CMDS
FAYETTE HOUSE
6040 HARFORD RD.

July 7, 2020

VIA EMAIL

Laura Hare Nirschl
Program Manager
Certificate of Need Division
Center for Health Care Facilities Planning & Development
Maryland Health Care Commission

RE: CMDS Residential, LLC- Matter No. 20-24-2441

Request for Completeness# 1 (June 25, 2020)

Dear Mrs. Laura Hare Nirschl,

In response to your letter dated June 25, 2020, please find enclosed the answers to your questions.

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.

Sincerely,

Andre Pelegrini

VP of Finance & Business Development

ASPIRE to Excellence® carf ACCREDITED

Corporate Offices:
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cmdsinc.com

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Background Information

1. Provide additional details about CMDS Residential, LLC's operation, history, and experience.
    - Provide similar information about any parent or related companies and companies owned or operated by CMDS Residential, LLC or its parent company. This includes any outpatient facilities, such as Turning Point Clinic.

CMDS Residential, LLC. was created in 2019 to provide inpatient (residential) substance abuse treatment. CMDS Residential, LLC and its sister company CMDS, Inc. are managed by CMDS Management, LLC. All three companies are 100% owned by Kevin Pfeffer. CMDS Management, LLC. also provides management for the largest Opioid Treatment Program (OTP) in Maryland, Turning Point Clinic. Since CMDS Residential, LLC is a new company and has not yet started operations, below is a description of the operations, history, and experience of its affiliate companies.

CMDS, INC.

CMDS, Inc. is located at 1850 N Milton Ave Baltimore, MD 21213 and operates outpatient mental health services and outpatient substance abuse services. It started providing mental health services in 2013 and outpatient substance abuse services in 2018. The company serves 300 patients in its mental health program and employs one mental health therapist and one Psychiatric Nurse Practitioner. However, CMDS, Inc. has recently been accredited to becoming an Outpatient Mental Health Center (OMHC) which will allow it to expand the mental health services it provides and to increase the staff count. CMDS, Inc. also provides outpatient (ASAM level 1) and intensive outpatient (ASAM level 2.1) substance abuse program which serve 50 patients and employ 5 counselors. CMDS, Inc. has recently been accredited to provide substance abuse partial hospitalization (ASAM level 2.5), which will enable the offering of outpatient substance use services up to 20 hours a week. All patients served by CMDS, Inc. are enrolled in Medicaid or Medicare and all CMDS Inc.'s programs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

TURNING POINT CLINIC

Turning Point Clinic is an Opioid Treatment Program (OTP) founded in 2003 and currently serves almost 2000 patients. Turning Point Clinic was one of the first OTPs in Baltimore City and has served over 11,000 patients with Medication Assisted Treatment (MAT), which is a comprehensive treatment model involving counseling, medication management, and medical care to treat patients diagnosed with opioid use disorders, since its opening. Turning Point Clinic employs 70 people including nurses, nurse practitioners, physicians, counselors, and administrative staff. Turning Point Clinic is also accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

CMDS MANAGEMENT, LLC

CMDS Management, LLC was created in 2016 and is the managing company of CMDS Residential, CMDS, Inc., and Turning Point Clinic. The company employs 13 people in its office in Columbia, MD. The IT staff

of CMDS Management, LLC has been able to develop state-of-the-art software that streamlined the operations of the programs it manages allowing them to achieve benefits not seen in similar programs in Maryland. Aside from developing tools to convert several manual tasks into automated ones, such as checking the eligibility of hundreds of patients' insurance in a matter of minutes; or creating its own billing claims totally in-house, CMDS Management, LLC has designed an array of technological tools to manage its programs. Using artificial intelligence (AI), CMDS Management, LLC deep audits all claims it submits to insurance companies; this tool checks counseling notes to ensure that they align with the requirements of payers before claims are submitted. Another tool that the IT staff of CMDS Management, LLC has created displays the number of available beds at CMDS Residential, LLC at all times and enables outside providers to refer patients to our program online.

State Health Plan

2. In regards to Sliding Fee Scale (Section .05C.), provide additional information regarding how you determine a client's ability to pay.
    - For example, is a worksheet or application involved? If so, please describe it and its uses and provide a copy.

If a patient who is admitted to the program does not have insurance, the patient may be eligible for our sliding fee scale program. A patient's ability to pay is determined by the answers the patient provides to a questionnaire and by the supporting documents provided with it. Acceptable documents are paystubs; tax forms; alimony documents; statement of disability, social security, or pension showing earnings. The questionnaire asks for the income of the patient and any other household member. Based on the patient's total household income, a patient may be eligible for the reduced charges described below. (Refer to Exhibit 49: Sliding Scale Fee Form, pg. 7)

If Patient's income level is	<100% of Federal Poverty level (FPL)	75% discount
If Patient's income level is	<150% but >100% of FPL	50% discount
If Patient's income level is	<200% but >150% of FPL	25% discount

Sliding Fee Scale

3. In regards to Outpatient Alcohol & Drug Abuse Programs (Section .05O.), confirm that the programs with which you have agreements provide the services described in this section (i.e. individual needs assessment and evaluation; individual, family, and group counseling; aftercare; and information and referral for at least one year after each patient's discharge from the intermediate care facility). If this information is included in your discharge policy, please provide an exact citation and excerpt the relevant information.

We confirm that the programs with which we have agreements provide the following services:

- Individual needs assessment and evaluation
- Individual, family, and group counseling
- Aftercare

The Discharge Planning and Referral Policies & Procedures has been updated to include language describing the one-year-follow-up-after-a-patient's-discharge-from-the-program procedure. (Refer to Exhibit 50: Discharge Planning and Referral Policies & Procedures – Updated, yellow highlight, pg. 8).

Criteria

Need

4. Provide a brief explanation as to why CMDS utilized the Track One methodology to justify its bed need.

In the absence of a methodological process that describes Track Two beds need, we used the methodology used for Track One beds. It is worth mentioning, however, that the lack of a methodology that details the beds need for Track Two does not indicate that beds are not necessary. Furthermore, we have gathered compelling evidence to legitimize our claim, such as:

- We demonstrated that there are no Track Two ICFs in East Baltimore and that our program would complement the services provided by other healthcare providers in the area
- We indicated that there is community support for our project by gathering letters of support from substance abuse providers, including two Track Two ICFs in the Central Region, Gaudenzia and Hope House Treatment Centers
- We showed that there is a need for detox beds by pointing out to wait list of existing Track Two ICFs in the Central Region (detailed below)

5. Provide additional details regarding the wait lists of other Track Two ICFs, wait times of patients seeking access to Levels 3.7 and 3.7WM care, recent data on overdose cases in the Central Region of Maryland, and any other data that supports CMDS's need claims.

Hope House Treatment Centers stated on its Track Two Revised Certificate of Need Application for the Central Region of Maryland, published on The Maryland Heath Care Commission website on 07/31/18, that it had 199 patients waiting for detox services at the time of the application (Refer to Exhibit 51: Hope House REVISED Certificate of Need Application (7/31/18), Relevant Excerpt [pg. 24 of the original document], yellow highlight, pg. 13 on this document. Full document can be accessed on: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/filed_2018/con_hope_house_2416_revised_app_20180731.pdf)/). Even though Hope House Treatment Centers does not state the wait times of patients seeking access to Levels 3.7 and 3.7WM care, Appendix C of its Revised Certificate of Need Application (07/31/18) showed monthly waiting lists ranging from 109 to 181 (Refer to Exhibit 52: Hope House REVISED Certificate of Need Application (7/31/18) Appendix C [pg. 12 of the original document], pg. 14 on this document. Full document can be accessed on: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/filed_2018/con_hope_house_2416_

revised_app_20180731.pdf)/. Aware of the need of more detox beds in the Central Region of Maryland, Hope House Treatment Centers wrote a letter to support our CON application.

Furthermore, as recent as February 2020, theTrack Two CON application for the Central Region of Maryland submitted by Pyramid Walden, LLC demonstrated the dire need for patients seeking detox care without being able to access it due to capacity limitations. Although Pyramid Health, LLC does not state the wait times of patients seeking access to Levels 3.7 and 3.7WM care, the program reported that from January 2019 to April 2019 it turned down 240 people seeking detox services because it did not have enough beds. (Refer to Exhibit 53: Pyramid Walden-Joppa Certificate of Need Application (2/26/20), Relevant Excerpt [pg. 20 of the original document], yellow highlight, pg. 15 on this document. Full document can be accessed on: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/Filed_2020/con_pyramid_walden_joppa_2440_application_20200226.pdf)

Another compelling indication that supports our claim that Track Two beds are needed in the Central Region of Maryland relies on the comparison between the population eligible for Medicaid and the inventory of Track Two beds from the projected year of the State Health Plan (2005) and current statistics (2019). As evidenced in the table below, the number of people eligible for Medicaid in the Central Region of Maryland grew 88% from 2005 to 2019. Nonetheless, the number of Track Two beds per 1,000 Medicaid eligible grew less than half of that, i.e. 40.35%. (Refer to Exhibit 54: CY' 05 Total Medicaid Eligible by County for Each Month, yellow highlight, pg. 16. Information can be accessed on: https://md-medicaid.org/eligibility/new/index.cfm. Refer to Exhibit 55: CY 19 Total Medicaid Eligible by County for Each Month, yellow highlight, pg. 17. Information can be accessed on: https://md-medicaid.org/eligibility/new/index.cfm)

Central Region of Maryland

Year	December '05	December '09	
Number of Track Two ICF Beds	117	309	% Change
Medicaid Eligibles			
Anne Arundel County	39,336	97,378	148%
Baltimore City	185,145	259,204	40%
Baltimore County	85,583	203,629	138%
Carroll County	10,672	23,328	119%
Harford County	21,462	45,809	113%
Howard County	17,128	46,814	173%
Total	359,326	676,162	88%
Number of Track Two Beds/1000 Medicaid Eligible Patients	0.33 (117)/(359,329/1000)	0.46 (309)/(676,162/1000)	40.35%

Change in Track Two Beds per 1,000 People Eligible for Medicaid from 2005 to 2019

Aside from the undisputable evidence of the need for Track Two beds in the Central Region of Maryland, which is validated by the waiting list of Hope House Treatment Centers and Pyramid Walden, LLC as well as the slow growth of Track Two ICFs to comport the increase in the Medicaid population in the proposed jurisdiction, the strongest argument to support the granting of our CON relies on the deleterious consequences brought upon Maryland in consequence of the coronavirus. The clear impact of the COVID-19 pandemic across Maryland further legitimizes our project as Maryland starts to experience an increase in the number of drug-related overdoses. Although the percentage of overdose-related deaths decreased 7% in the Central Region of Maryland in Q1 20 compared to Q1 19, drug overdoses increased 2.6% across the State (refer to table below for details).

County	*2019*	*2020*	*Difference*	County	*2019*	*2020*	*Difference*
Allegany	7	13	6	Harford	19	19	0
Anne Arundel	49	52	3	Howard	8	12	4
Baltimore City	239	205	(34)	Kent	3	1	(2)
Baltimore	76	80	4	Montgomery	19	26	7
Calvert	8	4	(4)	Prince George's	14	37	23
Caroline	5	4	(1)	Queen Anne's	4	1	(3)
Carroll	14	8	(6)	Somerset	1	3	2
Cecil	11	20	9	St. Mary's	4	4	0
Charles	3	6	3	Talbot	3	3	0
Dorchester	1	6	5	Washington	24	30	6
Frederick	20	13	(7)	Wicomico	8	7	(1)
Garrett	0	2	2	Worcester	7	5	(2)
				Statewide Total	**547**	**561**	**14**

Opioid-Related Intoxication Deaths by County Q1 19 vs. Q1 20

Retrieved from: https://bha.health.maryland.gov/Documents/OOCC%20CY20%20Q1%20OD%20Death%20data%20June2020.pdf [pg. 8]

As the pandemic worsened entering Q2 20, the number of death-related overdoses is also expected to increase. Even though official statistics for Q2 20 will not be released for another two to three months, the 2.6% increase in the number of drug-associated fatalities across the state is a clear indication of the effects of the pandemic as a result of several factors, including the rise in unemployment. The unemployment rate in the Central Region of Maryland jumped from 20.1% in March 20 to 60.6% in the

first month of Q2 20 (refer to table below for details).

Unemployment Rate by County	January 2020	February 2020	March 2020	April 2020
Anne Arundel County	3	3	2.9	10
Baltimore city	4.9	4.7	4.9	11.9
Baltimore County	3.6	3.6	3.6	10.8
Carroll County	2.9	3	2.8	9.4
Harford County	3.3	3.4	3.3	10.4
Howard County	2.6	2.7	2.6	8.1
			20.1	60.6

Unemployment in the Central Region of Maryland
Retrieved on 06/30/20 from: https://www.dllr.state.md.us/lmi/laus/

The exponential increase in the unemployment rate predicts an ominous reality as there is a significant correlation between unemployment and drug overdoses and utilization of healthcare services. A study by Alex Hollingsworth, Christopher J. Ruhm, and Kosali Simon published on the National Bureau of Economic Research in 2017 finds that the opioid-death rate rises by 3.6% and emergency-room visits rise by 7% whenever the unemployment rate increases by one percentage point in a given county. (Refer to Exhibit 56: Correlation Between Unemployment and Overdoses. Relevant Excerpt [pg. 2 of the original document], yellow highlight, pg. 19 on this document. Full document can be accessed on: https://www.nber.org/papers/w23192.pdf). Although official drug-related fatalities for Q2 2020 won't be released until August or September 20, according to this prediction, the Central Region of Maryland should have experienced a 145.8% increase in the number of drug-related deaths and a 283.5% increase in the number of ER visits in April 20 alone. The death toll and the cost associated with such statistics can be significantly mitigated if there are enough detox beds available.

Availability of More Cost-Effective Alternatives

6. In your discussion of alternatives, an explanation of why each alternative was not cost-effective was included. Conversely, please explain why the project that CMDS has chosen to pursue is the most cost-effective.

The detox beds provided by CMDS Residential is the most cost-effective solution because it will quickly meet the current demand for withdrawal management services in the Central Region of Maryland. The turndown data provided by Pyramid Health, LLC and the waiting list present at Hope House Treatment Centers demonstrate the dire need for detox services. Although both programs have expanded their detox bed capacity, the proposal by CMDS Residential provides a rapid solution for the absence of detox beds in East Baltimore where stakeholders have identified a need. Moreover, the repurposing of an existing building also provides this resource in a very cost-effective manner.

General Information

7. Will policies/procedures, such as Infection Control/PPD, be updated with new COVID precautions?

Yes. We created specific policies & procedures to address COVID-19.

EXHIBIT 49
SLIDING SCALE FEE FORM

CMDS
FAYETTE HOUSE
6040 HARFORD RD.

SLIDING SCALE FEE APPLICATION

PATIENT ID: _____ DOB: _____

ADDRESS: _____ PHONE: _____

Please, list household income below.

NAME	RELATIONSHIP	INCOME ($)	FREQUENCY OF PAYMENT	SOURCE
	Applicant			

Total annual income: _____

Please, provide any documentation that may help us determine your eligibility for the sliding fee scale. Such documentation may include paystubs, tax forms, alimony documents, statement for disability, social security, or pension showing earnings.

I attest that the information provided on this form is accurate. Any misrepresentation from my part may result in me losing the benefits of the sliding fee scale program.

Signature:_____ Date: _____

EXHIBIT 50
DISCHARGE PLANNING AND REFERRAL POLICIES & PROCEDURES – UPDATED

POLICY, PROCEDURE, & PLAN MANUAL **SUBJECT:** D/C Summary

POLICY FOR DISCHARGE SUMMARY

Within one week after discharge, there should be entered into the client's chart a discharge summary describing the reasons for treatment, services offered, response to treatment and the client's status or condition upon discharge. The client's strengths, needs, abilities and preferences shall be reviewed at this time**.** A discharge summary shall be completed on all clients who have been officially admitted to the program, regardless of the length of the treatment episode or the status of the discharge.

The Primary Counselor, or designee shall be responsible for completing the discharge summary within one week of discharge. The discharge summary shall be reviewed and signed by the Clinical Director and Nurse Practitioner/Physician (when applicable). A discharge summary progress note shall be written detailing the type of discharge, the living location or treatment program the client is entering, the clients emotional state and behavioral status, how the client feels about leaving the program. And when applicable, the person transporting the client.

The discharge summary shall be maintained in the client record.

Each discharge summary shall contain the following elements:

Client Identification Data

Dates of Treatment

Discharge Status

Services Provided

Diagnosis (DSM VI)

Client History

Presenting Problem

Treatment Goals

Progress in Treatment

Physical & Psychological Condition on Discharge

Prognosis

Aftercare Plans

Continuing Treatment Needs

Notification of Referral, P.O., and Family Members

Signatures of Nurse/Counselor, Supervisor, and Physician (when applicable)

POLICY & PROCEDURES FOR REFERRALS

A. POLICY

CMDS Residential staff shall provide continuity of care by providing information and referral for at least one year after a patient's discharge from the program. This will be achieved by collaborating with other community social, health, welfare, behavioral health and criminal justice agencies to each provide appropriate services. Due to the wide area being serviced, sources of referrals will be varied. Clients may originate from courts, prisons, hospitals, etc. The staff have established and maintained referral agreements with a wide variety of human service agencies to provide ancillary services to clients once in treatment.

B. PHILOSOPHY

The program is part of the total continuum of services. The responsibility of the staff is to cooperate with other community social, health and criminal justice agencies to provide continuity of quality care to the alcoholic person. The key to the cooperation is for each organization or agency to provide and to refer to other organizations for services staff are not qualified to provide.

Treatment of individuals with substance use disorders, substance abuse and mental health disorders (Co-occurring), or Women with Children require that the treatment plan contain physical, social and medical objectives. Where possible, the relationship to other agencies shall be defined in writing in the form of a contract or agreement.

Examples of use of the referral process are:

1. Examinations, assessments and consultations that are not within the domain of expertise of the staff.

2. Special treatment services

3. Assistance of other resources that can contribute to the client's well-being; i.e., literacy, parenting skills, vocational rehabilitation, child development, behavioral health etc.

C. PROCEDURE

When making a referral to other services or programs, the staff shall appropriately notify the receiving service or program of the desire for transfer, the physical and behavioral status of the patient, any unusual circumstances of the case, and the elements of the aftercare plan. This conversation shall take place in person or by telephone and shall be documented in the patient record. Prior to referral to or from services or programs outside of CMDS, the proper release of information form shall be completed. The information consent shall include the following federally approved elements:

1. Name of the program that will make the disclosure
2. Name of the organization or person to which the disclosure is made
3. Name of the patient or participant
4. Purpose or need for the disclosure
5. Nature of the information to be disclosed
6. Date of condition upon which the consent will expire and a statement that the consent may be renewed
7. Date the consent is signed
8. Signature of the client or participant

D. Outgoing referrals

If a client is not appropriate for admission (residential), then he/she may be referred to another agency. This is documented on the intake interview form. If a residential client is in his/her 30-days of treatment and it is perceived that he/she is in need of additional services, this is discussed in staff meeting and

documented on a Case Consultation form. When a client completes treatment and is referred elsewhere for aftercare services, this is done by telephone, as well as by letter. The referral is also documented on the Aftercare Plan and Discontinuance of Service Summary, which are forwarded to the referral.

E. Incoming

Incoming referrals are made by the referral agency or individual contacting any of the staff, either by telephone or letter. When contact is made, a time is set for an intake interview. Admission to the program is based on the information received during the interview. The referral source is documented on the intake interview form. All referrals are made by the counselors with approval of the Clinical Director.

F. Client-initiated

If a client feels that there are services she needs that are not being met by the program, he/she may request a referral to another service provider. The request is not to be made to the client's primary Counselor. The Counselor will communicate the request to the counseling supervisor who, in turn, will follow the procedures outlined above under "Outgoing Referrals".

G. Medically related referrals

In all cases of referrals to the program from a medical professional, the call will be forwarded to the nurse on duty. When possible, the nurse will gather all pertinent information relevant to the general physical condition and needs of the client being transferred, This information will include, but is not limited to: medications, concomitant physical condition, special procedures, appointment dates (medical), drug abuse (if known).

H. Follow-up reporting on medically related referrals

The nursing staff (when applicable to the program) is responsible to notify the appropriate referring medical professional:

1. Within 3 days after a client's admission. The purpose of this contact will center on providing information relating to the client's physical status, as well as to gather pertinent information from the referral source.

2. At least one week prior to discharge. The purpose of this contact will center on providing information relating to the client's physical status and aftercare plan information necessary to assure continuity of care for the client with that health professional.

Applicant Response:

Maryland is already experiencing a Heroin Epidemic and the Governor has declared a State of Emergency. The implementation of this service will directly provide life-saving Detoxification, Stabilization and Effective Treatment to patients in Prince George's County (where we are the only Inpatient Addiction Service Provider) and the surrounding Counties. We have an extensive Waiting List of Patients who want to come to our program. Our Waiting List presently has 199 patients wanting services of Hope House Treatment Center.
See Appendix C for waitlist numbers.
See Appendix R for Patient-Served Days
Letters attesting to the need of detox beds have been submitted to our stakeholders. We are currently waiting for those letters to be returned and will send an amendment to the Certificate of Need as they are received.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Hope House Treatment Center in Laurel is the only Inpatient Addiction Program in Prince George's County with the ability to provide 3.7D and 3.7 Residential Services. As part of the planning process, we experienced a growing number of patients wanting these dire services to the point that we had to have a Waiting List. Additionally, the alternative treatment approach is for patients to receive detoxification treatment in a local hospital

EXHIBIT 52
HOPE HOUSE REVISED CERTIFICATE OF NEED APPLICATION (7/31/18)
RELEVANT EXCERPT

Appendix C

Waitlist Numbers

January 2018	**138**
February 2018	**109**
March 2018	**113**
April 2018	**154**
May 2018	**180**
June 2018	**181**

*The waitlist is a living list that is often changed due to a patient's status change from waitlist to active, hold, or contacted status. Our electronic medical record system does not have the capability to pull waitlist numbers from a given day/month/year. In January 2018, Hope House Treatment Centers joined an initiative with the local health department to communicate waitlist numbers for data tracking purposes. For that reason, waitlist numbers are only available from January 2018 until the present day.

EXHIBIT 53
PYRAMID WALDEN-JOPPA CERTIFICATE OF NEED APPLICATION (2/26/20)
RELEVANT EXCERPT

Pyramid Walden, LLC
ICF Turndowns by County January - April, 2019

County	Jan	Feb	Mar	Apr	Grand Total
Allegany	0	0	0	0	0
Anne Arundel	27	41	27	41	136
Baltimore	5	25	9	32	71
Baltimore City	0	3	4	4	11
Calvert	11	18	7	11	47
Carroll	1	0	0	1	2
Cecil	3	2	0	3	8
Charles	12	26	25	34	97
Frederick	1	2	2	8	13
Harford	0	4	1	10	15
Howard	1	0	1	3	5
Kent	0	1	0	0	1
Montgomery	0	6	4	11	21
Out of State	1	5	4	13	23
Prince George's	4	19	12	30	65
Somerset	0	0	2	0	2
St. Mary's	98	42	28	47	215
Washington	6	0	2	3	11
Wicomico	0	1	2	0	3
Worcester	1	0	1	0	2
Grand Total	171	195	131	251	748
Total Central Maryland	34	73	42	91	240

Although Pyramid Walden currently only operates ICF services in Southern Maryland, the above table shows that our Call Center receives and accepts calls from individuals and referral sources from throughout the State of Maryland. The highlighted areas are the Counties in the Central Maryland Region.

Using the State Plan's assumed Length of Stay of 14 Days, we have identified that in order to provide access to the individuals who contacted our Call Center during this 120-day period of time would require additional Track 2 ICF beds as follows:

- Entire State of Maryland: Treating the 748 persons Turned Down would require 87.3 additional beds
- Central Maryland: Treating the 240 persons Turned Down would require 28 additional beds.

Applicant is requesting the maximum allowed 50 Track 2 ICF beds due to the demonstrated need for 87 additional beds in the State of Maryland, just to serve the

20

EXHIBIT 54
CY' 05 TOTAL MEDICAID ELIGIBLE BY COUNTY FOR EACH MONTH

CY '05 TOTAL ELIGIBLES BY COUNTY FOR EACH MONTH

COUNTY	JAN05	FEB05	MAR05	APR05	MAY05	JUN05	JUL05	AUG05	SEP05	OCT05	NOV05	DEC05
Allegany	12,897	12,850	12,896	12,874	12,883	12,909	13,004	13,009	13,002	12,984	12,983	12,908
Anne Arundel	38,772	38,799	38,898	38,919	38,990	38,991	39,130	39,208	39,387	39,455	39,373	39,336
Baltimore City	185,641	185,283	185,781	185,864	185,814	185,865	185,127	185,499	185,682	185,805	185,543	185,145
Baltimore County	83,163	83,169	83,397	83,683	83,998	84,187	84,984	85,222	85,575	85,743	85,565	85,583
Calvert	7,354	7,341	7,352	7,364	7,415	7,439	7,511	7,580	7,583	7,580	7,575	7,546
Caroline	6,221	6,223	6,269	6,308	6,346	6,355	6,370	6,402	6,405	6,419	6,404	6,418
Carroll	10,589	10,565	10,600	10,580	10,560	10,583	10,611	10,674	10,730	10,755	10,710	10,672
Cecil	12,742	12,739	12,808	12,747	12,681	12,706	12,738	12,780	12,791	12,772	12,759	12,758
Charles	13,781	13,806	13,852	13,887	13,922	13,859	13,881	13,911	14,002	14,004	13,896	13,908
Dorchester	6,774	6,764	6,790	6,779	6,804	6,797	6,830	6,845	6,848	6,841	6,857	6,880
Frederick	16,459	16,424	16,475	16,506	16,592	16,627	16,724	16,726	16,841	16,930	16,931	16,933
Garrett	5,870	5,832	5,844	5,834	5,808	5,778	5,786	5,800	5,808	5,799	5,822	5,798
Harford	21,296	21,268	21,342	21,350	21,371	21,382	21,444	21,461	21,467	21,609	21,533	21,462
Howard	16,453	16,447	16,532	16,603	16,667	16,689	16,840	16,882	17,112	17,164	17,152	17,128
Kent	2,810	2,823	2,840	2,832	2,844	2,818	2,872	2,871	2,905	2,893	2,881	2,890
Montgomery	74,446	74,609	75,086	75,363	75,541	75,706	74,041	74,433	74,947	75,077	75,019	75,147
Out of State	1,214	1,210	1,201	1,207	1,173	1,167	1,200	1,213	1,211	1,214	1,226	1,217
Prince George's	104,811	104,997	105,690	105,756	106,061	106,321	104,468	104,818	105,683	105,962	105,834	105,747
Queen Anne's	4,142	4,134	4,165	4,184	4,204	4,203	4,180	4,172	4,163	4,148	4,136	4,120
Somerset	4,853	4,838	4,852	4,864	4,866	4,856	4,845	4,865	4,867	4,851	4,867	4,848
St. Mary's	10,694	10,704	10,745	10,735	10,714	10,778	10,862	10,912	10,973	10,951	10,933	10,907
Talbot	4,336	4,353	4,347	4,370	4,381	4,386	4,330	4,333	4,345	4,338	4,324	4,314
Washington	19,429	19,409	19,537	19,550	19,555	19,586	19,920	20,031	20,058	19,949	19,929	19,949
Wicomico	16,826	16,860	16,983	16,914	17,013	17,043	17,008	17,062	17,103	17,068	17,077	17,077
Worcester	6,531	6,549	6,592	6,577	6,589	6,556	6,576	6,569	6,557	6,568	6,538	6,511
TOTALS	688,104	687,996	690,874	691,650	692,792	693,587	691,282	693,278	696,045	696,879	695,867	695,202

As of end April 2020.

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Data and support provided by:

MARYLAND
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EXHIBIT 55
CY' 19 TOTAL MEDICAID ELIGIBLE BY COUNTY FOR EACH MONTH

CY '19 TOTAL ELIGIBLES BY COUNTY FOR EACH MONTH

COUNTY	JAN19	FEB19	MAR19	APR19	MAY19	JUN19	JUL19	AUG19	SEP19	OCT19	NOV19	DEC19
Allegany	21,954	21,949	22,008	22,035	22,023	22,042	22,058	22,106	22,099	22,132	22,152	22,147
Anne Arundel	96,211	96,353	96,565	96,605	96,779	96,849	96,980	97,137	97,087	97,257	97,184	97,378
Baltimore City	257,538	257,871	258,569	258,411	258,825	258,681	259,224	259,730	259,541	259,666	259,413	259,204
Baltimore County	200,645	201,051	201,690	202,147	202,396	202,356	202,836	203,221	203,076	203,479	203,536	203,629
Calvert	14,481	14,503	14,502	14,491	14,516	14,471	14,485	14,465	14,459	14,452	14,459	14,448
Caroline	11,998	12,052	12,084	12,077	12,092	12,072	12,068	12,065	12,069	12,099	12,079	12,128
Carroll	23,476	23,449	23,461	23,416	23,419	23,373	23,401	23,404	23,344	23,349	23,315	23,328
Cecil	26,489	26,480	26,531	26,411	26,463	26,361	26,409	26,388	26,392	26,376	26,394	26,422
Charles	32,321	32,362	32,509	32,496	32,501	32,504	32,615	32,631	32,778	32,878	32,833	32,921
Dorchester	13,035	13,067	13,064	13,002	12,992	12,979	13,009	12,982	12,961	12,978	13,003	13,015
Frederick	41,414	41,440	41,571	41,578	41,687	41,644	41,725	41,754	41,807	41,874	41,805	41,777
Garrett	8,645	8,662	8,643	8,641	8,615	8,573	8,598	8,574	8,598	8,606	8,570	8,572
Harford	45,470	45,565	45,634	45,663	45,777	45,700	45,849	45,929	45,939	45,885	45,848	45,809
Howard	46,375	46,468	46,580	46,551	46,553	46,527	46,563	46,674	46,547	46,637	46,709	46,814
Kent	5,017	5,018	5,020	5,008	4,999	4,985	5,001	5,002	5,021	5,044	5,023	5,005
Montgomery	187,689	188,126	188,646	189,036	189,482	189,335	189,857	190,110	190,070	190,485	190,640	191,039
Out of State	1,900	1,883	1,864	1,830	1,779	1,741	1,714	1,685	1,631	1,606	1,584	1,548
Prince George's	226,877	227,318	228,384	229,285	229,994	230,038	230,904	231,767	231,882	232,826	233,029	233,307
Queen Anne's	8,399	8,386	8,409	8,415	8,414	8,386	8,423	8,433	8,390	8,401	8,353	8,339
Somerset	8,873	8,907	8,921	8,925	8,921	8,890	8,897	8,918	8,907	8,940	8,914	8,914
St. Mary's	22,782	22,862	22,890	22,906	22,912	22,963	23,026	23,002	23,035	23,035	23,005	22,978
Talbot	8,495	8,482	8,520	8,526	8,543	8,544	8,524	8,526	8,537	8,553	8,540	8,528
Washington	44,455	44,535	44,605	44,559	44,641	44,673	44,788	44,788	44,730	44,712	44,614	44,571
Wicomico	34,725	34,772	34,895	34,844	34,905	34,973	35,024	35,064	34,931	35,014	34,980	34,981
Worcester	13,455	13,425	13,398	13,390	13,427	13,376	13,366	13,378	13,395	13,418	13,419	13,357
TOTALS	1,402,719	1,404,986	1,408,963	1,410,248	1,412,655	1,412,036	1,415,344	1,417,733	1,417,226	1,419,702	1,419,401	1,420,159

As of end April 2020.

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Data and support provided by:

MARYLAND
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EXHIBIT 56
CORRELATION BETWEEN UNEMPLOYMENT AND OVERDOSES
EXCERPT

Macroeconomic Conditions and Opioid Abuse
Alex Hollingsworth, Christopher J. Ruhm, and Kosali Simon
NBER Working Paper No. 23192
February 2017, Revised March 2017
JEL No. I1,I12,I15

ABSTRACT

We examine how deaths and emergency department (ED) visits related to use of opioid analgesics (opioids) and other drugs vary with macroeconomic conditions. As the county unemployment rate increases by one percentage point, the opioid death rate per 100,000 rises by 0.19 (3.6%) and the opioid overdose ED visit rate per 100,000 increases by 0.95 (7.0%). Macroeconomic shocks also increase the overall drug death rate, but this increase is driven by rising opioid deaths. Our findings hold when performing a state-level analysis, rather than county-level; are primarily driven by adverse events among whites; and are stable across time periods.

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