Craig Tanio, M.D.
Chairman

Ben Steffen
Executive Director

STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE BALTIMORE, MARYLAND 21215
AREA CODE 410-764-3460 FAX 410-358-8811

STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

ALCOHOLISM AND DRUG ABUSE INTERMEDIATE CARE FACILITY TREATMENT SERVICES

COMAR 10.24.14

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APPENDIX

10.24.14 State Health Plan for Facilities and Services: Alcohol and Drug Abuse Treatment Services

.01 Incorporation by Reference.

This Chapter is incorporated by reference in the Code of Maryland Regulations.

.02 Introduction.

A. Purposes of the State Health Plan for Facilities and Services.

The Maryland Health Care Commission has prepared this Chapter of the State Health Plan for Facilities and Services ("State Health Plan" or "Plan") in order to plan for the establishment of an integrated system of care that assures geographic and financial access to a range of quality health care services at a reasonable cost for all residents. The Commission views the State Health Plan, of which this Chapter is a part, as a policy blueprint for shaping and reshaping the health care system toward these ends through the action of public agencies and the cooperation of the private sector. The Commission undertakes an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and that balances considerations of affordability, access, and quality. In every aspect of the Plan, and in its individual Certificate of Need decisions, the Commission carefully weighs issues of access to services against the cost of those services to society.

The State Health Plan serves two purposes:

(1) It establishes health care policy to guide the Commission's policies and those of other health-related public agencies, and to foster specific actions in the private sector. Activities of state agencies must, by law, be consistent with the Plan.

(2) It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in service capacity are encouraged, and that all major expenditures for health care facilities are needed and consistent with the Commission's policies. The State Health Plan, therefore, contains policies, standards, and service-specific need projection methodologies that the Commission uses in making Certificate of Need decisions.

The purposes of this State Health Plan Chapter are to increase access to care for indigent and gray area populations, and to foster good quality, cost-effective, and integrated alcohol and drug abuse facilities and services. To meet these goals, the Chapter coordinates and integrates the planning of alcohol and drug abuse services, proposes methods to contain healthcare costs, encourages more efficient and effective alternative service delivery systems, and forecasts future need.

B. Legal Authority for the State Health Plan for Facilities and Services

The State Health Plan for Facilities and Services is adopted under Maryland's health planning law, Maryland Code Annotated,[1] Health-General §19-121(a)(2). This Chapter fulfills the Commission's legal responsibility to adopt a State Health Plan for Facilities and Services at least every five years and to review and amend the Plan annually, or as necessary.

Health-General Article §19-121(a)(2) states that the State Health Plan shall include:

(i) The methodologies, standards, and criteria for certificate of need review; and

(ii) Priority for conversion of acute capacity to alternative uses where appropriate.

The authority of the Plan with respect to the responsibilities of other state agencies and departments is stated in §19-121(f):

> All state agencies and departments, directly or indirectly involved with or responsible for any aspect of regulating, funding, or planning for the health care industry or persons involved in it, shall carry out their responsibilities in a manner consistent with the State Health Plan for Facilities and Services and available fiscal resources.

In addition, §19-115 provides that the Governor shall direct, as necessary, a state officer, or agency, to cooperate in carrying out the function of the Commission.

C. Organizational Setting of the Commission.

The Commission is an independent agency located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as provided under §19-103(c), are to :

[1] Unless otherwise noted, statutory references are to the Health General Article.

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by advocating policies and systems to promote the efficient delivery of and improved access to health care services, and to enhance the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services.

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan, and a modified health benefit plan for medical savings accounts;

(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners.

(8) Ensure utilization of the medical care data base as a primary means to compile data and information, and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Develop a uniform set of effective benefits to be offered as substantial, available, and affordable coverage in the non-group market in accordance with §15-606 of the Insurance Article;

(12) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article; and

(13) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors.

The Commission has sole authority to prepare and adopt the State Health Plan for Facilities and Services and to issue Certificate of Need decisions and exemptions based on that Plan. Subsection §19-121(e) requires the Secretary of Health and Mental Hygiene to make annual recommendations to the Commission on the Plan and permits the Secretary to review and comment on the specifications used in its development. However, §19-110(a) prohibits the Secretary from disapproving or modifying any determinations the Commission makes regarding the State Health Plan. The Commission pursues effective coordination with the Secretary and State health-related agencies in the course of developing its plans and plan amendments. As required by statute, the Commission coordinates with the hospital rate-setting program of the Health Services Cost Review Commission to assure access to care at reasonable costs. The Commission also coordinates its activities with the Maryland Insurance Administration. Any changes to the State Health Plan are submitted to the Governor and become effective 45 days thereafter, unless the Governor notifies the Commission of an intent to modify or revise the Plan or any amended chapter.

D. Applicability and Plan Content.

The statute defining medical services for the purpose of Certificate of Need coverage for addictions treatment in acute general hospitals and intermediate care facilities is found at §19-123(a)(4)(i)(1) and (4). In addition, §19-123(4)(ii) includes in the definition of medical service any subcategory of intermediate care services for which need is projected in the State Health Plan.

This Chapter repeals and replaces COMAR 10.24.14 State Health Plan: Alcoholism and Drug Abuse Treatment Services, which comprises one chapter of the overall State Health Plan for Facilities and Services for Maryland.

Issues and policies for alcohol and drug abuse treatment services are discussed in Regulation .03. Regulation .04 discusses the docketing requirements for Certificate of Need applications, .05 addresses Certificate of Need approval rules for new and existing intermediate care facilities, .06

lists the preferences for Certificate of Need approval, .07 describes the bed need methodology and .08 lists the definition of terms used in the Chapter.

.03 Alcohol and Drug Abuse Treatment Services

A. Introduction

The Commission has identified several issues which may be grouped into the following five broad issue areas, including access to care, funding, quality, data collection, and continuum of care. These areas directly impact intermediate care facilities for chemically dependent individuals.

B. Statement of Issues and Policies

1. Access To Care

While financial access for the indigent and gray area population has been improving, it continues to be Maryland's major problem in providing alcohol and drug abuse treatment services.[2] Historically, there has been and continues to be a two-tier system of care based upon the individual's ability to pay.[3] Individuals without the means to pay for treatment in private facilities have been either denied care or forced to wait several weeks for care in a publicly-funded facility that is reimbursed at less than half the rate of private facilities. Public facilities, length of stay is on average three days less than in private facilities.[4] Alcohol and drug abuse treatment, especially intermediate care, is not only out of reach of much of the indigent population, but is also too expensive for many low- and middle-income individuals. Publicly-funded intermediate care facilities (ICFs) are presently faced with growing waiting lists, while many private programs are experiencing relatively low occupancies.[5] While the goals of financial access and a one-tier system of care will be difficult to attain, the Commission sees increased financial access for the poor as one means toward the creation of a one-tier system of care. Therefore, it is the Commission policy to create a separate review procedure to increase access to additional bed need for public ICFs, subject to the limitation of public funding, in exchange for the facility providing a majority of its care to the indigent population and requiring

[2] Between FY 99 and FY 00, the total number of intermediate care facility discharges decreased by 11 percent from 8,435 to 7,579. However, the number of indigent discharges increased by 26 percent from 3,758 to 4,730 over the same time period.

[3] Substance Abuse Management Information Systems ("SAMIS") data show the disparity between public and private programs. Some private programs having only 10 percent of their population represent the indigent or gray area clients.

[4] Substance Abuse Management Information Systems, Length of Stay by Payor 1999-2000, Alcohol and Drug Abuse Administration, April 2001.

[5] Based on SAMIS reports, occupancy rates in private ICFs range from the low 40 to 75 percent in CY 2000.

partnerships among state, local jurisdictions, and non-profit providers. These ICFs are referred to in the State Health Plan as "Track Two facilities".

The Commission has projected separate bed need projection mechanisms for public and private patients in order to increase access to care for indigent patients and reduce competition among those facilities that take predominantly private patients. The Commission determines ICF private bed need on a regional rather than jurisdictional basis to help ensure financial feasibility of new facilities that are of sufficient size to provide quality care.

The Commission's projected range of bed need for private intermediate care facilities reflects the impact of utilization review by managed behavioral care organizations that has produced low occupancies in most facilities. This range gives the Commission the flexibility to review projects in light of issues relating to financing, capacity, and quality. These ICF beds are referred to in this State Health Plan as "Track One beds".

Another component of access is the needs of special populations. Clients and their families reflect the diversity of our population, including differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender. Treatment should be responsive to the needs of different cultures and population groups, and to the client's family structure, social support structure, and community environment.

Certain groups have had inadequate access to treatment because of barriers, such as the lack of specialized or culturally relevant programs, lack of appropriate training for treatment staff, and lack of child care and interpreters.[6] The treatment system has also had difficulty treating the more chronic and difficult-to-treat patients and designing programs to meet their special needs.

The alcohol and drug abuse treatment system should improve services for individuals addicted to or abusing one or more substances (poly-addicted) and those who have co-existing conditions (mental illness and addiction). Providers should assure that patients with co-existing diagnoses of either alcohol or drug abuse and a psychiatric disorder are treated in the program appropriate to their primary diagnosis. Both conditions should be considered in planning for the treatment of this population.

[6] U.S. Department of Health and Human Services, SAMHSA, *Improving Substance Abuse Treatment: The National Treatment Plan Initiative*, Rockville, Maryland , November 2000.

Gender may be a barrier to treatment because programs have historically been aimed at men, and there are a limited number of programs oriented to the treatment of women and juveniles. To identify and treat the underserved female population and provide child care to their children, increased outreach efforts and alternative programming can be more efficiently directed toward, and coordinated with, primary care and obstetrical/gynecologic providers, the usual points of entry for women into the health care system.

Alcohol, cocaine, and intravenous drug abuse are strongly associated with multiple obstetrical complications and high rates of perinatal morbidity and mortality. Clinical reports and studies have confirmed that drug use during pregnancy can harm a pregnant woman, and her unborn child, and effect aspects of the child's development after birth.[7] Health care providers in routine drug treatment programs are not trained to address the specialized medical, psychological, and psycho-social problems that are presented by pregnant addicts and their addicted infants. The development and expansion of treatment programs for the pregnant addict will reduce the number of obstetrical complications, ensure the delivery of healthier infants, provide effective family planning, and provide long-term health benefits for both mothers and children.[8] [9]

State and local funding permit substance abuse treatment services to be provided to less than two-thirds of the prison and jail population. Increased treatment capacity in correctional facilities would help identify and treat many of the chronic recidivists who cost the treatment and criminal justice system a disproportionate share of state resources. The Alcohol and Drug Abuse Administration has significantly increased its commitment to this population.[10] The Division of

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[7] Alcohol Resources and Health, *Prenatal Exposure To Alcohol,* Vol. 24, No. 1 2000; 32-41. Maternal alcohol consumption during pregnancy can cause serious birth defects, of which fetal alcohol syndrome (FAS) is the most devastating. Recognizable by characteristic craniofacial abnormalities and growth deficiency, this condition includes severe alcohol-induced damage to the developing brain. FAS children experience deficits in intellectual functioning; difficulties in learning; memory; problem-solving; and attention; and difficulties with mental health and social interactions. Fetal Alcohol Syndrome (FAS) is currently the major cause of mental retardation in the Western world.

[8] Daley M, Argeriou M, McCarty D, Callahan JJ Jr, Shepard DS, Williams CN.The Impact Of Substance Abuse Treatment Modality On Birth Weight And Health Care Expenditures. *Journal of Psychoactive Drugs.* : Vol. 33, No. 1, Jan-Mar, 2001: 55-66.

9 Daley M, Argeriou M, McCarty D, Callahan JJ Jr, Shepard DS, Williams CN. The Costs Of Crime And The Benefits Of Substance Abuse Treatment For Pregnant Women. *Journal of Substance Abuse Treatment,* Vol. 19 , No.4, Dec. 19 2000: 445-58.

[10]The ADAA is committed to funding jail-based treatment programs begun by federally funded Byrne Grant resources through the Governor's Office of Crime Control and Prevention. Historically, the ADAA funds approximately two new programs each year which are demonstrated to be an effective treatment resource, Memorandum, dated June 11, 2001, from Ray Miller.

Parole and Probation cannot duplicate the services provided by public or private agencies, but should be in a position to purchase services for a selected number of parolees and probationers under its jurisdiction. The potential payoffs to the system and society may be great if additional dollars are allocated to meet this need.

Services for children and adolescents have historically been under funded and unavailable in several areas of the state. Adolescents have special treatment needs because of their stage of life, including family problems and social dysfunction. A family-centered approach should be encouraged in the treatment of the population, when appropriate. There is a need for increased coordination and collaboration among the many agencies, especially the Department of Juvenile Justice to provide outreach, early intervention, and services to adolescents.

Two lesser known underserved populations are the hearing-impaired and the elderly. As outreach efforts are intensified and the hearing-impaired are made aware of the availability and accessibility of treatment and interpreter services, funds need to be provided to make services available. In addition, studies show that alcohol consumption rates among those over 60 are as high as for middle-aged adults.[11] As the elderly population grows, overmedication, prescription drug abuse, and over-the-counter drug abuse are expected to become more serious. The Commission supports providing substance abuse treatment services for persons with special needs including the hearing impaired and the elderly.

Policy 1.0 **The Commission will create a separate Certificate of Need review track to encourage public intermediate care facilities to increase access to services for indigent and gray area patients. To be considered for this review track, a project must document and secure public funding, make a commitment to allocate more than half of its capacity to treat the indigent and gray area population, and create an active partnership with local and state governments.**

[11] Atkinson, R.M. Age Specific Treatment of Older Adult Alcoholics, Alcohol Problems and Aging, NIAAA, Rockville, Maryland 2001.

Policy 1.1 **The Commission will require private intermediate care providers to achieve and maintain a specified minimum level of care to treat publicly funded indigent and gray area populations.**

Policy 1.2 **The Commission will support the development of programs to treat special and underserved populations, including: addicted pregnant women; mothers and their infants; women; the elderly; the homeless; low-income individuals; the disabled; minorities; persons involved with the criminal justice system; and others with special needs. All programs should be responsive to the needs of different cultures and to the client's family structure, social support structure, and community environment.**

2. Funding for Alcohol and Drug Treatment Services

In FY 1999, the Alcohol and Drug Abuse Administration has estimated that 232,807 individuals were in need of alcohol and drug abuse treatment.[12] In Maryland, problems associated with drug and alcohol abuse cost the state between $1.3 billion and $5.5 billion a year.[13] For every $1 spent on treatment, studies have shown, $5-$7 is saved in addiction-related costs including criminal justice, child welfare and education.[14] Over the past decade in Maryland, as a result of budget cuts and managed care, twelve private intermediate care facilities for addiction rehabilitation care were closed and several substance abuse programs were discontinued within hospitals.

As a result of significant support for expanding and improving drug and alcohol treatment services, the General Assembly passed legislation in 1998 (House Bill 149) establishing a Task Force to Study Increasing the Availability of Substance Abuse Programs ("Drug Treatment Task Force" or "Task Force"). The Drug Treatment Task Force published a needs assessment that identified scarce availability of several treatment modalities in each jurisdiction, including detoxification services, residential treatment, and halfway

[12] Estimate formulated by the Alcohol and Drug Abuse Administration & Center for Substance Abuse Research, 1999.
[13] Center for Substance Abuse Research. University of Maryland 1995.
[14] Gerstein et al , *The National Treatment Evaluation Study: Final Report*, Rockville, MD, 1997.

house/transitional placements.[15] This Task Force's needs assessment identified 20 of the 24 Maryland jurisdictions as needing intermediate care facilities or detoxification services.[16]

To address the downsizing of programs, the impact of utilization review by managed care, and reduction in services caused by state budget cuts, the Task Force has recommended increasing the baseline drug and alcohol treatment system funding for operational and capital expansion by an additional $300 million over the next ten years, from both public and private sources such as private health insurance.[17]

Policy 2.0 **The Commission will support efforts to significantly increase both public and private funding for drug and alcohol treatment to close the treatment gaps and to create an effective system of care.**

3. Quality of Care

Alcoholism and drug dependence are treatable illnesses. Individuals suffering from these illnesses deserve effective, state of the art treatment; however, the quality of treatment varies across the treatment system within Maryland. There is no system-wide, agreed upon quality measurement protocol. Lack of understanding and skepticism about the effectiveness of treatment has been a barrier to its expansion. Currently, the addiction field relies on an array of different approaches to assess the quality of care, including the use of different performance measures, practice guidelines, accreditation, licensing and certification, and credentialing.

To attain higher standards of care, the alcohol and drug abuse treatment system must promote the development and application of new knowledge and treatment approaches as well as innovations that improve efficiency and responsiveness. The system should make the best possible use of resources provided for care, and must be fully accountable to clients and families, to funding sources, and to the public.

A performance measurement system would help ensure this accountability. By annually evaluating information from drug and alcohol treatment programs on specific performance indicators, the State would be able to improve its management of the drug and alcohol treatment

[15] Id.
[16] Drug Treatment Task Force: *Filling In the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems,* February 29, 2000.
[17] Drug Treatment Task Force Final Report, *Blueprint For Change: Increasing the Effectiveness of Maryland's Drug and Alcohol Treatment Systems,* February 2001.

system. A performance measurement system may help build public support for additional treatment resources and expansion of these services. In collaboration with Maryland's drug treatment provider community, the Maryland Department of Health and Mental Hygiene, and the U.S. Department of Health and Human Services, the Drug Treatment Task Force has developed a core set of indicators to identify research-based performance measures.[18]

In addition to episodic monitoring, uniform monitoring of treatment facilities needs to be an ongoing process. ICFs have not been inspected by the state licensing authority from 1995 to 2001 due to a decision by the Department of Health and Mental Hygiene to rely upon Joint Commission on Accreditation of Healthcare Organizations (JCAHO) "deemed status" for certification and to not inspect ICF programs.[19] Currently there are four ICF in Maryland programs that are not JCAHO accredited. The Commission needs to rely upon other qualitative standards to ensure quality in these programs. To move closer toward a one-tier system of care, there must be uniformity among accreditation requirements.

Policy 3.0 **To improve the effectiveness of the drug and alcohol treatment system and its programs, the Commission will support efforts to implement a statewide performance measurement system as recommended by the Drug Treatment Task Force.**

Policy 3.1 **Each Maryland intermediate care facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or CARF …The Rehabilitation Accreditation Commission or other accrediting body deemed appropriate by the Department of Health and Mental Hygiene and must also be certified by the Office of Health Care Quality of the Department of Health and Mental Hygiene.**

[18] The core set of indicators identified by the Drug Treatment Task Force include: drug/alcohol use, criminal involvement, employment status, and living arrangements. p.27.

[19] In 1995, the Office of Health Care Quality (formally the Office of Licensing and Certification Programs) made the decision to no longer inspect facilities due to reallocation of resources. JCAHO accreditation would be used as a "deemed status" for the facility. However, House Bill 403 passed in the 2001 General Assembly now requires all ICFs to be inspected and certified by the State.

4. Data Collection Systems

Gaps within the treatment system contribute to the difficulty of transferring patient-specific information from one system to another and of collecting comprehensive individual data. For systems to interface effectively, they must effectively share data. Currently, data systems with overlapping clients often do not exchange information. These systems frequently lack updated information systems, standard reporting requirements, and consistent and clear communications process.

Complicating matters is that the collection of data for detoxification and rehabilitative addiction care is inadequate and incomplete. Historically, the State Health Plan requires Certificate of Need applicants to report to the Substance Abuse Management Information System (SAMIS). However, SAMIS is not integrated with hospital data bases that include inpatient, emergency room, and outpatient data. Particularly important are five elements of data: patient origin; payor source; readmissions, length of stay; and charge per admission. SAMIS collects all the elements except change per admission. It is important to have a data system that can follow patients as they move into different parts of the treatment continuum. The collection of data must protect patient confidentiality and be consistent with federal and state regulations.

Although the Alcohol and Drug Abuse Administration can track individuals who obtain care in state-certified treatment programs, it cannot track individuals through all settings. For this reason, it is difficult to evaluate the quality and cost-benefit of the specific kinds of care.

Policy 4.0 **The Commission will support efforts to develop a more comprehensive and integrated data collection and management system administered by the Alcohol and Drug Abuse Administration through the Substance Abuse Management Information System (SAMIS) to obtain data required to plan for needed services, to evaluate outcomes, and to assess treatment innovations.**

Policy 4.1 **The Commission will support efforts to require all public and private intermediate care facilities to report on a regular basis to SAMIS data required to support planning for services.**

5. The Continuum of Care

There is limited capacity systemwide to provide treatment to addicted individuals.[20] The development of additional intensive, rehabilitative, and other outpatient services may provide alternatives for families to receive care near their homes and assist family members in the process of recovering together from addiction.

Economies of scale, quality of care, and distribution of services to increase geographic accessibility need to be considered in planning for the alcohol and drug abuse treatment system. Providers within the system should keep abreast of current trends, new and more effective treatments methods, and changing public priorities and policies. Public agencies and both public and private payors need to monitor the development of the treatment system to assure that, as treatment modalities change, programs incorporate these changes.

All acute general hospital emergency rooms provide substance abuse-related services. The Commission supports the development of regionalized systems of emergency care to meet the increasing demand for services.[21] Due to intensified utilization review by third party payors, and the inability of many acutely addicted patients to pay for hospital care, there are few hospitals that specialize in addiction care.[22] Since individual hospitals have reduced the availability of detoxification services, regionalization of services may assure continued access to hospitals for those who require this level of care.

Policy 5.0 **Each jurisdiction or region should have a balanced service system with increased capacity for intensive, rehabilitative and other kinds of outpatient and community based services, where needed.**

Policy 5.1 **The Commission, in cooperation with the Alcohol and Drug Abuse Administration, should support the development of regionalized acute detoxification units.**

[20] Drug Treatment Task Force: *Filling In the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems,* February 29, 2000.

[21] Alling, F.A. Detoxification and Treatment of Acute Sequelae. In: Lowinson, J.H., Ruiz, P., Millman, R.B., eds. *Substance Abuse: A Comprehensive Textbook.* Baltimore, MD: Williams and Wilkins; 1992.

[22] Alcohol and Drug Abuse Administration, Substance Abuse Directory, 2000.

.04 Docketing Requirements for Certificate of Need Applications to Establish Intermediate Care Facilities Providing Substance Abuse Treatment Services

The Commission reviews Certificate of Need applications to establish new ICFs or to expand existing ICFs providing substance abuse treatment services, depending on the level of publicly-funded treatment provided in the facility. Private beds, ("Track One") as defined at Regulation .08, refers to facilities that admit a majority of private-pay patients, and Publicly-funded beds, ("Track Two") also defined at Regulation .08, refer to those facilities with 50 percent or more of their beds funded by any combination of public funds.

A. The following requirements apply to both Track One and Track Two Certificate of Need applications.

(1) The Commission will docket Certificate of Need applications from applicants that apply only for either private bed capacity (Track One) or publicly-funded bed capacity (Track Two).

(2) The Commission will docket a Certificate of Need application for expansion of an existing intermediate care facility only if the applicant has been operating the facility for at least two years and is documented by the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) or by the applicant as having an 85 percent average annual occupancy rate of its beds for two consecutive years prior to the applicant's letter of intent. Occupancy calculated on the basis of physical bed capacity deemed usable by the applicant, when this differs from licensed bed capacity, can be found to comply with this standard, based on the applicant's documentation of physical bed capacity.

B. The following docketing requirements apply only to applicants to establish a Track Two intermediate care facility for substance abuse treatment.

(1) The Commission will docket a Certificate of Need for publicly-funded beds, as defined in Regulation .08 of this Chapter, only if the applicant proposes to reserve 50 percent or more of its proposed annual adolescent or adult intermediate care facility bed days for indigent and gray area patients.

(2) The Commission will docket a Certificate of Need application for new publicly-funded beds, as defined in Regulation .08 of this Chapter, to establish a new intermediate care facility, or to expand an existing facility only if the applicant:

(a) Provides a signed letter of commitment from the Alcohol and Drug Abuse Administration, or a signed agreement with one or more state or jurisdictional authorities that documents sufficient funding for the bed and service capacity proposed at the new facility, and

(b) Documents, through Memoranda of Understanding (MOUs), linkages with related state and local government agencies, defining:

(i) Areas of cooperation and shared responsibilities; and

(ii) The applicant's agreement to screen, evaluate, diagnose, and treat individuals with alcohol or drug diagnoses, including uninsured, underinsured, and court-committed persons;

I Documents that if the affected jurisdiction or region has a written plan that shows the need for the applicant's proposed service and that the applicant's proposal is consistent with the local plan(s);

(d) Documents that the applicant, in cooperation with the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration will use approved admission criteria, to assure proper placement of mentally ill substance abusers, and will:

(i) Treat mildly mentally ill substance abusers;

(ii) Treat or refer the moderately mentally ill substance abuser to a more appropriate facility and program; and

(iii) Refer the severely mentally ill substance abuser to a facility with a medically appropriate level of care.

(e) Documents that the applicant will provide priority to each affected jurisdiction's residents for admission to the facility, regardless of their ability to pay for treatment.

(f) Documents that the entire facility, including existing and proposed intermediate care facility beds, will meet the annualized indigent and gray area requirements as specified in Regulation .08.

.05 Certificate of Need Approval Rules and Review Standards for New Substance Abuse Treatment Facilities and for Expansions of Existing Facilities

A. Approval Rules Related To Facility Size. Unless the applicant demonstrates why a relevant standard should not apply, the following standards apply to applicants seeking to establish or to expand either a Track One or a Track Two intermediate care facility.

(1) The Commission will approve a Certificate of Need application for an intermediate care facility having less than 15 beds only if the applicant dedicates a special population as defined in Regulation .08.

(2) The Commission will approve a Certificate of Need application for a new intermediate care facility only if the facility will have no more than 40 adolescent or 50 adult intermediate care facility beds, or a total of 90 beds, if the applicant is applying to serve both age groups.

(3) The Commission will not approve a Certificate of Need application for expansion of an existing alcohol and drug abuse intermediate care facility if its approval would result in the facility exceeding a total of 40 adolescent or 100 adult intermediate care facility beds, or a total of 140 beds, if the applicant is applying to serve both age groups.

B. Identification of Intermediate Care Facility Alcohol and Drug Abuse Bed Need.

(1) An applicant seeking Certificate of Need approval to establish or expand an intermediate care facility for substance abuse treatment services must apply under one of the two categories of bed need under this Chapter:

(a) For Track One, the Commission projects maximum need for alcohol and drug abuse intermediate care beds in a region using the need projection methodology in Regulation .07 of this Chapter and updates published in the *Maryland Register*.

(b) For Track Two, as defined at Regulation .08, an applicant who proposes to provide 50 percent or more of its patient days annually to indigent and gray area patients may apply for:

(i) Publicly-funded beds, as defined in Regulation .08 of this Chapter, consistent with the level of funding provided by the Maryland Medical Assistance Programs (MMAP), Alcohol and Drug Abuse Administration, or a local jurisdiction or jurisdictions; and

(ii) A number of beds to be used for private-pay patients in accordance with Regulation .08, in addition to the number of beds projected to be needed in Regulation .07 of this Chapter.

(2) To establish or to expand a Track Two intermediate care facility, an applicant must:

(a) Document the need for the number and types of beds being applied for;

(b) Agree to co-mingle publicly-funded and private-pay patients within the facility;

(c) Assure that indigents, including court-referrals, will receive preference for admission, and

(d) Agree that, if either the Alcohol and Drug Abuse Administration, or a local jurisdiction terminates the contractual agreement and funding for the facility's clients, the facility will notify the Commission and the Office of Health Care Quality within 15 days that that the facility is relinquishing its certification to operate, and will not use either its publicly- or privately-funded intermediate care facility beds for private-pay patients without obtaining a new Certificate of Need.

C. Sliding Fee Scale. An applicant must establish a sliding fee scale for gray area patients consistent with the client's ability to pay.

D. Provision of Service to Indigent and Gray Area Patients.

(1) Unless an applicant demonstrates why one or more of the following standards should not apply or should be modified, an applicant seeking to establish or to expand a Track One intermediate care facility must:

(a) Establish a sliding fee scale for gray area patients consistent with a client's ability to pay;

(b) Commit that it will provide 30 percent or more of its proposed annual adolescent intermediate care facility bed days to indigent and gray area patients; and

(c) Commit that it will provide 15 percent of more of its proposed annual adult intermediate care facility bed days to indigent or gray area patients.

(2) A existing Track One intermediate care facility may propose an alternative to the standards in Regulation D(1) that would increase the availability of alcoholism and drug abuse

treatment to indigent or gray area patients in its health planning region.

(3) In evaluating an existing Track One intermediate care facility's proposal to provide a lower required minimum percentage of bed days committed to indigent or gray area patients in Regulation D(1) or an alternative proposal under Regulation D(2), the Commission shall consider:

(a) The needs of the population in the health planning region; and

(b) The financial feasibility of the applicant's meeting the requirements of Regulation D(1).

(4) An existing Track One intermediate care facility that seeks to increase beds shall provide information regarding the percentage of its annual patient days in the preceding 12 months that were generated by charity care, indigent, or gray area patients, including publicly-funded patients.

E. **Information Regarding Charges.** An applicant must agree to post information concerning charges for services, and the range and types of services provided, in a conspicuous place, and must document that this information is available to the public upon request.

F. **Location.** An applicant seeking to establish a new intermediate care facility must propose a location within a 30-minute one-way travel time by automobile to an acute care hospital.

G. **Age Groups.**

(1) An applicant must identify the number of adolescent and adult beds for which it is applying, and document age-specific treatment protocols for adolescents ages 12-17 and adults ages 18 and older.

(2) If the applicant is proposing both adolescent and adult beds, it must document that it will provide a separate physical, therapeutic, and educational environment consistent with the treatment needs of each age group including, for adolescents, providing for continuation of formal education.

(3) A facility proposing to convert existing adolescent intermediate care substance abuse treatment beds to adult beds, or to convert existing adult beds to adolescent beds, must obtain a Certificate of Need.

***H.* Quality Assurance.**

(1) An applicant must seek accreditation by an appropriate entity, either the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), in accordance with CFR, Title 42, Part 440, Section 160, the CARF…The Rehabilitation Accreditation Commission, or any other accrediting body approved by the Department of Health and Mental Hygiene. The appropriate accreditation must be obtained before a Certificate of Need-approved ICF begins operation, and must be maintained as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its accreditation continues in good standing, and an applicant seeking to establish an ICF must agree to apply for, and obtain, accreditation prior to the first use review required under COMAR 10.24.01.18; and

(b) An ICF that loses its accreditation must notify the Commission and the Office of Health Care Quality in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended.

(c) An ICF that loses its accreditation may be permitted to continue operation on a provisional basis, pending remediation of any deficiency that caused its accreditation to be revoked, if the Office of Health Care Quality advises the Commission that its continued operation is in the public interest.

(2) A Certificate of Need-approved ICF must be certified by the Office of Health Care Quality before it begins operation, and must maintain that certification as a condition of continuing authority to operate an ICF for substance abuse treatment in Maryland.

(a) An applicant seeking to expand an existing ICF must document that its certification continues in good standing, and an applicant seeking to establish an ICF must agree to apply for certification by the time it requests that Commission staff perform the first use review required under COMAR 10.24.01.18.

(b) An ICF that loses its State certification must notify the Commission in writing within fifteen days after it receives notice that its accreditation has been revoked or suspended, and must cease operation until the Office of Health Care Quality notifies the Commission that deficiencies have been corrected.

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(c) Effective on the date that the Office of Health Care Quality revokes State certification from an ICF, the regulations at COMAR 10.24.01.03C governing temporary delicensure of a health care facility apply to the affected ICF bed capacity.

I. **Utilization Review and Control Programs.**

(1) An applicant must document the commitment to participate in utilization review and control programs, and have treatment protocols, including written policies governing admission, length of stay, discharge planning, and referral.

(2) An applicant must document that each patient's treatment plan includes, or will include, at least one year of aftercare following discharge from the facility.

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,

(g) The Department of Juvenile Justice and local juvenile justice authorities, if applying for beds to serve adolescents.

K. **Sources of Referral.**

(1) An applicant proposing to establish a new Track Two facility must document to demonstrate that 50 percent of the facility's annual patient days, consistent with Regulation .08 of this Chapter, will be generated by the indigent or gray area population, including days paid under a contract with the Alcohol and Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority.

(2) An applicant proposing to establish a new Track One facility must document referral agreements to demonstrate that 15 percent of the facility's annual patient days required by Regulation .08 of this Chapter will be incurred by the indigent or gray area populations, including days paid under a contract with the Alcohol or Drug Abuse Administration or a jurisdictional alcohol or drug abuse authority, or the Medical Assistance program.

L. **In-Service Education**. An applicant must document that it will institute or, if an existing facility, maintain a standardized in-service orientation and continuing education program for all categories of direct service personnel, whether paid or volunteer.

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.

N. **Voluntary Counseling, Testing, and Treatment Protocols for Human Immunodeficiency Virus (HIV).** An applicant must demonstrate that it has procedures to train staff in appropriate methods of infection control and specialized counseling for HIV-positive persons and active AIDS patients.

O. **Outpatient Alcohol & Drug Abuse Programs.**

(1) An applicant must develop and document an outpatient program to provide, at a minimum: 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.

(2) An applicant must document continuity of care and appropriate staffing at off-site outpatient programs.

(3) Outpatient programs must identify special populations as defined in

Regulation. 08, in their service areas and provide outreach and outpatient services to meet their needs.

(4) Outpatient programs must demonstrate the ability to provide services in the evening and on weekends.

(5) An applicant may demonstrate that outpatient programs are available to its patients, or proposed patient population, through written referral agreements that meet the requirements of (1) through (4) of this standard with existing outpatient programs.

P. **Program Reporting.** Applicants must agree to report, on a monthly basis, utilization data and other required information to the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) program, and participate in any comparable data collection program specified by the Department of Health and Mental Hygiene.

.06 Preferences for Certificate of Need Approval.

A. In a comparative review of applicants for private bed capacity in Track One, the Commission will give preference to a proposed project seeking Certificate of Need approval to establish or expand an intermediate care facility if the project's sponsor will commit to:

(1) Increase access to care for indigent and gray area patients by reserving more bed capacity than required in Regulation .08 of this Chapter;

(2) Treat special populations as defined in Regulation .08 of this Chapter or, if an existing alcohol or drug abuse treatment facility, treat special populations it has historically not treated;

(3) Include in its range of services alternative treatment settings such as intensive outpatient programs, halfway houses, therapeutic foster care, and long-term residential or shelter care;

(4) Provide specialized programs to treat an addicted person with co-existing mental illness, including appropriate consultation with a psychiatrist; or,

(5) In a proposed intermediate care facility that will provide a treatment program for women, offer child care and other related services for the dependent children of these patients.

B. If a proposed project has received a preference in a Certificate of Need review pursuant to this regulation, but the project sponsor subsequently determines that providing the identified type or scope of service is beyond the facility's clinical or financial resources:

(1) The project sponsor must notify the Commission in writing before beginning to operate the facility, and seek Commission approval for any change in its array of services pursuant to COMAR 10.24.01.17.

(2) The project sponsor must show good cause why it will not provide the identified service, and why the effectiveness of its treatment program will not be compromised in the absence of the service for which a preference was awarded; and

(3) The Commission, in its sole discretion, may determine that the change constitutes an impermissible modification, pursuant to COMAR 10.24.01.17C(1).

.07 Bed Need Projection Methodologies.

A. Acute Inpatient Bed Need. Need for alcohol and drug abuse acute inpatient beds is combined with the need for other medical/surgical beds and is projected in accordance with the methodology found in the Acute Inpatient Services Chapter of the State Health Plan for Facilities and Services for Facilities and Services, COMAR 10.24.10.

B. Intermediate Care Private Bed Need (Track One).

(1) Period of Time Covered.

(a) The base year is the most recent year for which the number of Medicaid recipients is available.

(b) The target year to which need is initially projected is five years from the base year.

(2) Age Groups.

(a) Need is projected separately for adolescent (12-17 years) and adult (18 years and over) populations.

(b) No need for children aged 0-11 is projected due to low prevalence.

(3) Geographic Regions. Need projections for Track I adolescent and adult facilities are made on a regional basis as follows:

(a) Western Maryland (Allegany, Garrett, Washington, Frederick , and Carroll Counties);

(b) Montgomery County;

(c) Southern Maryland (St. Mary's, Calvert, Charles, and Prince George's Counties);

(d) Central Maryland (Baltimore City and Baltimore, Harford, Howard, and Anne Arundel Counties) and;

(e) Eastern Shore (Cecil, Kent, Queen Anne's, Talbot, Caroline, Dorchester, Wicomico, Worcester, and Somerset Counties.

(4) Assumptions.

(a) Need is assumed to increase in proportion to the age-adjusted growth in population in each region.

(b) The size of the indigent population is assumed to remain the same from the base to the target year.

(c) Prevalence rates used in each age group are assumed to remain constant.

(i) A 15 percent prevalence rate for the adolescent population at-risk of alcohol or drug abuse, and an 8.64-percent prevalence rate for the adult population, are assumed.[22]

(ii) 20 percent of the at-risk adolescent population and 25 percent of the at-risk adult population are assumed to need some kind of treatment.

(d) 95 percent of the population in need of treatment are assumed to require some form of services, while five percent are assumed to require only information to recover without services.

(e) 12.5 to 15 percent of the adolescent target treatment population are assumed to require care in an intermediate care facility for all regions. For all regions except the Eastern Shore, 12.5 to 15 percent of the adult target treatment population are assumed to require care in an intermediate care facility. For the Eastern Shore it is assumed that 15 to 30 percent of the adult target treatment population are assumed to require care in an intermediate care facility.

(f) 20 percent of adolescents and 10 percent of adults receiving care in an intermediate care facility are assumed to require readmission during the year discharged from a facility.

(g) Projected in-migration is based upon out-of-state-generated discharges in the base year.

(h) Existing beds funded by contract with the Alcohol and Drug Abuse Administration and with local jurisdictions that are assumed to serve indigent patients are excluded from the Track I projections and ICF bed inventory.

(i) Existing beds in which charity care is provided within Track I facilities without public funding that are assumed to serve indigent and gray area patients are not excluded from the population for which need is projected.

(j) Projected need is for Maryland facilities only.

[22] Prevalence estimates have been reviewed by the Alcohol and Drug Abuse Administration and by the Center for Substance Abuse Research and are calculated using the *NIMH Epidemiologic Catchment Area Program Estimates, Archives of General Psychiatry*, 1984 for the adult population, and the National Household Survey on Drug Abuse, Population Estimates, Office of Applied Studies, SAMHSA 1996, Rockville, MD, Office of Applied Studies for the adolescent population.

(5) Data Sources.

(a) Population projections are obtained from the most recent figures prepared by the Maryland Office of State Planning.

(b) The indigent population is obtained by identifying the number of indigent and medically indigent federally and non-federally matched Medical Assistance recipients for the 12-17 and 18 and older age groups by region for the most recent calendar year of data available from the Medical Assistance program of the Department of Health and Mental Hygiene.

(c) The adult prevalence rate is developed from the recent national survey data from the National Institute of Mental Health, and the adolescent prevalence rate is obtained by trending the annual survey of high school drug use conducted by Maryland State Department of Education.[23]

(d) Utilization data from the Alcohol and Drug Abuse Administration's Substance Abuse Management Information System (SAMIS) is used to determine the average length of stay, the rate of in-migration and the readmission rates.

(e) The number of discharges of out-of-state residents who received care in Maryland in the base year is obtained from SAMIS data.

(f) The inventory of private and publicly-funded intermediate care adolescent and adult beds are those beds:

(g) Certified by the Office of Health Care Quality; and

(h) Identified and recognized as providing intermediate care by the Commission and by the Alcohol and Drug Abuse Administration, regardless of licensure status.

(6) Revisions.

(a) The Commission will revise the need projections every two years to account for updated population projections, changes in the inventory of licensed and certified beds, and changes in the number of Medical Assistance recipients.

(b) Revised need projections will be published as a notice in the *Maryland Register.*

[23] Maryland Adolescent Survey Maryland State Department of Education, 1998.

(7) **Method of Calculation for Private Beds.** The need for private beds is calculated as follows:

(a) Identify by geographic region the non-indigent Maryland population for the 12-17 years and 18 years and above age groups by subtracting the number of Medical Assistance recipients from the projected Maryland population for the target year.

(b) Estimate the adolescent and adult populations at risk of alcohol and drug abuse by multiplying the non-indigent population in Maryland by a prevalence rate of 0.15 for the adolescent population and a prevalence rate 0.0864 for the adult population.

(c) Estimate the non-indigent adolescent and adult target population by multiplying the at-risk adolescent population by 0.20 and the at-risk adult population by 0.25. Estimate the non-indigent adolescent and adult populations requiring some form of treatment by multiplying the adolescent and adult target populations by 0.95.

(d) Estimate the non-indigent adolescent and adult target treatment populations requiring care in an intermediate care facility by multiplying the adolescent target treatment population and the adult target treatment population by 0.15.

(e) Estimate the intermediate care treatment populations requiring readmission in the target year by multiplying the adolescent intermediate care treatment population by 0.20 and the adult intermediate care treatment population by 0.10.

(f) Calculate the total number of persons requiring intermediate care by adding the intermediate care treatment population, readmissions, and the number of out-of-state discharges from intermediate care facilities in the base year.

(g) Calculate the gross number of adolescent and adult intermediate care beds required by multiplying the total number of persons requiring intermediate care by a 22-day average length of stay for adolescents and a 14-day average length of stay for adults, and dividing by the product of 365 and 0.85.

(h) Calculate the adjusted inventory of intermediate care beds by subtracting the number of intermediate care beds in facilities recognized by the Commission as serving at least 30 to 50 percent publicly-budgeted indigent patients from the total number of licensed and certified beds that are identified by the Commission as providing intermediate care, including beds that may be licensed for psychiatric care that are included in the inventory.

(i) Calculate the total net number of adolescent and adult intermediate are beds needed by subtracting the adjusted inventory from the gross number of intermediate care beds needed.

(8) Mathematical Formulas.

(a) Definition of Terms. Terms used in subsection (b) below are defined in the following table:

Term	Definition
h	Region
k	Age group, where adolescents = 12-17 and adults = 18 and older
m	Minimum and maximum intermediate care treatment rate, where 1 = 0.125 and 2 = 0.15
NIPOP	Non-indigent Maryland population
POP	Maryland population in the target year
IPOP	Indigent Maryland population
ARPOP	Population at risk of substance abuse
PREV	Prevalence rate of substance abusers, where 0.15 = adolescent and 0.0864 = adult
TPOP	Target population
TPR	Target population rate, where 0.20 = adolescent and 0.25 = adult
TTPOP	Target treatment population
ICTPOP	Intermediate care treatment population
ICTR	Intermediate care treatment rate
READD	Readmissions
RR	Readmission rate, where 0.20 = adolescents and 0.10 = adults
TOTPOP	Total population requiring intermediate care treatment in Maryland
OOSPOP	Discharges of out-of-state patients
GPNEED	Gross private intermediate care beds needed
ALOS	Average length of stay
AINV	Adjusted inventory of private intermediate care beds
PINV	Inventory of intermediate care beds that comprise facilities at least 50 percent of whose annual patient days are generated by indigent or gray are population consistent with Regulation .08
TNEED	Total net intermediate care bed need

(b) The need projection methodology described above is shown in the following table in mathematical form:

$NIPOP_{hk}$	=	$POP_{hk} - IPOP_{hk}$
$ARPOP_{hk}$	=	$(NIPOP_{hk})(PREV_k)$
$TPOP_{hk}$	=	$(ARPOP_{hk})(TPR_k)$
$TTPOP_{hk}$	=	$.95(TPOP_{hk})$
$ICTPOP_{hkm}$	=	$(TTPOP_{hk})(ICTR_{km})$
$READD_{hkm}$	=	$(ICTPOP_{hkm})(RR_k)$
$TOTPOP_{hkm}$	=	$(ICTPOP_{hkm} + READD_{hk} + OOSPOP_{hk})$
$GPNEED_{hkm}$	=	$(TOTPOP_{hkm})(ALOS_k)/(365)(.85)$
$AINV_{hk}$	=	$INV_{hk} - PINV_{hk}$
$TNEED_{hkm}$	=	$GPNEED_{hkm} - AINV_{hk}$

C. Intermediate Care Publicly-Funded Bed Need (Track Two).

The Commission has established criteria for approval of projects outside of the bed need methodology. Such projects must demonstrate need and meet additional standards, as provided in Regulation .04C.

.08 Definitions.

A. In this Chapter, the following terms have the meanings indicated.

B. **Terms Defined.**

(1) "Acute alcohol and drug abuse services" means emergency and detoxification services provided to individuals requiring 24-hour medical or psychiatric care as a result of life-threatening or serious acute or chronic alcohol or drug abuse, or medical psychiatric illness associated with substance abuse, provided in licensed acute general hospitals defined in Health-General Article §19-301(f)-(g), Annotated Code of Maryland.

(2) "Alcohol and Drug Abuse Administration" means the agency of the Department of Health and Mental Hygiene responsible for planning and funding treatment of persons abusing or addicted to alcohol or other drugs.

(3) "Alcoholism and drug abuse rehabilitation" means rehabilitation provided in any of five settings: intermediate care (ICF-C/D) facilities for the treatment of alcohol abuse (previously called quarterway programs); hospital-based alcoholism rehabilitation units; long-term residential care programs; residential drug abuse treatment facilities; and alternative rehabilitation care (alternative living unit, non-residential intermediate care, intensive and other outpatient programs).

(4) Charity Care.

(a) "Charity care" means care for which there is no means of payment by the patient or any third party payor, except public funding.

(b) "Charity care" does not mean the uninsured or partially insured days designated as deductibles or copayments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer or between a provider and a patient, or a waiver of payment due to family relationship, friendship, or professional courtesy.

(5) "CON-approved" beds means those beds that are approved by the Commission to provide care but have not yet been licensed, or have not yet received general certification by the Office of Health Care Quality, as required to begin providing services.

(6) "Detoxification" means the systematic medically-supervised reduction of the effects of alcohol or drugs and the effects of alcohol or drug withdrawal in the body, which commonly occurs in one of four settings: acute general hospitals (acute detoxification only);

alcoholism rehabilitation units and intermediate care facilities (sub-acute detoxification only); non-hospital detoxification (sub-acute only); or non-health care settings (self-induced withdrawal).

(7) "Emergency alcohol and drug abuse service" means evaluation and treatment for life-threatening medical complications of alcohol or drug abuse.

(8) "General certification" means the status given to an intermediate care facility by the Department of Health and Mental Hygiene's Alcohol and Drug Abuse Administration upon compliance with program standards found in COMAR 10.47.10.05,C granted to any alcoholism or drug abuse treatment program which fully meets all standards established by the Alcohol and Drug Abuse Administration.

(9) "Gray area population" means those persons who do not qualify for services under the Maryland Medical Assistance Program but whose annual income from any source is no more than 180 percent of the most current Federal Poverty Index, and who have no insurance for alcohol and drug abuse treatment services.

(10) "Halfway house" means a facility for rehabilitating recovering alcohol or drug abusers who need a community-based residence that provides a controlled, supportive, alcohol-free and drug-free environment and who are ambulatory and capable of self-care but are not yet ready to return to their families or to live on their own. Services often include informational, social, and recreational activities; vocational rehabilitation; and self-help group meetings, including individual and group counseling for a length of stay ranging from three to twelve months.

(11) "Indigent population" means those persons who qualify for services under the Maryland Medical Assistance Program, regardless of whether Medical Assistance will reimburse for alcohol and drug abuse treatment.

(12) "Intensive outpatient program" means the outpatient programs intended for alcohol or drug abusers who live at home but require an intensive therapeutic environment that provides treatment several hours a day, up to seven times per week, often in evenings, during weekends, or both, and provides a full range of group and individual therapy, counseling, and educational programs.

(13) "Intermediate care facility" means a facility designed to facilitate the sub-acute detoxification and rehabilitation of alcohol and drug abusers by placing them in an

organized therapeutic environment in which they receive medical services, diagnostic services, individual and group therapy and counseling, vocational rehabilitation, and work therapy while benefiting from the support that a residential setting can provide.

(a) An adolescent intermediate care facility is programmatically designed to serve those 12-17 years of age for lengths of stay of 30-60 days.

(b) An adult intermediate care facility is programmatically designed to serve those 18 and older for lengths of stay of 7-21 days.

(14) "Jurisdiction" means any of the 23 Maryland counties or Baltimore City.

(15) "Long-term care facility" means a program with a treatment regimen that provides continuous treatment for over 60 days, including halfway houses, therapeutic communities, long-term residential care programs, and other alternative stay programs that provide care over an extended period of time.

(16) "Long-term residential care program" means a program serving chronic alcoholic substance abusers who: are ambulatory and not in need of daily nursing, medical, or psychiatric care; have a history of multiple admissions to alcoholism or drug abuse treatment facilities in addition to physical and mental disabilities as a result of prolonged alcohol or drug abuse; and have been identified as persons for whom a controlled environment and supportive therapy is necessary for an indefinite period of time. Services include meals, medical and psychiatric services, individual and group therapy and counseling, and education, recreation, and work therapy.

(17) "Mental Hygiene Administration" means the agency of the Department of Health and Mental Hygiene responsible for planning and funding the treatment of mentally ill persons.

(18) "Office of Health Care Quality" means the agency of the Department of Health and Mental Hygiene responsible for the licensing, certification, and quality assurance of health care facilities.

(19) "Outpatient alcoholism and drug abuse treatment program" means care provided on both a scheduled and non-scheduled basis to alcohol or drug abusing persons and their families whose physical and emotional status allow them to live at home while obtaining treatment in settings such as local health departments, hospital clinics, community centers, private counseling centers, and private physicians' offices.

(20) "Private beds" mean intermediate care facility beds not sponsored by local jurisdictions and without significant funding by the state or local jurisdictions, the need for which is identified in accordance with Regulation .07 of this Chapter to serve patients in a facility providing no less than 30 percent of its annual patient days to the indigent and gray area population for an adolescent intermediate care facility and no less than 15 percent of the facility's annual patients days for an adult intermediate care facility (Track One).

(21) "Publicly-funded beds" means intermediate care beds in facilities owned and wholly operated by the State or substantially funded by the budget process of the State; or in facilities substantially funded by one or more jurisdictional governments, which are established jointly by providers and the jurisdiction or jurisdictions to meet the special needs of their residents and that reserve at least 50 percent of their proposed annual adolescent or adult bed capacity for indigent and gray area patients (Track Two).

(22) "Relapse" means an interruption or termination of the recovery process as a result of resumption of the use of alcohol or drugs and the deterioration of lifestyle and level of functioning that is an integral part of the disease of addiction for which appropriate intervention strategies should be incorporated at each level of treatment.

(23) "Self-help groups" means Narcotics Anonymous, Chemical Dependence Anonymous, Alcoholics Anonymous, Women for Sobriety, and other voluntary fellowships or groups that support persons in recovery from drug and alcohol and provide individual needs assessment, treatment planning, referral to additional sources of care, treatment, and aftercare.

(24) "Special populations" means those populations that historically have not been, or are not now served by the alcohol and drug abuse treatment delivery system including, women and women with dependent children, the elderly, the homeless, the poor, adolescents, persons with mixed dependencies, hearing impaired, the disabled, minorities, and others with special needs.

(25) "Sub-acute detoxification" means short-term treatment for the intoxicated or overdosed individual who may be appropriately treated outside an acute care hospital.

(26) "Substance Abuse Management Information System" (SAMIS) means the Alcohol and Drug Abuse Administration's management information system to which intermediate care facilities and other alcohol and drug abuse facilities and programs must report utilization, cost, and other data.

(27) "Support services" means alcohol and drug abuse services such as diagnosis, information and referral, ambulatory care treatment, individual and family counseling, treatment follow-up, and privately organized therapeutic group counseling.

(28) "Uncompensated care" means that portion of a facility's charges that it is unable to collect from either patients or a third-party payor, and includes both charity care and bad debts.

APPENDIX

TABLES

Table 1
Gross and Net Private Intermediate Care Facility (ICF) Bed Need Projections
For Adolescents (Ages 12-17), 2005

	Western Maryland (1)	Montgomery County	Southern Maryland	Central Maryland (2)	Eastern Shore	Total
Projected Population- 2005	50,497	74,334	96,929	194,025	32,754	448,539
Indigent Population	6,906	6,677	14,079	41,228	7,084	75,974
Non-Indigent Population	43,591	67,657	82,850	152,797	25,670	372,565
Est. No. of Substance Abusers (15%)	6,539	10,149	12,428	22,920	3,851	55,885
Estimated Annual Target Population (20%)	1,308	2,030	2,486	4,584	770	11,177
Estimated No. Requiring Treatment (95%)	1,242	1,928	2,361	4,355	732	10,618
Estimated Range Requiring Intermediate Care (12.5%-15%)						
Minimum	155	241	295	544	91	1,327
Maximum	186	289	354	653	110	1,593
Estimated Range Requiring Readmission (20%)						
Minimum	31	48	59	109	18	265
Maximum	37	58	71	131	22	319
Total Discharges from Out-of-State	0	0	0	8	0	8
Range Requiring Intermediate Care						
Minimum	186	289	354	661	110	1,601
Maximum	224	347	425	792	132	1,919
Gross Private Bed Need Range (22 ALOS - 85% Occupy.)						
Minimum	13	21	25	47	8	114
Maximum	16	25	30	56	9	136
Existing Private (3) ICF Inventory (No. of Beds)	0	0	0	68	0	68
Net Intermediate Private Bed Need Range						
Minimum	13	21	25	(0)	8	64
Maximum	16	25	30	(0)	9	80

Notes:
(1) Western Maryland includes Carroll County
(2) Negative bed need is tabulated as zero (0)
(3) Does not include facilities within the juvenile justice system.

Source: Maryland Health Care Commission (Data on ALOS and discharges from out-of-state are from the Substance Abuse Management Information System; data on the indigent population is from the Maryland Medical Assistance Program, June 2000; population projections are from the Maryland Office of Planning, updated February 2000; and the ICF bed inventory is based on Commission files and a telephone survey conducted in June 2000.)

Table 2
Gross and Net Private Intermediate Care Facility (ICF) Bed Need Projections
For Adults (Ages 18+), 2005

	Western Maryland (1,2)	Montgomery County	Southern Maryland	Central Maryland	Eastern Shore (4)	Total
Projected Population- 2005	445,321	682,209	834,128	2,308,229	298,418	4,568,305
Indigent Population	23,501	23,523	41,187	129,424	21,642	239,277
Non-Indigent Population	421,820	658,686	792,941	2,178,805	276,776	4,329,028
Est. No. of Substance Abusers (8.64%)	36,445	56,910	68,510	188,249	23,913	649,354
Estimated Annual Target Population (25%)	9,111	14,228	17,128	47,062	5,978	162,339
Estimated No. Requiring Treatment (95%)	8,656	13,516	16,271	44,709	5,679	154,222
Estimated Range Requiring Inter. Care (12.5%-15%)						
Minimum	1,082	1,690	2,034	5,589	1,420	19,278
Maximum	1,298	2,027	2,441	6,706	1,988	23,133
Estimated Range Requiring Readmission (10%)						
Minimum	108	169	203	559	142	1,928
Maximum	130	203	244	671	199	2,313
Total Discharges from Out-of-State	10	0	4	204	12	230
Range Requiring Intermediate Care						
Minimum	1,200	1,858	2,241	6,351	1,574	21,435
Maximum	1,438	2,230	2,689	7,581	2,199	25,677
Gross Priv. Bed Need Range (14 ALOS - 85% Occupy.)						
Minimum	54	84	101	287	71	968
Maximum	65	101	121	342	99	1,160
Existing Private ICF Inventory (3)	111	10	0	80	42	243
Net Intermediate Private Bed Need Range						
Minimum	(0)	74	101	207	29	411
Maximum	(0)	91	121	262	57	531

Notes:
(1) Western Maryland includes Carroll County
(2) Negative bed need is tabulated as zero (0)
(3) Does not include ICFs in the adult justice system
(4) At the request of ADAA, assumptions for the Eastern Shore are that 25%-35% will require ICF care.

Source: Maryland Health Care Commission (Data on ALOS and discharges from out-of-state are from the Substance Abuse Management Information System; data on the indigent population is from the Maryland Medical Assistance Program, June 2000; population projections are from the Maryland Office of Planning, updated February 2000; and the ICF bed inventory is based on Commission files

COMAR 10.24.14
Table 3
Inventory of Private Intermediate Care Facility (ICF) Alcohol and Drug Abuse Treatment Beds for Adults and Adolescents: Maryland, October 2000

Region/Facility Name	Adult ICF Beds			Adolescent ICF Beds		
	Certified by DHMH	CON Approved	Total	Certified by DHMH	CON Approved	Total
WESTERN MARYLAND	111	0	111	0	0	0
Mountain Manor	111	0	111	0	0	0
MONTGOMERY COUNTY	10	0	10	0	0	0
Montgomery General	10	0	10	0	0	0
SOUTHERN MARYLAND	0	0	0	0	0	0
CENTRAL MARYLAND	80	0	80	68	0	68
Mountain Manor	0	0	0	68	0	68
Ashley	80	0	80	0	0	0
EASTERN SHORE	42	0	42	0	0	0
Warrick Manor	42	0	39	0	0	0
MARYLAND TOTAL	**243**	**0**	**243**	**68**	**0**	**68**

Source: Maryland Health Care Commission (Data reported is based on Commission files and a telephone survey conducted in June 2000 and updated in October 2000.)

COMAR 10.24.14
Table 4
Inventory of Publicly-Funded Intermediate Care Facility (ICF) Alcohol and Drug Abuse Treatment Beds for Adults and Adolescents: Maryland, October 2000

Region/Facility Name	Adult ICF Beds			Adolescent ICF Beds		
	Certified by DHMH	CON Approved	Total	Certified by DHMH	CON Approved	Total
WESTERN MARYLAND	64	0	64	33	0	33
Finan Center						
Massie Unit	25	0	25	0	0	0
Jackson Unit	0	0	0	33	0	33
Carroll Addiction Rehab Center	20	0	20	0	0	0
Shoemaker Womens Program	19	0	19	0	0	0
MONTGOMERY COUNTY	32	0	32	0	0	0
Avery Treatment Center	32	0	32	0	0	0
SOUTHERN MARYLAND	40	0	40	0	0	0
Anchor @ Walden-Sierra	20	0	20	0	0	0
Reality House	20	0	20	0	0	0
CENTRAL MARYLAND	117	0	117	20	0	20
Pathways	20	0	20	20	0	20
Hope House	18	0	18	0	0	0
Turek House	63	0	63	0	0	0
Arc House	16	0	16	0	0	0
EASTERN SHORE	53	0	53	0	0	0
Whitsett Rehab Center	20	0	20	0	0	0
Hudson Center	33	0	33			
				0		
MARYLAND TOTAL	**306**	**0**	**306**	**53**	**0**	**53**

Source: Maryland Health Care Commission (Data reported is based on Commission files and a telephone survey conducted in June 2000 and updated in August 2001.)

COMAR 10.24.14
Table 5
Summary of Net Intermediate Care Facility (ICF) Private Bed Need Range, by Region and Age Group: Maryland, 2005
(Track One)

Region	Age Group	Intermediate Care Facility (ICF) Bed Need Range (2005)
Western Maryland		13-16
	Adolescents	13-16
	Adults	0
Montgomery County		95-116
	Adolescents	21-25
	Adults	74-91
Southern Maryland		126-151
	Adolescents	25-30
	Adults	101-121
Central Maryland		207-262
	Adolescents	0
	Adults	207-262
Eastern Shore		21-29
	Adolescents	8-9
	Adults	29-57
Maryland State Total		459-574
	Adolescents	64-80
	Adults	411-532

(*) Negative bed need is tabulated as zero.

Source: Maryland Health Care Commission, October 2000