January 18, 2019

Via FedEx 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 Modified CON Application for Baltimore Detox Center Docket No. 18-03-2419 that was submitted on January 10, 2019.

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
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Linthicum, MD 21090
david@delphihealthgroup.com

Interested Party Comments by Maryland House Detox, LLC on the Modified CON Application of Baltimore Detox Center in Response to MHD's Interested Party Comments

Pursuant to COMAR 10.24.01.08(E)(3)(a)(ii), MHD submits the following response to BDC's Modified Application submitted on January 10, 2019.

MHD's presentation that the proposed project by BDC fails to comply with numerous CON review criteria has been exacerbated, and affirms its opposition to the approval of the CON application. Pursuant to COMAR 10.24.01.08(F)(2)(a)(ii), BDC has failed to meet the enclosed standards in COMAR 10.24.01.08(G)(3) in its Modified Application in response to MHD's Interested Party Comments.

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 that defines BDC's application process clearly raises more questions than provides answers and should alarm Maryland's governing bodies and industry professionals. BDC again clearly fails to meet the burden of proof for these standards in its Modified Application and should by denied a CON.

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.

Disqualifying Definition of Intermediate Care Facility

Through application of its own language, staffing plan, CON table package, and accompanying calculations, BDC has submitted a fatally flawed CON application. BDC has provided information that conflicts with its own previous and current submissions; and with COMAR and the State Health Plan's definition of an Intermediate Care Facility. Under COMAR 10.63 and previously 10.47, all ASAM 3.7 level services (including 3.7WM and 3.7) are considered under the umbrella of an ICF, over which MHCC has jurisdiction and for which BDC has submitted its application for approval. Either BDC does not understand how to apply the regulations that govern it or it has simply submitted inaccurate information to MHCC. To distinguish the terms used throughout this response:

- ASAM level 3.7WM is defined by ASAM as "Medically-Monitored Inpatient Withdrawal Management Services"[1], by the State of Maryland as "Medically-Monitored Residential Withdrawal Management"[2], and by Maryland's BHA CARF Reference Grid as "Inpatient Treatment/Detoxification/Withdrawal Management"[3].

[1] https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care
[2] COMAR 10.63.03.18 http://www.dsd.state.md.us/comar/comarhtml/10/10.63.03.18.htm
[3] CARF is the accrediting organization BDC has identified from which it will seek accreditation. Reference Grid is attached in Appendix A.

- ASAM level 3.7 is defined by ASAM as "Medically-Monitored Inpatient Services" [1], by the State of Maryland as "Medically-Monitored Intensive Residential"[4], and by Maryland's BHA CARF Reference Grid as "Inpatient Treatment" [3.]
- ASAM level 3.5 is defined by ASAM as "Clinically Managed High-Intensity Residential Services"[5], by the State of Maryland as "Residential-High Intensity"[6], and by Maryland's BHA CARF Reference Grid as "Residential Treatment"[7].

MHCC confirmed that residential services outside of the 3.7 level services will not be considered in a CON review. In an August 3, 2015 determination of non-coverage issued during the CON review of RCA-E Docket No. 15-07-2363, Executive Director Ben Steffen confirmed that "[t]he Maryland Health Care Commission has determined that [the] definition [of intermediate care facilities] corresponds to the subacute 'inpatient' level of care and services in the American Society of Addiction Medicine's Patient Placement Criteria [("ASAM")]. This would include Level III.7, medically-monitored intensive inpatient treatment and Level III.7- D, medically-monitored inpatient detoxification services." Thus, an "intermediate care facility" does not encompass residential services below the 3.7 level.

Throughout its application process, and continuing through its response to MHD, BDC has proposed interchangeable names, descriptions, lengths of stay, census, and admissions figures for the "residential" portion of their application. BDC has conflated the term "residential" to either mean 3.7 services or the "residential" services listed in the tables it provided under its modified application. It can very reasonably be deduced from BDC's language, tables, LOS assumptions, and decreases in staffing concentrations that it intends for patients to step down from either 3.7WM or 3.7 level services into the "residential" level of care, that the "residential" level of care highlighted in these tables is a less intensive level that (usually ASAM 3.5 or lower – and licensed in Maryland as such) and does not fall under the definition of an ICF and subsequent jurisdiction of MHCC. BDC has included these services in its narrative to be considered for approval under a total of 24 ICF beds, but it has not included these services in its subsequent tables, modified calculations for admissions and staffing, and related budgets.

According to the tables below submitted by BDC under its modified application, BDC only proposes that it will have 2,750 patient days, an average LOS of 10 days, and an average daily census (ADC) of 8 in the 10 beds designated as an ICF (3.7 and 3.7D) – which is the only portion that falls under the jurisdiction of MHCC.

[4] COMAR 10.63.03.14 http://www.dsd.state.md.us/comar/comarhtml/10/10.63.03.14.htm

[5] https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care
[6] COMAR 10.63.03.13 http://www.dsd.state.md.us/comar/comarhtml/10/10.63.03.13.htm
[7] CARF is the accrediting organization BDC has identified. Reference Grid in Appendix A.

BALTIMORE DETOX CENTER

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

3.7 and 3.7D separate from "Residential"

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

3.7 and 3.7D separate from "Residential"

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

3.7 and 3.7D separate from "Residential"

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

3.7 and 3.7D separate from "Residential"

It appears as though BDC does in fact only plan to treat an average of 8 patients per day in 3.7 level services. BDC has contradicted itself in requesting 24 beds, has not provided a sufficient explanation of the "3.7 residential" services, and should clearly be denied its request for 24 beds.

BDC's modified application states:

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

It is in this statement that BDC confirms that it's staffing plan is only designed for an average daily census of 8, not the 24 that is has applied for. This remains true throughout its modified application even though BDC uses the term "residential" in its narrative to describe 3.7 care provided (distinguished from 3.7WM by BDC).

Disqualifying Length of Stay Assumption

BDC's assertion that its average LOS is 28 days is in direct conflict with the SHP and MHCC. The SHP holds that the average LOS for an ICF is calculated at 14 days (COMAR 10.24.14.07(B)) and MHCC confirms that the only accurate LOS calculation for ICF services (3.7 and 3.7WM) is 14 days in its CON Staff Report on RCA-E Docket No. 15-07-2363[8]. BDC's 28-day assertion also contradicts widely accepted LOS for the 3.7 and 3.7WM levels of care within the SUD treatment field and. BDC bases its entire modified staffing plan and operating budget on an assumption that contradicts state law and all known SUD treatment authorization LOS – effectively disqualifying BDC's application as fatally flawed.

MHD reports an average LOS in 3.7WM of 6.03 days. Ashely Father Martin's Ashley reports an average LOS in 3.7WM of 4.24 days in its Interested Party Comments to RCA-E Docket No. 15-07-2363. BDC seems in some respects to contend that its 3.7WM and 3.7 levels of care will operate interchangeably (from tables and calculations it has submitted), and in other respects that the 3.7 level of care will follow the 3.7WM level to provide the subsequent "residential" days. By continuously providing for a 28 day LOS in its narrative, BDC contends that it will only treat a total of 275 patients per year. According to all accounts in BDC's charts, these patients should equate to 2,750 bed days per year in the actual ICF beds. This directly contradicts BDC's claim that its ICF will have a total of 7,700 bed days (see Patient Days Table above) in its ICF beds. BDC's bed days for its ICF and subsequent CON application should only entail the 2,750 it admits it has planned for. This remains problematic, though, as an average LOS of 28 days is the foundation upon which BDC's total patient day and discharge numerations are built. BDC's Modified Application relies on this assumption as its core tenent. All subsequent calculations and narratives should be rejected at face value as an absolute contradiction of all accepted practices, knowledge, and the letter of the law contained in the SHP.

To further support the conclusion that BDC has submitted an application that is fatally flawed, BDC again only proposes 10 beds to be licensed as 3.7 and 3.7WM in Table C of its modified Application Table Package. This would be consistent with earlier the proposals relating to total number of discharges, bed days, LOS, and ADC. BDC contends that its staffing plan and its related budget is designed for these ICF patients and these patients only.

[8]http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2016_decisions/con_rca_earleville_2363_decision_2011202.pdf

TABLE C. STATISTICAL PROJECTIONS - ENTIRE FACILITY	2019	2020	2021	2022
4. NUMBER OF LICENSED BEDS				
a. Residential	14	14	14	14
b. III.7 and III.7D	10	10	10	10
h. Other (Specify/add rows of needed)				
TOTAL LICENSED BEDS	***24***	***24***	***24***	***24***

3.7 and 3.7D separate from "Residential"

In a direct admission of this fact, BDC's modified application states:

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

BDC will discharge 275 patients following an average length of stay of 28 days which represents an average of between five and six new patients per week. See chart below. This projected volume of patients is well within the capabilities of the proposed workforce of BDC.

In an attempt to justify its modified staffing plan, these statements and charts confirm that BDC has only planned to provide staffing for ICF services to 7-8 patients per day in 10 beds, not the 24 it has applied to do so. In conflating the definitions of "residential" services, BDC has confused itself as to what actually falls under the definition of an ICF and how many ICF beds it will actually be operating.

In its confusion, an additional critical flaw occurs when it considers the revenue for these "residential" services as a part of the revenue for the ICF services. In Table D of its Modified Application, total revenue for all years indicates that BDC calculated its revenue based on total patient days of approximately 7,700 and not the 2,750 it designates for ICF. A detailed discussion of this substantial miscalculation will follow in the section dedicated to financial viability.

COMAR 10.24.14.05(M): Sub-Acute Detoxification

BDC's statement that MHCC should "disregard the comments of MHD" regarding staffing is false in and of itself because BDC did in fact only modify its application to account for additional staff only as a response to MHD's interested party comments that highlighted its deficiencies. BDC then sought to clarify its staffing plan further to indicate that the staffing plan is sufficient for treating on average 8 patients in an ICF bed with the remainder to be treated in "residential" services. BDC states:

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

While the proposed staffing pattern may be sufficient in theory if BDC intends to operate 10 ICF beds, BDC has not provided any explanation or narrative as to how the modified staffing pattern it has submitted will provide the coverage necessary to meet Maryland's regulations and industry best practices. BDC continues to approach this with minimal concern.

Even if BDC intended for the additional 14 "residential" beds to be considered as a part of the ICF it is applying for, it must meet COMAR 10.63.03.14(A)(4) and (5) that states that a 3.7 level of care "*meet[s] the requirements for withdrawal management services as outlined in Regulation .18 of this chapter."* COMAR clearly states that 3.7 level services should be staffed in accordance with 3.7WM levels. MHD does not agree that BDC's staffing plan would be sufficient for an ADC of 21 and total bed count of 24 and presents that it is relevant to highlight BDC's attention to patient care when BDC continues to support a staffing plan that only provides 6 nurses, 1 full time medical provider, and 1 full time therapist for 24 patients in any inpatient or residential setting.

MHD maintains its contention that BDC is understaffed to perform at any of these levels. Particularly, BDC fails to meet the COMAR standard 10.63.03.14(C)(3) that medical providers "be available to provide onsite monitoring of care and further evaluation on a daily basis." 1 medical director and 1 contractual medical provider cannot provide the level of service required by regulation. This does not take into account the level of medical, clinical, and support service required by best practices and industry standards as discussed by MHD in its Original Interested Party comments. BDC only added one Case Manager to non-medical staff in its modified application. For a caseload of 24 patients, BDC plans for its 1 therapist and 2 case managers to complete the duties and functions of both therapists and case managers. State regulations call for a patient to therapist ratio of 1:8 and industry best practices call for a patient to case manager ratio of 1:8. Rather than create a staffing plan that meets these standards, BDC proposes that these positons could and should actually perform the duties of 2 full time positions simultaneously. These duties would require each staff member to assess, plan, facilitate, and coordinate care and discharge plans for 8 patients as a case manager while simultaneously conducting group sessions for 36 hours per week, conduct all individual sessions for 8 patients, conduct all family sessions for 8 patients, and complete documentation in the medical record. This is an impossible and unrealistic task.

It is clear that BDC does not meet the standards of COMAR 10.24.14.05(M) for 24 patients. BDC should not be granted a CON for 24 beds at the ICF level, as it has demonstrated it does not cannot apply the standards, best practices, and staffing levels to operate 24 ICF beds.

COMAR 10.24.14.05(J): Transfer and Referral Agreements

BDC 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. Subsequently, BDC does not have agreements with Track One providers for transfers from its ICF. BDC did not provide agreements that satisfied the spirit of this standard or MHCC's requests, hence the list provided below with comments from MHD:

Northwest Hospital – BDC's Transfer and Referral Agreement with Greater Baltimore Medical Center does not indicate any title or name of the party that has signed it.
Local Community Mental Health Center – The public record does not indicate that BDC has submitted the referral agreement from PsychNP Wellness Center.
Baltimore County's Mental Health and Alcohol and Drug Abuse Authorities Center – The public record does not indicate that BDC has submitted any referral agreement to this end.

In response to BDC's comparison to MHD's transfer and referral agreements – MHD's agreements were relevant for the Track One population it serves. The relevancy of referral agreements is particularly important because BDC lacks the relevant Track One providers to refer to and from. BDC should not be puzzled by MHD's comments, as BDC has not addressed its lack of transfer and referral agreements from Track One provides when it is proposing to operate a Track One facility. Although BDC's list of transfer and referral agreements may be many, it does not contain resources that can reasonably be described as "extending or complimenting" its care of Track One patients. The SHP would not bifurcate between tracks of facilities marked by public and private payors if it were not a relevant concern. Contrary to BDC's claims, MHD's transfer and referral agreements were relevant in content and quality, rather than measured in quantity from entities representing a separate track of payor.

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

Financial Viability

BDC states in its modified application:

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

This is a false statement. BDC submits revenue attributed to 24 beds covering 7,700 bed days with expenses (and related staffing plan) attributed to 10 beds covering 2,750 bed days. As discussed above, BDC's application is inherently flawed because it considers the revenue for "residential" services as a part of the revenue for the ICF services. BDC's staffing plan and related expenses only account for the care of 10 beds.

In Table D below from BDC's Modified Table Package, total revenue for all years indicates that BDC calculated its revenue based on total patient days of approximately 7,700 and not the 2,750 that should be designated for ICF (right column). BDC submits the assumption that Inpatient Revenue is calculated at $1,108 per day and assumes an Allowance for Bad Debt at 30% of Gross Revenue. MHD has provided a calculation of revenue based on the 2,750 bed days BDC

has produced staffing levels (left column) for with a side-by-side comparison proposed BDC calculations.

Indicate CY or FY	2022 **Corrected 10 Beds/2,750 Patient Days**	2022 **BDC Proposed 24 Beds/7,700 Patient Days***
1. REVENUE		
a. Inpatient Services	$3,047,000	$8,531,600
b. Outpatient Services	N/A	N/A
Gross Patient Service Revenues	***$3,047,000***	***$8,531,600***
c. Allowance for Bad Debt	$914,100	$2,559,480
e. Charity Care	$457,050	$1,279,740
Net Patient Services Revenue	***$1,675,850***	***$4,692,380***
f. Other Operating Revenues (Toxicology - U/A)	$540,000	$540,000
NET OPERATING REVENUE	***$2,215,850***	***$5,232,380***
2. EXPENSES		
a. Salaries & Wages (including benefits)	$2,538,865	$2,538,865
b. Contractual Services	$117,000	$117,000
f. Project Depreciation (60 months)	$55,450	$55,450
i. Other Expenses (See TABLE D.1.)	$1,800,171	$1,800,171
TOTAL OPERATING EXPENSES	**$4,511,486**	**$4,511,486**
3. INCOME		
a. Income From Operation	**$(2,295,636.37)**	**$720,893.63**
b. Non-Operating Income		
SUBTOTAL	**$(2,295,636.37)**	***$720,893.63***
c. Income Taxes		
NET INCOME (LOSS)	**$(2,295,636.37)**	***$720,893.63***

BDC's application is fatally flawed. If it applies for the 2,750 patient days (10 beds) it suggests it actually needs in its Modified Application, it is not financially viable.

Additionally, BDC cannot develop viable LOS and patient day calculations, a related robust staffing plan, and subsequent budget that meet the requirements of COMAR 10.24.01.08(G)(3) as explained by MHD in its first Interested Party Comments and by BDC's own admission in its

Modified Application to provide services to 24 ICF beds. BDC fails all tests in the application of logic, third party payor behavior, and BDC's own narrative to reach any design in which it is a financially viable project. The lack of a thoughtful and thorough application of industry norms related to average length of stay, progression of patients through levels of care, staffing patterns and related revenue recognition continue to characterize BDC's application process and should disqualify it from providing ICF services in Maryland.

While BDC does provide a thorough explanation to justify its use of toxicology testing, it does not answer the most relevant questions raised pertaining to its inclusion towards financial viability. BDC does not address how this revenue is attributable to the BDC entity. Does the BDC entity wholly own a lab that provides diagnostic services or is the lab owned by an entity outside of BDC? BDC should explain how $540,000 of its revenue is attributable to a source that it cannot or will not confirm is a part of the BDC entity. If BDC cannot claim this revenue as its wholly own, then it should explain how it can attribute any of the revenue that is collected from laboratory services to BDC. If this revenue is not wholly attributable to the BDC entity, then it should not be figured into financial considerations. If BDC can attribute this revenue to the BDC entity, then with the adjusted revenue projections for 10 beds, toxicology now represents an astonishing 25% of its Net Revenue. BDC again fails to prove financial viability through the inclusion of such an outsized portion of its revenue to a non-core service.

It is through BDC's own flawed application and tables that it proves that it is not financially viable on multiple fronts, through multiple sensitivity tests, and should consequently be denied a CON.

Community Support

BDC does not directly address or remedy the concerns that MHD raises surrounding its seemingly numerous letters of support from individuals and entities across the state. In a noteworthy event, MHD notes that Chance Ashman Galliker of Magnolia New Beginnings contacted MHCC to rescind Magnolia New Beginning's Letter of Support for BDC on January 10, 2019.

BDC also provides the following list of letters of support with comment from MHD:

Senator Shirley Nathan-Pulliam – The public record does not indicate that BDC has submitted a letter of support.
Delegate Pat Young – The public record does not indicate that BDC has submitted a letter of support.
Mike Gimbel – Mike Gimbel is a paid contractor of BDC and related entities.
Frank Biden – The public record does not indicate that BDC has submitted a letter of support.

BDC should not be puzzled by MHD's comments regarding letters of support, as BDC falsely recounts MHD's letters of support. Contrary to BDC's inaccurate claims, MHD did in fact submit a letter of support from Anne Arundel County's Health Officer (its home county), Dr. Jinlene Chan, in its original application. MHD's letters of support were furnished by

stakeholders in its home county or by relevant Track One providers. MHD's letters of support were relevant in content and quality, rather than measured in quantity.

BDC's claim that it has demonstrated sufficient evidence of community support can similarly be made to the contrary as it has garnered its own level of opposition from providers in the state. The comments furnished in the letter signed by 12 SUD providers should not only be considered and included in the record, they should be taken as a sign of caution and concern from BDC's proposed peers. In fact, BDC makes no effort to address the most relevant issues raised by MHD in its Interested Party Comments:

BDC's response regarding RITL's payor audits and subsequent "rebranding" still 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.

BDC proposes that the root cause for the closure of its formerly related entity, Recovery In The Light, was the result of a payor audit and not in fact the result of the investigation by news outlets into fraudulent practices. If this claim is true and BDC cannot explain how a payor audit caused one of its related entities to shutter its doors, how can it ensure the state of Maryland that it will not do the same if BDC becomes the subject of a similar audit?

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 has approached this standard with a minimum of concern.

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

BDC continues to approach 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 payor mix of all other existing health care providers, an identification of the likely source in increased patients per payor, and an analysis supporting the claim that other Track One providers will not be effected by BDC. BDC states:

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

MHD has only ever provided objective facts to MHCC throughout its own CON application process and subsequent interested party comments to BDC's CON application. To that end, MHD submits a statement from MARC (Appendix B) affirming that the information provided in its initial Interested Party Comments is factual and should not be dismissed by BDC as "hearsay". MHD does not contend that employees should not be free to take any opportunities available to them. Rather, these facts were included to provide precedent that actions by BDC's related entities have in fact negatively affected other providers as it relates to BDC's claims to the contrary and its omission of a thorough analysis.

Summary

Considering each individual cause above, BDC's CON application should be denied. When the totality of the individual causes is considered in each of MHD's Interested Party Comments, 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 that explain its conflation of "residential" services, days, and related bed counts, the core tenent that an average LOS in an ICF is 28 days, and subsequent patient volumes justify its modified staffing plan. There are no remedies available to BDC that make it a financially viable project or a project that has meaningful support in its home community and with its Track One peers. BDC has consistently failed to prove it possesses the sophistication to safely and accurately create a viable plan. In the case of BDC, it is clear that MHCC should not sacrifice quality of care, patient safety, 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

BH Program Descriptions/CARF Reference Grid

BH Program Descriptions/CARF Reference Grid
Revised – July 17, 2018

All programs accredited through CARF using the ***Behavioral Health Standards Manual**** must meet the applicable standards in Section 1, ASPIRE to Excellence® and Section 2, General Program Standards. The chart below is meant to be a one-page reference guide identifying the *primary* chapter(s) of Section 3, Core Treatment Program Standards and/or Section 4, Core Support Program Standards that correspond to each of the program descriptions identified in the Community-Based Behavioral Health Programs and Services regulations (COMAR 10.63). Depending on the type of service(s) being delivered and population(s) served, additional Section 3, Core Treatment Program Standards (e.g., Detoxification/Withdrawal Management) and/or Section 5, Specific Population Designation Standards (e.g., Children and Adolescents, Criminal Justice) may also apply.

Specific questions regarding applicability and/or interpretation of specific accreditation standards should be referred to CARF.

BH Program Description	2018 CARF Standards (July 1, 2018 – June 30, 2019)
Group Homes for Adults with Mental Illness	Community Housing
Integrated Behavioral Health Programs	Outpatient Treatment
Intensive Outpatient Treatment 2.1	Intensive Outpatient Treatment
Mobile Treatment Services	Assertive Community Treatment
Outpatient Mental Health Centers	Outpatient Treatment
Outpatient Treatment Level 1	Outpatient Treatment
Partial Hospitalization Treatment Level 2.5	Partial Hospitalization
Psychiatric Day Treatment Programs	Partial Hospitalization
Psychiatric Rehabilitation Programs for Adults	Community Integration
Psychiatric Rehabilitation Programs for Minors	Community Integration and C&A standards*
Residential: Low Intensity 3.1	Community Housing and Outpatient Treatment
Residential: Medium Intensity 3.3	Residential Treatment
Residential: High Intensity 3.5	Residential Treatment
Residential: Intensive 3.7	Inpatient Treatment
Residential Crisis Services	Crisis Stabilization
Residential Rehabilitation Programs	Community Housing
Withdrawal Management Services	Detoxification/Withdrawal Management
Respite Care Services	***Employment & Community Services Manual*** or ***CYS Manual**** applies
Supported Employment Programs	***Employment & Community Services Manual***** applies
Opioid Treatment Services	***Opioid Treatment Programs Manual*** applies

* For programs serving C&A *only* and using the ***CYS Manual***, "Community Transition" applies if serving the TAY population *only* **OR** "Community Youth Development" applies when serving youth of all ages.

** For programs serving C&A *only*, the program may choose to be reviewed under the applicable Core Program Standards from the ***Child and Youth Services (CYS) Standards Manual*** (ASPIRE to Excellence and General Program Standards from that manual also apply).

*** For SEP, the Community Employment Services standards, including both Job Development and Employment Supports, apply.

APPENDIX B

Statement by Maryland Addiction Recovery Center (MARC)

MARYLAND
ADDICTION RECOVERY CENTER

Maryland Addiction Recovery Center

8600 LaSalle Road Suite 212

Towson, MD 21286

Maryland Health Care Commission:

This letter is in reference to the Maryland House Detox interested party comments filed on December 14th, 2018 in the matter of Docket No. 18-03-2419 by Baltimore Detox Center. Please take this letter as an affirmation that the information Maryland House Detox provided in their comment regarding MARC staff is factual and should not be dismissed as "hearsay". The staff positions referenced were accurate and left our program in a position of vulnerability given the amount of staff, key positions they held, and the short timeline that they were hired at BDC related facilities.

If you have any questions or need any further information, please do not hesitate to reach out to MARC.

Sincerely,

Samuel Bierman

Executive Director

Maryland Addiction Recovery Center

APPENDIX C

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.

January 18, 2019
Date

Signature of Owner or Board-designated Official

Director of Corporate Business Development
Position/Title

David Stup
Printed Name