December 14, 2018

Via Hand Delivery and Electronic Submission (Email)

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

Re: In the Matter of Docket No. 18-03-2419 by Baltimore Detox Center

Mr. McDonald,

Please find the enclosed Interested Party Comments of Maryland House Detox on the CON Application for Baltimore Detox Center Docket No. 18-03-2419.

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

Sincerely,

David Stup
Director of Corporate Business Development
Delphi Behavioral Health Group
817 S Camp Meade Rd
Linthicum, MD 21090

Comments by Maryland House Detox, LLC on the Original Application, First Round of Completeness Information, and the Second Round of Completeness Information of the CON Application of Baltimore Detox Center

Pursuant to COMAR 10.24.01.08(F)(1), Maryland House Detox, LLC (MHD) seeks interested party status from the Maryland Health Care Commission (MHCC) in the matter of Docket No. 18-03-2419 by Baltimore Detox Center (BDC) to establish a Track One 24-bed Intermediate Care Facility in Woodlawn, MD. MHD operates a 16-bed ICF in Linthicum, MD and was granted a Certificate of Need (CON) by MHCC on December 15, 2016 in Docket No. 16-02-2374.

MHD has been awarded numerous executive citations for its work in the community from the Governor's Office of State of Maryland, the Office of Maryland's US Senator Chris Van Hollen, the Anne Arundel County Executive's Office, and the Anne Arundel County Council (Appendix A). Consistent with its approved CON, day-to-day operations, and corporate mission, MHD fully supports the expansion of substance use disorder (SUD) treatment in the state of Maryland. However, it is concerned that the proposed project by BDC fails to comply with numerous CON review criteria, and opposes the approval of the CON application. Pursuant to COMAR 10.24.01.08(F)(2)(a)(ii), BDC has failed to meet the following standards in COMAR 10.24.01.08(G)(3) throughout numerous application and completeness responses:

> (a) State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.
>
> (d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.
>
> (f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, 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.

COMAR 10.24.01.08(G)(1) states that "in proceedings on a Certificate of Need application, the burden of proof that the project meets the applicable criteria for review, by a preponderance of the evidence, rests with the applicant." The incomplete and inaccurate information provided by BDC in its application and completeness responses is at its best careless and at its worst negligent or misleading. Through the careful and watchful application of industry best practices, simple arithmetic, and the requirement for complete information, BDC fails to meet the burden of proof for these standards and should by denied a CON.

MHD Qualifies as an Interested Party to the BDC Application

Pursuant to COMAR 10.24.01.01(B)(20)(e), MHD qualifies as an interested party to the BDC application as "a person who can demonstrate to the reviewer that the person would be adversely affected, in an issue area over which the Commission has jurisdiction, by the approval of a proposed project."

For the reasons found in COMAR 10.24.01.01(B)(2)(a), MHD is defined as an adversely affected person because it "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 or in a contiguous planning region if the proposed new facility or service could reasonably provide services to residents in the contiguous area". MHD provides the same service as BDC operating as an ASAM level III.7.WM (formerly designated III.7.D.) Intermediate Care Facility (ICF) for the purposes of performing medically monitored inpatient detoxification, in the same Central Maryland Planning Region in which BDC proposes its facility.

Additionally, for the reasons found in COMAR 10.24.01.01(B)(2)(d), MHD is defined as an adversely affected person because it "can demonstrate to the reviewer that [it] 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." As BDC has alarmingly 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 – areas over which the Commission has jurisdiction. BDC has not met the burden of proof that it can operate a viable facility, thus 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. A letter signed by 12 SUD providers operating in the State of Maryland has previously been furnished to MHCC outlining industry concerns of BDC's operations.

MHD is vigilant to highlight that the following errors, omissions, and facts in BDC's application – that evaluated individually are cause for major concern – viewed in their totality demonstrate that BDC is not qualified to operate an ICF in the State of Maryland, has not met the burden of proof that for the applicable criteria for review, and should be denied a CON. MHD submits the following comments as an interested party to BDC's CON application.

COMAR 10.24.01.08(G)(3)(a): State Health Plan. An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

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.

Throughout its application process, BDC fails to demonstrate that it has the capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate staffing standards. Perhaps one of the most alarming elements of BDC's CON application is the staffing standards displayed in the CON Table Package, Table E – Workforce Information. The most recent submission of staffing standards is found in BDC's Completeness Response # 1 dated July 25, 2018 under Attachment 18.

Staff	Count
CEO	1.0
COO	1.0
Clinical Director	1.0
Compliance Officer / QA / HR	1.0
Director of Admissions	1.0
Outreach Coordinators	3.0
Total Administration	8.0
Direct Care Staff *(List general categories, add rows if needed)*	
Medical Director	1.0
Director of Nursing RN	1.0
Nurse RN	6.0
Clinician	1.0
Total Direct Care	9.0
Support Staff *(List general categories, add rows if needed)*	
Admission / Insurance	1.0
Intake Coordinator	1.0
Case Manager	1.0
Maintenance Tech	1.0
Behavioral Health Tech	11.0
Total Support	15.0
REGULAR EMPLOYEES TOTAL	***32.0***

BDC plans for and submits a staffing standard that is out of touch with the quantity and classes of staff required to safely and effectively operate an ICF. It is ineffectual and renders the proposed project non-operational as detailed in the discussion below.

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. COMAR 10.63.03.14(C) states that Medically Monitored Services:

C) A residential-intensive level 3.7 program shall employ a physician, nurse practitioner, or physician assistant who:

1. *Assesses each patient in person within 24 hours of admission or earlier, if medically necessary;*
2. *Assesses each patient thereafter, as medically necessary; and*
3. *Is available to provide on-site monitoring of care and further evaluation on a daily basis.*

And COMAR 10.47.02.09(E) states that Medically Monitored Services require:

> *(2) Physician, Physician Assistant, or Nurse Practitioner Services.*
> *(d) A physician or physician assistant shall provide on-site monitoring and further evaluation of patients undergoing detoxification on a daily basis*

And COMAR 10.47.02.09(C) states that a program shall have:

> *(4) On-site physician, physician assistant, or nurse practitioner coverage available to provide initial assessment and documented referral for care, and to monitor progress in treatment;*
> *(5) A physician on call 24 hours a day*
> *(6) Nursing services, between 7 a.m. and 11 p.m., 7 days a week, including:*
> *(a) 8 hours a day, 5 days a week coverage by a registered nurse; and*
> *(b) The remainder of coverage by a licensed practical nurse*

In addition to regulatory statues, insurance companies develop and employ standards of care that are providers are required to comply with in order to be reimbursed. As an example, Cigna Insurance Guidelines have a description of Inpatient Substance Use Detoxification (p.57 Appendix B) that requires:

> *Appropriate medical professionals are available, including physician visits at least once each day and 24-hour nursing staff monitoring"* and has expectations of Inpatient Substance Use Detoxification (p.58) that *"Physician follow-up occurs daily or more frequently as needed."*

BDC's staffing plan as found in Table E Workforce Information for medical staff is as follows:

Medical Staff	Count
Medical Director	1.0
Director of Nursing RN	1.0
Nurse RN	6.0

BDC's proposed Workforce Information is negligent to call for 1 medical provider for 24 patients. Best practices, Maryland State regulations, and insurance guidelines call for

medical providers to provide on-site monitoring of an inpatient level of care in addition to further follow up and evaluation on a daily basis for every patient. BDC plans for 1 medical provider to be able to monitor inpatient care for the entire program, complete evaluations for every admission including a History and Physical Examination and a Psychiatric Evaluation, conduct daily follow-ups with every patient lasting at least 15 minutes and provide 24-hour on-call coverage. The daily follow ups alone would encompass 6 hours a day at full capacity if every follow up only took 15 minutes. This does not account for documentation into the medical record, assessing new admissions, and organizing the medical care for the facility. According to BDC, all of these duties would rest with 1 medical provider 365 days of the year with no coverage for any days off, vacation, or emergencies for all 24 patients. It is impossible for 1 medical provider to provide the number of hours required for the intensity of medical services at the inpatient level of care. For comparison, MHD employs 3 FTE and 1 PRN medical providers to cover a 16-bed unit. BDC is at the very least 4 medical providers shy to effectuate the minimum quality of care expected at the inpatient level of care.

BDC's Workforce Information is also negligent in its call for 6 nursing staff for 24 patients. Best practices, Maryland State regulations, and insurance guidelines call for 24-hour nurse monitoring of patients an inpatient level of care. Industry best practices call for a 1:8 patient to nurse ratio at the inpatient level of care. 3 nurses would have to be provide care at all times for 24 patients. It is impossible for 6 nurses to provide 24-hour coverage to 24 patients at a minimum of 3 per shift. According to BDC, these 6 nurses would each work 84 hours per week to provide adequate coverage. For comparison, MHD employs 13.5 FTE nursing personnel. BDC is at the very least 14 nursing personnel shy to effectuate the minimum quality of care expected at the inpatient level of care.

Industry standards for SUD inpatient treatment call for a 1:8 patient to therapist/counselor ratio. Staffing requirements by the state of Maryland found in COMAR 10.47.02.09(C)(3) for level III.7 Medically Monitored Intensive Inpatient Treatment call for: "*a patient to alcohol and drug counselor ratio not exceeding eight patients for one full-time alcohol and drug counselor.*

BDC's staffing plan as found in Table E Workforce Information for clinical staff is as follows:

Clinical Staff	Count
Clinician	1.0
Case Manager	1.0

BDC's Workforce Information calls for 1 Clinician for 24 patients. This is outside of best practices and Maryland State regulations. It does not comply with 10.47.02.09(C)(3) requiring the patient to alcohol and drug counselor not to exceed 1:8. Furthermore, in its Completeness Response # 2, Question # 4.a. (p. 4), BDC states that "[the consumer] will attend 36 hours of group a week, receive individual counseling and participate in case management and discharge planning." It is impossible for 1 clinician to carry a primary caseload of 24 patients, conduct all group sessions for 36 hours per week, conduct all

individual sessions for 24 patients, conduct all family sessions for 24 patients, and complete documentation in the medical record. For comparison, MHD employs 2 FTE clinical staff for 16 patients. BDC is at the very least 2 clinicians shy to effectuate the minimum quality of care expected at the inpatient level of care.

BDC's Workforce Information calls for 1 Case Manager for 24 patients. Not only is it impossible for 1 case manager to effectively assess, plan, facilitate, and coordinate care and discharge plans, but industry best practices call for a patient to case manager ratio of 1:8. For comparison, MHD employs 2 FTE case management staff for 16 patients. BDC is at the very least 2 case managers shy to effectuate the minimum quality of care expected at the inpatient level of care.

BDC's staffing plan as found in Table E Workforce Information for support staff is as follows:

Staff	Count
Behavioral Health Tech	11.0

BDC's Workforce Information calls for 11 behavioral health techs for 24 patients. Industry best practices call for a staff roster of 1:1 to 1.5 patient to BHT ratio at the inpatient level of care to cover all hours. For comparison, MHD employs 12 FTE behavioral health techs. BDC is at the least 7 to 13 support staff shy to effectuate the minimum quality of care expected at the inpatient level of care.

It is rather noteworthy that BDC plans for more Outreach Coordinators than it does for each medical providers, clinicians, and case managers.

Per COMAR 10.24.01.08(G)(3)(a), BDC has failed to meet the requirement of 10.24.14.05(M). It is clear from the staffing plan submitted in its application that BDC has not "demonstrated 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." The absence of a deliberate and contemplative staffing plan that complies with minimum licensure requirements, insurance reimbursement guidelines, and industry standard protocols demonstrates that BDC lacks the basic understanding of how to staff medically monitored inpatient detoxification and treatment - a level of care that carries the risk of death – and should be grounds for denial.

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 letters 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; and,

Throughout its application process, 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. In BDC's Completeness Response #2, MHCC asks for an update on BDC's progress on obtaining signed transfer and referral agreements with:

a. Northwest Hospital and/or Sinai Hospital;
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. Baltimore County's mental health and alcohol and drug abuse authorities;
e. The Behavioral Health Administration and the Mental Health and Hygiene Administration; and
f. Any Baltimore County agencies that provide prevention, education, driving while intoxicated programs, family counseling, and other services

BDC provides the following chart as a summary of its transfer and referral agreements:

Category	Facility/Organization
Acute Care Hospital	Greater Baltimore Medical Center (GBMC) Life Bridge Health Systems
Halfway houses, therapeutic communities, long-term care facilities, and local alcohol and drug abuse intensive and other outpatient programs	MISHA House, Turning Corners, Hope House Treatment Center, New Life Addiction Counseling, One Promise Counseling and DUI Education, Concerted Care Group
Local Community Mental Health Center	Harford County Health Department

BDC fails to comply with this State Health Plan standard by notably omitting the following specific requirements of MHCC:

a. Northwest Hospital and/or Sinai Hospital;

BDC does not have a transfer or referral agreement with Northwest Hospital or Sinai Hospital that details either hospital's agreement to accept BDC's patients when/if the need arises to manage cases which exceed, extend, or complement BDC's capabilities. It is particularly noteworthy that BDC is proposing to operate a medically monitored inpatient level of care but does not have a process or hospital to receive patients who will inevitably require hospitalization.

c. Local community mental health center or center(s)

BDC incorrectly contends that a letter of support from the Harford County Health Department represents a transfer or referral agreement from its local community mental

health center. BDC does not have a transfer or referral agreement with a local community mental health center that details the center's agreement to accept BDC's patients when/if the need arises to manage cases which exceed, extend, or complement BDC's capabilities. For comparison, the Baltimore County Health Department is 9 miles from the proposed site while the Harford County Health Department is 41 miles. The Harford County Health Department could not be described as local in this case, nor does a letter of support represent a transfer or referral agreement.

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

   BDC does not have a transfer or referral agreement with Baltimore County's mental health and alcohol and drug abuse authorities that details the agencies' agreement to accept BDC's patients when/if the need arises to manage cases which exceed, extend, or complement BDC's capabilities. It is particularly noteworthy that BDC is proposing a new facility in Baltimore County but does not have the support of the county's own health department. For comparison, the Baltimore County Health Department is 9 miles from the proposed site while the Harford County Health Department is 41 miles.

   Additionally, Under COMAR 10.63.06.02(A)(3)(a), all programs are required to have an agreement to cooperate between the program and the Local Area Addiction Authority. This rests with the Baltimore County Health Department – an agency that BDC has yet to contact, garner support from or obtain referral agreements with.

e. The Behavioral Health Administration and the Mental Health and Hygiene Administration

   BDC does not have a transfer or referral agreement with Behavioral Health Administration and the Mental Health and Hygiene Administration that details the agencies' agreement to accept BDC's patients when/if the need arises to manage cases which exceed, extend, or complement BDC's capabilities.

Per COMAR 10.24.01.08(G)(3)(a), BDC has failed to meet the requirement of 10.24.14.05(J) by omitting the transfer or referral agreements from the above-named agencies. It is clear from the agreements provided that BDC does not act in accordance with the spirit of this State Health Plan standard. It has not provided viable solutions for resources connected to its project that are undeniably necessary to operate a safe and thorough medically monitored inpatient setting. Again, the absence of a comprehensive plan that complies with the State Health Plan demonstrates that BDC lacks the wherewithal to operate this level of care in the state of Maryland and should be grounds for denial.

While BDC is proposing to establish a Track One ICF in Baltimore County, notably every organization it has listed as providing a transfer or referral agreement, letter of support, and other type of agreement provided throughout its application process can reasonably be described as a Track Two provider. Since BDC has chosen to pursue a project that will be funded through private insurance – and therefore through support from and cooperation with other Track One providers in the state – it is not unreasonable to expect that its sources of incoming and outgoing

referrals also be described as Track One. Not only does this demonstrate BDC's inability to garner support for its proposed project, but it also calls into question the viability of the project, which will be explored in the following section.

COMAR 10.24.01.08(G)(3)(d): Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Availability of Resources Necessary to Sustain the Project

In failing to demonstrate its capacity to admit and treat alcohol or drug abusers requiring sub-acute detoxification by documenting appropriate staffing standards, BDC's application for a CON should be denied approval. BDC also fails to meet COMAR 10.24.01.08(G)(3)(d). As explained in the previous section, it is physically impossible to apply the staffing standards provided by BDC to operate a 24-hour medically monitored inpatient ICF. Once the necessary (and overtly reasonable) staffing standards described above are applied, BDC's proposed project becomes financially unviable by failing in any scenario for its revenues to exceed its expenses from its day-to-day operations.

As required by MHCC, BDC submitted its most recent Workforce Information (Table E) in the CON Table Package in its Completeness Response # 1. Table E below provides a side-by-side comparison of the appropriate staffing standards described in the section above to the staffing standards proposed by BDC. MHD assumed the salary amounts based on its experience and the salary amounts submitted by BDC. A summary of Table E shows that BDC proposed to operate a 24-bed medically monitored inpatient detoxification and intensive inpatient treatment program with a total of 32 full time employees at an annual cost of $2,510,853. The comparison of the appropriate staffing standards shows that BDC would need a total of 61 full time employees at an annual cost of $5,102,737 to effectively operate this level of care. *MHD assumed the following salaries:*

Medical providers at $175,000 each (market rate for experienced medical provider)
Nurses at $82,500 (BDC's proposed salary)
Clinicians at $60,000 (market rate for experienced master's level clinicians)
Case managers at $44,000 (BDC's proposed salary)
BHT at $35,000 (BDC's proposed salary)

Table E below shows that BDC has grossly underestimated the size, scale, and scope of effectively staffing for its proposed project. The appropriate staffing expenses should be approximately double the amount that BDC submitted to MHCC.

Table E: Appropriate vs Proposed Workforce Information

Job Category	Appropriate FTEs	Average Salary per FTE	Appropriate Total Cost *(staffing standard applied).*	BDC Proposed FTEs	BDC Proposed Total Cost
1. Regular Employees					$0
Administration *(List general categories, add rows if needed)*					$0
CEO	1.0	$130,000	$130,000	1.0	$130,000
COO	1.0	$95,000	$95,000	1.0	$95,000
Clinical Director	1.0	$82,000	$82,000	1.0	$82,000
Compliance Officer / QA / HR	1.0	$65,000	$65,000	1.0	$65,000
Director of Admissions	1.0	$80,000	$80,000	1.0	$80,000
Outreach Coordinators	3.0	$45,000	$135,000	3.0	$135,000
Total Administration	8.0		$587,000	8.0	$587,000
Direct Care Staff *(List general categories, add rows if needed)*					$0
Medical Director	1.0	$240,000	$240,000	1.0	$240,000
**Add - Medical Providers	4.0	$175,000	$700,000	0.0	$0
Director of Nursing RN	1.0	$115,000	$115,000	1.0	$115,000
Nurse RN	6.0	$82,500	$495,000	6.0	$495,000
**Add - Nurse RN	14.0	$82,500	$1,155,000	0.0	$0
Clinician	1.0	$95,000	$95,000	1.0	$95,000
**Add - Clinician	2.0	$60,000	$120,000	0.0	$0
Total Direct Care	29.0		$2,920,000	9.0	$945,000
Support Staff *(List general categories, add rows if needed)*					$0
Admission / Insurance	1.0	$55,000	$55,000	1.0	$55,000
Intake Coordinator	1.0	$40,000	$40,000	1.0	$40,000
Case Manager	1.0	$44,000	$44,000	1.0	$44,000
**Add - Case Manager	2.0	$44,000	$88,000	0.0	$0
Maintenance Tech	1.0	$55,000	$55,000	1.0	$55,000
Behavioral Health Tech	11.0	$35,000	$385,000	11.0	$385,000
**Add - Behavioral Health Tech	7.0	$35,000	$245,000	0.0	$0
Total Support	24.0		$912,000	15.0	$579,000
REGULAR EMPLOYEES TOTAL	*61.0*		$4,419,000	*32.0*	$2,111,000
2. Contractual Employees					$0
Administration *(List general categories, add rows if needed)*					$0
Dietician (per diem)			$25,000		$25,000
CONTRACTUAL EMPLOYEES TOTAL			$25,000		$25,000
Payroll Taxes (Employer)			$543,537		$259,653
Benefits *(State method of calculating benefits below):*					0.0
					$0
TOTAL COST	*61.0*		*$4,987,537*	*32.0*	*$2,395,653*
***TOTAL COST with Benefits*	*61.0*		*$5,102,737*	*32.0*	*$2,510,853*

As required by MHCC, BDC submitted its most recent Revenues and Expenses (Table D) in the CON Table Package in its Completeness Response # 1. Table D below provides a side-by-side comparison of the appropriate expenses translated from the section above to the expenses proposed by BDC. To provide BDC the benefit of the doubt in the exercise, MHD provided calculations from BDC's self-reported most profitable calendar year of 2022. A summary of Table D shows that BDC projected Net Income of $865,906 in its most profitable year. This projection by BDC of course assumed the untenable and unrealistic staffing expenses described above. The comparison of revenues and expenses that include the appropriate staffing standards shows that BDC fails to be a financially profitable project in its projected "profitable" year, with expenses outpacing revenues by $1,750,978. No reasonable operator would pursue a project that lost this amount money year over year, let alone claim that the project was viable and sustainable financially. In no year, with no combination of appropriate staffing levels, does BDC become a financially viable project.

Table D: Appropriate vs Proposed Revenues and Expenses

1. REVENUE	**APPROPRIATE CY 2022**	**BDC PRPOSED CY 2022**
a. Inpatient Services	$8,531,600	$8,531,600
b. Outpatient Services	N/A	N/A
Gross Patient Service Revenues	***$8,055,160***	***$8,531,600***
c. Allowance For Bad Debt	$2,559,480	$2,559,480
e. Charity Care	$1,279,740	$1,279,740
Net Patient Services Revenue	***$4,692,380***	***$4,692,380***
f. Other Operating Revenues (Toxicology)	$540,000	$540,000
NET OPERATING REVENUE	***$5,232,380***	***$5,232,380***
2. EXPENSES		
a. Salaries & Wages (including benefits)	$5,102,737	$2,485,853
b. Contractual Services	$25,000	$25,000
f. Project Depreciation	$55,450	$55,450
j. Other Expenses (Specify/add rows if needed)	$1,800,171	$1,800,171
TOTAL OPERATING EXPENSES	**$6,983,358**	**$4,366,474**
3. INCOME		
a. Income From Operation	**$(1,750,978)**	**$865,906**
SUBTOTAL	***$(1,750,978)***	***$865,906***
NET INCOME (LOSS)	***$(1,750,978)***	***$865,906***

It is noteworthy to highlight that BDC included "Toxicology – U/A" as a source of Other Operating Revenue in its submission of Table D to MHCC. In its most profitable year, the amount submitted for toxicology revenue represents 62% of its projected net income ($540,000 in toxicology revenue to $865,905.63 in profit). BDC submitted this as a source of revenue without any explanation as to how this revenue stream will be generated, how its assumptions and calculations for this amount were derived, and most importantly, if this revenue actually in fact belongs to the entity BDC. Experienced medical professionals would surmise that this revenue is reasonably tied to a clinical laboratory that performs toxicology analyses on urine specimens. BDC provides no explanation as to how this source of revenue is viable as a part of BDC, nor does it provide an explanation as to how this source of revenue is sustainable – as it is arguable that the contrary is more likely. SUD industry professionals may be alarmed to find this revenue stream included in the BDC application as evidenced from widely accepted experience and well-documented accounts of the past 5 years detailing urine drug screen testing as an unreliable and rather copious stream of revenue in the treatment field. The New York Times chronicled urinalysis revenue as something that was once considered "liquid gold", attracting unscrupulous individuals and companies as something that is now unsustainable (Appendix C). Forbes details a publically-traded addiction treatment company who has seen its stocks crumple because of its "outsized net margins" shrinking due to its compressing urinalysis revenue contribution (Appendix C).

Per COMAR 10.24.01.08(G)(3)(d), BDC has failed to meet the requirement that it be a financially sustainable project by failing to demonstrate a revenue and expense model that produces profits and by submitting additional revenue streams with no identification, explanation or guarantee of the sources and the calculation assumptions of that revenue. The project should thus be denied.

Community Support

Per COMAR 10.24.01.08(G)(3)(d), BDC has also failed to demonstrate that it has sufficient community support necessary to implement and sustain the project. BDC has failed to provide evidence of support from any of its local and governing agencies. BDC has also failed to provide evidence of support or incoming referral agreements from any number of Track One providers whose support will be necessary to sustain ongoing operations at BDC.

Throughout its application process, BDC provided documents claiming to support the project with little to no background information on who provided the support, in what capacity the organization supports BDC, and how that support would sustain the project. Below is a summary of the documents purported to demonstrate community support provided by BDC that cannot be relied upon as meeting this standard. Notably absent from BDC's submission is any support from Baltimore County organizations.

Letters of Support:

BDC Letters of Support; Original Application, Attachment 12:

- Ajenendra Munoz – no identifying information or organization
- Leann Bedsaul – no identifying information or organization
- Magnolia New Beginnings – non-profit organization located in Marblehead, Massachusetts located 429 miles from the proposed site and is not located within the state.
- Greenbelt CARES Youth and Family Services Bureau – "a community-oriented, family based agency offering a variety of services free or low cost to citizens of Greenbelt and to members of the surrounding communities". Greenbelt, MD is 35 miles from the proposed site and is not located within the proposed planning region.
- Nathan's Ridge – located 30 miles from BDC and is not located within the proposed planning region.

BDC makes no mention and provides no narrative or explanation as to how the letters of support meet the burden of proof that it does in fact have community support to sustain its project. Informed readers of BDC's application are left to wonder exactly why BDC submitted letters of support from organizations that reasonably have no bearing or influence on the proposed operations, including letters from out-of-state non-profit organizations.

Referral Agreements:

> BDC Letters of Support and/or Referral Agreements; Completeness Response # 1, Attachment 29

- Evolve Life Centers – Track Two
- MISHA House – Track Two
- Turning Corners – Track Two
- Hope House Treatment Center – Track Two
- New Life Addiction Counseling – Track Two
- One Promise Counseling and DUI Education – Track Two
- Concerted Care Group – Track Two
- Harford County Health Department – Track Two

BDC makes no mention and provides no narrative or explanation as to how its transfer agreements meet the burden of proof that it does in fact have enough support to sustain its project. Informed readers of BDC's application are left to wonder exactly how BDC plans to maintain referrals sufficient to sustain a Track One facility when its transfer and referral agreements all come from Track Two providers and where BDC plans to transfer its Track One patients when it does not have agreements with Track One providers. BDC also failed to provide a referral agreement in its Completeness Response # 2 Question # 10 for the University of Maryland Baltimore Washington Medical Center.

To the contrary, 9 Track One providers (12 total providers) in the state were so concerned about BDC's application, they submitted a letter to MHCC and other governing bodies on July 16, 2018 (Appendix D). BDC's response (Appendix D) regarding RITL's payor audits and

subsequent "rebranding" raises more questions than it answers. In normal circumstances, a payor audit that finds no claims against an entity would not result in that entity shuttering its doors. An entity with diversified commercial payor sources would rely on other commercial payors while an audit was being conducted and would anticipate the return of a normal revenue stream from the payor in question. If no claims were in fact found in the audit, then RITL would continue to enjoy a "financially viable" existence. Questions remain as to why a new entity was created to operate in the same location and provide the same services as RITL. BDC's response also fails to explain its connection or to provide any context related to the doctor involved in the lawsuit claiming fraudulent billing practices only that the lawsuit. BDC has not remedied

BDC has failed to meet the burden of proof in COMAR 10.24.01.08(G)(3)(d) that is has community support to sustain a viable project. The body of evidence submitted by BDC demonstrates that BDC does not in fact have real, meaningful community support and has approached this standard with a minimum of concern.

COMAR 10.24.01.08(G)(3)(f): Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, 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.

Detrimental Impact

BDC makes frequent mention and connection to Foundations Recovery Center (FRC) throughout its application process as a related entity in providing SUD treatment services. FRC is a new provider in the state, and in order to fully staff FRC, it engaged in a coordinated effort to recruit core staff from an established SUD provider in Baltimore County. Below is a list provided by Maryland Addiction Recovery Center (MARC) detailing FRC's successful targeting of core staff at MARC:

- Primary therapist
- Admissions specialist
- Medical coordinator
- Therapist assistant
- Admissions director
- Vocational director

The evidence provided by BDC in its application demonstrates that it in fact does not have a sound staffing plan in place. As the only other freestanding detox in the state and a model that BDC seeks to replicate, MHD stands to be adversely affected by BDC's lack of staffing standards and proven recruiting tactics. Recent CON applications and interested party comments detail the well documented shortage of licensed and qualified SUD staff in the state (Pathways Interested Party Comments to Recovery Center of America Earleville Docket No. 15-16-2363 dated 11/16/2015 and Pathways Interested Party Comments to Modified Application RCA-E dated 2/3/2016 and Father Martin's Ashley Pathways Interested Party Comments to Modified

Application RCA-E dated 2/3/2016) and the adverse effects of new CON applicants directly recruiting established providers' essential staff.

Throughout its application process, BDC approaches this standard with a minimum of care and calculation. In both of its Completeness Requests (Question # 27 and Question # 15), MHCC asks for an analysis of the impact on the payer mix of all other existing health care providers, an identification of the likely source in increased patients per payer, and an analysis supporting the claim that other Track One providers will not be effected by BDC. In providing no real staffing plan, no identification of Track One patient sources, and no thoughtful analysis of the impact to other providers, BDC fails to meet COMAR 10.24.01.08(G)(3)(f) and threatens to adversely impact MHD.

Summary

Considering each individual cause above, BDC's CON application should be denied. When the totality of the individual causes is considered, the evidence is clear that BDC has not met the burden of proof necessary to be issued a CON. There is no remedy available to BDC to alter a staffing standard to meet COMAR 10.24.14.05(M). In submitting a staffing plan that does not cover all required hours and regulations and falls short of best practices, BDC has proven to MHCC beyond a shadow of a doubt that it cannot "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." BDC does meet the standards in COMAR 10.24.01.08(G)(3)(d) as it is clearly not a financially viable project and does not have community support to sustain itself. BDC has not demonstrated its ability to staff its project or set forth a thoughtful analysis of the impact it may have on the delivery of care in the state. In the case of BDC, it is clear that MHCC should not sacrifice quality of care and public interest for quantity of beds.

Pursuant to COMAR 10.24.01.09(A)(3), MHD also respectfully requests oral arguments before a recommended decision is prepared.

APPENDIX A

Maryland House Detox Executive Citations

This Citation Is Presented To

Maryland House Detox

***

IN CELEBRATION OF ITS GRAND OPENING

With appreciation for all it does to provide treatment for patients in addiction recovery, and with gratitude for all that its dedicated staff will do to make a difference in the lives of others.

Chris Van Hollen

United States Senator

On This Day,
The Twenty-Eighth of June,
Two Thousand Eighteen

The State of Maryland

Governor of the State of Maryland, to

MARYLAND HOUSE DETOX , Greetings:

Be it Known: That on behalf of the citizens of this State,

in recognition of ***the occasion of the groundbreaking ceremony for the first stand-alone, inpatient detox center in Maryland… in appreciation of the important contribution this facility will make to both the local community and to our state; and as our citizens join together at the local and state levels to combat the deadly opioid crisis plaguing our communities throughout the nation,***

we are pleased to confer upon you this

Governor's Citation

Given *Under My Hand and the Great Seal of the State of Maryland,*
this **28th** *day of* **November**
Two Thousand **and seventeen**

Governor

Lt. Governor

Secretary of State

ANNE ARUNDEL COUNTY
MARYLAND

Executive Citation

The Citizens of Anne Arundel County, Maryland

salute

Maryland House Detox

In recognition of your groundbreaking ceremony as the first stand-alone, inpatient detox center in the state of Maryland.

Maryland House Detox will provide a vital service of medically monitored detoxification along with a highly personalized and compassionate transition into the next level of care for those seeking treatment, allowing them to begin their journey toward recovery with dignity.

We commend you for playing such an important part in the recovery process as we work together to fight the heroin and opioid epidemic that has not only affected our county, but our state and nation as well.

We extend to you our sincere thanks and best wishes for continued success in all your future endeavors.

ANNE ARUNDEL COUNTY MARYLAND

STEVEN R. SCHUH
County Executive
November 28th, 2017

COUNTY COUNCIL OF ANNE ARUNDEL COUNTY

Citation

presented to

Maryland House Detox

on the occasion of its

Ribbon Cutting and Launch Reception

Wishing you much success with the opening of your first stand-alone, inpatient detox center in the state of Maryland; and with deep appreciation for your commitment to serve the citizens of Anne Arundel County.

Peter Smith	*1st District*	*Andrew C. Pruski*	*4th District*
John J. Grasso	*2nd District*	*Michael A. Peroutka*	*5th District*
Derek Fink	*3rd District*	*Chris Trumbauer*	*6th District*

Jerry Walker — *7th District*

June 28, 2018

COUNTY COUNCIL OF ANNE ARUNDEL COUNTY

Citation

presented to

Maryland House Detox

on the occasion of its

Groundbreaking Ceremony

Wishing you much success with the groundbreaking of your new center and with deep appreciation for your commitment to serve the citizens of Anne Arundel County.

Peter Smith — *1st District*

Andrew C. Pruski — *4th District*

John J. Grasso — *2nd District*

Michael A. Peroutka — *5th District*

Derek Fink — *3rd District*

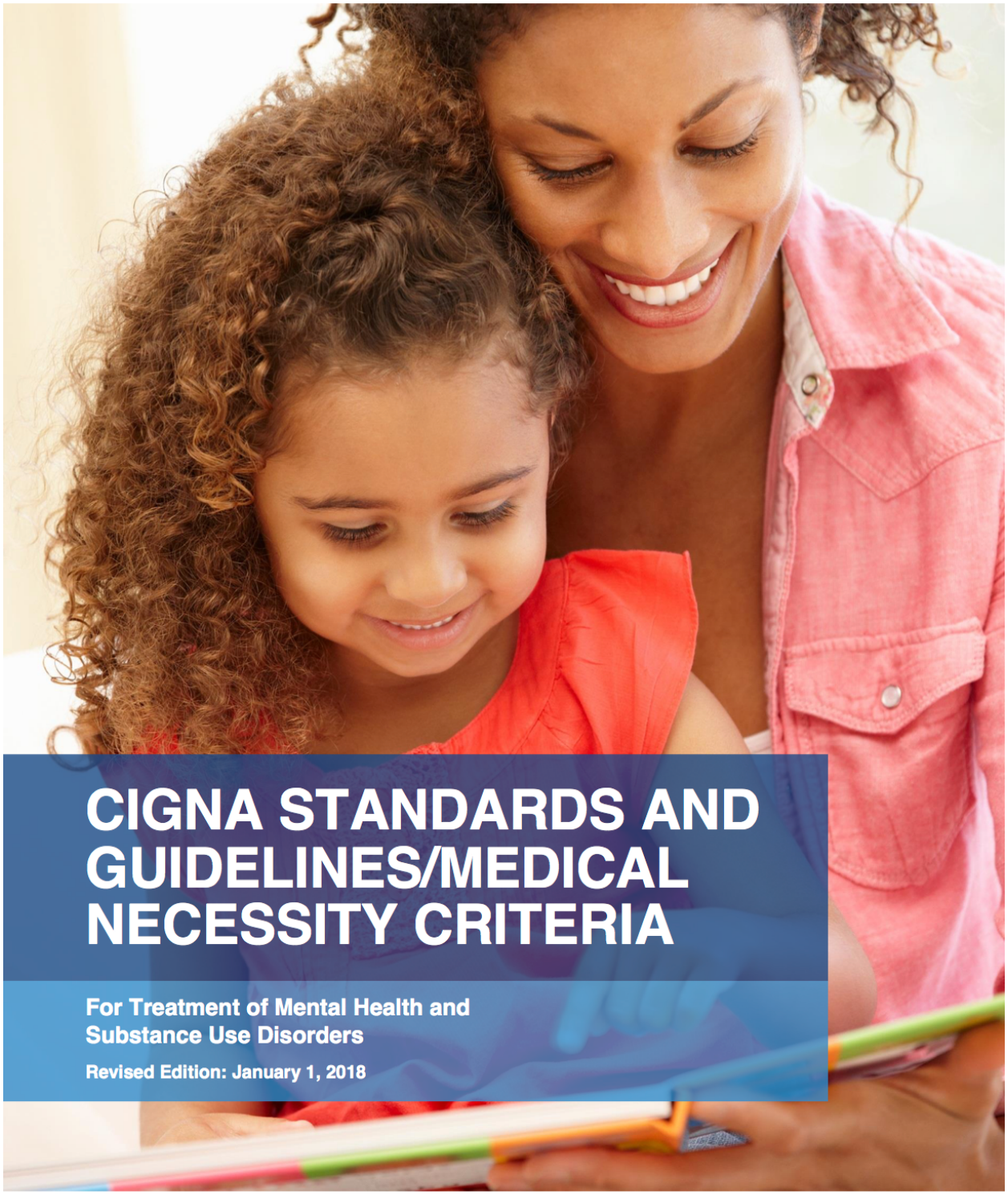
Chris Trumbauer — *6th District*

Jerry Walker — *7th District*

November 28, 2017

APPENDIX B

Cigna Standards and Guidelines


CIGNA STANDARDS AND GUIDELINES/MEDICAL NECESSITY CRITERIA
For Treatment of Mental Health and Substance Use Disorders
Revised Edition: January 1, 2018

Together, all the way.℠

Cigna

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Foreword

Over the last several years, with the passage of The Federal Mental Health Parity and Addiction Equity Act in 2008 and The Patient Protection and Affordable Care Act in 2010, the health care industry has evolved and increased in complexity. There is increased benefit coverage for people with mental health and substance use conditions, and these new laws have brought about changes in the way health care coverage is managed. As a result, some of the barriers that individuals have faced in obtaining the proper diagnosis and essential treatment for their condition have been addressed; however, we continue to be faced with a shortage of mental health and substance use disorder services and clinicians in many areas of the country. And, despite Americans having a more sophisticated understanding of mental illness, along with an increased awareness through exposure on television and in the media, studies show that there is persistent social stigma attached to people with mental illness and substance use disorders.

With over 150 million Americans covered under employer-based insurance, and millions more now covered through the state and federal exchanges, it is essential that we all work together to take advantage of the advances and opportunities brought by these new regulations. We all share the desire to see every individual receive the best care possible. In doing so, we have the responsibility to collaborate with each other to leverage each individual's health care benefits and to deliver the most effective care in the most appropriate setting at the right time.

Several key areas are necessary to consider as we engage in a cooperative and inclusive dialogue, including variations in standards of care across the country and health care disparities for people with mental health and substance use disorders. Also there are still significant gaps in service between mental health clinicians and general medical clinicians, and current regulations impede our ability to fully share important clinical information with other treating clinicians. This is important not only as we attempt to provide an integrated and holistic health care experience for individuals, but this also perpetuates the stigma associated with behavioral health and substance use disorders.

With all of the complexity in health care, we support practitioners in exercising their professional judgment to make informed decisions and offer quality care. We also support a consistent application of evidence-based guidelines to enhance clinical judgment and to ensure that treatment includes consideration of the practices that have been shown to be most effective for each individual's condition. In keeping with this commitment, we have continued to develop our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders. These Criteria are intended to be a working document to help set expectations and facilitate a shared responsibility. These Criteria do not replace clinical judgment, and we recognize that they require adaptation to the unique situations of each individual patient, as well as to relevant state regulations and licensing standards.

We hope this document will prove to be a worthwhile resource, and we thank our practitioners for the outstanding work they do in helping individuals to live healthier, more balanced lives. At Cigna, we support open dialogue with our clinician community and all of our customers. We also welcome ongoing feedback to find ways that we can all work together to better serve you.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health

Core Principles

General Overview

Cigna is committed to helping the people we serve improve their health, well-being, and sense of security. That is our mission. We realize that this is not possible without the understanding that mental health is equally important to physical health. There is a growing awareness across the United States of the influence of mental health and substance use conditions and the burden they place on individuals, families, and society. We believe that effective treatment for any illness must address mental health and physical health together. In fact, effective mental health and substance use disorder treatment is a cornerstone to driving holistic health and well-being. Taking this holistic view helps the people we serve be more productive at work, and more importantly, more productive at home with their families and in their communities.

At Cigna, we strongly believe that the core principle that guides mental health and substance use disorder care is that access to high quality care should be assured for everyone. This is true regardless of the diagnosis, treatment setting, type of clinician, geographic location, or the gender, ethnicity, or socioeconomic background of the individual seeking care. According to the 2005 Institute of Medicine report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions," there are six dimensions that need to be addressed in achieving high quality care for patients.[1] Quality mental health and substance use disorder care needs to be: safe, effective, patient-centered, timely, efficient, and equitable. Acceptance of these six dimensions of care is essential to delivering the most effective and most appropriate care to every patient. This Institute of Medicine report also identifies the importance of patient care being coordinated over time and across people, functions, activities, and treatment settings so that each patient receives the maximum benefit from their treatment services. It is from this core principle that Cigna has continued to develop our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders.

Medical Necessity Criteria

Cigna begins with evidence-based guidelines as the basic platform to define established standards of effective care. Scientific evidence is the vital element in the development of an informed decision-making process for patients and their clinicians. Over the last 18 years, the Surgeon General[2], the President's New Freedom Commission on Mental Health[3], and the Institute of Medicine[1] have all produced reports that highlight the importance of improving the dissemination and adoption of evidence-based practices. Effective treatment is ultimately linked to the consistent use of these evidence-based clinical practices and the ability of mental health and substance use disorder clinicians to effectively execute these therapies.

Cigna has adopted nationally developed and published clinical practice guidelines of the American Psychiatric Association, the American Association of Pediatrics and the National Institute on Alcohol Abuse and Alcoholism due to their acceptance as the best of evidence-based practice for mental health and substance use disorders. These evidence-based clinical practices then serve as a decision support tool to help define the most appropriate treatment setting and help assure consistency of care for each individual. Cigna has chosen not to adopt private, proprietary medical necessity criteria from companies such as McKesson Health Solutions or MCG, but to develop and implement our own. This decision strongly reflects our philosophy that Cigna's Criteria should reflect the mutual consensus of all of our stakeholders, be transparent and available to everyone, and be flexible enough to continuously adapt to the changes in mental health and substance use disorder treatment systems.

In the development of our Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders, Cigna has listened to the messages and feedback from patients, families, advocacy groups (MHA and NAMI), professional associations (American Psychiatric Association, American Academy of Child and Adolescent Psychiatrists, American Psychological Association, Association for Ambulatory Behavioral Healthcare, and the American Society of Addiction Medicine), regulatory bodies, psychiatrists,

psychologists, and therapists across the country. We have attempted to incorporate the strongest, evidence-based points into our Criteria. These Criteria then become a working document to help set expectations and to facilitate a joint working relationship and shared responsibility between Cigna and mental health and substance use disorder clinicians.

It is important to note that these Criteria are established as national standards. However, we recognize that many states have established state-specific standards and expectations for care, and have codified these into state laws, regulations and licensing rules. Sometimes specific levels of care or programs are not available in certain markets. Cigna always approaches the application of these Criteria allowing for exceptions to be made to comply with state regulatory and licensing standards.

Cigna is proud to keep the development process of our Criteria open and transparent to the public. We appreciate the active and meaningful role that patients, clinicians, and advocates have in determining how the scientific evidence is applied in our Criteria. In addition to listening to their input, we have also worked to write our Criteria in words that everyone can understand. Our Criteria are only of value when we can have open, clear, and complete discussions, and when individuals and their clinicians can understand and use the Criteria in their behavioral healthcare decision making.

Cigna believes that all treatment decisions that are made in alignment with these Criteria must be first and foremost clinically based. Care must be patient-centered and take into account the individuals' needs, clinical and environmental factors, and personal values. These Criteria do not replace clinical judgment, and every treatment decision must allow for the consideration of the unique situation of the individual. In this way, the Criteria promote advocacy for the patient and enhance the collaboration between Cigna and clinicians to achieve optimal, patient-centered outcomes. They also promote consistent communication and coordination of care from one treatment setting to the next. Finally, our Criteria, and their application, are always governed by the terms of each individual customer's benefit plan and in accordance with applicable federal and state laws and regulations.

Providing every individual with access to quality, evidence-based, patient-centered care is the core tenet of our approach at Cigna. It is from this approach that our Standards and Guidelines - Medical Necessity Criteria for Treatment of Mental Health and Substance Use Disorders help drive improvements in holistic health care and ensure consistent, meaningful outcomes for everyone.

Douglas Nemecek, M.D., M.B.A.
Chief Medical Officer – Behavioral Health

[1]Improving the Quality of Health Care for Mental and Substance Use Conditions, Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Board of Health Care Services. Washington DC: National Academies Press, 2005.

[2]Mental Health: A Report of the Surgeon General. Office of the Surgeon General, Public Health Service, Department of Health and Human Services. Washington DC, 1999.

[3]Achieving the Promise: Transforming Mental Health Care in America, The President's New Freedom Commission on Mental Health, Department

Substance Use Disorders Treatment

SECTION IV.

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Acute Inpatient Substance Use Detoxification

Standards and Guidelines

Medical Necessity – In considering coverage for any level of care, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents. Although benefit plan definitions of Medical Necessity/Medically Necessary vary to some degree, they commonly require the service or supply to be:

- In accordance with the generally accepted standards of medical practice,
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and,
- Not primarily for the convenience of the patient or Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Examples of Cigna standard definitions of Medical Necessity can be located at:
http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions.

Description – Acute Inpatient Substance Use Detoxification is utilized when the following services are needed:

- Around-the-clock intensive, psychiatric/medical, and nursing care including continuous observation and monitoring,
- Acute management to prevent harm or significant deterioration of functioning and to ensure the safety of the individual and/or others.
- Medications are prescribed and adjusted as indicated to assure that the individual has a safe and effective withdrawal from alcohol, sedative-hypnotic medications, or opiates.
- Appropriate medical professionals are available, including physician visits at least once each day and 24 hour nursing staff monitoring,
- Daily monitoring of medication effects and side effects; and,
- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

Admission Considerations for Acute Inpatient Substance Use Detoxification:

- Prior to admission, there has been a face-to-face assessment by a licensed clinician with training and experience in acute psychiatric emergencies and medical detoxification, to determine if this level of care is medically necessary and clinically appropriate due to a significant risk of a severe withdrawal syndrome.
- This level of care is not justified by simple intoxication or fear of withdrawal. Therefore, elevated blood alcohol level without any associated withdrawal symptoms is not enough to justify detoxification treatment.
- It is recognized that life-threatening intoxication/poisoning (i.e. endangering vital functions – central nervous system, cardiac, respiratory) may need acute medical attention, but that attention is generally not considered detoxification. In such cases, treatment at a medical/surgical unit may be needed and medical necessity criteria are applied when the individual has acute and severe medical problems such as:
  - Acute onset of seizures, severe electrolyte imbalance, gastrointestinal bleeds, cardiac complications, acute liver failure, or other serious medical complications, OR

- Underlying substance use is of such severity that it will likely cause severe and acute medical complications in the near future requiring acute medical management.

Expectations for Acute Inpatient Substance Use Detoxification:

- A documented diagnosis of a substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, and evidence of acute distress/impairment and risk for a severe withdrawal syndrome.
- A thorough Evaluation by a psychiatrist or addictionologist is completed within 24 hours of admission.
- A medical assessment and physical examination is completed within 24 hours of admission.
- Daily active, comprehensive care by a treatment team that works under the direction of a Board eligible/Board certified psychiatrist or addictionologist.
- Physician follow-up occurs daily or more frequently as needed.
- All medical and psychiatric evaluations should include consideration of the possibility of relevant co-morbid conditions.
- Within 48 hours of admission, there is outreach with existing providers and family members to obtain needed history and other clinical information, unless clinically contraindicated.
- For individuals under the age of 18, a face-to-face assessment that includes both the child/adolescent and the family is completed within 24 hours of admission by a licensed behavioral health clinician with training and experience consistent with the age and problems of children and adolescents.
- The facility will rapidly assess and address any urgent behavioral and/or physical issues.
- Coordination of treatment planning with community treatment providers, employers, or any involved legal authorities is an essential part of treatment and discharge planning.
- **Family Involvement** – Prompt and timely family involvement is expected at every level of treatment plan development, unless doing so is clinically contraindicated or would not be in compliance with existing federal or state laws. Family involvement is important in the following contexts:
  - **Assessment** – The family is needed to provide **detailed initial history** to clarify and understand the current and past events leading up to the admission.
  - **Family therapy** is relevant to the treatment plan and will occur as frequently as needed to achieve the treatment goals, but no less than once weekly, unless clinically contraindicated, and should be on a face-to-face basis.
    - However, if the family lives more than 3 hours from the facility, telephone contact for family therapy must be conducted at least weekly, along with face-to-face family sessions as frequently as possible.
    - Telephonic sessions are not to be seen as an equivalent substitute for face-to-face sessions or based primarily on the convenience of the provider or family, or for the comfort of the patient.
  - **Discharge planning.**
- **An Individualized Treatment Plan** is completed within 24 hours of admission. This plan includes:
  - A clear focus on the issues leading to the admission and on the acute symptoms that need to improve to allow treatment to continue at a less restrictive level of care.

- Multidisciplinary assessment of mental health issues, substance use, medical illness(s), personality traits, social supports, education, living situation, and internal and external motivations for treatment.
- The treatment plan results in interventions utilizing medication management, social work involvement, individual, group, marital and family therapies as appropriate.
- Goals that are clear and achievable with limited timeframes and a focus on reduction of the symptoms that led to the admission,
- Clear, objective and observable discharge criteria.
- A discharge plan that includes coordination with family and community resources to allow a smooth transition to a less restrictive level of care, family integration, and continuation of the recovery process.

› The Treatment Plan is not based on a pre-established programmed plan or time frames.

Individuals progress in their treatment at different rates. Medical Necessity and length of stay are to be assessed individually to ensure appropriate treatment for the appropriate length of time rather than based on a pre-determined program.

For individuals with a history of multiple re-admissions and treatment episodes, the treatment plan needs to include clear interventions to identify and address the reasons for previous non-adherence/poor response and clear interventions for the reduction of future risks.

› **Discharge Planning** will start at the time of admission and include:

- Coordination with family, outpatient providers, and community resources to allow a smooth transition back to home, family, work or school and appropriate treatment at a less restrictive level of care.
- Timely and clinically appropriate aftercare appointments with at least one appointment within 7 days of discharge.
- Prescriptions for any necessary medications, in a quantity sufficient to bridge any gap between discharge and the first scheduled follow-up psychiatric/medical appointment.

Medical Necessity Criteria – Acute Inpatient Substance Use Detoxification

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
3. The individual is at risk for a severe withdrawal syndrome as evidenced by **one or more of the following**:

   A. **Severe Alcohol and/or Sedative-Hypnotic Withdrawal** with evidence of recent use of these substances and **one or more of the following**:

      i) Abnormal vital signs (blood pressure, temperature, pulse, and respirations), or elevated scores on clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), AND some or all of the following observable,

objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting, clouding of sensorium, delirium, seizures, and/or hallucinations, OR

ii) The Individual has a pattern of alcohol and /or benzodiazepine use of such severity that it will likely result in a severe withdrawal syndrome with acute medical complications in the immediate future requiring acute 24 hour medical and nursing management, OR

iii) Prior complicated and potentially life-threatening withdrawal with a history of seizures, delirium tremens, or hallucinations associated with alcohol and/or sedative-hypnotic use or withdrawal.

B. **Severe Opiate Withdrawal** as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, sweating, diarrhea, dilated pupils, irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and/or yawning,

AND

4. **One or more of the following must apply:**

   A. The presenting signs and symptoms require active treatment that can only be safely and effectively provided in a 24 hour per day setting with nursing care and daily medical interventions,

   B. The Individual is currently suffering from symptoms of a severe mental illness or has such irrational or bizarre thinking that he/she could not be safely treated in a less intensive level of care.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.

2. One or more of the following criteria must be met:

   A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.

   B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement, when clinically indicated

   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

3. All of the following must be met:

   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.

   C. Continued stay is not primarily due to a lack of external supports.

References

References:

General Psychiatry

1) American Psychiatric Association Practice Guidelines, American Psychiatric Association Publishing, Arlington, VA, 2003-2014. http://psychiatryonline.org/guidelines.aspx
2) Behavioral Health Levels of Care, Milliman Care Guidelines®, 20th Edition, Seattle, WA, MCG Health, LLC, 2016.
3) American Psychiatric Association, Diagnostic and Statistical Manual of Mental disorders, Fifth Edition (DSM-5), American Psychiatric Publishing, Arlington, VA, May 2013.
4) American Psychiatric Association: Practice Guidelines for the Psychiatric Evaluation of Adults, 3rd Edition. Arlington, VA, American Psychiatric Publishing, 2016.

Child and Adolescent Psychiatry

5) Practice Parameters, The American Academy of Child and Adolescent Psychiatry, Washington, DC, http://www.aacap.org/cs/clinical_care_quality_improvement/practice_parameters
6) Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry, June 2010.
7) Winters, N.C. & Pumariega, A., The Work Group on Community-Based Systems of Care, the Committee on Community Child and Adolescent Psychiatry, and the Work Group on Quality Issues, Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care, J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(2):284-299.
8) TRICARE/CHAMPUS standards for Residential Treatment Centers (RTCs) Serving Children and Adolescents, TRICARE Reimbursement Manual 6010.57-M, Feb. 12,2008, Chapter 11, Addendum H.
9) Bukstein, O.G. and the Work Group on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Substance Use Disorders, J. Am. Acad. Child Adolesc. Psychiatry, 2005;44(6):609–621
10) Lock, J. & La Via, M.C., and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders, J Am Acad Child Adolesc Psychiatry 2015;54(5):412–425.

11) Sachs, M. and Madaan, V., Electroconvulsive Therapy in Children and Adolescents: Brief Overview and Ethical Issues, Sponsored by AACAP Ethics Committee, January, 2012.

Residential Treatment

12) Psychiatric Residential Treatment Facilities (PRTF) Clarification, Center for Medicaid and State Operations/Survey and Certification Group, Ref: S&C-07-15, February 16, 2007.

13) Preauthorization Requirements for Residential Treatment Center Care, TRICARE Policy Manual 6010.54-M, August 1, 2002, Chapter 7, Section 3.4.State Regulation of Residential Facilities for Adults with Mental Illness, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, www.samhsa.gov

See also (6), (8)

Partial Hospital Programs and Intensive Outpatient Programs

14) Standards & Guidelines for Partial Hospitalization Programs and Intensive Outpatient Programs, Fifth Edition, Association for Ambulatory Behavioral Healthcare (AABH), 2012

15) Definition of Partial Hospitalization. The National Association of Private Psychiatric Hospitals and the American Association for Partial Hospitalization, Psychiatric Hosp. 21(2):89-90, 1990

16) Outpatient Hospital Psychiatric Services, Medicare Benefit Policy Manual, Chapter 6, Section 70 - Hospital Services Covered Under Part B, A3-3112.7, HO-230.5 (Rev. 157, 06-08-12)

17) Medicare Hospital Manual, Section 230.7, Outpatient Partial Hospitalization Programs (PHP), Department of Health and Human Services (DHHS), Health Care Financing Administration (HCFA), 2000 Clinical Issues in Intensive Outpatient Treatment. (Treatment Improvement Protocol (TIP) Series, No. 47). 2006. http://www.ncbi.nlm.nih.gov/books/NBK64093/

Substance Use Disorders

18) Practice Guidelines for the Treatment of Patients with Substance Use Disorders, American Psychiatric Association Publishing, Arlington, VA, 2006

19) The ASAM Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, American Society of Addiction Medicine, Inc, Chevy Chase, MD, 2013.

20) Texas Commission on Alcohol and Drug Abuse (TCADA) Guidelines, Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, Texas Administrative Code, Title 28, Part 1, Chapter 3, Subchapter HH, 2011.

21) SAMHSA/CSAT Treatment Improvement Protocol (TIP) Series. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1993-. http://www.ncbi.nlm.nih.gov/books/NBK82999/

i) Clinical Issues in Intensive Outpatient Treatment. (Treatment Improvement Protocol (TIP) Series, No. 47). 2006. http://www.ncbi.nlm.nih.gov/books/NBK64093/

ii) Detoxification and Substance Abuse Treatment. (Treatment Improvement Protocol (TIP) Series, No. 45). 2006. http://www.ncbi.nlm.nih.gov/books/NBK64115/

iii) Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. (Treatment Improvement Protocol (TIP) Series, No. 43). 2006. http://www.ncbi.nlm.nih.gov/books/NBK64164/

iv) Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. (Treatment Improvement Protocol (TIP) Series, No. 40). 2004. http://www.ncbi.nlm.nih.gov/books/NBK64245/

v) Brief Interventions and Brief Therapies for Substance Abuse. (Treatment Improvement Protocol (TIP) Series, No. 34) 1999.

vi) http://www.ncbi.nlm.nih.gov/books/NBK64947/

See also (9)

Eating Disorders

22) Practice Guidelines for the Treatment of Psychiatric Disorders, Treatment of Patients with Eating Disorders, Third Edition, American Psychiatric Association Publishing, 2010.

23) Lock, J. & La Via, M.C., and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders, J Am Acad Child Adolesc Psychiatry 2015;54(5):412–425.

24) National Institute for Clinical Excellence, Eating Disorders, Clinical Guide 9, January 2004.

25) American Academy of Family Physicians, Diagnosis of Eating Disorder in Primary Care, Table 6, Level of Care Criteria for patients with eating disorders, 2003.

See also (10)

Autistic Spectrum Disorders

26) Volkmar F, Siegel M. et al, and the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autistic Spectrum Disorder, J Am Acad Child Adolesc Psychiatry. 2014; 53:237-257.

27) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers, Second Edition, Behavior Analyst Certification Board, Inc. (BACB), 2014 http://bacb.com/wp-content/uploads/2015/07/ABA_Guidelines_for_ASD.pdf.

28) Warren Z, Taylor JL, McPheeters ML, Worley K, Veenstra-Vander Weele J., Future Research Needs: Interventions for Adolescents and Young Adults With Autism Spectrum Disorders. Future Research Needs Paper No. 20 (Prepared by Vanderbilt Evidence-based Practice Center under Contract No. 290-2007-10065-I). AHRQ Publication No. 12-EHC129-EF. Rockville, MD: Agency for Healthcare Research and Quality. September 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm

Electroconvulsive Therapy

29) Practice Parameter for Use of Electroconvulsive Therapy with Adolescents, AACAP Official Action, J. Am. Acad. Child Adolesc. Psychiatry, 2004; 43(12):1521–1539.

30) Sachs M. and Madaan V., Electroconvulsive Therapy in Children and Adolescents: Brief Overview and Ethical Issues, Sponsored by AACAP Ethics Committee, January, 2012.

See also (11)

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APPENDIX C

New York Times

https://www.nytimes.com/interactive/2017/12/27/business/urine-test-cost.html

https://www.nytimes.com/interactive/2017/12/27/business/drug-addiction-rehab.html

Forbes

https://www.forbes.com/sites/danmunro/2015/04/27/inside-the-35-billion-addiction-treatment-industry/#60860a2117dc)

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The New York Times

Business

In Pursuit of Liquid Gold

There is big money in drug testing. That means urine, and bills that cantop a quarter-million dollars for a few months of tests for a single patient.

By DAVID SEGAL Photographs by JOHNNY TERGO for the New York Times

With drug abuse rising, an array of companies have found new ways to turn the problems of addicts into billable fortunes. And few are as profitable as those focused on the lowliest byproduct of any stint in rehab: urine.

Testing has long been part of recovery, a way for clinics to ensure that patients are staying clean. But starting in 2010, as opioid abuse evolved into a crisis and the Affordable Care Act offered insurance to millions more young people, the cost of urinalysis tests soared.

It was soon common for clinics and labs to charge more than $4,000 per test, and to test clients two or three times a week.

Today, many clinics have pushed into an industry once dominated by stand-alone labs, running their own testing operations and, in some cases, pocketing far more from urine testing than from other aspects of treatment. With huge profits for the taking, clinic-owned labs are multiplying — and upending the testing industry.

IN THIS SERIES

- Addiction Inc.
- The Giant, Under Attack
- City of Addict

"In a lot of these places, the patients are basically just there to urinate, and management calls them 'thoroughbreds,'" said Bill Griffin, a retired insurance fraud investigator in Florida. "This

- Phone and a Mission This is a billion-dollar fraud in Florida alone."

The tests have caught the attention of the F.B.I. and the Palm Beach County State Attorney's Office, which launched a task force — called Operation Thoroughbred — to investigate clinics and sober living homes.

Insurers are also fighting back. In January, UnitedHealthcare filed a lawsuit seeking $100 million from Next Health, a network of labs, claiming that it had paid doctors bribes as well as kickbacks of 20 percent of revenue for overpriced and medically unnecessary urine and saliva samples.

Next Health countersued for unpaid claims in October and called UnitedHealthcare's case a "shakedown."

Some clinic-owned labs have returned fire, too, with lawsuits claiming that they are owed millions for urinalysis tests that insurers refused to cover. One lab, Living Tree Laboratories, which shares ownership with A New Start, a clinic in West Palm Beach, Fla., is suing UnitedHealthcare for $12 million.

One of A New Start's clients was a 23-year-old named John Baker. A few months after he started treatment there, in early 2015, two bills arrived at his father's home. They cataloged dozens of urinalysis tests both from Living Tree and from the sober home where he lived, which ran its own urinalysis lab.

Total cost: $260,000.

"We were shocked," said Lizz DeWolfe, Mr. Baker's mother. "It didn't seem possible."

'From Drugs to Money'

Rehab centers and labs say extensive testing is necessary because clients are getting high with rare designer drugs and exotic combinations of over-the-counter medications. Mr. Baker's urine, for instance, was tested for amphetamines, antidepressants, antipsychotics, barbiturates, benzodiazepines (a class of sedatives), and the list goes on.

The tests, though, did not search for the one drug Mr. Baker, a weight lifter, was actually taking: steroids. When managers at his sober home found the steroids in his possession, he was evicted. Three days later, his body was discovered in the parking lot near a friend's apartment. He had overdosed on heroin.

Thousands of small, clinic-owned labs have quietly sprouted nationwide, ramping up the competition for independent labs that once dominated the industry. The clinics that have yet to jump into the lab business are now inundated with breathless pitches from companies that specialize in helping to set up complete, ready-to-run labs for clients. “15 samples per day could yield $800,000 in profit!” read one email sent last year by Mercedes Medical, a supply company in Sarasota, Fla.

In recent months, insurers have started to ratchet down reimbursement rates for urine tests, but profit margins remain enticingly high. The windfall has roiled the rehab industry, which is in the midst of a kind of civil war.

On one side are the clinic owners who have never cashed in on urinalysis and are aghast at the cascade of money now pouring into the pockets of their competitors. They tend to be the loudest critics of those on the other side of this battle — the clinic owners who realized that their clients’ urine is a path to riches.

“Some of these places have cleared $400,000 a month in profit,” said Brian Crowley, the chief executive of Integra Enterprizes, which consults with clinics that want to open labs. “A lot of the people who start these treatment centers are reformed abusers, and it’s as though they turn from one craving to another — from drugs to money.”

A Markup of 2,000 Percent

Known as J. J. to friends, Mr. Baker entered A New Start six years after he had become a heroin addict in his hometown, Forkston Township, Pa. At 6 feet 2 inches and just 140 pounds, he had been bullied in high school, according to his mother, and found community with a crowd that was into drugs.

A New Start is an outpatient program, which means that it offers therapy but not housing. So Mr. Baker lived at a nearby sober home called Seamless, with about 15 other drug users. Because Seamless had its own urine testing lab, Mr. Baker, like countless other patients, provided samples to both his sober home and his treatment facility.

All of Mr. Baker’s samples were sent to the 46,000-square-foot Alexandria Innovation Center, where the labs for both A New Start and Seamless were based. Anywhere from 25 to 200 specimens a day arrived at A New Start’s lab, according to Theresa Lee, former chief scientist for the company.

“Monday is the busiest day,” she said, “because that’s when all the weekend samples arrive.”

Samples are first run through a screening analyzer, a device that can detect more than a dozen drugs, such as cocaine and marijuana. This is called a qualitative test — or more colloquially, a screen.

It is a more expensive version of the $20 test sold at drugstores, the kind prospective employees are asked to take before starting new jobs. The lab version of a screen looks for the same drugs as the one sold at CVS, but is far more sensitive, which is to say that it can detect smaller amounts of drugs.

Labs are reimbursed by the federal government for screens on Medicare patients at a maximum of about $80 per test. For each of Mr. Baker’s screens, A New Start’s lab billed $1,980. It’s common for private insurers to reimburse at higher rates than public programs, and in very rare cases — for certain back surgeries, for instance — private insurers can pay twice as much as Medicare. A New Start’s lab was asking 2,375 percent the government rate.

The screen was the cheap part.

A New Start’s lab also ran Mr. Baker’s urine through a liquid chromatography-mass spectrometry device, which costs about $250,000 and looks like an immense photocopier attached to an espresso machine. It conducts quantitative tests — often called confirmations. These cover a wider range of drugs and determine how much of a particular drug is in a patient’s urine.

For Medicare patients, the government reimburses between $117 and $254 per confirmation test. For each of Mr. Baker’s, A New Start’s lab charged more than $4,000. At the same time, the lab owned by Seamless was conducting both screen and confirmation tests on Mr. Baker’s urine, too.

Costs aside, there is the question of whether confirmation tests were even necessary in Mr. Baker’s case. All of his screens had come back negative. Typically, confirmations are conducted only if a screen comes back positive.

Nicole Sauvola, a lawyer for A New Start and its lab, said that even when screens are negative, confirmation tests are often essential. That’s because confirmations detect and measure a wide variety of exotic drugs, including synthetic stimulants and muscle relaxants, as well as the commonly abused drugs found by screens.

“Physicians and psychologists who are working in this field will tell you that every one of these kids would be dead without drug testing,” she said. “Because as soon as we get a handle on one drug, the triggers lead to another. And we’ve got kids going to Walgreens and buying cough syrup and getting high, or taking

Imodium and other anti-diarrhea medications and ending up in the emergency room because Imodium can give you a high like heroin."

'Drugs That Haven't Been Seen in Years'

To get an independent assessment of the testing procedures used by A New Start's lab, Ms. Sauvola recommended speaking to the American Society of Addiction Medicine, which publishes industry benchmarking guides. The group, in turn, recommended one of its former presidents, Louis Baxter.

Dr. Baxter declined to discuss the specifics of Mr. Baker's tests. But generally speaking, "having two separate entities testing one patient, that is irregular," Dr. Baxter said. "One source can test a patient and then share that information with the other."

He added that he is troubled when intensive outpatient programs also own labs. Though they are not legally prohibited, "I can tell you the practice has been investigated by state licensing authorities" around the country, Dr. Baxter said.

One independent lab owner who examined Mr. Baker's bills was struck by the number of drugs for which he had been tested. Urine tests are often tailored to the client, said David Muskat, the chief executive of Synergy Diagnostic Laboratory and a critic of overtesting. People addicted to heroin are typically tested for opiates, marijuana and other types of downers. Testing for amphetamines and other uppers makes less sense, he said.

"These guys were testing for everything you could possibly buy at a Walgreens, everything you could possibly get from a psychiatrist and a number of drugs that haven't been seen in years," Mr. Muskat said of the Mr. Baker's tests. "The kid was negative for six straight months, which means they didn't have to test so often."

Which means, in Mr. Muskat's opinion, the tests were about money.

Blue Cross of Northeastern Pennsylvania covered a small fraction of Mr. Baker's $260,000 urinalysis bill, and his family declined to pay the rest. Ms. Sauvola, the attorney for A New Start, said some unpaid invoices are written off as uncollectable.

Some bills wind up in court. In the lawsuit filed by A New Start's lab against UnitedHealthcare, the lab said the insurer had denied millions of dollars in medically necessary substance abuse treatments. In a motion to dismiss,

UnitedHealthcare called the tests “unjustified” and “excessive” and said that A New Start’s lab had billed $188,305 for tests conducted on a single patient in the span of four and a half months.

Following the Money Makers

When Mr. Baker was a client, A New Start and its urinalysis lab were owned by Moshe Dunoff. He is currently in prison, having pleaded guilty to a 2009 scheme described by the Securities and Exchange Commission as a “‘boiler room’-type offering fraud.”

The scheme, according to court documents filed by federal prosecutors, raised $1.5 million through phone calls to people who were told they were buying discounted securities from a fictitious brokerage called Gruber and Green.

Ms. Sauvola, A New Start’s lawyer, said that Mr. Dunoff was addicted to drugs at the time of the scheme and is a dramatically different person today. “He has five years of sobriety,” she said. “Like every other addict I know, he got himself into stupid situations and made bad decisions, solely because he was looking to use drugs, not because he was looking to rip anybody off.”

It isn’t hard to find former clients of A New Start who rave about Mr. Dunoff. “He saves peoples’ lives,” said Rich Sarafian, a former heroin user who is now a barber. “And I don’t mean three or four lives. I mean 50 or 60 lives. He’s involved. He cares about his clients, he tries to run the best possible rehab.”

Behind every urinalysis test is a doctor who must sign a requisition — essentially a note stating that a client’s urine should be tested. For some doctors, requisitions can be a lucrative side business, producing fees between $3,000 and $8,000 a month from each clinic or sober home. Some doctors work with more than one facility at a time.

One of the doctors overseeing Mr. Baker’s urinalysis tests was Dr. Michael Ligotti, who was listed as the medical director for nine different treatment centers as of October, according to records kept by the Florida Department of Children and Families.

Dr. Ligotti’s name has appeared often enough on insurance bills that he has attracted the notice of Southeast Florida Recovery Advocates, a group of activists trying to raise awareness about abuses in the drug treatment industry.

Part of that, they say, is highlighting the role that doctors play in enriching clinics and sober homes by approving unnecessary urinalysis tests.

Late last February, the group held a protest on the sidewalk next to Dr. Ligotti's office. One of the protesters had a placard that read "Stop Killing Our Kids." Another read, "We demand physician ethics."

A call to Dr. Ligotti's office was returned by his lawyer, Benton Curtis, who said his client would not answer questions. "Dr. Ligotti has enjoyed a sterling reputation in South Florida for years as a respected doctor, family man and a civically involved member of the community," Mr. Curtis wrote in an email.

Dr. Ligotti, in a 2013 letter to Florida's Department of Families and Children, wrote that some treatment facilities have used his name "in an unauthorized fashion." In that letter, however, he added that he could not identify which ones.

During Mr. Baker's first few months at Seamless, he appeared to do well. But to a few counselors and his friends, he seemed overly focused on working out at a nearby gym. Their concern grew when Mr. Baker started taking steroids, according to several of his acquaintances including Dustin Williams, who became friends with Mr. Baker at Seamless.

The house managers at Seamless found Mr. Baker's steroid prescription. Nearly every sober home has zero tolerance for medication that isn't part of a client's recovery. That was why, on Aug. 25, 2015, Mr. Baker was evicted.

"I was at work, and he called and said he was getting kicked out," Mr. Williams said.

Mr. Baker also spoke to his mother, Ms. DeWolfe, a few times that day. "He was really upset," she said. "The kid had no place to go. I texted him at 7:58 that night and got no response. He always got back to me. I knew by noon the next day that something bad had happened."

Ms. DeWolfe and Mr. Williams started looking for Mr. Baker on Aug. 26. They called hospitals, police stations and morgues.

Creating a Monster in the 'Wild West'

The boom in clinic-owned labs started in earnest around 2014, but it would be inaccurate to say that such labs were overbilling. There were no guidelines

about how much to charge or how often to test.

“It was the Wild West,” said Mr. Crowley, the clinic consultant. “We had created a monster.”

The size of bills for urinalysis tests was determined through trial and error by the clinics, said John Lehman of the Florida Association of Recovery Residences, which has been battling substandard operators for years. Insurers were sent bills for tests and if they were paid, the cost of the test would go up when new bills were submitted. Mr. Lehman said that early experiments with billing yielded about $4,200 per test, and each client was tested five times a week. That adds up to $21,000 in billings per week, per client. Some clinics had more than 40 clients.

It took years to realize what was happening, insurance executives said. That was mostly because urinalysis tests had never before cropped up as a billing issue, and the doctor-signed requisitions ordering the tests gave them the aura of medical authority.

But in 2015, the Justice Department announced that Millennium Health, a San Diego company that operates labs, had agreed to pay $256 million to resolve allegations that the company had overbilled Medicare and Medicaid for unnecessary urine and genetic tests. Among the findings: Seniors were routinely tested for PCP, also known as angel dust.

“I don’t care if they send it to me in a Ziploc bag,” a Millennium executive was quoted as saying, according to the government’s complaint. “I want their urine.”

A spokeswoman for Millennium said in a recent email that the company has had new owners and new leadership since 2015. Millennium, she wrote, now adheres “to the highest standards of responsible and ethical business practices.”

A Bottle of Water and a Needle

The night he was bounced from Seamless, Mr. Baker called a friend — Mr. Sarafian, the barber who had also been a client at A New Start.

“He wanted to get high,” recalled Mr. Sarafian, who was also relapsing at the time. “So he picked me up at my apartment, I got in his car and we went together to meet somebody where he bought some heroin.”

The friends had dinner at a Miami Subs, where Mr. Baker complained that he felt he had been picked on by the house managers at Seamless. Then, they drove to Mr. Sarafian's apartment complex. Mr. Baker stayed in the parking lot to shoot up alone in his car.

On Aug. 28, he was found by a maintenance worker, holding a bottle of water and a hypodermic needle. A medical examiner ruled his death an accidental overdose.

Two former managers at Seamless declined to discuss Mr. Baker's departure from the premises.

Apportioning blame when an addict dies is difficult. Clinic owners who have not opened their own labs contend that the money to be made off addiction treatment has made it easy to put profits over people.

"A drug test costs more than a day of therapy, and that has a way of changing priorities," said Andrew Burki, the chief executive of Life of Purpose Treatment, a group of clinics focused on students. "And the timing of all this could not be worse. We are in the midst of one of the worst health pandemics since the Spanish Flu. More Americans will die from opiates this year than in the entire Vietnam War."

Even with insurance companies cutting their reimbursement rates, the boom in lab construction has not abated, according to people like Andy Wright, the president of Mercedes Medical, the Sarasota-based company that sells lab equipment. He said that he sees more than a dozen new labs built each month.

George McNally the former owner of the defunct House of Principles, a sober home in West Palm Beach, described an anecdote he heard not long ago at an Alcoholics Anonymous meeting. "A guy there, who works at a treatment center, was talking about how he had somehow messed up these five U.A.s," Mr. McNally recalled, using the shorthand for urinalysis tests.

The man's boss had berated at him, Mr. McNally said: "Don't you know — this stuff is liquid gold?"

Correction January 24, 2018

An earlier version of this article misidentified the plaintiff in a lawsuit against UnitedHealthcare. It is Living Tree Laboratories, not A New Start, a rehab clinic. The two companies are separate but have common ownership. Dr. Michael Ligotti oversaw urine tests for John Baker, a client at A New Start, through an unrelated company.

https://nyti.ms/2E0brRD

The New York Times

Business

The Giant, Under Attack

One of America's biggest rehab companies built an empire. But after a patient namedGary Benefield died, its enemies — investors and business rivals alike — struck hard.

By MICHAEL CORKERY and JESSICA SILVER-GREENBERG Photographs by JOHNNY TERGO for the New York Times

On the last day of his life, Gary Benefield expressed hope for the future. He was finally about to "get right," he said.

A Harley-riding tough guy and retired utility worker, Mr. Benefield had let addiction get the better of him. He was downing a dozen Budweisers a day and smoking nonstop, despite needing an oxygen tank to breathe. But that July day in 2010, he was headed to A Better Tomorrow, a California treatment center promising 24-hour care while he got sober.

Mr. Benefield was about to join the millions of Americans who have placed their fate in the hands of the nation's sprawling, haphazardly regulated addiction-treatment industry. It is a wildly profitable business, thanks in large part to addicts like Gary.

He kissed his wife, Kelly, goodbye at the tiny airport in Show Low, Ariz., a town named for the lucky turn of a playing card more than a century earlier. "He told me he loved me," she said later. That evening, he checked in at the treatment center.

IN THIS SERIES

- Addiction Inc.
- In Pursuit of Liquid Gold

The next morning, as dawn broke over A Better Tomorrow's postage-stamp lawn and stucco walls, two new voice mail messages awaited an employee

- A Doctor With a Phone and a Mission

One came from Kelly Benefield, asking: Could someone help her bring Gary a cake that day? It was his 53rd birthday.

The other came from a manager: Gary Benefield was dead.

A Land of Opioids and Opportunity

America is convulsed by an addiction crisis — painkillers, heroin, alcoholism, meth — and its victims die with tragic regularity. But Mr. Benefield's case is extraordinary.

His death in July 2010 kicked off a six-year battle that very nearly brought down one of the biggest addiction-treatment companies in the country, an epic clash between an addiction-treatment multimillionaire and a college kid and budding financial wizard.

On one side was Michael Cartwright, a former addict pursuing his dream of building a nationwide empire of trustworthy drug-treatment clinics — a kind of Mayo Clinic for addiction. His Nashville, Tenn., company owned the clinic where Mr. Benefield had died.

On the other was Chris Drose, who, uninspired by his class work at Furman University, became fascinated with short selling — a risky investment strategy of trying to make money by betting that a company's stock will fall.

In Mr. Cartwright's company, the college junior saw a very big "short." And he attacked.

Addiction treatment is one of the most lucrative health care industries to emerge in a generation, a massive business fed by a national addiction crisis that, by most measures, is out of control. Drug overdoses kill more Americans than car accidents, but only a fraction of the country's 23 million addicts go into rehab, creating an untapped market — and an enormous business opportunity.

Yet the industry focused on curing addiction has its shortcomings. One of the most significant: There is little consensus on the most effective ways to treat patients.

Should patients travel far from home, as Mr. Benefield did, to isolate them from temptation? Or should they stay close to their support networks of family and

friends? Should they be treated with medications that reduce the appetite for opioids? Or should they be coached to conquer their illness through willpower?

The field is also covered by a patchwork of regulations that haven't kept pace with its growth. That has created room for opportunistic small operators to spring up, some with questionable track records.

The industry started taking off when President George W. Bush in 2008 signed a law requiring insurers to pay for rehab. The 2010 Affordable Care Act expanded coverage further. Suddenly just about anyone with insurance could get help.

Today, private insurance covers treatment for millions of working and middle-class Americans. Annual spending by private insurers on opiate addiction alone rose more than 1,000 percent in the five-year period ending in 2015, to roughly $721 million, according to Fair Health, an independent nonprofit that keeps a database of private insurance claims.

Mr. Cartwright's company, American Addiction Centers, operates treatment centers in eight states around the country. That was how Mr. Benefield ended up in a treatment facility in California: Eager to get sober, he and his wife searched online from their home in Arizona for a clinic, found A Better Tomorrow — which eventually became part of Mr. Cartwright's business — and then called up to book a spot.

This account of Mr. Benefield's final days, and the battle over American Addiction Centers, draws on interviews with executives, front-line employees, addicts, police and investors, as well as thousands of court documents.

A Wall Street Payday Worth Millions

On October 3, 2014 — four years after Mr. Benefield's death — Michael Cartwright and his business partner, Jerrod Menz, rang the opening bell on the New York Stock Exchange to announce the first of day trading in their company's shares. Mr. Cartwright, standing next to his teenage daughter, clapped. Mr. Menz gave the thumbs up.

At the close of trading that day, shares in American Addiction Centers held by the two men — the two largest shareholders — were worth a combined $202 million.

It was a crowning achievement for both men, but particularly for Mr. Cartwright, who had started his career running a rehab center for mentally ill addicts in inner city Nashville.

In 2012, Mr. Cartwright started buying up smaller providers, including one that had been started by Mr. Menz, his longtime friend, in Southern California, and assembling them into a national chain.

Mr. Cartwright himself had abused drugs as a younger man, "anything I could get my hands on," he said in an interview. Mr. Cartwright also spent time in a psychiatric hospital after a breakdown, an experience that helped to shape his belief that anyone can overcome addiction as long as they have the right mind-set.

He credited his grandmother's tough love with helping him turn his life around. "She wasn't about to let me wallow in my own poop," he wrote in his book, "Believable Hope."

Addiction should be overcome by willpower and hard work in therapy, Mr. Cartwright said. Other treatment providers put more emphasis on medicines to help addicts — particularly opiate addicts — function in the long term.

The treatment world is split by methodology and motivation — inpatient and outpatient, religious and secular, nonprofit and moneymaking. Such a Balkanized industry seemed ripe for consolidation by a businessman like Mr. Cartwright.

With aggressive internet marketing and a central call center, Mr. Cartwright pulled in patients from around the country. Patients stay for weeks at a time in a treatment house, undergoing therapy paid for by private insurance.

"If you can create a great brand, which I think Michael can," said Lucius Burch III, an early investor in American Addiction Centers and a former chairman of a Nashville company that runs private prisons, "you have an opportunity to build a huge company."

An Easter Egg Hunt for Something Bad

But there were people who believed they saw big vulnerabilities in that emerging brand, including a college student in South Carolina.

With bushy eyebrows and a boyish face, Mr. Drose comes from a family of skeptics and crusaders. His grandfather helped plot the assassination of Rafael Trujillo, a dictator in his native Dominican Republic, in the 1960s.

He remembered the day, in late 2014, that he discovered the investment idea that would launch his career. He was 19, sitting on a purple armchair in his dorm room at Furman, where he liked to spend his spare time scanning financial filings in search of stocks to "short," or bet against.

"It's like a big Easter egg hunt," Mr. Drose said recently. "Except, for something bad."

That day, one company stood out to him — American Addiction Centers. In just a few months in existence as a publicly traded stock, its shares had risen a blistering 60 percent.

Any time a stock rises that quickly, short sellers like Mr. Drose sense an opportunity. But there was something else that piqued his interest.

A business that profited from people's desperation seemed like "an industry that might have something weird going on," Mr. Drose said.

But weird wouldn't begin to describe the world he was about to enter.

Culling through American Addiction Centers' public filings, he noticed that a health insurer had sued one of the company's subsidiaries, claiming that it had conducted unnecessary drug tests on patients' urine. Posing as a prospective patient, Mr. Drose called the company and asked how often it conducted drug tests, and came to believe that American Addiction Centers was testing much more frequently than other providers.

He wrote an article about his findings on a website called Seeking Alpha, which short sellers frequent for investment tips. The company's stock promptly dropped 10 percent.

That was a big win for anyone short-selling the stock. Short sellers borrow shares in a company, then sell them hoping that the price falls. Their goal is to buy back the shares later, at a cheaper price, and return them to the lender. The price decline is their profit.

In Nashville, Mr. Cartwright watched his stock fall, and was stunned. "We found no substantiation for any one of his claims," he said in an interview, referring to Mr. Drose's article.

Battle lines were being drawn and Mr. Drose's work was attracting attention elsewhere. Kingsford Capital, a hedge fund based outside of San Francisco,

hired him as a consultant and told him to keep digging into the treatment business.

And another interested party had noticed Mr. Drose's work, too: a man named Charles Hill, who ran a treatment center in Temecula, Calif., the town where Mr. Benefield had died.

Mr. Hill told Mr. Drose that he knew a great deal about American Addiction Centers. He congratulated him on his article about the urine testing, and suggested he start searching for lawsuits brought by families of patients who had died in California. "You've been looking in the wrong place," he told Mr. Drose.

Following Mr. Hill's advice, Mr. Drose flew to California in the spring of 2015. He may have been working for a major hedge fund, but he was so young — still only 20 — that he had to pay extra to rent a car.

The two men met at Mr. Hill's rehab center in Temecula, a maze of cul-de-sacs and shopping plazas book-ended by the velvet green Santa Rosa mountains and the snowcapped peaks of the San Bernardino range.

Mr. Hill thought the college kid was an investigative reporter. So he was thrilled to have someone to listen to his concerns about the treatment business.

"I didn't even know what short selling was," Mr. Hill recalled.

Competing Methods and Deep Differences

Standing five feet seven inches in scuffed leather boots and faded jeans, Mr. Hill is a former painkiller addict and a natural storyteller. The story that perhaps best defines his life involved a football injury back in the 1990s. It shaped his personal philosophy of drug treatment, one that puts its trust in modern medications — and is at odds with people like Mr. Cartwright, who want patients to ultimately lead a truly drug-free life.

Mr. Hill was injured at the age of 42, too old to be playing tackle football. But eager to relive his high school glory days, Mr. Hill — his nickname is Rocky — had joined some friends to start a full-contact football league, The Over the Hill Pigskin Shootout. They used old pads donated by the Los Angeles Rams.

One fateful tackle, though, ended the fun. He tore the rotator cuff in each of his shoulders. His doctor prescribed a powerful painkiller, Norco.

And Mr. Hill — who was already in the addiction treatment business — became an opiate addict himself.

When he tried to stop taking the Norco, his life unraveled. He couldn't sleep. He subsisted on Ensure, the nutrition drink, because eating made him vomit. He considered suicide.

A doctor specializing in pain management told Mr. Hill that the opiates had permanently altered his brain. Therapy and group meetings couldn't fix that.

The doctor prescribed Mr. Hill a different drug, buprenorphine, which satisfies the craving for opiates but does not result in a high. Minutes after the first dose dissolved under Mr. Hill's tongue, the world righted itself.

"Before, it felt like someone had put a vacuum in me and sucked out all the joy," Mr. Hill said. "And then, it was like someone had suddenly reversed it."

Mr. Hill's successful treatment with buprenorphine was for him a revelation. Today, he sends the opiate addicts he treats to a local doctor for a prescription for the same drug he still takes every morning.

For many addicts, that prescription is all they need to get on with their lives, Mr. Hill said. Mr. Cartwright, by contrast, believes that ultimately "abstinence has to be the goal," he said in an interview.

That is only the start of their differences.

Mr. Cartwright's company specializes in enrolling addicts in intensive inpatient programs, often far from their families — where they stay full-time in a sober living center with other recovering addicts.

Mr. Hill prefers an outpatient approach that is close to the patient's support network. During the day, addicts come to Mr. Hill's two-story building, where they meet with therapists. At night, they go home.

Mr. Hill believes the inpatient model is motivated more by greed than doing good. Inpatient providers can bill insurers up to $10,000 for 28 days of services; Mr. Hill charges $1,400 a month for his outpatient treatments.

Stumbling Across 'a Gold Mine'

There is great debate about which treatment approaches work best, and even how to measure their efficacy.

“A lot of organizations say they have the cure, but they have no incentive to try to prove it through the data,” said Robert Poznanovich, executive director of Business Development at Hazelden Betty Ford Foundation, one of the best-known addiction-treatment providers in the United States.

Hazelden offers a mix of outpatient and inpatient treatment. Modern addiction treatment grew directly from Hazelden and its secluded farm in Minnesota. In 1949, a group of businessmen and a Catholic priest pioneered the idea of bringing alcoholics to a rural location, where the men (they were all men back then) could focus on the 12-step principles without the distractions and temptations of everyday life.

The approach became known as the Minnesota Model and was copied by other nonprofits for decades. Then, the new insurance laws in 2008 and 2010 transformed what had largely been a government-funded and charitable-minded field into an enticing for-profit business. In just a few years, that gave rise to a $35 billion industry of inpatient programs such as the one offered by American Addiction Centers.

Mr. Hill’s concerns about American Addiction Centers were not just about the debate between inpatient vs. outpatient philosophies of treatment. He told Mr. Drose about patients who had died in rehab homes around Temecula and nearby Murrieta that Mr. Cartwright later acquired.

The deaths, Mr. Hill contended, showed how the company was unequipped to deal with medically fragile addicts. Yet, Mr. Hill claimed that for years the company kept taking those patients, assuring them that they would receive adequate care.

As far back as 2008, Mr. Hill had told the California agency that oversees drug-treatment programs that he believed some patients at Mr. Menz’s facilities (ones that later became part of American Addiction Centers) were in danger. When some of the dead patients’ families later filed lawsuits against those companies, he followed every twist and turn of the cases.

He had also spent a good part of 2011 and 2012 working with Hardy Gold, a prosecutor in the state attorney general’s office who was interested in Mr. Benefield’s death. The two began trading emails discussing aspects of the investigation — emails that would later cause headaches for the prosecutor. At one point, Mr. Gold visited Mr. Hill’s office to get a tutorial on the addiction-treatment industry.

During that time, American Addiction Centers sued Mr. Hill for defamation, saying he had made false statements about its patient care. A judge dismissed the suit.

Mr. Hill kept up his attacks on American Addiction Centers. And in Mr. Drose, he believed that he had found a new way to take on the company.

Mr. Drose spent hours talking to Mr. Hill that day in Temecula. When he returned home, his backpack was stuffed with lawsuits, depositions and autopsy reports. “Damn,” Mr. Drose said he thought at the time. “I left there thinking I had stumbled across a gold mine.”

Open Beds and ‘Closing a Sale’

Mr. Drose returned to Kingsford’s offices in Atlanta, took over a glass-enclosed conference room, and made piles of documents related to each death.

None of the deaths had been disclosed to investors when the stock of American Addiction Centers began trading publicly.

The dead included Shaun Reyna, an alcoholic, who killed himself with a shaving razor in one of the company’s treatment houses. Mr. Reyna’s widow said in a 2014 lawsuit that the staff had ignored signs that her husband was suffering withdrawal symptoms that required urgent medical care. The case is expected to go to trial early in 2018.

There was also Gregory Thomas, who hanged himself from a bridge one block from the company’s main office in Temecula in November 2010. He had been brought to the office by a company employee, but never went through with the treatment.

Mr. Thomas’s body hung from a bridge for several days before anyone noticed. A judge ruled that the company wasn’t liable because Mr. Thomas had not been admitted.

But the circumstances of Mr. Benefield’s death, as detailed in a lawsuit his wife brought in 2011, stood out.

The treatment house that he ended up traveling to, A Better Tomorrow, was founded by Mr. Menz, Mr. Cartwright’s partner in American Addiction Centers. It would become a core part of the publicly traded company.

When Mr. Benefield called A Better Tomorrow in late July 2010, he was about to help the company solve a problem: a patient shortage.

There were too many empty beds, Mr. Menz had told his staff members at a monthly meeting, and they needed to fill them. The employees — who referred to signing up new patients as "closing a sale" — understood the risk of failure.

"If you're not closing," Jody Brueske, the former sales representative who enrolled Mr. Benefield would later testify in a separate case involving his death, "you're going to be the next one walking out the door."

From their kitchen in Springersville, Ariz., the Benefields did not know any of that. All they knew was that A Better Tomorrow had come up in an internet search. A former snowboarder, Mr. Benefield was so excited he even packed his gym clothes, thrilled at the prospect of getting healthy again, according to court records. Ms. Benefield declined to be interviewed; her statements primarily come from court documents.

Hope's Sudden Turn to Horror

From his first phone call to his death, Mr. Benefield's relationship with A Better Tomorrow lasted a mere two days. Compressed into those 48 hours is a case study in how financial pressures and business motivations can collide with the needs and expectations of the fragile patients who represent the industry's bread and butter.

Just days after the staff meeting led by Mr. Menz, Ms. Brueske took the call from Mr. Benefield and his wife, Kelly. His case was pretty typical — an out-of-control drinking problem that was hurting someone's marriage. But one thing set it apart: Mr. Benefield had chronic lung disease that forced him to use an oxygen tank.

Ms. Brueske had never dealt with a patient who used oxygen. But she felt that she couldn't turn anyone away, because much of her pay came from commissions, she later testified.

According to a court transcript, a lawyer grilled Ms. Brueske on that point, asking her: "Did you feel personally pressured to get more clients in because of that sales meeting?"

Ms. Brueske responded, "Yes."

Ultimately, Ms. Brueske assured the Benefields that A Better Tomorrow could provide the oxygen he needed.

In an interview, Mr. Cartwright disputed the sales rep's testimony. He said that her perception of the pressures to fill beds "did not match reality." He said the company would never promise to provide oxygen to a patient, because it would require a prescription. "If she promised that, she was out there on an island," he said.

But from the moment Mr. Benefield stepped off the plane in California, there were signs the company wasn't equipped to handle his care.

A Better Tomorrow sent a driver to pick him up at the San Diego airport. When that driver, a recovering meth addict with no medical training, got to the airport, he found that Mr. Benefield was having trouble breathing. His oxygen tank was empty.

The driver's supervisor instructed him to give Mr. Benefield a sedative called Serax, even though Mr. Benefield had not been prescribed that drug. According to a transcript of court testimony, the Serax pills were leftovers from previous patients that were simply kept in the car in case the driver needed to administer a sedative on the spot.

Mr. Menz, in an interview, said it had never been company policy to dispense drugs without a prescription, nor did the company keep leftover medicine.

The driver and other employees also testified that staff members were discouraged from taking patients to a hospital emergency room — even when they appeared to be in distress — because A Better Tomorrow might risk losing a paying customer. The feeling was, "they are taking our clients," the driver said of the hospital.

The treatment house where Mr. Benefield was taken was not a medical facility but a five-bedroom home with a two-car garage and a hot tub in the back. And the employees there did not know what to make of Mr. Benefield's behavior — they were familiar with addiction symptoms, not respiratory ailments.

The afternoon of Mr. Benefield's arrival, as he grew more distressed, the house's employees called their managers at home for guidance. One supervisor they phoned — a licensed massage therapist and marriage counselor, not a doctor — told them to administer more sedatives.

Mr. Benefield's oxygen tank remained unfilled.

That night, the employees found that Mr. Benefield had slid out of bed and was sitting on the floor. They hoisted him back into bed. When they went to check

on him again in the morning, he was dead.

As part of the testimony by Ms. Brueske, the sales rep who worked with the Benefields, she described her boss's advice after she learned of the death of her client. "You need to get thicker skin," she recalled her saying. "People die in rehab all of the time."

Mr. Drose said that he wasn't sure what to think after he reviewed the testimony and other documents. "I've seen companies screw over shareholders," Mr. Drose said. "This company seemed like it was hurting people."

An 'Abandoned or Malignant Heart'

But despite piles of documents detailing tragic deaths, it wasn't clear to him that he had enough useful material to move the stock price down, which remained his ultimate goal. After all, addiction patients die with tragic regularity.

Mr. Drose's boss at Kingsford Capital, the hedge fund where he was working, also wasn't sure what all the material added up to.

"This seems like a lot of stuff," Mr. Drose said his boss had told him as he stood among his piles of documents in the summer of 2015. "But what is really in here?"

A spokesman for Kingsford said the "firm does not comment on its investments."

Bit by bit, Mr. Drose struggled to piece together the meaning of the deaths at American Addiction Centers.

He determined — after filtering through the reams of legal filings and other documents he had collected — that the prosecutor, Mr. Gold, had taken an interest in Mr. Benefield's case. After speaking with a former police detective about what the possible charges against the company could be, he came up with a startling theory: The company could face a murder charge.

It was a wild idea. No other public company in California history had been charged with murder.

In California, second-degree murder involves someone acting with "implied" malice that reflects an "abandoned or malignant heart." While that might sound

like a legal concept straight out of Edgar Allan Poe, the theory was that the employees who gave Mr. Benefield sedatives, instead of taking him to the hospital, may have acted with implied malice.

Mr. Drose liked the sound of that. “Second-degree murder is what will destroy this company,” Mr. Drose wrote in an email to Mr. Hill. “I am sure of it.”

A Financial Killing From Others’ Misfortune

On and off in the years since Mr. Benefield’s death, a cast of characters — the empire builder Mr. Cartwright, the budding short-seller Mr. Drose, the crosstown rival Mr. Hill — had made A Better Tomorrow and American Addiction Centers a focus of their lives. Some hoped to build it up. Others dreamed of tearing it down.

Mr. Cartwright and Mr. Drose, in particular, saw fortunes to be made.

But in Mr. Benefield’s death, would a company — and by extension, an industry — be held to account? Would future patients benefit from the lessons learned from his death?

On July 21, 2015, a prosecutor charged a subsidiary of American Addiction Centers and four employees with second-degree murder in the Benefield case.

The company’s stock price fell 53 percent, erasing more than half its value in just one day.

Mr. Cartwright, vacationing in Italy, didn’t know what hit him. He called his board of directors to ask for help figuring out what to do.

One board member, the Nashville investor Mr. Burch, recently recalled his advice to Mr. Cartwright. “You can’t run away from it,” Mr. Burch told him. “There is not much you can do if someone calls you a son of a bitch, other than deny it and prove you are not. You get all the bullets you can, and fire at the enemy as quickly as you can.”

That’s exactly what Mr. Cartwright did.

First his company lawyers argued, among other things, that the official coroner’s report said Mr. Benefield had died of natural causes, but the prosecutor had relied on paid testimony from a different coroner to make a case for homicide. The lawyers got the murder charge reduced to abuse.

That was a big win. But Mr. Cartwright was just getting started.

“How do you bring a murder charge on a five-year-old, natural-cause death?” Mr. Cartwright said recently. “It makes no sense.”

Looking for answers, two private investigators were sent to interview Mr. Drose in Atlanta. Only then did Mr. Cartwright discover how all his enemies fit together.

Mr. Drose said that he had guessed that a murder charge might be coming — well before the actual charge was made public.

This gave Mr. Cartwright powerful new ammunition in his court battle: He didn’t believe Mr. Drose had merely guessed. He suspected someone had leaked confidential grand jury information to an investor in a position to make a financial killing.

“I think the charge was brought to make money,” Mr. Cartwright said in the interview earlier this year. “Can I prove it? No.”

Presented with that argument, the judge said that Mr. Gold, the prosecutor, appeared to have a conflict because of his relationship with Mr. Hill, but that it was not enough to unfairly influence the case. But by then, it was June 2016, almost six years since Mr. Benefield’s death. Two key witnesses had died and the case was running out of steam. Ultimately, American Addiction Centers agreed to pay a $200,000 fine and allow a monitor to oversee its operations in California.

In a statement, a spokeswoman for the California attorney general’s office emphasized that “the judge concluded that any connection between Mr. Gold and Mr. Hill did not create a likelihood of unfairness to the defendants in the case.”

The unprecedented murder case against a company, which would have sent a message to American Addiction Centers — and, by extension a desperately needed but poorly understood industry — had fizzled out.

‘One Man’s Trash Is Our Treasure’

Today, Mr. Cartwright is still angry that his company had to fight off what he considers an unfair attack. The stock price is hovering around a quarter of its peak value, diminishing his personal wealth.

But American Addiction Centers is growing again. In September, it bought a treatment company with a 114-bed hospital in Massachusetts. As part of the deal, it also acquired several toll-free numbers to generate referrals, including 1-800-ALCOHOL.

And he points out that while the care at American Addiction Centers has evolved since Mr. Benefield's death, the resulting court fight did not prompt him to alter his treatment practices. "Why would I change policies and procedure because of someone dying of a heart attack at 3 o'clock in the morning?" he said.

His persistent critic, Mr. Hill, worries about what he considers the industry's sorry state and the quality of addiction treatment. "It is going to take turning the field upside down," he said. But he has also moved on, buying a place in Mexico where he enjoys swimming with dolphins. One day he hopes to retire there.

Christopher Drose's work earned him a spot on Forbes magazine's "30 Under 30" list of up-and-coming young investors. Today he works for a new hedge fund in New York doing what he loves: digging up dirt on companies, and betting against them.

"Some part of me likes to see people who are not telling the truth come face to face with it," Mr. Drose said. "I've found a way to express that with stocks."

American Addiction Centers has estimated that short sellers walked away with $250 million because of Mr. Benefield's death and the murder charge against the company. Mr. Drose called that number overstated but declined to say how much money he made.

In 2015, Kingsford Capital sent out a holiday letter detailing its investment successes, which mentioned the murder charge involving American Addiction Centers. In the letter, the firm summed up its strategy that year as finding "gifts from garbage."

"One man's trash," Kingsford Capital wrote, "is our treasure."

Today in America, overdoses claim more lives than guns. Yet as the addiction crisis deepens, patients and their families are still struggling to sort out the most effective forms of treatment offered by the sprawling industry.

Mr. Benefield, a bear of a man with a big drinking problem, had pursued his hope of getting well. His wife, Kelly, was left to settle a civil wrongful-death lawsuit against the company that they had hoped would help him.

On Facebook, years after he died, Ms. Benefield wrote, "I miss him so much."

Correction December 27, 2017

An earlier version of this article misstated the number of years since Gary Benefield's death. Mr. Benefield died seven years ago, not 11.

IN THIS SERIES

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Inside The $35 Billion Addiction Treatment Industry

Dan Munro Contributor
Pharma & Healthcare
I write about the intersection of healthcare innovation and policy.

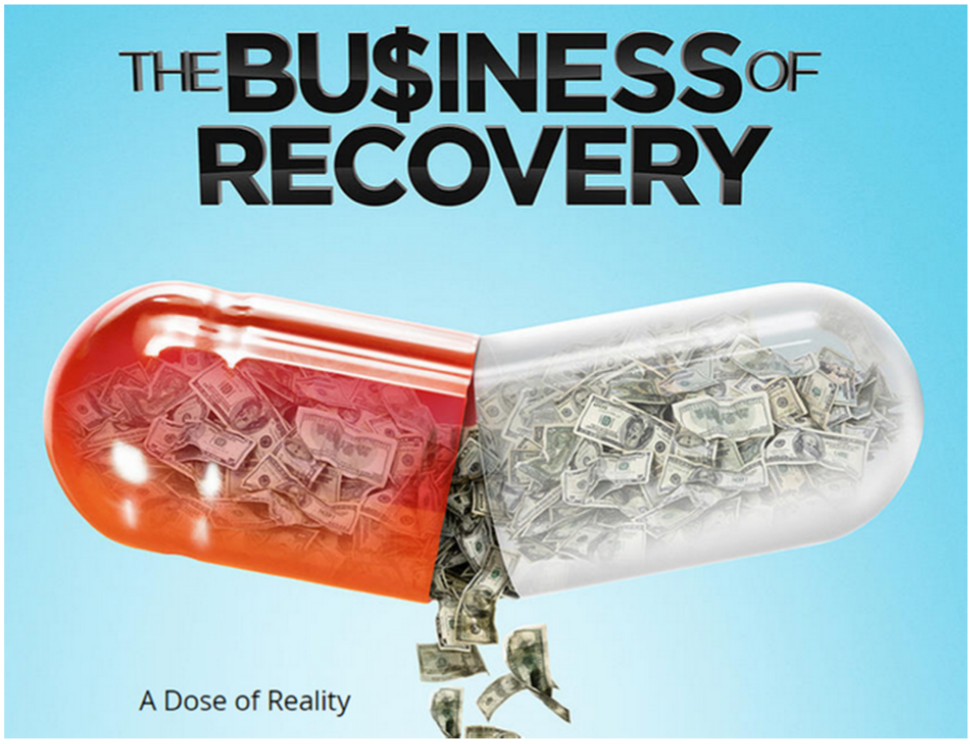
The National Council on Alcoholism and Drug Dependency estimates that over 23 million Americans (age 12 and older) are addicted to alcohol and other drugs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), just under 11% (2.5 million) received care at an addiction treatment facility in 2012. SAMHSA also estimates that the market for addiction treatment is about $35 billion per year.

The vast majority of addiction treatment is based either partially or entirely on the 12 Steps of Alcoholics Anonymous (AA), but is there scientific evidence to support AA as a clinical treatment? Should addiction treatment centers make enormous profits by simply funneling substance abusers into the free fellowship of AA?

These are the primary questions behind The Business of Recovery – a new documentary that opened earlier tonight at the Newport Beach Film Festival. Like many documentaries, there are some startling statistics – including this provocative one delivered early in the 81-minute film.

> *I became the Director of the Alcoholism Treatment Unit at Harvard's McLean Hospital. I've probably treated a couple of thousand people who have one addiction or another. Almost all residential treatment programs in the United States are 12 Step based, so their effectiveness will depend entirely on whether 12 Step programs work and the statistics for AA are not good. It is helpful for 5O10% and that's a good thing. That's 5O10% of people*

who are being helped by A.A. Oit's a lot better than zero percent Obut it shouldn't be thought of as the standard of treatment because it fails for most people Ofor the vast majority of people. **Lance Dodes**, MD – Addiction Expert & Author – Harvard Medical School Graduate in The Business of Recovery



As a part of the annual film festival in Southern California, the film is being shown again Tuesday evening and the producers are working toward a broader, public release later this year. The critical assessment of addiction treatment is both timely and sobering.

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> *12 Step programs are very popular, but if you're looking for figures and randomized trials and scientifically rigorous studies of how they work and for how many people they work* O*you will not find those studies. You will find anecdotal evidence* O*for people that it did work [for]* O*but unfortunately we don't have the scientific basis to say how many of all those people that tried a 12 Step program* O*how many of those did not succeed.* **Ruben Baler** – Health Scientist, National Institute on Drug Abuse in The Business of Recovery

The film is timely because the market does seem poised for accelerated growth based on a number of key attributes.

1. A real–estate component that can easily scale to any size – including the private, single family residence (called "sober living homes" Oby one estimate over 10,000 in Arizona alone).
2. Freshly minted federal mandates for payment parity with other chronic or acute health conditions like cancer or diabetes.
3. Almost no federal, state or municipal oversight for credentials or treatment pricing.
4. Advertised success rates of 80% (or higher) with no scientific evidence.

This last one is the most troubling since addiction is often couched in clinical terms like "disease" and "treatment." The AMA first defined alcoholism as an illness (1956) and then a disease (1966), but there's little scientific evidence to support a disease diagnosis. That also makes it challenging to categorize any program based on the 12 Steps of AA as clinical treatment – even if there is a billing code.

> *AA is not really a treatment* O*it's a fellowship. If you go to your doctor to be treated for cancer or heart disease you expect your doctor to be doing what the science says is the best treatment available for what you have. That has not been the standard in addiction treatment.* **William R. Miller**, PhD – Emeritus Distinguished Professor University of New Mexico in The Business of Recovery

Two events last year (not included in the documentary) also signal a healthy and growing commercial industry.

The first was the merger between two iconic treatment brands – the world-renowned Betty Ford Center and Hazelden (founded in 1949). The combined non–profit entities are now simply the Hazelden Betty Ford Foundation. As with many non–profits, there are no outside investors to satisfy, but the salaries of key execs are often in the high six–figures (and well above averages for even practicing physicians – any specialty).

The second event was the IPO last fall of AAC Holdings, Inc. – which is really the first attempt at a publicly traded company exclusively for addiction treatment (the AAC stands for American Addiction Centers). The quoted price range for a 30-day "treatment plan" (again – revolving largely around AA) was $15,000 to $26,000. The Hazelden Betty Ford Foundation is easily twice that amount and other, more exotic treatment facilities (often catering to celebrities in swank resort–style locations) can easily run into the low six–figures.

As a publicly traded company – something that Betty Ford and Hazelden have both intentionally avoided – AAC has already hit some significant headwinds in the form of accusations, short–sellers and legal scrutiny. One of the reasons is that a sizable source of high–margin revenue appears to be urine testing which can be used in high–volume and is relatively easy to game for serial revenue and profits.

> *On March 3, 2015, SeekingAlpha published an article asserting, among other things, that AAC Holdings: (i) conducts unnecessary urine drug tests that contribute to its outsized margins; and (ii) lowered its provision for doubtful accounts after acquiring a revenue management company from its CEO and president's spouses, which boosted its net income before its IPO. On this news, shares of AAC Holdings fell $3.54 per share or over 10% from its previous closing price to close at $30.37 per share on March 3, 2015, damaging investors.* The Rosen Law Firm (announcing its investigation into potential securities claims on behalf of investors)

The lack of certification also supports a very low barrier to becoming an addiction treatment counselor.

> *There is no mandatory national certification exam for addiction counselors. The 2012 Columbia University report on addiction medicine found that only six states required alcohol and substance-abuse counselors to have at least a bachelor's degree and that only one state, Vermont, required a master's degree. Fourteen states had no license requirements whatsoever Onot even a GED or an introductory training course was necessary Oand yet counselors are often called on by the judicial system and medical boards to give expert opinions on their clients' prospects for recovery.* **Gabrielle Glaser** – The Irrationality of Alcoholics Anonymous (The Atlantic)
>
> *So we developed this history of providers being people who are themselves in recovery Ooriginally with no educational requirement at all. In New Mexico, we now have a Bachelors degree required to be a substance abuse counselor and it was quite controversial to do that. I don't know of any other lifeOthreatening illness where it's controversial if you should have a college education to treat it, but it has been in the addiction field.* **William R. Miller**, PhD – Emeritus Distinguished Professor University of New Mexico in The Business of Recovery

Even the judicial system contributes to the confusion by often mandating AA attendance to offenders who arrive in court as the result of criminal charges associated with substance abuse (most commonly driving under the influence).

> *It is completely inappropriate and dangerous for courts to be mandating AA treatment. This amounts to malpractice. It's medical malpractice by the judge. It's as foolish as if the judge said to you 'ok Oyou have an infection OI mandate that you take penicillin because I believe that's the effective drug.* **Lance Dodes**, MD – Addiction Expert & Author – Harvard Medical School Graduate in The Business of Recovery

Outside of AA, newer alternatives are also gaining broader awareness, acceptance – and real scientific evidence of efficacy (JAMA meta–analysis here).

> *I made the documentary One Little Pill to help spread awareness about a treatment for alcoholism that literally saved my life. It's called the Sinclair Method and it's based on using the FDA approved generic drug naltrexone to create an effect known as pharmacological extinction. The success rate is very high Onearly 80%. I also started a nonOprofit called the C3 Foundation as a more direct way to help people find the clinical information and doctors that support the use of this life saving treatment.* **Claudia Christian** – Actress

New drugs will also challenge the conventional wisdom around AA being the primary – often only solution to substance abuse. There is also the very real possibility that AA is not helping people with other mental or behavioral disorders that can be easily masked by substance abuse. The AA mantra of "more meetings" could well be counterproductive to many who arrive at the fellowship with a wide range of psychological, behavioral and other clinical issues.

Ultimately, whether AA is scientifically effective – for whom and how many – is a secondary issue. No one argues that it has helped to destigmatize substance abuse and it definitely helps some. Unlike for-profit treatment plans, however, AA has never had fees or dues of any kind since its inception in 1935 – and likely never will. The real issue then is a $35 billion a year industry that's largely based on funneling substance abusers into the free fellowship of AA – or simply providing large doses of AA meetings themselves.

To be sure, there's a lot of hand–waving, glitzy marketing and pseudo–science to justify the enormous cost associated with treatment plans, but little proof of scientific efficacy. Court mandated attendance isn't profitable, of course, but it does legitimize the process of funneling people into A.A. in ways that also benefits the industry at large.

As highlighted through several tragic stories in the documentary, family members are naturally eager to spend whatever money they have – and often money they

don't have – in desperate attempts to save loved ones from the harsh realities of substance abuse and addiction. Preying on this strong desire is the very real and profitable business of recovery – and one that the documentary exposes with clear–eyed and sober detail. I do hope the film finds a way to a larger public audience. There's still so much we don't know about substance abuse and addiction – except – at least according to one compelling film – how to turn it into a very lucrative business.

Also on Forbes:

Gallery: The Best Jobs In Healthcare In 2015

APPENDIX D

Letter from Providers to Governing Bodies re: BDC

BDC Response to Letter

July 16, 2018

Dear Sir or Madam:

We are writing to you as a concerned group of providers to address the recent licensure of a group of treatment centers in the State of Maryland. In addition, we would like to work with you to establish state-wide communication and a working group to put formal guidelines around licensure.
While we are focused on increasing access to care, we want to ensure that we do not sacrifice ethics and quality for access.

Of immediate concern is the ongoing Certificate of Need and licensure request for the Baltimore Detox Center. This interconnected organization has already obtained licensure for "Florida Model" sober homes and outpatient treatment in Maryland and is now seeking a Certificate of Need (CON) to provide detoxification services. We are deeply concerned that licensure for a detoxification level of care - which carries the risk of death - may be issued to a provider that has been proven to walk a very thin between non-compliance, fraud, and potential criminal behavior in other states.

In addition to the above, we would like to request an investigation into the licensing of Fresh Start Recovery Center, Foundations Recovery Center and the unlicensed MD Recovery Homes. These facilities have a strong connection with shared ownership and operating personnel through a parent company named Amatus Health Group with the Recovery In The Light (RITL) and Coconut Grove Recovery facilities in Florida. See Attachment 1 which provides a print screen of Amatus Health's website listing its facilities including (1) Foundations Recovery Center, (2) Fresh Start Recovery, and (3) More Life Recovery. Of note, the entity for MD Recovery Homes, LLC is registered and owned by the same individual who self-identifies as the Operations Manager of the RITL facility in Florida and an owner of Baltimore Detox Center as well as a founder of Amatus Health. Attachment 2 provides screenshots of Amatus Health's website listing its team members. Attachment 3 provides screenshots which show this connection.

RITL and Coconut Grove Recovery facilities have been under investigation by local news outlets in South Florida for various violations, including referring patients to sober homes that were not certified by the Florida Association of Recovery Residences (FARR) as required for a licensed treatment center to legally refer patients. See Attachment 4. Since the release of this information, RITL has closed its doors and Coconut Grove Recovery resolutely rebranded its outward facing brand as "More Life Recovery". See Attachment 5. It is possible that Coconut Grove Recovery maintains its Florida state licensure through this DBA as an effort to avoid public and governmental scrutiny. RITL and More Life Recovery share the same address in Hollywood, FL. See Attachments 6 & 7 showing the shared address of 5001 Hollywood Blvd, Hollywood, Florida.

Most egregiously, RITL has been named as a defendant in a civil suit claiming it used a physician's information to fraudulently bill for urinalysis services while clients were under treatment. See Attachment 8 - Ligotti vs. United HealthCare Services:

- Page 8 – *"Dr. Ligotti never authorized the use and disclosure of his personal information on claims for reimbursement to United form any substance abuse treatment facility or sober living home"*
- Page 45 Paragraph 231 – *"Recovery In The Light intentionally made statements and submitted fraudulent claims alleging a false relationship with Dr. Ligotti"*

- Page 45 Paragraph 242 – *All charges violating Florida Statute 483.201*

RITL allegedly utilized Dr. Michael Ligotti's License to submit fraudulent claims.

In addition to the above, it has come to our attention that Foundations Recovery Center has allegedly retained an individual named Josh Fischer for patient acquisition. Josh is the operator of a non-profit Maryland corporation named "Hope Dealer Foundation". This non-profit operates a website and Facebook support group that people suffering from addiction look to for treatment resources. See http://www.hopedealerusa.org/ and https://www.facebook.com/groups/iamahopedealer/about/. Foundations Recovery Center allegedly pays Josh Fischer a fee or retainer potentially to screen and route inquiries from the non-profit organization to Foundations Recovery Center and Fresh Start Treatment Center. These relationships can result in a form of patient brokering as documented in The Verge's May 21, 2018 article *Predatory Behavior Runs Rampant in Facebook's Addiction Support Groups*). See Attachment 9.

The application for the CON by Baltimore Detox references a letter of community support from Lynn Fowler Miller. Lynn is a self-proclaimed "mom advocate" in Maryland for people seeking substance use treatment but has been identified in an article claiming a number of reportedly questionable practices See Attachment 9 and 10.

We have recently met with State Senator Brian Feldman who has taken a significant interest in protecting consumers receiving addiction treatment. Senator Feldman is a member of the Maryland State Senate Health Subcommittee and has expressed to be in attendance to all meetings regarding this matter. Senator Feldman has also expressed interest in introducing legislation for the next legislative session regarding patient brokering and other laws that will protect consumers moving forward.

In closing, we feel that information provided in this letter warrants an investigation to protect the health, safety, and standards in the State of Maryland. The ongoing licensure of these facilities and the current CON request advance a high level of risk to a population of individuals that have special needs and deserve high quality, effective care. We respectfully request that the Behavioral Health Administration commence an investigation into Fresh Start Recovery Center and Foundations Recovery Center. We also respectfully request that the Maryland Health Care Commission commence an investigation into the CON request for Baltimore Detox Center regarding these matters.

Sincerely,

Sam Bierman

CEO

Maryland Addiction Recovery Center

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Director of Operations

Delphi Behavioral Health Group

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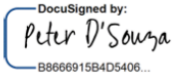

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August 30, 2018

VIA PDF & U.S. 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 the response of the Baltimore Detox Center ("BDC") to the July 16, 2018 correspondence from Mr. Sam Bierman, CEO, Maryland Addiction Recovery Center and other substance abuse providers (the "Providers") sent to the MHCC dated July 16, 2018. BDC understands that this correspondence is in the record despite the fact that the Providers have not sought or obtained interested party status consistent with the requirements set forth at COMAR 10.24.01.08 Procedure for Review of Applications. BDC is compelled to respond to this correspondence to assure that the record does not contain any unanswered false or misleading documentation.

Provided below please find the brief factual responses to the unfounded accusations and false statements made by the Providers. Of course, BDC assumes that the Providers submitted their comments in good faith in the interest of quality health care. With that said, it appears that the Providers have failed to conduct even a minimal level of due diligence. This minimal attention to the truthfulness of their statements does seriously concern BDC. In any event, the comments provided below are intended to assure that the record is accurate.

The Providers state that their concern is that a license may be issued to "a provider that has been proven to walk a very thin [?] between non-compliance, fraud, and potential criminal behavior." This statement, in addition to being unfounded (in particular because nothing has been proven), is both factually inaccurate and defamatory. First to be clear, BDC is a new entity which has not provided services in Maryland or elsewhere. With respect to "related entities" (common or overlapping ownership), the Maryland providers Fresh Start Recovery Center and Foundations Recovery Center are licensed and accredited and have had no compliance issues.

Moreover, the out of state entities are licensed and accredited and have had no compliance issues. There is not and have never been any allegations of fraud or criminal behavior by any government agency with respect to any of these providers.

With respect to the allegations about the Florida facilities, first there is no reason to respond to allegations about "investigations by local news outlets in South Florida". BDC would rather focus on the facts. Michael Silberman (an owner of Amatus Health and BDC) did have an ownership interest in Recovery in the Light ("RITL"). The only "compliance issue" was that RITL made referrals to a sober home with common ownership which was not certified by the Florida Association of Recovery Residences ("FARR") for a period of approximately 1½ months.

RITL voluntarily shut its doors August 2017; a decision which was made after several payor audits (which were being conducted statewide). Those audits did not result in any claims being made against RITL but the burdens of those audits and the associated business costs resulted in RITL not being financially viable. Once RITL closed its doors, the principals determined to do a major overhaul with staff and rebranding. Coconut Grove Recovery did rebrand (and file a d/b/a as More Life Recovery). There have been no governmental audits or allegations accusing Coconut Grove/More Life Recovery of fraud or criminal behavior. The Providers state "It is possible that that Coconut Grove Recovery maintains its Florida state licensure through this DBA as an effort to void public and governmental scrutiny." This last statement is another inflammatory and totally unfounded statement and an example of the Providers' lack of business understanding about a d/b/a and rebranding.

The Providers then go on to maintain that "[m]ost egregiously" RITL has been named as a defendant in a civil law suit claiming it used a physician's name to fraudulently bill for urinalysis services." A minimal amount of due diligence would have revealed to the Providers that per the attached Notice of Dismissal, RITL was dismissed from that lawsuit with prejudice; because the claims made in the lawsuit were based on billed charges for services provided prior to RITL even being in business.

With respect to allegations about Josh Fischer being retained for "patient acquisition", Mr. Fischer no longer works for Foundations Recovery Center or a related entity. He worked for Foundations Recovery Center as an outreach coordinator for several months and was paid a fixed salary. Mr. Fischer never engaged in "patient acquisition" or "patient brokering" on behalf of Foundations or any related entity.

Last, there is a stated concern that a "Mom advocate" supports the BDC application. It is impossible to understand why that would raise a concern.

We look forward to the completion of the review and docketing by the MHCC of the BDC CON application submitted on March 23, 2018. Of course, BDC and its related Maryland providers would be happy to participate in any legitimate working groups within the State to

assure that Maryland residents are protected and have access to high quality substance abuse treatment services.

Sincerely,

Carolyn Jacobs

CJ:arh
Attachment

cc: Ruby Potter

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APPENDIX E

Affirmations

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

December 14, 2018
Date

Signature of Owner or Board-designated Official

Director of Corporate Business Development
Position/Title

David Stup
Printed Name