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January 10, 2019

VIA EMAIL & REGULAR MAIL

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

Re: Baltimore Detox Center
Matter No. 18-03-2419

Dear Mr. McDonald:

Provided below please find pursuant to COMAR 10.24.01.08F.(3) the responses of Baltimore Detox Center ("BDC") to the Interested Party Comments (the "Comments") submitted by Maryland House Detox ("MHD"). Provided below are detailed responses to the specific matters raised by MHD in its filing dated December 14, 2018 and received by BDC on December 21, 2018. Before responding to MHD's specific allegations that BDC has failed to meet any of the applicable State Health Plan standards or other regulatory requirements, BDC first submits preliminary comments regarding MDH's status as an Interested Party.

BDC understands and acknowledges that MHD is an Interested Party pursuant to COMAR 10.24.01.01B.(2)(e) because pursuant to COMAR 10.24.01.01B.(2)(a) MHD is "authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan". BDC would like to point out, however, that contrary to the assertions of MHD on page 2 of the Comments, MHD has failed to "demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction" pursuant to COMAR 10.24.01.01B.(2)(d). BDC's discussion herein demonstrates that its approval will not result in a detrimental impact on MHD or other providers or the community.

Provided below, please find the responses of BDC to MHD's specific allegations that BDC has failed to meet applicable State Health Plan standards or other regulatory requirements. The BDC application and the responses below demonstrate that BDC has met its burden of proof pursuant to COMAR 10.24.01.08G.(3)(a) with respect to all State Health Plan standards, policies, and criteria.

I. **COMAR 10.24.14.05(M) - Sub-Acute Detoxification**. An applicant must demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate admission standards, treatment protocols, staffing standards and

physical plant configuration. MHD maintains that "BDC fails to demonstrate that it has the capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate standard staffing standards." (See page 3 of Comments). As explained below, BDC's staffing plan is appropriate for the treatment it will provide.

MHD states in particular that BDC has not demonstrated this staffing capacity in its CON application because despite the assertion of BDC that it meets appropriate staffing standards for 24 patients, BDC's staffing plan is out of touch with the quality and classes of staff needed to safely and effectively operate an ICF. MHD further states that as medically monitored inpatient treatment is the most complex level of SUD care licensed outside of a hospital setting, widely accepted best practices and regulatory guidelines dictate that the staffing standards focus on the medical component of care and not simply clinical therapy. MHD states that because BDC lacks a basic understanding of how to staff medically monitored inpatient detoxification and treatment, its staffing plan should be found deficient, and its CON application should be denied.

MHD cites three Maryland regulations in its comments: COMAR 10.63.03.14C., COMAR 10.47.02.09E. and COMAR 10.47.02.09C. as well as Cigna Insurance Guidelines in support of its assertion that the BDC staffing plan fails to meet applicable standards and requirements. MHD states the BDC staffing plan is inadequate because it provides: for medical staff 1 FTE for its Medical Director, for nursing 1 FTE for its Director of Nursing, and 6 FTEs for its Nurse RNs and this plan is not sufficient to meet best practices, Maryland regulations and insurance guidelines.

RESPONSE:

BDC's program plan demonstrates that its capacity to admit and treat alcohol and drug abusers requiring sub-acute detoxification services meets applicable standards.

First, please take note that BDC is not proposing to treat 24 patients per day requiring subacute detoxification as assumed by the Comments of MHD.

BDC proposes to commence operations and begin to admit and treat patients in CY 2019 and projects that by CY 2022, the second full year of utilization, BDC will discharge 275 patients following an average length of stay of 28 days which represents an average of between five and six new patients per week. See chart below. This projected volume of patients is well within the capabilities of the proposed workforce of BDC. While BDC has a physical capacity of 24 beds, the BDC staffing plan is designed to address the actual projected patient day utilization in CY 2022 which is an average daily census of 21 total patients: between 7 and 8 patients are projected to require sub-acute detoxification services and between 13 and 14 patients will be receiving residential services.

BALTIMORE DETOX CENTER

DISCHARGES	2019	2020	2021	2022
a. Residential				
b. III.7 and III.7D				
TOTAL	***157***	***236***	***260***	***275***

PATIENT DAYS	2019	2020	2021	2022
a. Residential	2,830	4,240	4,670	4,950
b. III.7 and III.7D	1,570	2,360	2,600	2,750
TOTAL	***4,400***	***6,600***	***7,270***	***7,700***

Average LOS	2019	2020	2021	2022
a. Residential	18	18	18	18
b. III.7 and III.7D	10	10	10	10
TOTAL	***28***	***28***	***28***	***28***

Average Daily Census	2019	2020	2021	2022
a. Residential	8	12	13	14
b. III.7 and III.7D	4	6	7	8
TOTAL	***12***	***18***	***20***	***21***

Source: Exhibit 18, Completeness Information, July 25, 2018.

When the staffing standards cited by MHD are considered in light of the service mix and patient census BDC is actually proposing to provide to its future sub-acute detoxification patients, the BDC staffing plan is both entirely sufficient and consistent with the State Health Plan standard. Thus, the State Health Plan standard applicable to sub-acute detoxification applies to the 275 patients to be admitted and treated for the 2,750 days of care at Level III.7 and III.7D, not the 24 patients per day MHD states is the BDC treatment capacity for subacute detox.

Documentation of the proposed workforce of the BDC was provided in BDC Response #1 dated July 25, 2018 and modified on January 9, 2019. (See January 9, 2019 Modification Attachments 19 and 20, Modified TABLEs D and E.)

In addition to the 32 FTEs proposed for BDC in the Completeness Exhibit 18, submitted on July 25, 2018, which was the subject of MHD's comments, BDC has modified its work plan for CY 2020 by adding: 1 Case Manager FTE and 1 Contractual Nurse Practitioner FTE. BDC proposes 34 FTEs for its detox and residential treatment facility in 2022, and professional dietician services provided under contract. At this level of staffing, the Level III.7 program at BDC will employ both a physician and contract with a nurse practitioner to assess each of the 275 patients in person within 24 hours of admission or earlier, assess each patient thereafter if medically necessary, and be available to provide on-site monitoring of care and further evaluation on a daily basis for BDC's 7 to 8 patients undergoing subacute detoxification. (COMAR 10.63.03.14C. and COMAR 10.47.02.09E.). The modified staffing plan at BDC for its Level III.7 program will assure the on-site physician/nurse practitioner coverage and nursing hours consistent with COMAR 10.47.02.09C. for the patients undergoing subacute detoxification (less than the 24 patients per day stated in the Comments).

With regards to nursing staff, BDC will employ six (6) full-time RNs and will have a registered nurse on-site 24/7/365, and one (1) additional RN acting as Director of Nursing, who will be on-site Monday-Friday, 9 am to 5 pm. BDC's clinical program also includes staffing two (2) Behavioral Health Technicians on-site 24/7/365. During the hours of 11 pm to 7 am, there will be three to four employees on site, all of whom will be trained in crisis management and cardiopulmonary resuscitation.

Other clinical staff positions proposed for the BDC include its full-time Clinical Director, one Masters Level Therapist and two Case Managers. These professionals are sufficient to meet the patient case load level of eight patients for one full-time alcohol and drug counselor set forth in Maryland regulations. The two (2) full-time Case Managers proposed by BDC are associate's or bachelor's level counselors and will have CAC-AD or CSC-AD credentials to handle the proposed patient case load.

Medical services will be provided by a full-time Medical Director and a Board-certified psychiatric nurse practitioner. Sufficient arrangements will be made by the Medical Director to assure medical service coverage. Clinical assessments at intake for all admitted patients will be made as well as daily rounds to be completed for patients during detoxification consistent with BDC protocols. Psychiatric evaluations will be provided to patients with past history of mental illness or a current psychiatric diagnosis. BDC management maintains that the staffing for the services proposed in its modified CON Application exceed the applicable standards for sub-acute detoxification.

In summary, the availability of BDC proposed staff is sufficient to meet all of the necessary requirements to meet the needs of 275 patients requiring detoxification services for an average of 10 days as well as the residential patients with an average length of stay of 18 days.

BDC's staffing plan to provide subacute detoxification services is comparable to the staffing plan reviewed and approved by the Maryland Health Care Commission in 2016 for MHD.

Shown below is a comparison between the staffing plan reviewed and approved by the MHCC for MHD and the proposed modified staffing plan proposed by BDC. In its approved staffing plan, MHD included comparable staffing for a Medical Director, and other positions necessary to treat 16 subacute detox patients per day in comparison to seven to eight subacute detox patients per day projected by BDC. In the Comments, MHD states that its current workforce consists of 11 FTE behavioral health technicians, and 13.5 nurses, a significant increase above the staffing plan in its CON Application that was reviewed and approved by the Commission. No other descriptions or explanations of the current staffing at MHD or the current number of patients being treated there for sub-acute detoxification were provided in MHD's comments.

Job Category	MDC FTEs	BDC FTEs
Medical Director	1	1
Clinical Director		1
Clinician		1
Psychiatric NP		1
Clinical Supervisor	1	1
Case Manager	2	2
Admissions Coordinator	1	1
Intake Coordinator		1
CRNP/PA	1.6	
Social Worker	2	
Director of Nursing		1
Nurse Supervisor	1	
Nurse RN		6
Nurse (Day)	1	
Nurse, PN (Evening)	2	
Nurse, PN (Night)	1	
Behavioral Health Tech	3	11
Dietician	0.2	*
TOTAL PATIENT CARE	16.8	27
Office Manager/HR/Accounting	1	
Compliance Officer/QA/HR		1
Executive Assistant	1	
Outreach Coordinators		3
Receptionist	1	
President/CEO	1	1
COO		1
CFO	1	
Marketing	1	
Public Relations	1	
Line Cook	1	**
Chef/Food Service Manager	2	**
Janitorial Staff	2	
Maintenance Tech		1
Driver	1	
TOTAL ADMIN/SUPPORT	13	7
TOTAL FTEs	29.8	34

* contracted on a per diem basis @ $25,000/year
** food service contracted out @ $215,000/yr

Source: Maryland House, CON Application, p. 146, March 21, 2016; BDC, Modified CON Application, January 9, 2019.

The State Health Plan standard for Subacute Detoxification applicable to the BDC CON application is the same standard that was applicable to the MHD CON Application that was reviewed and approved two years ago. BDC's interpretation of that standard is entirely consistent with the review and approval of the MHD CON Application to establish its 16-bed detox facility. In that application, in its second full year of utilization, MHD projected 980 discharges and 5,700 patient days at an average length of stay of six days, and more than twice the 2,750 sub-acute detoxification patient days projected by BDC.

MARYLAND HOUSE DETOX

DISCHARGES	2015	2016	2017	2018
h. Other CD	0	0	725	980
TOTAL	***0***	***0***	***725***	***980***

PATIENT DAYS	2015	2016	2017	2018
h. Other CD	0	0	4,350	5,700
TOTAL	***0***	***0***	***4,350***	***5,700***

Average LOS	2015	2016	2017	2018
h. Other CD	0	0	6	6
TOTAL	***0***	***0***	***6***	***6***

Average Daily Census	2015	2016	2017	2018
h. Other CD	0	0	12	16
TOTAL	***0***	***0***	***12***	***16***

Source: CON Application, Completeness Responses, May 4, 2016.

For all of the reasons stated above, the Commission should disregard the comments of the MHD and find that BDC's CON Application is consistent with State Health Plan standard COMAR 10.24.14.05(M).

II. COMAR 10.24.14.05(J): Transfer and Referral Agreements.

(1) An applicant must have written transfer and referral agreements with facilities capable of managing cases which exceed, extend, or complement its own capabilities, including facilities which provide inpatient, intensive and general outpatient programs, halfway house placement, long-term care, aftercare, and other types of appropriate follow-up treatment.

(2) The applicant must provide documentation of its transfer and referral agreements, in the form of letter of agreement or acknowledgement from the following types of facilities:

- **(a) Acute care hospitals;**
- **(b) Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs;**
- **(c) Local community mental health center or center(s);**
- **(d) The jurisdiction's mental health and alcohol and drug abuse authorities;**
- **(e) The Alcohol and Drug Abuse Administration and the Mental Hygiene Administration;**
- **(f) The jurisdiction's agencies that provide prevention, education, driving-while-intoxicated programs, family counseling, and other services;**

MHD maintains that "BDC fails to demonstrate its ability to obtain written transfer and referral agreements with facilities capable of managing cases which exceed, extend or complement its own capabilities." (See page 7 of Comments) That statement is factually incorrect.

RESPONSE

As indicated on BDC's November 18, 2018 completeness related submission (See pages 1 and 2 of that submission) (and as referenced on page 8 of the Comments), BDC has transfer and referral agreements with an acute care hospital: Greater Baltimore Medical Center (please note that there is no requirement for an agreement with the closest hospital), halfway houses, and other local alcohol and drug abuse intensive and other outpatient treatment facilities. BDC will be serving not only the Baltimore metropolitan area but also all of Central Maryland and therefore will have transfer and referral arrangements throughout Central Maryland.

MHD inaccurately states that BDC fails to comply with the State Health Plan standard by notably omitting the following "specific requirements of MHCC"; none of which are actual requirements. Nonetheless BDC responds to each alleged "failure" below. (As set forth below, there is no requirement to have a transfer and referral agreement with each and every entity set forth below. In fact, BDC has transfer and referral agreements and /or letters of support or interest from entities in each of the categories below.)

a. Northwest Hospital and/or Sinai Hospital;

BDC does not have a transfer or referral agreement with Northwest Hospital or Sinai Hospital. It is in the process of seeking such an agreement. It does have an agreement with Greater Baltimore Medical Center. Thus, BDC has a process and a hospital to receive patients who will inevitably require hospitalization. BDC plans to eventually have transfer and referral agreements with Northwest or Sinai and Baltimore Washington Medical Center.

b. Local community mental health center or center(s);

BDC has a transfer agreement with PsychNP Wellness Center in Towson. BDC will continue to seek support from other local community mental health centers.

c. Baltimore County's mental health and alcohol and drug abuse authorities;

BDC is pleased to have submitted a letter of support from the Harford County Health Department. BDC continues to seek support from Baltimore County's mental health and alcohol and drug abuse authorities. BDC will have the required agreement pursuant to COMAR10.63.06.02.A.(3)(a), to cooperate with the Local Area Addiction Authority.

As set forth below, upon MHD's submission of its CON application it did not have a transfer and referral agreement with its local mental health and alcohol and drug abuse authorities.

d. The Behavioral Health Administration and the Mental Health and Hygiene Administration;

BDC has reached out to the Office of Health Care Quality and been advised that "We do not provide letters of support to providers opening new programs because we are also the agency that will be providing licensure. We want to avoid any conflict of interest."

BDC will continue to communicate with the Behavioral Health Administration and the Mental Health and Hygiene Administration.

What is notable to BDC is that at the time of submission of its CON application **MHD did not have transfer and referral agreements with Anne Arundel County Health Department, Anne Arundel County Mental Health Agency or the Maryland Behavioral Health Administration** (see page 13 of December 15, 2016 Staff Report Maryland House Detox Docket No. 16-02-2374 (the "MHD Staff Report")). MHD then maintained that "[u]pon CON approval, the applicant will finalize and enter into arrangements for the transfer and referral of these patients to these local providers." BDC is quite puzzled by MHD's statements that BDC is inconsistent with this standard in circumstances where BDC has reached out to various agencies, with plans to finalize the transfer and referral agreements upon CON approval. Under MHD's analysis, MHD should not have been found compliant with this standard. In any event, BDC is compliant with the standard above.

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

RESPONSE

Financial Viability

BDC has demonstrated a financially viable project as evidenced by its revenues and expenses as submitted in the modified Certificate of Need Application submitted on January 9, 2019. Modified TABLE D. projects that BDC will produce operating income of $720,893 in CY 2022. (See January 9, 2019 Modification, Attachment 19)

With respect to "Toxicology - U/A' as a source of Other Operating Revenue, urinalysis drug/alcohol testing is a necessary aspect of all levels of care in the addiction treatment industry. This testing ensures not only confirmation of abstinence or presence of only prescribed medications in a patient's system, but also assists in the safety of the early recovering individual and monitoring the strong likelihood of relapse early on in the recovery process. BDC will follow best practice procedures for appropriately administering medically necessary testing of all patients.

The detox/inpatient level of care (LOC) presents a unique situation in terms of appropriate administration of urinalysis testing, as patients do not have access to the outside community and remain confined to the treatment center. BDC performs only what is medically necessary in terms of frequency of testing; the standard testing procedure would be a comprehensive panel at the time of admission and another comprehensive panel completed at discharge. The initial test is used to determine what the patient has been using prior to admission, as self-report is often not accurate. Alcohol and benzodiazepines being present in the patient's system could indicate a potentially life-threatening detox if not monitored appropriately. This initial test allows BDC to appropriately determine the correct detox protocol, which continues to be monitored closely throughout the patient's stay.

The comprehensive panel urinalysis at discharge is used to ensure the patient is not leaving the treatment facility with any drugs in his or her system that were not prescribed. It is also helpful information for a referral facility, as this is a common transition for patients moving

from detox/inpatient LOC to a lower level of care. When a patient transfers to another facility, BDC will provide a final urinalysis prior to the admission process at the transfer facility, which can determine if an individual uses drugs/alcohol in transition to the new facility. Ultimately, the purpose of this test is to make sure the patient is leaving detox/inpatient safely and free from any substances that were not prescribed during their treatment.

There are times when a urinalysis drug/alcohol screen may be necessary outside of admissions and discharge. This could occur when there is suspicion that a patient is under the influence of something not prescribed. Despite very rigorous patient searching procedures, it is possible that a patient could bring something into the facility or have something brought in. In this case a comprehensive panel drug/alcohol screen would be completed as soon as a staff member suspected the patient may be under the influence. This individual would be removed from the rest of the community and screened. If positive for non-prescribed substances, the medical/clinical team could then make a determination of next steps. Another time additional screening may be necessary is when an individual leaves against medical advice (AMA) and returns within a short timeframe, as this can and does happen in this LOC. This patient would be discharged and readmitted with a new comprehensive panel completed to confirm no use occurred during the time they were outside of the facility.

At BDC, the main concern is the safety of the patients while they are in BDC care. Urinalysis testing gives BDC the ability to ensure that patients are not at risk of harming themselves while detoxing from drugs/alcohol through use of additional substances not prescribed. In the BDC detox/inpatient LOC, BDC makes sure that that testing is medically necessary and ultimately helps create a safe environment for individuals entering one of the most challenging parts of the recovery process.

Thus, "Toxicology - U/A" as a source of "Other Operating Revenue" is wholly unrelated to the abuses described in Appendix C of the Comments.

Community Support

MHD maintains that "BDC has also failed to demonstrate that it has sufficient community support necessary to implement and sustain the project. See Comments at page 13. That statement is both incorrect and wholly unsubstantiated as evidenced by the support BDC has submitted to date. Provided below is a list and description of current support letters which include the full range of advocates and local and government agencies, and the support of BDC's State Senator and Delegate.

Senator Shirley Nathan-Pulliam is a Maryland State Senator overseeing District 44 in which BDCs proposed site is located. Senator Pulliam prior to being a public servant worked as an RN for a number of years throughout the world. Senator Pulliam understands the need for additional treatment services; especially these services located closer to local residents in need of substance abuse treatment.

Delegate Pat Young oversees District 44B in Baltimore County which encompasses the surrounding areas in which BDC's proposed site is located. Delegate Young understands the need for additional treatment services within Baltimore County and the entire Central Maryland Region. He was born and raised in Baltimore County and supports the application of BDC due to the need for treatment services.

The Char Hope Foundation is an organization located in Bel Air, Maryland with the following mission: "providing sober living opportunities, financial aid, supervised agricultural learning experiences, and community outreach to help educate the public about addiction awareness." The Char Hope Foundation helps adults move forward toward a full recovery, a healthier lifestyle and a life free from addiction." Mayra Derbshire Program Manager of Char Hope Foundation Inc. and Leann Bedsoul provided letters of support due to their understanding of the importance of the need additional treatment services in the Central Maryland Region.

Lynn Fowler Miller sits on the Board of Maryland Heroin Awareness Advocates, a grassroots non-profit focused on providing support, advocacy and education to individuals and families suffering from addiction. Lynn provides support, outreach and education to families with loved ones suffering from addiction across the state. She provided support with the understanding that additional treatment options of this magnitude are needed in the Central Maryland Region and across the state of Maryland.

Chance Ashman Galliker is the Vice President of Magnolia New Beginnings which is based out of Massachusetts. Chance resides in Maryland and provides tremendous support to individuals and families suffering from addiction throughout the state and the country. Chance is a certified Intervention Professional and is actively assisting residents of Maryland including individuals located in the Central Maryland Region.

Mike Gimbel is a well-known treatment and education advocate based in the Central Maryland Region. Mr. Gimbel served as the Baltimore County Drug Czar for multiple years and has been a pillar in the recovery community for over 40 years. Mr. Gimbel provides outreach, education and prevention efforts to individuals and families throughout Maryland and the country. Aside from his advocacy and education work, he acts as an expert on substance abuse treatment, prevention and education on a multitude of different platforms including his own television show "Straight Talk".

Lifebridge Health is a non-profit hospital organization founded in Baltimore, Maryland. Lifebridge has multiple locations in the Central Maryland Region including Baltimore County. **Dawn Hurley** provided support to the application of BDC and acts as the Assistant Vice President of Behavioral Health Services for Lifebridge Health.

The Harford County Health Department is located within the Central Maryland Planning Region. **Andrea Pappas** provided support to the application of BDC and acts as the Director of the Behavioral Health Department in Harford County. The Behavioral Health Department in Harford County provides education, outreach, prevention and treatment to individuals in Harford County at various locations.

Frank Biden is a well-known professional and advocate for substance abuse treatment and recovery. He is the **CEO of the National Recovery Council** which provides education and policy development throughout the country. Aside from being the brother of Vice President Joe Biden, Frank serves diligently to ensure that politicians are educated, and open to discussion on the current epidemic in the United States.

Nathans Ridge is a non-profit sober living community located in Montgomery County, Maryland. **Lorelei Irons** is the Founder of Nathans Ridge which provides structured sober living to both male and females recovering from substance abuse disorders. Her work in the community is strong and she supports the application of BDC due to the low treatment availability not only in Montgomery County, but throughout the state of Maryland.

Alejandra Munoz is a community advocate who headed the **STEER program** in Montgomery County, Maryland. STEER is a project that works directly with law enforcement and first responders to provide support and treatment navigating to individuals arrested for substance use related crimes or whom have overdosed. Alejandra supports the application of BDC due to low treatment availability not only in Montgomery County but throughout the state of Maryland.

Andrew Darby is an LCSW-C and former Clinical Director of Kolmac Outpatient Recovery Centers at their Gaithersburg, Maryland office. Andrew has been working in the field for numerous years and supports the application of BDC due to low treatment availability throughout the State.

Greenbelt Cares is a community organization through the City of Greenbelt to provide family counseling, prevention efforts, and crisis intervention. Greenbelt Cares is in support of the application of BDC due to the need for higher availability of treatment services throughout the state of Maryland.

Noah Nordheimer is the Founder of Concerted Care Group, a local Opioid Treatment Program with locations in Baltimore and Frederick, Maryland. Noah has seen firsthand the need for additional treatment services, and a lack of referral sources for higher levels of treatment services such as the proposed services in the application of BDC.

BDC is particularly proud to have the support of its local elected representatives: Delegate Pat Young and Senator Pulliam.

Again, BDC is puzzled by the MHD comments in light of the fact that according to the MHD Staff Report, the only letters received in support of the MHD project were from Adrienne Mickler, Executive Director of Anne Arundel County Mental Health Agency, Inc. and Jim Haggerty, CEO of Maryland Recovery. Based on the standard set forth by MHD in the Comments, MHD would have been noncompliant with this standard. Furthermore, the list of letters of support received on behalf of MHD pales in comparison to those received by BDC.

BDC has demonstrated sufficient evidence of community support.

IV. COMAR 10.24.01.08G(3)(f) - Impact on Existing Providers and the Health Care Delivery System

The only detrimental impact argument raised by the Comments is in regards to staffing and an allegation of staff "poaching.' MHD has not lost any staff members. There is no evidence submitted of staff shortages. Based on the overwhelming need for this service it is not difficult conclude as concluded by BDC that approval of its project will not result in a detrimental impact on existing providers and the health care delivery system. In fact, there will be a positive impact on the health care delivery system.

MHD maintains that "As BDC has alarming failed to produce a viable staffing standard, MHD along with all other operators of SUD treatment ICFs in the state, stand to suffer detrimental staffing and consequently volume impacts if BDC is approved." This conclusion is lacking both evidence and logic.

RESPONSE:

First, BDC has provided a viable staffing standard.

Second, it defies logic to understand why a non-viable staffing standard would have a detrimental staffing impact on other providers. In fact, if BDC staffing were so "minimal" it should have virtually no impact on other providers. MHD has failed to provide any evidence whatsoever that there are staffing shortages with respect to the various types of staff required to staff an SUD provider.

MHD makes reference to a list allegedly provided by Maryland Addiction Recovery Center "detailing FRC's successful targeting of core staff at MARC" on page 15. First, MARC is not an interested party and therefore this information should be disregarded because it is not provided by MARC and therefore is nothing more than hearsay. Moreover, these employees are in a free market and should be free to take any opportunities available to them.

It is also puzzling to BDC why a result of non-viable staffing at BDC would be detrimental volume impacts at MHD. Perhaps MHD is suggesting that MHD will not be able to staff its facilities if BDC is approved. Again, there is no evidence to support that assumption. With respect to volume, as MHD is well aware, the Maryland Health Care Commission correctly found a need for between 113 and 160 additional Track One beds to be located in Central Maryland in 2020 (see MHCC Decision, Docket No. 16-02-2374, December 16, 2016). Obviously, even after the approval of MHD and the approval of BDC there still will be a substantial need in Central Maryland.

Next, on page 2 of the Comments MHD maintains that because "BDC has not met the burden of proof that it can operate a viable facility…if BDC is approved to operate in the State of Maryland, all SUD ICFs (including MHD) will be harmed as public and industry confidence in

the quality of SUD ICF treatment will dwindle.' In response and as explained above, BDC has demonstrated that it has met the burden of proof to operate a viable facility. Again, there is no evidence whatsoever to support the idea that even if one provider were not at the highest quality (which is not and will not be BDC) -- there is no evidence to suggest that public and industry confidence will dwindle.

Last with reference to "the letter signed by 12 SUD providers" previously furnished, those comments should not be considered because they have not been submitted in accordance with applicable regulations to gain standing. If they were to be considered, please refer to the response submitted by BDC on August 30, 2018.

BDC is qualified to operate an ICF in the State of Maryland, has met the burden of proof for the applicable criteria for review, and should be granted a CON.

BDC respectfully requests that the Commission deny the request of MHD for oral argument. Of course, if that request were granted, BDC also requests the opportunity for oral argument.

Sincerely,

Carolyn Jacobs

Carolyn Jacobs

cc: William D. Chan
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