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ATTORNEYS AT LAW

THOMAS C. DAME
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October 24, 2016

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

VIA EMAIL and HAND DELIVERY

Re: Recovery Centers of America – Upper Marlboro & Waldorf
4620 Melwood Road OPCO, LLC
11100 Billingsley Road OPCO, LLC
Matter Nos. 15-07-2363 & 15-08-2362

Dear Ms. Potter:

On behalf of applicants 4620 Melwood Road OPCO, LLC and 11100 Billingsley Road OPCO, LLC, we are submitting twelve copies of their Response to 10/17/16 Comments Submitted by Interested Party in the above-referenced matters. I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies as noted below.

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

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures
cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Joel Riklin, Program Manager

#572548
013522-0005

William Chan, Health Policy Analyst, HSP&P/CON
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Dianna E. Abney, M.D., Health Officer, Charles County (w/ enclosure)
Pamela B. Creekmur, RN, Health Officer, Prince George's County (w/ enclosure)
JP Christen, Chief Operating Officer, Recovery Centers of America
Edmund J. Campbell, Jr., Esq.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Ella R. Aiken, Esq.

IN THE MATTER OF RECOVERY CENTERS OF AMERICA – UPPER MARLBORO & WALDORF Docket Nos. 15-16-2364 & 15-08-2362	*	BEFORE THE MARYLAND HEALTH CARE COMMISSION

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

RESPONSE OF 4620 MELWOOD ROAD OPCO, LLC AND 11100 BILLINGSLEY ROAD OPCO, LLC TO COMMENTS SUBMITTED BY INTERESTED PARTY ANNE ARUNDEL GENERAL TREATMENT SERVICES

4620 Melwood Road OPCO, LLC ("Melwood") and 11100 Billingsley Road OPCO, LLC ("Billingsley"; collectively "Applicants"), subsidiaries of Recovery Centers of America ("RCA"), by their undersigned counsel, submit this response to the comments filed by interested parties Anne Arundel General Treatment Services, Inc. *d/b/a* Pathways ("Pathways") addressing Applicants' October 7, 2016 Modifications in Response to the September 20, 2016 Project Status Conference. For the reasons set forth below and throughout the Applicants' filings in this review, Applicants respectfully request that the Reviewer recommend approval of the pending applications for Certificates of Need.

ARGUMENT

I.
APPLICANTS' CHARITY CARE COMMITMENT COMPLIES WITH THE REVIEWER'S RECOMMENDATION AND WITH COMAR § 10.24.14.05D

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

#573271
013522-0005

> (1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:
>
> > . . .
> >
> > (c) Commit that it will provide 15 percent or more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

COMAR § 10.24.14.05D (emphasis added). During the September 20, 2016 Project Status Conference, the Reviewer directed Applicants, pursuant to this standard, to "make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days" in response to COMAR § 10.24.14.05D. September 20, 2016 Letter from Reviewer summarizing the Project Status Conference (the "September 20, 2016 Letter"), Exhibit 14. Applicants did just that. October 7, 2016 Modification, Exhibit 33 (Melwood), Exhibit 34 (Billingsley), Tables G, H J, and K. Consistent with the Reviewer's comments during the Project Status Conference, and with Applicants' commitment to provide a continuum of care across residential and detox services to their patients, Applicants distributed the resulting amount of charity care across detox and residential services.

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

A. Applicants demonstrated that a modification to Standard .05D is appropriate based on their commitment to provide a continuum of charity care services.

Pathways argues that Standard .05D either requires that a facility provide charity care equal to 15% of the bed days or net revenue for all services offered by a facility, or, that if the 15% requirement is limited to detox services only, the standard can only be met by providing the charity care within detox services, and may not be met by distributing the charity care commitment across detox and residential services.

The former interpretation is plainly incorrect. Standard .05D only requires a charity care commitment with respect to detox services. The text of that standard applies the 15% charity care requirement to "annual adult intermediate care facility bed days." *Id.* The Maryland Health Care Commission ("MHCC") has confirmed that the term "intermediate care facility," includes only detox services. In an August 3, 2015 determination of non-coverage, Executive Director Ben Steffen confirmed that "[t]he Maryland Health Care Commission has determined that this definition [of intermediate care facilities] corresponds to the subacute 'inpatient' level of care and services in the American Society of Addiction Medicine's Patient Placement Criteria. This would include Level III.7, medically-monitored intensive inpatient treatment and Level III.7-D, medically-monitored inpatient detoxification services."[1] August 3, 2015 Letter, Exhibit 15. Thus, an "intermediate care facility" does not encompass residential

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

services. Indeed, the August 3, 2015 Letter confirms that the establishment of residential services "does not require CON review and approval." *Id.*

The latter half of Pathways' argument, that Applicants may not meet the charity care requirement by distributing the dollar amount of care required by the standard across detox and residential services, is also incorrect. Standard .05D expressly gives an applicant the flexibility to demonstrate that the charity care requirement should be modified. Applicants' prior filings contain lengthy argument and discussion as to why a modification of the charity care requirement is appropriate in these circumstances. Applicants highlighted, in part, that it would be clinically inappropriate to provide charity care to patients at the detox level only, and that, while no charity care was required for residential services, Applicants would make the commitment to provide charity care patients with a continuum of care.

The Reviewer concluded, as the Standard allows, that Applicants provided a basis for modification of Standard .05D. The September 20, 2016 Letter states, "From a public policy perspective, the provision of a full range of care is much more desirable than the situation where an indigent or low income patient would receive detox services and then be released to others for additional needed care." September 20, 2016 Letter.

Moreover, contrary to Pathway's assertion, the plain intent of Standard .05D supports the modification. Not only does the Standard itself expressly allow modification, but the State Health Plan Chapter confirms that the Commission's intent is to "increase access to care for indigent and gray area populations" COMAR

§ 10.24.14.02B, and avoid "a two-tier system of care based upon the individual's ability to pay." COMAR § 10.24.14.03B(1). Applicants' modification to Standard .05D increases access to substance use disorder treatment by providing charity care services in the residential setting, which are often provided in a private pay setting, and avoids incentivizing two tiers of service where only full-pay patients receive both levels of care.

Finally, Pathways' warning that the modification in Applicants' charity care commitment could result in providers meeting the charity care requirement through outpatient services only is unfounded. Standard .05D requires an applicant to demonstrate why the charity care requirement should be modified. The Commission has authority to reject a modification that proposed to meet the standard through the provision of outpatient charity care alone.

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

Pathways' argument that Applicants' charity care commitment does not meet Standard .05D because it is calculated in terms of net revenue instead of patient bed days has no merit. As an initial matter, as described above, the Standard expressly allows modification for good cause, and Applicants' projections comply with the Reviewer's directive at the Project Status Conference. Furthermore, while Applicants state their commitment in terms of net revenue, it can just as easily be translated into detox bed days by reviewing the financial projection tables. The statistical and financial projections contain both patient bed day data and revenue data. In FY 2019, for example, Billingsley is projected to have 23,313 detox patient days. October 7, 2016 Modification, Exhibit 34,

Table I. Fifteen percent of those days is equal to 3,497 days. Detox net revenue for the same year, before charity care, is $20,046,600, for an average detox daily rate of $860. *Id,* Table J. The total FY 2019 charity care commitment is $3,006,990. *Id,* Table G. That amount divided by the average daily rate of $860 would demonstrate the total number of detox bed days that could be paid for with the charity care commitment. $3,006,990 divided by $860 equals 3,497 days. Thus, Applicants' charity care commitment can easily be stated in terms of bed days or net revenue using the statistical and financial projections.

Expressing charity care in terms of bed days only would only result in a lower amount of charity care to patients. Applicants' detox rates are higher than their residential rates. The average daily reimbursement rate for detox services is $860, before charity care is factored into net revenue. The average daily rate reimbursement rate for residential services, before charity care, is $724.[2] Thus, if Applicants committed to provide 3,497 bed days to charity care patients across their detox and residential services, instead of $3,006,990 in net revenue, they would actually provide less charity care than if Applicants used net revenue as their means of measurement.

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[2] *See* October 7, 2016 Modification, Exhibit 33 (Melwood) and Exhibit 34 (Billingsley), Tables F, G, H, I, J, and K. This number is stated the other filings in this review, but can also be calculated, for any year, by subtracting outpatient services revenue and detox net revenue, before charity care, from the entire facility net revenue, before charity care, and dividing that amount by the number of residential days in that year.

C. Pathways' additional arguments lack merit.

Pathways' additional critiques of Applicants' charity care commitment are not persuasive. Pathways argues that modifying the charity care standard to allow Applicants to distribute their charity care across their services should not be allowed because Applicants do not believe it is clinically appropriate to discharge patients after detox treatment, and thus Applicants are only doing what they are clinically required to do. Applicants should not be penalized for having high standards of care. Furthermore, Pathways overlooks that Applicants have been unwilling throughout this review to commit to develop these projects if required to provide 15% charity care across their continuum of services. Applicants have instead highlighted that such a requirement would impose a barrier to entry on a private, for-profit entities and would discourage development of these much needed services by private providers in the future.

Pathways' final argument suggests that Pathways misunderstands Applicants' modification. Pathways states that Applicants have shown that they would make less money if required to provide 15% charity care consistent with the standard, and should not be granted a modification on this basis alone. While profit is a legitimate incentive to consider in encouraging development of much needed services, it need not be considered here. Although Applicants previously resisted the requirement to provide 15% charity care, and have put forth arguments for reducing this requirement in prior filings, Applicants have now committed to providing the full dollar amount required by the

Standard – 15% of their net revenue for the only CON regulated services in this review.[3] Whether or not Applicants are allowed to distribute this amount across detox and residential services does not impact Applicants' profits.

II. Applicants Provided Transfer and Referral Agreements and Will Accept Conditional CON Approval

COMAR §10.24.14.05J requires Applicants to have written transfer and referral agreements with facilities capable of managing cases which exceed, extend or complement their own capabilities. Applicants provided three transfer and referral agreements – two with substance use disorder providers, and one with Sheppard Pratt Health System. Sheppard Pratt offers treatment of co-occurring psychiatric and addiction issues at its two campuses, as well as education programs and referral services.[4]

COMAR § 10.24.1405K requires Applicants to enter into referral agreements for the provision of indigent and gray area care as a means of ensuring that such care is provided. As stated in their Modifications, Applicants are actively seeking referral agreements from the Maryland Department of Health, Behavioral Health Administration, and county Health Departments for Charles and Prince George's Counties.

As Pathways remarks, Applicants have reached out to many providers and agencies for referral agreements on several occasions. However, Applicants have encountered reluctance by some third parties to confirm any agreement or intent until

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[3] As Pathways points out, the Standard refers to bed days, not net revenue. However, as described in these comments, revenue can easily be restated in terms of bed days.

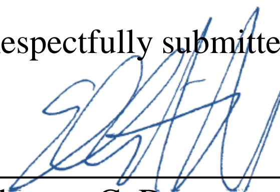
[4] *See* https://www.sheppardpratt.org/faqs.

Applicants receive CON approval. Compliance with this standard rests in the hands of third parties not involved in this review, and with their own internal policies and practices. As Applicants previously expressed their willingness to accept a CON conditioned on the execution of additional agreements, there is no legitimate health policy reason to delay a decision on the basis of this issue alone.

CONCLUSION

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

Respectfully submitted,



Thomas C. Dame
Ella R. Aiken
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(410) 727-7702

Attorneys for
4620 Melwood Road OPCO, LLC, and
11100 Billingsley Road OPCO, LLC

Date: October 24, 2016

TABLE OF EXHIBITS

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 24th day of October, 2016, a copy of the Response of 4620 Melwood Road OPCO, LLC and 11100 Billingsley Road OPCO, LLC to Comments Submitted by Interested Party was served by email and first-class mail on:

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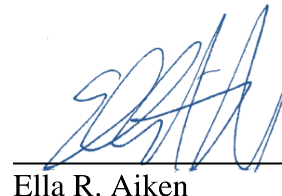

Ella R. Aiken

#573271

EXHIBIT 14

STATE OF MARYLAND

Craig Tanio, M.D.
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

September 20, 2016

By E-Mail and U.S. Mail

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

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

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

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

Dear Counsel:

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

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

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

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

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

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

Project Costs

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

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

As I noted at project status conference, regarding RCA's proposal for meeting charity care requirements, I am pleased that each applicant has committed charity care dollars to provide the full range of needed care to indigent and gray area patients, both in detoxification and residential care. From a public policy perspective, the proposed provision of a full range of care is much more desirable than the situation where an indigent or low income patient would receive detox services and then be released to others for additional needed care.

Each applicant must make a charity care commitment equivalent to 15% of the net revenue associated with total detox patient days (i.e., for the Level 3.7-D patient beds for which CON approval is sought). While the 2015 modified applications' proposed charity care figures for RCA-Earleville and RCA-Waldorf appear to meet the standard, the amount of funds proposed by RCA-Upper Marlboro for charity care to such patients does not appear to be equivalent to the 15% of the net revenue for its detox bed days. As I noted, the applicants should determine whether new cost estimates and tables necessitate the need for changes from the 2015 modified applications.

COMAR 10.24.14.05J: Transfer and Referral Agreements

Each applicant must update information regarding its executed transfer and referral

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

COMAR 10.24.14.05K: Referral Sources

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

Project Drawings

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

Other

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

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

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

Sincerely yours,

Randolph S. Sergent
Commissioner/Reviewer

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

EXHIBIT 15

STATE OF MARYLAND

Craig P. Tanio, M.D
CHAIR

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

August 3, 2015

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

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

Dear Ms. Aiken and Mr. Dame:

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

Alcoholism and drug abuse ICFs are defined, in COMAR 10.24.14, as facilities "designed to facilitate the subacute detoxification and rehabilitation of alcohol and drug abusers by placing them in an organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide." The Maryland Health Care Commission has determined that this definition corresponds to the subacute "inpatient" level of care and service in the American Society of Addiction Medicine's Patient Placement Criteria. This would include Level III.7, medically-monitored intensive inpatient treatment and Level III.7-D, medically-monitored inpatient detoxification services.[1]

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

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

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

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

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

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

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

Sincerely,

Ben Steffen
Executive Director

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