Key accomplishments included: 1) inspiring a five year clinical vision; 2) setting standards of performance for staff; 3) coaching and developing staff; 4) collaborating with other key departments in the hospital; and 5) creating a culture of excellence, ongoing professional development, and support. As part of this effort, I spearheaded a long-term agenda aimed at delivering evidence-based treatments in a private non-profit community hospital setting. Our model was disseminated at national conferences and included several phases including: 1) conducting program and staff readiness/competency assessments; 2) developing training materials that matched manager and staff readiness; 3) implementing training; 4) disseminating evidence-based manuals; 5) providing appropriate supervision; and 6) measuring fidelity to the model.

Prior to working at Bronx-Lebanon, I was an integral member of a team at Columbia Eastside Psychiatric Associates that brought several new service lines, including addictions treatment and couples/family interventions, to a 25 year-old day treatment program. I wrote the business plan for the couples/family component and developed the evening addictions outpatient program; both were well-received by leadership and are currently very successful.

Finally, I have worked as a Motivational Interviewing consultant to several organizations, including Proceed, Inc. (funded by the CDC), New York State Office of Alcoholism and Substance Abuse Services (OASAS), New York City Health and Hospitals Corporation (NYHHC), and the National Center on Addiction and Substance Abuse (CASA) at Columbia University. I have presented at major conferences on various addictions and mental health topics, both nationally and internationally, and have served as a consultant on NIDA and NIMH-funded grants.

To summarize, my strengths are: 1) developing, inspiring, and implementing a strategic vision; 2) multidisciplinary collaboration and team-building in a management context; 3) expert clinical knowledge and a passion for helping others; 4) moving managers and clinicians toward excellence through setting expectations and coaching; and 5) building a board of directors and cultivating donor opportunities. I have both the financial acumen, leadership skills and clinical knowledge needed to lead an economically successful organization that provides quality service delivered by satisfied employees.

I am extremely interested in learning more about Recovery Centers of America, particularly the Earlville site, as it fits with both my professional development and relocation goals. Attached are my Curriculum Vitae for your review. Thank you in advance for your time.

Sincerely,

Barbara Kistenmacher, Ph.D.
Executive Director, Hazelden New York