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STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

DOCKET NO. 22-32515-CON

LANDMARK RECOVERY OF CONNECTICUT, LLC
ESTABLISHMENT OF A NEW HEALTH CARE FACILITY

VIA ZOOM AND TELECONFERENCE

Public Hearing held on Wednesday, July 20, 2022, beginning at 10:06 a.m. via remote access.

H e l d B e f o r e:

DANIEL J. CSUKA, ESQ., Hearing Officer

Administrative Staff:

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****All participants were present via remote access.**

(Whereupon, the hearing commenced at 10:06 a.m.)

HEARING OFFICER CSUKA: Good morning, everyone. Landmark Recovery of Connecticut, LLC, the applicant in this matter, seeks to establish a new health care facility pursuant to Connecticut General Statutes, Section 19a-638(a)(1). Specifically, it is seeking to establish a new detox/residential facility in New London for the treatment of substance use disorders.

Today is July 20, 2022, and it's 10 -- actually it's 10:07 a.m. My name is Daniel Csuka. Victoria Veltri, the former executive director of the Office of Health Strategy, designated me to serve as the hearing officer for this matter to rule on all motions and to recommend findings of fact and conclusions of law upon the completion of the hearing. Section 149 of Public Act No. 21-2, as amended by Public Act No. 22-3, authorizes an agency to hold a hearing by means of electronic equipment. In accordance with this legislation, any person who participates orally in an electronic meeting shall make a good faith effort to state his or her name and title at the outset of each occasion that the person participates orally during an uninterrupted dialogue or series

of questions and answers. We ask that all members of the public mute their device that they are using to access the hearing and silence any additional devices that are around them.

This public hearing is held pursuant to Connecticut General Statutes, Section 19a-639a(f)(2). Although this does not constitute a contested case under the Uniform Administrative Procedure Act, the manner in which OHS conducts these proceedings will be guided by the UAPA and the regulations of Connecticut state agencies.

Office of Health Strategy staff is here to assist me in gathering facts related to this application and will be asking the applicant's witnesses questions. They may also ask the intervenor questions as well. I'm going to ask each staffperson assisting with questions today to identify themselves with their name, spelling their last name, and OHS title. So we're going to start first with Steve.

MR. LAZARUS: Good morning. Steven Lazarus, L-A-Z-A-R-U-S.

HEARING OFFICER CSUKA: Thank you. And Annie.

MS. FAIELLA: Good morning. Annie

Faiella, F-A-I-E-L-L-A.

HEARING OFFICER CSUKA: Thank you. Also present is Mayda Capozzi, spelled C-A-P-O-Z-Z-I. She's a staff member for our agency, and she's assisting with the hearing logistics and will also gather the names for public comment later on.

The certificate of need process is a regulatory process, and as such, the highest level of respect will be accorded to the applicant, the members of the public, the intervenor and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be maintained by all present during these proceedings.

This hearing is being transcribed and recorded, and the video will also be made available on the OHS website and its YouTube account. All documents related to this hearing that have been or will be submitted to the Office of Health Strategy are available for review through the CON portal which is accessible on our website.

In making my decision, I will consider and make written findings of fact in accordance

with Section 19a-639 of the Connecticut General Statutes.

Lastly, as Zoom notified you in the course of entering the hearing, I do wish to point out that appearing on camera in this virtual hearing you are consenting to being filmed. If you wish to revoke your consent, please do so at this time.

So with that, we are going to move on. The CON portal contains a table of record that was uploaded a couple days ago. As of that table of record, exhibits were identified in the table from A to W. There are some others that I will get to. And I realize that the applicant has also taken issue with one of those exhibits, which we will also get to, in connection with its motion to strike that was filed yesterday or the day before, I don't recall which.

The applicant is hereby noticed that I am taking administrative notice of the following documents: The Statewide Health Care Facilities and Services Plan, the Facilities and Services Inventory, the OHS acute care hospital discharge database and All-payer claims database. A relevant excerpt from that was uploaded as Exhibit

V on July 18th. I may also take administrative notice of hospital reporting system financial and utilization data, and also prior OHS final decisions that may be relevant here.

Counsel for the applicant, Ms. Volpe, can you please identify yourself for the record.

MS. VOLPE: Sure. Thank you. My name is Michele Volpe, V-O-L-P-E. I'm counsel to the applicant in this proceeding, Landmark.

HEARING OFFICER CSUKA: Thank you. And counsel for the intervenor, High Watch Recovery Center, can you please identify yourself for the record.

MS. FELDMAN: Thank you. Good morning, my name is Joan Feldman, "F," like in "Frank," E-L-D-M-A-N, and I am with the law firm Shipman & Goodwin in Connecticut.

HEARING OFFICER CSUKA: Thank you. So as I mentioned, I will get to the exhibits in a moment, but first I thought I should address some of the recent filings, specifically Landmark's request for reconsideration, its objection and its motion to strike, as well as High Watch's response. I have reviewed all of the submissions. Thank you for your filings. They were helpful.

I'm going to start first with Landmark's request for reconsideration. I am going to grant the request but deny Landmark the relief requested. High Watch has made a showing that they satisfy the statutory and regulatory criteria that guide today's hearing. Landmark can cross-examine High Watch on its submission, and I will give the documents and testimony whatever weight they are due.

Next, is Landmark's motion to strike the prefiled testimony. To the extent that it seeks to strike the entire prefile testimony of Mr. Schwab, I'm going to deny that as well. High Watch's counsel has represented in writing that her witness will be available and will adopt his testimony on the record. In the future I would -- we are going to change policy a little bit. I would just ask that, if at all possible, that prefile testimony be notarized. But given her representation, I'm going to not strike the testimony in its entirety.

To the extent that the applicant has moved to strike portions of High Watch's prefile testimony, I'm going to deny that motion as well except as it pertains to request Nos. 4 and 10.

So No. 4 concerns the last statement on page 2 of Mr. Schwab's prefile testimony which reads, "This pace and growth is a bellwether for further rapid growth and the very likely goal of selling or flipping the applicant's business enterprise, including the 48 bed facility to private equity in the near future." It's possible, I'm not going to limit all inquiry into this general area though, for example, I think it could be fair to ask questions about what Landmark's plans are for the future.

As to No. 10, that concerns the entirety of the second full paragraph on page 7 of Mr. Schwab's prefiled testimony. It begins, "Moreover, it is clear that the applicant is unfamiliar with the State of Connecticut's regulatory requirements," et cetera.

So that is my ruling on those submissions that were submitted over the past couple of days. The exhibits that will be added to the table of record are Exhibit X, which is the table of record itself; Exhibit Y, which is Attorney Volpe's notice of appearance; Exhibit Z, which is Landmark's request for reconsideration, objection and motion to strike; and Exhibit AA,

which is intervenor's response to that filing.

So, with all of that said, Attorney Volpe, are there any other objections to the exhibits in the table of record, the additional exhibits I identified, or the noticed documents?

MS. VOLPE: Thank you, Hearing Officer Csuka. I would just like an opportunity to, for the record, just note our objections on your ruling and decision, if I can just have a minute to address that. You know, for everyone, I'm Michele Volpe. I'm counsel for the applicant in these proceedings. And we just want it noted in the record that while this hearing is being called in accordance with (f)(2), we do feel that it puts the applicant at a disadvantage that the agency is allowing intervenors and affording them, you know, all the general rights that a hearing would be in a contested case, yet the applicant is at a disadvantage in that they're procedurally being prohibited from certain rights, specifically rights to appeal in this proceeding depending on the OHS's decision.

So, you know, intervenors and others are being afforded great deference in allowing to cure their deficiencies with their status in this

proceeding. In fact, you know, there have been multiple deficiencies, and great deference has been provided to them to cure. However, again, the applicant is being denied certain extended procedural rights regarding the fact that this is not being conducted as a contested case, and we just want that on the record.

You know, the other item we'd like to point out is we appreciate you granting certain motions on our striking provisions of the intervenor testimony. However, then allowing the applicant to be crossed on that, you know, we're taking issue with that and are also noting our objection to that as well. So, we did want to be on record on that point, but we respect your rulings and of course are going to abide by those in this proceeding.

HEARING OFFICER CSUKA: Thank you. And of course if there are questions that are asked, if you have further objection, you are free to raise those at the time they are posed as well.

MS. VOLPE: We will.

HEARING OFFICER CSUKA: So thank you. So --

MS. FELDMAN: Hearing Officer Csuka,

may I respond to that statement?

HEARING OFFICER CSUKA: Certainly.

MS. FELDMAN: Thank you very much. This is Joan Feldman speaking, counsel for High Watch. To have such a chilling effect on testimony which is in the best interest of the public and the health care system in the state which serves individuals with substance use disorders is highly questionable, in my opinion. I think it's very important to put the truth out there, the facts out there, and have individuals who have firsthand experience in the State of Connecticut to provide free unfettered testimony and let the hearing officer decide the weight to be given to any of the statements or testimony provided.

Historically, the agency has always had a philosophy or approach toward these proceedings which allowed, you know, as much testimony from the public, from intervenors, from interested parties, and it served the agency and the health care delivery system very well. So I just, on behalf of my client, I'm quite shocked by this position. I think it's nothing more than an attempt to muffle what is important testimony.

Thank you.

HEARING OFFICER CSUKA: Thank you, Attorney Feldman. And I did note in one of your recent submissions that you provided a few docket numbers as well where historically the agency has permitted intervenors even in (f)(2) hearings. So thank you for that.

MS. FELDMAN: Correct. Thank you.

MS. VOLPE: I'd just like to address that. Obviously, the applicant welcomes the opportunity for anyone to offer facts at the hearing and provide information. My specific points were to take issue with the procedural deficiencies in that the intervenor did, you know, have an opportunity to request a hearing and neglected to do so during the statutory period. So, you know, and they were allowed to cure, you know, deficiencies, significant deficiencies in their submission for party status. So that was really the point of our objection was to note the procedural shortcomings that had been allowed to be corrected.

And, you know, I would just add that the applicant should be given great deference in this proceeding. And to the extent that there are

deficiencies that OHS notes with the ability to approve its application, we would, you know, like the same sort of courtesy to let us know what are those shortcomings or deficiencies to the extent they even exist. So, it was really just to note some of the procedural points that we wanted to highlight.

MS. FELDMAN: I'm going to keep this very short and just say that counsel for the applicant keeps talking about deference to the applicant. Nowhere in the statute is there a provision that says that the agency should not allow testimony at a deference to the applicant due to procedural issues that have been corrected or the fact that this is a discretionary hearing. So I think, you know, it's important to proceed here and provide whatever testimony we can offer, and we're available for cross-examination. Thank you.

HEARING OFFICER CSUKA: Thank you. My ruling will stand, but I do appreciate your comments, both of you. So all identified and marked exhibits are going to be entered as full exhibits with the exception, of course, of those two provisions and the prefile testimony that were

stricken.

(Exhibits X, Y, Z and AA: Received in evidence - described in index.)

HEARING OFFICER CSUKA: Attorney Volpe, do you have any additional exhibits you wish to enter at this time?

MS. VOLPE: Not at this time.

HEARING OFFICER CSUKA: Okay. And Attorney Feldman, how about you, do you have any?

MS. FELDMAN: I don't, but I do have a question regarding Exhibit C.

HEARING OFFICER CSUKA: Okay.

MS. FELDMAN: And, again, it could be something that I missed. But you referred to the applicant's response to the first completeness letter, dated March 30th, and I thought it was dated March 29th.

HEARING OFFICER CSUKA: Annie, let's see --

MS. VOLPE: There's a footnote in your table of record, Hearing Officer, that says, unless otherwise indicated, all dates refer to the date on which the documents were uploaded.

HEARING OFFICER CSUKA: Okay. Yeah, it is dated March 29th.

MS. FAIELLA: It was uploaded on the 30th.

HEARING OFFICER CSUKA: Okay.

MS. VOLPE: Thank you.

HEARING OFFICER CSUKA: So that would explain that inconsistency.

MS. FELDMAN: Okay. Because the footnote relates to Exhibit A, so I'm just questioning that.

HEARING OFFICER CSUKA: Okay.

MS. FELDMAN: I just want to confirm that I'm looking at the right exhibit.

HEARING OFFICER CSUKA: Thank you for bringing that to my attention. We will -- so there will be a table of record that's uploaded after the hearing, and we'll certainly go through with a fine tooth comb and make sure that to the extent there are any other inconsistencies like that, we will address them.

MS. FELDMAN: Thank you.

HEARING OFFICER CSUKA: So with that, we are going to proceed in the order established with the agenda for today's hearing. I do wish to advise the applicant that we may ask questions related to your application that you feel have

already been addressed. We will do this for the purpose of ensuring that the public has knowledge about your proposal and for the purpose of clarification. I do want to reassure you that we have reviewed your application, the completeness responses, the prefile testimony, et cetera. And trust me when I say I will do so many times before issuing a decision.

As this hearing is being held virtually, we ask that all participants, to the extent possible, enable the use of video cameras when testifying or commenting. And as I mentioned earlier, all participants should mute their devices whenever possible, especially when we go off camera or take a break. We will do our best to ensure that we turn off the recording and turn off the video during the breaks, but it's possible that they may continue, and whatever happens on video or audio will be recorded.

Public comment taken during the hearing will likely go in the order established by OHS during the registration process; however, I may allow public officials to testify out of order. I or the OHS staff will call each individual by name when it is his or her turn to speak. Registration

for public comment will take place at 2 p.m. and is scheduled to begin at 3 p.m. If the technical portion of this hearing has not been completed by 3 p.m., public comment may be postponed until the technical portion is complete. The applicant's witnesses must be available after the public comment as well as the intervenor's witnesses as OHS may have follow-up questions based on the public comment.

Are there any other housekeeping matters or procedural issues that we need to address before we start? Attorney Volpe?

MS. VOLPE: Well, I'd like to make some opening remarks and request that administrative notice be taken of certain other dockets, you know, if we can just do that maybe at the end of my remarks, or if you'd like it now, we can do it now, whatever your preference is.

HEARING OFFICER CSUKA: We can do it at the end of your remarks.

MS. VOLPE: Okay. And then in terms of the agenda, after the public comment period I know you have closing remarks. And, you know, if need be, we'd just like an opportunity to address anything as well at that time after public

comment.

HEARING OFFICER CSUKA: Okay. That's fine.

And Attorney Feldman, do you have any other housekeeping matters?

MS. FELDMAN: No, I do not.

HEARING OFFICER CSUKA: Okay. So we're going to move on to the technical portion of this hearing. I'm going to start first with the applicant. Ms. Volpe, do you have an opening statement?

MS. VOLPE: Yes, I have very brief remarks, and then I'd like to have Chris Kang present testimony in support of the application.

So the application before you addresses a dire need in Connecticut for residential facilities to help fight the debilitating opioid and substance use crisis in Connecticut. People are dying and overdosing at alarming rates. Inpatient evidence-based substance use treatment being offered by Landmark is the foundational building block to combating this growing problem in Connecticut. It's inflicting thousands of Connecticut residents, and it's particularly the most vulnerable residents in our state.

The need for Landmark in Connecticut, and particularly in the New London region, is overwhelming. To put it bluntly, Connecticut residents are dying or becoming disabled at an alarming rate. Nearly every state agency has made substance abuse, use, and opioid crisis a priority issue. The Connecticut Department of Social Services definitively stated in its recent CMS waiver that Connecticut is experiencing one of the most significant public health crisis in history.

Also, in the Statewide Health Care Facilities Plan in the 2016 supplement OHS, this agency, identified substance abuse issues as one of the leading health care needs of most Connecticut communities. These are the state's words, not our words, not Landmark's words. Based on the state's assessment of this crisis, it would be unconscionable for OHS to deny an able, ready, willing and financially sound quality-proven substance use disorder treatment provider to come to Connecticut and provide these needed services to its residents. This application clearly services a public need.

Landmark is here today to serve the Medicaid population of Connecticut and all

residents irrespective of payer. Landmark is willing to expand Medicaid, and they're here to attest to that under oath. During the pending application, CMS approved the Medicaid waiver which will positively impact Medicaid beneficiaries in Connecticut. Landmark is in support of this waiver and will take the necessary steps to be a Medicaid provider in Connecticut. It has an established record in other states of doing just that.

OHS has approved other substance use treatment facilities recently, and we respectfully request that administrative notice be taken of the following dockets approving such residential facilities including, but not limited to, Paramount Wellness Retreat. That was an agreed settlement under Docket No. 21-32502. Also, Mountainside Treatment Center, that's Docket No. 20-32399. Silver Hill Hospital, Docket No. 21-32403. The intervenor also had a docket presented with High Watch Recovery Center, 20-32346, obviously evidencing the great need. And Birch Hill Recovery Center, that's Docket No. 17-32192. So we respectfully request that you take administrative notice of those dockets.

I would like to introduce Mr. Chris Kang, who is part of the executive team for Landmark, and he serves as their general counsel. He's going to provide testimony and evidence to further support applicant's approval of the CON application and supplement the vast amount of evidence in the docket before OHS.

We also just want to note that because the applicant and I are in two different locations, which all of us are because of the virtual hearing, you know, we may on occasion need to communicate with each other. So we may do that via email or text, and I just want to have that noted for the Hearing Officer.

So with that said, I'd like to introduce Mr. Kang. Thank you.

HEARING OFFICER CSUKA: Thank you, Attorney Volpe. But just before I start -- or before Mr. Kang starts, Attorney Feldman, do you have any objections to me taking administrative notice of those dockets?

MS. FELDMAN: With one clarification. I am counsel for Silver Hill Hospital, and that docket number, nothing changed there. It was just a change of licensure status. It was not any

addition of beds or reduction in beds. It was just basically to relicense more appropriately their transitional living program to residential beds, but those have been in existence for over 50 years. Thank you.

HEARING OFFICER CSUKA: Okay.

MS. FELDMAN: Otherwise no objection.

HEARING OFFICER CSUKA: Okay. Thank you, Attorney Feldman.

Ms. Volpe, did you want to respond to that?

MS. VOLPE: Well, just that they are residential beds, you know, offering services particularly relevant to this proceeding.

MS. FELDMAN: We agree.

HEARING OFFICER CSUKA: Okay. Thank you. So I'm sorry to interrupt. Attorney Kang, you can take the floor.

CHRIS KANG: Thank you. My name is Chris Kang. I'm a member of the executive team and serve as the general counsel of Landmark Recovery Louisville and its affiliates, including the applicant. I'd like to thank everybody for the opportunity to speak today in support of our certificate of need application.

As you are aware, we are committed to opening a 48 bed facility in New London, Connecticut that will provide detox and patient residential services to folks who struggle with substance use disorder. At this time, we currently operate 11 facilities across the United States with 21 more facilities in their development. Our goal is to operate 40 facilities by the end of 2023. Our rapid expansion is driven by the enormous need for resources to treat those effected by SUD, especially the opioid epidemic. We are requesting the CON to bring our resources and evidence-based treatment program to Connecticut and specifically the New London community.

There are many public benefits to Landmark opening the proposed facility. Primarily, we'll be able to save more lives from the devastating impact of SUD and improve outcomes for the people with SUD.

Second, we'll be able to add new inpatient bed capacity to the state, importantly to the greater New London area, to expand available inpatient treatment options.

Third, we'll be able to offer high

quality and comprehensive SUD care to our patients.

As everyone is aware, OHS is charged with a statutory mandate to evaluate the CON based on specific guiding principles set forth in Connecticut Law. This application should be approved because it meets all of the statutory CON criteria. I would like to spend the time today going through those criteria and setting forth how Landmark has met each and every statutory factor.

Factor number one, the project is consistent with any applicable policies and standards adopted in regulation by the Department of Public Health. Countless Connecticut state agencies and organizations have made dealing with the destruction and loss of life on account of the opioid epidemic a priority. Top of the list is the standard of care for SUD treatment. As set forth in the application on page 13, the OHS Statewide Health Care Facilities and Services Plan, the 2016 supplement, specifically called out substance use disorder as one of the leading health care needs in Connecticut. OHS itself has identified SUD treatment as a leading health care need, and this project is directly aimed at

expanding treatment for those suffering from SUD. This proposal meets that critical need.

Second factor, there is a favorable relationship of the proposed project to the Statewide Health Care Facilities and Services Plan. Back in 2012, the Statewide Health Care Facilities and Services Plan estimated Connecticut had around 281,000 individuals needing treatment for SUD. Of that population size, it estimated that only around 47,000 would seek treatment, only about 70 percent of the population. As presented in the application on page 13, Landmark discussed data available in the OHS Statewide Health Care Facilities and Services Plan 2020 supplement. The data suggests that much improvement can be made in helping those in need to receive help before they end up in the emergency department. For these reasons and others, OHS has addressed SUD as a high priority health care need. Landmark's establishment of the proposed facility and increasing the state's capacity for SUD care is fully aligned with the Statewide Health Care Facilities and Services Plan.

Number three, there is a clear public need for the health care facility. We cannot

underscore this point enough. There is a significant public need for SUD treatment. As we addressed on page 7 of the application, 723 individuals died from unintentional overdose in 2015. The final number from 2021 is 1,526, more than double. The fact that Connecticut residents are dying and becoming disabled from substance abuse is evidence enough that insufficient capacity exists to counter the SUD crisis. Indeed, in its recent CMS waiver application, the Connecticut Department of Social Services stated Connecticut is experiencing one of the most significant public health crisis in its history. Overdoses are not subsiding and persons affected by SUD continue to need services in the state. As set forth throughout the application, there are countless statistics that all point to the conclusion that SUD is having a devastating impact on Connecticut residents and, in particular, the New London community.

Just to recap some of them here, as noted on page 7 of the application, SAMHSA reporting in 2019 that Connecticut has a higher than national average prevalence rate for SUD among young adults. As mentioned before, we also

sent information that overdose deaths rose nearly twofold during the past six years. This data is directly from the Connecticut DPH.

On page 11 of the application, we summarized articles supporting that Connecticut has a statistically high overdose death rate. Connecticut also has a relatively high incidence of acute care hospitalization and emergency department visits with a significant financial and resource burden to Connecticut providers on top of the pandemic.

In response to Completeness Question No. 1, New London County has seen an uptick in overdose deaths in the past few years increasing from 42 in 2019 to 59 in 2021. We also noted that DUI fatalities are on the rise in Connecticut from approximately 40 in 2015 to about 80 in 2020. Likewise, DPH has published data documenting overdose deaths from January 2022 through March 2022 were comparable to previous years.

It's important to emphasize the overwhelming community support for this application as well. Attached to our application are numerous letters of support from local officials and community group representatives.

Being on the ground, they know the benefits that our proposed facility can bring to the New London community. All of this overwhelmingly demonstrates the need for additional residential detoxification and SUD treatment facilities. Statistics provided established that there is no shortage of substance use and SUD in Connecticut. Even with the harrowing statistics and the high need, the major population area in the proposed service area only have a total of 62 inpatient SUD beds available. It speaks volumes that the Connecticut Department of Social Services specifically sought the Section 1115 Waiver to allow Medicaid patients to have access to such services.

Factor No. 4, we have satisfactorily demonstrated how this proposal will positively impact the financial strength of the health care system in the state, and the proposal is financially feasible for Landmark. The proposal helps the financial strength of the Connecticut health care system. The goal of the SUD inpatient treatment is to treat the individual and get them on the path to health. By doing this, individuals improve their overall physical and mental health.

In turn, they are less likely to have inappropriate ED or inpatient hospital usage. The financial burden and the cost of how the SUD crisis is being dealt with in Connecticut cannot be emphasized enough. Landmark has the resources and infrastructure available to make SUD treatment less costly over time resulting in financial benefits to the Connecticut health care system. SUD facilities are also highly cost effective sending for treatment compared to inpatient hospitalization.

This evidence does not just come from those promoting SUD treatment facilities. As discussed before, Connecticut recognized the financial benefits of specific SUD treatment as it has sought the CMS waiver approval for SUD facility benefit coverage this year. As noted in the response to Completeness Question No. 5, it is estimated that for every dollar spent on SUD treatment, $4 in health care costs are saved, and $7 in criminal justice costs are saved. SUD treatment offers significant savings to Connecticut's health care system.

It is also financially feasible for Landmark. Landmark has a track record of

providing financially viable services that remain as stable providers in the community. Our financial predictions demonstrate that the services will quickly be profitable and will likely exceed the first year projections. This is especially true when I examined Exhibit V which OHS was kind enough to provide. The data from OHS shows that in 2020 the average allowed amount per day was 1,073.16 per day with the median being $902.34 per day. The number in 2021 showed a lower amount, but the average allowed amount per day was still $733.09 per day with the median being 650 per day.

For comparison, I would like to share our budgeted numbers as of May 2022. Our facility located in Louisville operates at a budgeted amount of $575. Our facility located in Indianapolis is $660 per day. Our facility located in Oklahoma City has $497 per day. And our facility located in Las Vegas has $501 per day. Our pro forma budget for the proposed facility, in fact, in New London is $585 per day. We are committed to maintain the constant accessibility of our facilities and prepared to work within the cost growth benchmarks pursuant to

Connecticut statute.

We can also compare the out-of-pocket costs shown in Exhibit V. Based on our current data, our average out-of-pocket costs for our patients this year is around $1,445 at our commercial facilities. Our average length of stay this year is around 26 days. This results in an average out-of-pocket cost of $55.57 per day. By comparison, the average in 2021 in Connecticut was $138.16 per day with the median being $55.45 per day. All of these numbers support that Landmark Recovery would be one of the most cost effective providers in Connecticut.

Factor No. 5, Landmark has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of health care delivery in the region including, but not limited to, provision of, or any change in access to services for Medicare recipients and indigent persons. Our facilities are recognized leaders in quality care. As noted in our application on page 5, we have been recognized for our award winning clinical programs. To maintain our standards, we implemented a robust internal audit program to

make sure that our facilities complied with all relevant requirements, including The Joint Commission standards.

As noted in our CMO, Dr. Kirby's letter on page 67 of the application, this means, among other things, we provide 24-hour nursing services and an in-house licensed provider available seven days per week. Page 11 and page 12 of our application has more information on the same.

We are especially proud of our clinical programming. As noted in our response to Completeness Question No. 22, we work with each patient from the day they arrive to begin the discharge process immediately. We work with them to develop personalized comprehensive written plans tailored to each patient's needs. Based on our survey of the market, we offer more one-on-one treatment hours than other providers. While we continue to collect data, we believe our quality of care speaks for itself. For example, as set forth in response to Completeness Question No. 9, Landmark has lower readmission rates compared to other providers in the country.

When it comes to serving the needs of Medicaid recipients and indigent persons, we are

very unique amongst the larger providers and that serving low-income patients is part of our mission. By end of this year, Landmark will likely become one of the largest, if not the largest, provider of inpatient beds for Medicaid patients. Given the recent approval of the Section 1115 Waiver, representatives of Landmark and its affiliates actually had multiple meetings with and are in active discussion with DMHAS as recent as yesterday about how Landmark can expand its facility in Connecticut to service the Medicaid population. Our charity care policy and offer of financial aid and prompt pay discount to those who qualify is all detailed in the application.

Cost savings are clear when it comes to SUD treatment. Funds spent on SUD treatment have real tangible cost savings to all health care stakeholders in the entire infrastructure of Connecticut. As noted in the response to Completeness Question No. 5, for every $1 spent on SUD treatment $4 in health care costs are saved and $7 in criminal justice costs are saved.

Factor No. 6, Landmark's proposed provision of health care services to relevant

patient population and payer mix including, but not limited to, access to service by Medicaid recipients and indigent persons. As we mentioned several times in our submitted documents, we believe in providing quality evidence-based care to anyone who seeks it. This is true regardless of income level. At this time, we anticipate that 55 percent of Connecticut residents have access to insurance to obtain services at the proposed facility. And as noted on page 22 of the application, we are excited about the development in Connecticut regarding the CMS demonstration waiver as this opens up more opportunity for residents of Connecticut to get the SUD care they need. As stated above, we are in active discussion with DMHAS to open our facilities to all Connecticut residents.

Factor No. 7, Landmark has satisfactorily identified the population to be served by the proposed project and satisfactorily demonstrated that the identified population has a need for proposed services. We have identified that there's a subset of people who need treatment but have not yet sought it. And as set forth in the response to Completeness Question No. 16, we

have outlined in the percentage of population that require SUD facility services. Unlike other medical conditions, people with SUD can live for a long time without treatment. Increasing capacity and promoting access to treatment and utilization can help bring people in sooner for treatment they desperately need. There are thousands of potential patients in the immediate area and tens of thousands in the Connecticut metropolitan area. Indeed, the Statewide Health Care Facilities Services Plan published in 2012 estimated that Connecticut had around 234,000 individuals who needed treatment for SUD but was not receiving it. Based on the publicly available data we examined, it does not appear that the number has substantially decreased. At this point in time, there is unanimous consensus that detox programs alone are not enough. Patients need the continuum of care to find success in their recovery. The services that Landmark will offer will be both detox and inpatient SUD care so patients are put on the best path forward to treatment. Over time Landmark will welcome the opportunity to partner with OHS and DMHAS to discuss how Landmark can contribute to Connecticut having a full range of

care available from ASAM 4.0 to 0.5 services.

No. 8, Landmark will not negatively impact the utilization of the existing health care facilities and health care services in the service area. The proposed new SUD facility will not negatively impact utilization of the existing health care facilities as there are minimal other SUD facility providers in New London. Further, the increase prevalence of SUD and opioid use supports an increased need for SUD capacity. More than half of Connecticut residents have access to SUD facility coverage through their commercial insurance.

Landmark will also have a positive impact on the community through paying taxes and as an employer. Based on the improvements we make to the proposed facility, the City of New London should have tens of thousands of dollars in additional real estate tax revenues each year. We also expect to bring around 50 jobs with an average salary and benefits well above median salary, wages of the current employee population in the New London area.

As noted in our response to Completeness Question 24, we also offer a

practicum program working with colleges and universities to educate future health care providers. This should help train the next generation of health care providers who will continue to serve the local community.

Landmark is also unique in that its recruiting team has a nationwide reach. In situations where the local employee pool cannot meet our needs, we are available to recruit providers from different areas. There are many examples where we encourage our existing staff to move from a different area where they have local ties. As part of this process, we often commit anywhere between $5,000 to $50,000 in fees and costs to recruit and recredential the providers. To the extent that Connecticut suffers from a shortage of skilled providers, we believe we can help improve that process by encouraging out-of-state providers who relocate near a proposed facility with competitive pay and benefits.

Factor No. 9, Landmark has satisfactorily demonstrated that the proposed project does not result in unnecessary duplication of the existing or approved health care services

or facilities. The target patient population to be served has been satisfactorily identified in the application as those persons with SUD. As set forth on page 47 of our application, Connecticut is not at capacity for SUD providers. Overdose deaths are growing, and SUD patients are still presenting in the emergency department at alarming and increasing rates. Despite these statistics, the New London area has a low number of SUD facility beds currently. There are so many patients who need SUD treatment that we anticipate 90 percent occupancy and likely more. See our projections on page 42 of the application for more details.

Further, we believe many of our patients will come from the area, but we are also likely to take patients from a distance. As noted on page 47, we aim to establish a collaborative relationship with other providers to best serve the community. This is because the SUD battle cannot be fought alone. SUD treatments vary in clinical theory and application, and patients deserve a variety of providers to find a facility that best fits their needs. We have a proven track record at our other facilities of working

closely and collaboratively with other organizations in the community.

This is especially true since one area that Landmark Recovery excels at is letting our communities know about the availability of our resources. This is especially true in our social media marketing, various apps like Facebook, Instagram, TikTok, Linked In and more. We have heard countless stories from our patients and their loved ones that they decided to reach out to us while browsing social media. Our world-class admission team is on standby 24/7 to congratulate and encourage those to take their first step towards recovery. Once the commitment is made, our staff at the facility make the arrival as smooth as possible, including our intake team meeting and transporting the patients directly to our facility.

Factor No. 10, Landmark has not failed to provide or reduce access to services by Medicaid recipients and indigent persons. As set forth throughout our application, the completeness question responses, and again in response to the issues list, we have affirmed our commitment to provide service to the Medicaid population. We

are absolutely committed to serving the Medicaid population as noted in our responses. Landmark will be looking at converting this current project into one that accepts Medicaid patients. We work with Medicaid providers in many states and look forward to doing so in Connecticut as well.

Factor 11, Landmark has satisfactorily demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the geographical region. Landmark will be a new provider in Connecticut and will help to improve the diversity of available SUD providers in the state. Patients will have greater choice in the state and particularly the New London region when it comes to inpatient SUD care.

Final factor, Landmark has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect health care costs or accessibility to care. There's no consolidation resulting from this proposal. As noted above, Landmark is a new service provider in Connecticut, and it will improve the diversity of available SUD providers in the state. Indeed, based on the information

shared by OHS in Exhibit V, Landmark will be one of the most cost effective providers in Connecticut.

In conclusion, Landmark is committed to being in Connecticut and will immediately seek a facility license from DPH upon approval of our CON application. We will of course maintain quality in accordance with DPH regulations and clinical guidelines. As stated, we are dedicated to keeping our costs down and will absolutely pursue commercial insurance for in network rates on DPH licensure. We have reviewed the average cost of care SUD that OHS provided, and we're confident that we are extremely competitive with our rates and will work to comply with the health care cost growth benchmark established by Connecticut.

As expressed today and throughout our application, our companies are committed to serving the Medicaid population, and the applicant will continue to maintain its policies to provide access to our services and care to the uninsured and underinsured patients in accordance with our charity care policies.

Again, thank you for your time today. We respectfully urge you to approve this

application to allow us to help Connecticut and its communities fight the substance use epidemic. We welcome any questions OHS may have.

HEARING OFFICER CSUKA: Thank you, Attorney Kang. I realize we went a little bit out of order. I forgot to swear you in. So if you wouldn't mind, please raise your right hand at this time.

H. C H R I S K A N G,

having been first duly sworn (remotely) by the Hearing Officer, testified on his oath as follows:

HEARING OFFICER CSUKA: Okay. Thank you. And also, do you adopt your prefile testimony?

THE WITNESS (Kang): I do.

HEARING OFFICER CSUKA: Okay. Thanks. I apologize for that, but I'm glad I remembered.

So with that, Ms. Volpe, do you have any other witnesses that you plan to present today?

MS. VOLPE: No, we do not. We had Mr. Kang go through the statutory requirements to establish and show OHS how each and every factor has been met, you know, with relevance to the

points in the application. So that concludes our direct presentation. We understand we have the burden of proof, and Mr. Kang walked through how we meet that burden. So that concludes our direct testimony regarding our provision in the application.

HEARING OFFICER CSUKA: Okay. Thank you. So we are going to move on to cross-examination by the intervenor, and that cross-examination should be limited to 19a-639, that criteria. And given that Attorney Kang's testimony focused really well on those criteria, I don't think that should be too difficult here.

Attorney Feldman, do you have any questions for Attorney Kang? You're on mute.

MS. FELDMAN: I do have some questions, and some of my questions relate to representations in the application. So I will proceed with my questions, and we'll see how that all goes. But I believe that they're all relevant questions.

CROSS-EXAMINATION

BY MS. FELDMAN:

Q. Good morning, Attorney Kang. This is Joan Feldman, and I am counsel for the intervenor. And I believe you said in your testimony that you

are the general counsel from Landmark; is that true?

A. That is correct.

Q. And in your role as general counsel, are you typically the spokesperson for Landmark in these regulatory proceedings?

A. Yes and no. Oftentimes my role as a general counsel is involved in, in terms of administrative hearings and any kind of zoning matters, land use matters, a lot of times which would require us to demonstrate why the community would need certain services.

Q. I see. And so I was just wondering why the owner of Landmark is not providing any prefile testimony at the hearing.

MS. VOLPE: I'm going to object to that. I don't see how it's relevant. This is sophisticated intervenor and applicants, and we regularly propose individuals to offer testimony that are not the president of the company. I don't see how it's relevant.

MS. FELDMAN: I think it's relevant because it demonstrates a commitment to this project in the State of Connecticut, and they had pointed out in their application that they're

going from 9 facilities to 22 in one year, and I just want to have a better understanding of that commitment by the owner.

MS. VOLPE: The applicant attested in the CON that they are committed to Connecticut and have the resources, so I think that question has been answered.

HEARING OFFICER CSUKA: I'm going to sustain the objection. He did represent that he's on the executive committee and that he's a member of the team that makes decisions on behalf of the company.

MS. FELDMAN: Okay.

BY MS. FELDMAN:

Q. Attorney Kang, do you have any professional training or expertise in substance use disorders?

A. Can you clarify that question? From a clinical sense?

Q. Yes.

A. Medical sense?

Q. Yes.

A. Not from a clinical sense, no.

Q. Okay. Or from a personal experience --

MS. VOLPE: I'm going to object to

that.

MS. FELDMAN: Okay. Withdrawn.

MS. VOLPE: It's irrelevant.

MS. FELDMAN: Well, you'll see that it's not irrelevant when my client testifies.

BY MS. FELDMAN:

Q. All right. So Attorney Kang, can you tell me whether the building you are proposing to use for this facility has been renovated or have renovations begun?

A. The renovations are complete.

Q. The renovations are complete, okay. So if this CON application is not approved, are there plans for that building?

MS. VOLPE: I'm also going to object to that question. And it should be noted that that building, even, you know, was offered up to the community during COVID, and, in fact, the New London community utilized the building to house homeless population. So certainly, you know, there would be opportunities for that building to be put to good use in the New London community.

HEARING OFFICER CSUKA: Attorney Feldman, did you have a response?

MS. FELDMAN: I think it's a pretty

fair question, straightforward. I don't know why we wouldn't want to know the answer to that question in terms of it's quite unusual. My experience is that most applicants don't begin or buy buildings to renovate until they have received approval from OHS.

MS. VOLPE: That speaks to their commitment to being in Connecticut --

MS. FELDMAN: I see.

MS. VOLPE: -- that they've already expended tremendous resources.

HEARING OFFICER CSUKA: I'm going to overrule the objection and remind Attorney Volpe that you can't testify on behalf of your client so -- well, you can speak on behalf of your client and certainly advocate on behalf of your client, but anything that you put into the record I can't rely on in connection with making a decision on this.

MS. VOLPE: So noted. Thank you.

BY MS. FELDMAN:

Q. Attorney Kang, does Landmark itself have any kind of ownership interest in the 89 Viets Street building?

A. We do not.

Q. You do not, okay. All right. In Question 6, in your response to OHS's completeness Question 6 provided by Landmark on March 29th, you state in responses to questions about the poverty level in New London that 54 percent of residents in Connecticut have commercial insurance; is that correct?

A. So that information is from the Kaiser Family Foundation. That is not our direct estimate. If you're not aware of what the Kaiser Family Foundation is --

Q. I am.

A. So that estimate came from them, not directly from our own independent research.

Q. But it was in your answer, it was a footnote to your answer, correct?

A. Yes, it was in the answer.

Q. Okay. So I believe in some of the filings before OHS whether you or counsel have stated that the focus should be on the primary service area; is that correct?

A. That is correct.

Q. So when you're talking about individuals with commercial insurance across the state, what is the relevance of that in connection

with this PSA?

A. I can answer that question. So if we use a number from the 2012 plan, I believe the number of patients who Connecticut estimates that needs services is 231,000. So if you were to take, let's say, half of it, right, we have 110,000 individuals who could use for SUD treatment, one of the more interesting things about what I've discovered during the CON process is that there seems to be kind of an antagonistic relationship between the providers in Connecticut, which frankly, from our perspective, having operated mostly in non-CON states we do not. I mean, we would welcome our competitors to open a facility right next to us because we understand that even if we accomplish one of our mission statement, which is to save 1 million lives, 1 million lives saved is not enough in the grand scheme. I'm sorry, go ahead.

Q. I'm sorry. No, go ahead, finish.

A. In the grand scheme of things, even if we were to save 1 million lives in 100 years, not enough. We need to do this together as a community.

Q. Okay. So, you also state in your

response to that same question that you're confident that patients that you will be able to serve are within a two-hour driving distance of this proposed location; is that correct?

A. Yes, typically two hours is our absolute limit.

Q. So then isn't it true then that you are looking to draw from providers or locations throughout the state and perhaps Rhode Island?

A. No, not necessarily. Our job, when we focus on our admission process, is to get people who need help. So typically speaking as a practical matter, I will be happy to provide the data after the hearing, but typically speaking most of our population come within I'd say a 30-minute driving radius to an hour, something along those lines. I can try to pull that data. Two hours is the maximum limit to provide our services typically because of the fact that when we have patients who do not have transportation, for example, we need to have our intake team to go get them, and two hours away is a challenge.

Q. So let's just go with the one-hour estimate. I mean, you did say two hours in your response to OHS. And I think it's, you know, of

interest to the intervenor in that two hours would basically cover the entire State of Connecticut which is a very small state. But going one hour from New London, would that bring you into New Haven?

A. I believe so. I'm not a hundred percent sure.

Q. Right. And are you aware that Yale New Haven Health provides services to individuals with substance use disorders?

A. During our research we truly focused on the primary service area, which is New London county and specifically New London and the surrounding areas. New Haven, certainly it's within a distance. But when we think about calculations, they really look at the nearby area, and then if there's a need or if there is space available, we look at expanding into the hour driving radius, two-hour driving radius.

One important -- sorry. One important point we want to make is, again, our goal, and this just comes from my loved ones struggling with opioid use, our theory is, essentially, that we have a very narrow period of time when somebody has a moment of lucidity and they're seeking help.

So if they are two hours away, there's no beds available and they need help, we will get that patient because our job is not to worry about necessarily profit. Our job is to worry about can we help these people.

Q. Attorney Kang, you're a very knowledgeable person, and that's obvious from your testimony that you just provided. I wondered if you have looked at the DMHAS website which is real-time availability of detox beds in the State of Connecticut.

A. Yes, I have.

Q. Did you know that as of today there were 14 beds in your PSA and 15 beds open in New Haven as of this morning?

A. I would have to double check but -- I would have to double check, unfortunately.

Q. Okay. Also, in your response to OHS's completeness questions, in Question 16 you state that 1 percent of the individuals in the PSA will need your services. I guess I'm just looking for clarification. Is that 1 percent reflective of individuals with a substance use disorder?

A. No, the 1 percent of the general population. So this is our internal data. It

just comes from having operated. We have currently about 600 beds. Having operated, in doing so, we have found that there's like a critical ratio that gets hit. So if the general population, anywhere between 1 percent to 2 percent of the statistical area, so not just the City of New London but the surrounding area, that's typically the available population base. It's not a peer-research study or anything like that, but it is something that we have in our data.

Q. So it's not based on actual information or data in the primary service area; is that correct?

A. It is based on our previous, our internal research.

Q. Okay. And is that 1 percent number the percentage of individuals that have a substance use disorder or the percentage of individuals that will actually seek treatment?

A. It's a general population. So the entire area 1 to 2 percent. Whether they seek -- our job, I suppose, is to encourage those individuals to come see us or our providers to get help.

Q. Okay. Also, in your application you state that when you expand to the East Hartford, Hartford area that your patient volume will increase to approximately 25,000 patients annually.

A. Could you point to that in the --

Q. Sure.

A. I'll review that.

HEARING OFFICER CSUKA: Mr. Kang, I just wanted to point something out. At least from my computer, it sounds as though you occasionally will trail off towards the end of your sentences. And I just, if you can, try to speak up towards the end of your sentences so that the court reporter can get everything.

THE WITNESS (Kang): I apologize.

BY MS. FELDMAN:

Q. So Attorney Kang, if you look at your response to Question 16 from OHS.

A. In the application or in the --

Q. The completeness questions, Exhibit C. I'll read the response, if that would be helpful. But the question was, "What percent of the PSA population does Landmark expect will need the services being proposed?"

A. That's correct.

Q. "What percent of those who need the services does Landmark expect to utilize the proposed services? Provide data to support these expectations." Your response in Exhibit C is, "Based on our priority data, we expect that 1 to 2 percent of the population within a one to two-hour driving distance will seek the type of care we provide at our facility each year. In New London County alone, that would be around 2,685 to 5,370 patients seeking treatment. But if we expand to the Hartford, East Hartford, Middletown, Connecticut metropolitan statistical area, then we're looking at 12,135 to 24,270 potential patients on an annual basis."

A. That is correct, yes.

Q. So isn't it true then your business plan is to expand beyond this facility in Connecticut?

A. No. Just to give you an idea, so we actually, if you go to our website, we actually track the number of graduates that we have. So since 2016, we have saved about 12,000 lives. So unless Landmark Recovery decides -- becomes a trillion dollar company and opens SUD treatment

facilities in every location, that amount of population, again, I cannot stress this enough, if Landmark Recovery meets its ambitious goal of saving one million patients in the next 100 years, it will not be enough to combat the epidemic. So we need providers like High Watch, we need other providers to do their part because it's a global health crisis.

Q. Are you saying then, Attorney Kang, that you did not state in your application or in your responses to the completeness questions that Landmark has a desire and plan, perhaps, to expand beyond New London?

A. Oh, no, absolutely, we will expand, but I just want to make this point clear. The expansion, as you may have seen from the application, one of our philosophy as a company is continuum of care. So just to give you, just to kind of explain what that is, when a patient walks into our door under our current health care system, oftentimes that patient will receive, let's say, anywhere between 21 days to 45 days of care, and they are, for lack of a better word, released into the world. And it's their responsibility to go find IOP, outpatient therapy,

and deal with all the challenges that come from being in recovery. Our hope is because for patient's sake is that we can offer 90 to 180 days of continuous care within one organization.

So it's not so much that we're expanding because we think Connecticut is the best market for us to make money. It's a clinical and medical philosophy that we have, that continuum of care is ultimately best. And at some point in time we want to bring all the services necessary from, again, from ASAM 4.0 to 0.5 so that every single patient has the best chance of being in recovery. The profit side doesn't really ultimately matter for us. It's just that we want to provide the continuum of care.

Q. Attorney Kang, I believe in your application, and I'm sorry if I don't have the exact spot, you stated that the plan for this facility would be to provide additional continuum of services at this location; is that correct?

A. In the future when we have a -- I believe for us to actually provide some of the other services we may need one other facility somewhere in Connecticut.

Q. So are you saying there would be no

other facilities planned in the State of Connecticut that would have detox beds?

A. No, that is not --

MS. VOLPE: I'm going to object to that. I mean, we're talking about this application. It's not clear to me how that speaks to the need. The witness has already testified that to the extent they need to offer a full continuum of care, they're going to do that, and they want to do that. So I'm not sure where this line of questioning is going or how it's related to the statutory factors.

MS. FELDMAN: Yes, and I am happy to respond. I believe it's because your client, in response to the completeness questions, Question 16, provided that data. And I'm questioning about the data that he provided in his submission and in his application. So I'm not just asking him out of thin air what his plans are for the company. This is what he just said himself, a million, you know, the plan for Landmark is to aggressively grow and take care of a million patients by year 100, so I do think these are relevant questions.

MS. VOLPE: So wasn't it asked and answered? And in his application --

MS. FELDMAN: Not clearly.

MS. VOLPE: -- he points to the data. He points to the data source. If you read the footnote, he says they're based on both private and public data, and he references the census. And he's pointed to the Kaiser Foundation. So the footnotes contain the data for OHS to know what the source is and authority.

MS. FELDMAN: They're very general cites, and it refers to the US Census data's website which doesn't really tell me exactly what the applicant is looking at. I don't want to perseverate about this issue. I just want my questions answered.

BY MS. FELDMAN:

Q. I don't plan to, you know, ask many more questions about it, but it is relevant to the issue of how does this proposal, which is very much tied to plans for future growth in the State of Connecticut and growth throughout the country, how does this proposal impact the other providers in the state, Attorney Kang?

A. There's a lot of --

HEARING OFFICER CSUKA: I'm going to overrule the objection.

MS. FELDMAN: Thank you.

A. That's a lot of different -- I'm sorry, I apologize. There's a lot of parts to that question. But ultimately at the end of the day what I can testify today is that currently we have 32 facilities in schedule. Out of the 32 facilities, there's only one facility in Connecticut. A lot of the other states which do not have a certificate of need process have welcomed us with open arms. They recognize the dire situation that their communities are in, and they would love to have us there.

When it comes to Connecticut specifically, ultimately at the end of the day our -- how do I put this -- our loyalty is not only to Connecticut, it's not necessarily to the other provider as well. Our loyalty is to the people who need help. If there are people who need help, that's what we are going to try to provide. And if that upsets other providers, you know, our job is to save lives, and we will do whatever we need to save lives.

Q. Okay. Thank you. I think in your prefile testimony that you provided at the beginning of this proceeding I believe you

mentioned that this year, or 2021, there were 59 deaths in New London; is that correct?

A. I believe so.

Q. Right. Do you know whether any of those individuals had commercial insurance?

A. I do not.

Q. Okay. Thank you. So are you aware that Connecticut ranks in the top ten states with the most residents living in a health provider shortage area? I believe 52 percent of the state's population is in a health provider shortage area.

A. I have not seen the data, but if you send it to me I'll be happy to review.

Q. Okay. So are you aware that there is a national shortage of qualified behavioral health clinicians right now given the mental health crisis, not only substance use disorder crisis?

A. Yes, absolutely.

Q. Okay. And are you aware that providers in the State of Connecticut, including Behavioral Health & Economics Network, NAMI, you know, a variety of providers are very concerned about Connecticut's behavioral health workforce shortage?

A. I would assume that that is the case, especially given the fact that every single state we operate there is a storage of -- I think this is a national issue, not necessarily even a Connecticut issue.

Q. Correct. So do you think that by, you know, planning to increase the number of beds in the State of Connecticut for substance use disorder when there's already a limitation on the number of clinicians and existing providers are struggling, do you think that there is going to be any negative impact by hiring Connecticut providers who are currently working with other substance use disorder providers?

A. So I understand the concern. The way -- and that challenge is actually, I would say just based on our experience being in about 15 states now, that's not a unique challenge to Connecticut. The way Landmark Recovery has been trying to solve that problem, there's multiple steps to our plan. Our first plan was our practicum student program. So we recruit providers, clinicians, nurses from not just our operating area, from the entire country. And we try to reach out to them and say, hey, would you

please send your, you know, trainees to basically work for us and get the experience. On top of that, one of the strategic decisions that we made as a company is to basically offer student loan reimbursements as a package because our idea was that if we were able to bring in these students, they get curriculum training, and after that they now not only know us and how we operate, but now on top of that they will get a good salary, and on top of that it will be tied to their student loans. We thought that would be an attractive package.

And one of the ideas that we are playing around with, I cannot say this is a guarantee but it is an active discussion, is that we would ultimately like to own our own university that trains nurses and clinicians. And if that plan is to go live, that would probably be in the next two years. Again, it's in the very preliminary stages, but at Landmark when we try to solve a solution, we have tried to find systematic solutions to a problem, and it seems like the systematic issue that we're facing is that we just don't have enough skilled workers. So if that means that we have to open a university to train

them, that's something that we'd be willing to do.

Q. Okay. Thank you. So does Landmark have any plans to hire any behavioral health clinicians that currently work in Connecticut?

MS. VOLPE: I'm going to object to that. I'm going to object to that. I mean, they have to, at some point they're going to post and advertise and recruit, and they don't know where they're going to come from.

MS. FELDMAN: Again, I'm going to have to object to counsel providing testimony. I don't think that's a basis for the objection. I think this is relevant to the fact that even the hearing officer inquired and recognizes that there's a workforce shortage and asked a specific question about it, and I am following up because my client has the same concern. So Attorney Kang just provided an answer which was very lovely but didn't specifically answer the question of whether or not he is going to on behalf of Landmark hire existing clinicians in the State of Connecticut. It's a simple question.

HEARING OFFICER CSUKA: I'm going to overrule that objection. So he can answer the question.

A. Absolutely. I am going to assume that somehow the employees that we hire for the New London facility would be providers who are already working in the State of Connecticut. I think that's fair to say. But as stated in our testimony, again, our recruiting team's reach is nationwide. We have opened facilities in, you know, what could be challenging locations in a historical sense just because of its remoteness, and we were able to fully staff it by combining benefits, competitive pay. And again, we have a world-class credentialing team who actually makes it very easy for providers to cross state lines and come to work for us in our facilities.

Q. So I think, if I heard you correctly, isn't it true that Landmark is in a position to offer all sorts of benefits to individuals to seek employment with Landmark?

A. So Landmark Recovery, if you do a little bit of research on our background, we made I don't know if it was a national headline, it was in the news, but we fully believe in salary transparency. So we have a program called the Escalator Program, where any individual can go onto our website and look at what rates their

position would be. And obviously not every single location has the same rates, but we have a guiding document called the Escalator Program. Depending on the region you're in, you can go on there, you can see what we pay. In our experience, we are not the highest payer in any given market. Typically, I would would say the highest paying jobs in any given market we've seen is at the nonprofit university hospitals, that's typically what we have seen, and also more large, let's say, health care systems. For us, you know, SUD providers it's typically we would say would be above average but not necessarily the highest in any given market.

Q. Thank you. I'm just going to ask you to refer, once again, to your response to Question 8 in the completeness questions, Exhibit C. You refer to charity care patients. And I'm just seeking some clarification. When you refer to charity care patients, are you basically talking exclusively about Medicaid patients?

A. No, no, absolutely not.

Q. Okay. So other than Medicaid patients, you provided a response, I believe, that on an annual basis you provide $1.1 million in charity

care across your facilities?

A. That's about correct. That's based on the actual data.

Q. And how many facilities does that include?

A. Four facilities.

Q. Four facilities, so about, would you say about $260,000 worth of charity care at each facility?

A. Yeah, I could pull the exact data, if that is relevant, but I would say that's about it.

Q. Okay. And does that number include Medicaid patients, the 1.1 million?

A. No. Medicaid patients, just to clarify that question. One of the advantages that Landmark Recovery has is that, again, we are probably, it's hard to say, my guess is that we are the only nationwide provider who focused on Medicaid programs. So when we have a patient who comes to our facilities and let's say they are low income, we have two jobs, actually, simultaneously. One is to refer them to our care, which we can offer at our Praxis facilities that only take Medicaid patients.

The second job we have is that we have

many situations where a patient comes in and they are uninsured when they should not be. In those situations, we help the patient get the care that they need because, you know, one of the most dangerous things that can happen is that you give -- so one of the reasons why we have sometimes issues with entities that's focused on charity care is that if you have an uninsured individual, they come into your system, you provide them with, let's say, 30 days of charitable care, what do they do afterwards? They don't have health insurance coverage. So again, our job at Landmark Recovery is finding systematic solutions. And the way we find systematic solutions is if a patient comes to us and says, hey, I don't have insurance, we have as part of the process we try to figure out how do we get them insurance.

Q. Okay. Thank you. But you do say in your response that quote, unquote, "In practice we allow our Landmark Recovery facilities to provide 1 percent to 2 percent of available days as charity care." Is that correct?

A. Yes, that's correct.

Q. Okay. Thank you. Let me ask you a

question because in your application and in your completeness responses to OHS I believe that you describe this concept of the Praxis facilities. Is that where patients with Medicaid and patients who receive charity care would go?

A. No, no. So the clear distinction is that our Praxis facility is for our Medicaid patients. Our Landmark Recovery facilities, as we have branded it, are where every other patient would go, so that would include our charity care patients, it would include our veterans, it would include what we call the tribal members recognized by the Indian Bureau of Affairs. So anything that does not fit to the Medicaid model would typically be treated at the Landmark Recovery facilities.

Q. And what is the reason or rationale for having Medicaid patients in a separate facility?

A. There's a couple. So from a more on the boring back end side, one of the reasons why we have a Praxis facility that's distinct from it is that administrative process required to serve Praxis patients is very different. So for example, utilization review, revenue collection management, all those sides, the function when it comes to effectively treating our patients are

very different from a commercial payer facility or a VA, the more tricky ones versus the Medicaid system which is typically actually much easier to do.

The bigger issue really at the end of the day what we have found is over the years we have found that specialization in facilities we believe is ultimately better for patient outcome. So just to give you an idea what we mean by that is, let's say a couple of the other facilities that we're working on at this time is a facility that only serves veterans who receive health benefits of the VA system. A person could ask why is that distinction relevant, but on the back end there's many, many different things that's happening that makes it easier for us to create tailored personalized curriculum for those patients because they have advantages that other patients may not have.

Q. Okay.

A. So just to continue, same thing with we are looking to establish facilities where all the patients would have what we call limited English proficiency. So let's say imagine a native Spanish speaker who is not able to speak, who

cannot understand clinical training because of the fact that their English is limited, in those situations how do we serve those patients. We have other facilities where our facility may be just dedicated to pregnant mothers. They also pose a different kind of medical challenge. I would just note --

Q. This is in your four facilities, this is how you --

A. This is from our growth plan moving forward.

Q. Ah, your growth plan. Okay. So let me ask you a question. Are you aware that there's a law in Connecticut that prohibits discrimination against Medicaid patients?

A. I would need to know more about that.

Q. Okay. And so while I understand that, you know, you might want to have tailored services for veterans and women and children, separating Medicaid patients on the source of their payment is you're stating because they're a different utilization review requirements essentially, is that what you're saying?

A. No, no, no, the main focus is on the curriculum programming. So, for example, imagine

that you are a successful physician struggling with alcoholism. Under their commercial insurance plan they have 45 days. Let's say, using another example in one of our Medicaid, I believe, the maximum number of days after detox is 21 days. So in those kind of facilities where there is a commingling of patients, let's say, is that at one point in time you have to tell the Medicaid patient, hey, you only have 21 days so please leave our facility, whereas they look around and they see all the individuals with better commercial insurance that are getting longer days so --

Q. But wouldn't you have patients in your Medicaid facility that come in at different times and leave at different times, isn't that how it --

HEARING OFFICER CSUKA: Attorney Feldman, just try not to interrupt the witness.

MS. FELDMAN: Okay. I'm sorry.

HEARING OFFICER CSUKA: It seemed like he was going to continue.

MS. FELDMAN: Okay. I apologize.

A. Yeah, and just to give you an idea, right. And so a lot of times one of the things that our curriculum does very well, so one of the

points we were trying to make is that we offer more one-on-one personal therapy time than I believe any other Medicaid providers. I might be wrong on that, but as far as we've seen no one matches it. And partially the reason why we do that is, one, it's better for the patient outcome; but two, we truly want to develop personalized curriculum. So the classes, let's say, that we offer at our Praxis facilities, may not be exactly the same as our commercial facilities.

So, for example, we have a module that we work on oftentimes. I believe it's called Life Skills. I'll have to double check the exact wording for it. But a life skill need for, let's say, a single mother on Medicaid who's low income, the life skills that they would need to find success after leaving us might be different from, let's say, a physician struggling with alcohol addiction because they require different kind of skills. And our job is to make sure that to facilitate personalized curriculum, and our experience has been that splitting the two facilities has made it easier. And our belief is that moving forward as we grow and grow the facilities will get split more individually

because of the fact that the curriculum training it's easier to focus and give the patients what they need.

Q. How many Praxis facilities do you currently operate?

A. We have five at this time.

Q. So you have five. Okay. So is that in addition to the four that you referred to before?

A. Yes.

Q. Okay.

A. Correct. Just to give you an idea, we currently, let me just see here, we have five Praxis facilities, six commercial facilities, and we have two Praxis facilities coming up in the next two months.

Q. Got it. Okay. So in each of the -- when you develop these Praxis facilities how large are they typically in terms of the number of beds?

A. Number of beds, I could find out for you if you give me a couple seconds. They vary in size. Let me see if I can find that here.

Q. Yeah, because I think in your response to Question 11 you stated some numbers for 2021.

A. Correct. So in our Medicaid facilities our largest facility, which is opening next month,

is 160 beds. The smallest Medicaid facility that we have would be 38, which is one of our first facilities in Louisville.

Q. Okay. Do you understand that when you open your Praxis facility that you'll need to go through the CON process again?

A. Yes, we do. And one of the discussions that we were having with DMHAS that we were having yesterday is, you know, what is the annual need. It's tricky, I understand that. Obviously as part of the Section 1115 waiver, there's a lot of regulatory work that has to be done, so we're not trying to step on toes. We understand that we are a newcomer. But again, we actually as a company, we don't have any preference for commercial over our Praxis facilities.

Q. And in these states where you're operating, do you get a special rate from Medicaid or --

A. No.

Q. No, okay. Well, how does it work with the IMD prohibition in other states, do all those states have waiver programs also?

A. Correct. So the only states that, as I'm aware, that we don't have it would be in

Nevada and Oklahoma. All other states have the waiver. In fact, I believe Kentucky was one of the first ones, which is why we opened there first, but in those states, typically speaking, the rates are public, so in other words, there's no competition between the providers about the rates, it's just out there. There are a couple states where there's managed care systems. There I think the rates may be a little bit different, but they're basically about the same. So in terms of that perspective, I mean, again, that's a really big difference. On the Medicaid system the administrative efficiency and operational efficiency is much easier because the fact that you're not dealing with in a commercial facility anywhere between 30 to 50 payers.

Q. Okay. Have you communicated to any other providers regarding sending them Medicaid business?

A. That is an interesting question. I do not personally, I have personally not, but we do have a team, Annie Mooney from our team, I believe, has spoken to a lot of the community, has done a lot of the community outreach, so ultimately I can find out that information.

MS. FELDMAN: I see. Okay. I have no further questions. Thank you for your time.

THE WITNESS (Kang): Thank you.

HEARING OFFICER CSUKA: Thank you. Attorney Volpe, do you have any redirect for Attorney Kang?

MS. VOLPE: I just have one redirect question for Chris.

REDIRECT EXAMINATION

BY MS. VOLPE:

Q. Chris, at the start of the cross there was a question on whether or not you were familiar with the DMHAS website.

A. Yes.

Q. And you indicated you were. And are you familiar with the fact that the number of beds on that site differs on a daily basis?

A. Absolutely.

Q. So are you aware that some days a facility could say it has four available beds and then the next day it could say zero?

A. Correct. That is absolutely true, which is one of the reasons why, if it's a very neat website, but internally at Landmark we maintain our own database of available beds. And

so when we look at the average, we try to look at it at a month time period because there might be one day because of, you know, just by random chance that we may have ten beds open which could be filled up in the next two days. So we need a broader perspective than just a one-day snapshot.

MS. VOLPE: Yes. Very good. I have no further questions for Chris. Thank you.

HEARING OFFICER CSUKA: Okay. Thank you. I think we should probably take a short break now.

Attorney Feldman, actually this goes to both of you, I'm trying to figure out whether we should take sort of an early lunch or a late lunch. So I don't know what you had in terms of --

MS. FELDMAN: Yeah. So Mr. Schwab is, as I mentioned, on the west coast and has, you know, it's a three-hour time difference and has scheduled meetings all day. So it would be our preference to just continue and take a late lunch.

HEARING OFFICER CSUKA: Okay. Attorney Volpe, are you okay with that?

MS. VOLPE: Yes, absolutely. We want to accommodate Mr. Schwab. I just want to, in

terms of format, so Mr. Schwab would be providing testimony or just adopting his prefile that was submitted? What is proposed?

MS. FELDMAN: He's going to -- go ahead.

HEARING OFFICER CSUKA: You can speak. Sorry, Attorney Feldman.

MS. FELDMAN: It's okay. He's going to speak regarding his prefile testimony. He's not going to read it, he's going to adopt it, but he has certain talking points that he is going to provide, just as Attorney Kang's prefile was not directly from his filed prefiled.

MS. VOLPE: So, I know --

MS. FELDMAN: It shouldn't take very long.

MS. VOLPE: Okay. Because I know he's got commitments in the afternoon. We just want to make sure he's going to be available during the whole proceeding to the extent we have any questions for him.

MS. FELDMAN: You know, we're inclined to just keep moving forward, charging along.

HEARING OFFICER CSUKA: Okay. OHS will likely also have some questions towards the end.

I don't expect those to take a terribly long time either. So for right now let's just take a five-minute break. We can come back at 11:51 and then we can pick up with the intervenor and the rest of the questions.

MS. VOLPE: Very good. Thank you.

HEARING OFFICER CSUKA: Thanks.

(Whereupon, a recess was taken from 11:45 a.m. until 11:53 a.m.)

HEARING OFFICER CSUKA: So now we are going to continue with the technical portion. We're going to get to the intervenor and that direct testimony.

So Attorney Feldman, I think you indicated that Mr. Schwab would be the only one testifying on behalf of the intervenor today; is that correct?

MS. FELDMAN: That is correct.

HEARING OFFICER CSUKA: Okay. Do you have an opening statement that you'd like to make?

MS. FELDMAN: Not necessary. I just have a closing.

HEARING OFFICER CSUKA: Okay. So just for the record, I would ask that you please identify Mr. Schwab by name and title. Actually,

you've already done that, so let's just move on to Mr. Schwab and I'll have him state his last name and I will swear him under oath.

So Mr. Schwab, can you just state your name for the record.

JERRY SCHWAB: I'm Jerry Schwab, S-C-H-W-A-B.

HEARING OFFICER CSUKA: And your title with High Watch is?

JERRY SCHWAB: President and CEO, High Watch Recovery Center.

HEARING OFFICER CSUKA: Okay. Please raise your right hand.

J E R R Y S C H W A B,

having been first duly sworn (remotely) by the Hearing Officer, testified on his oath as follows:

HEARING OFFICER CSUKA: Thank you. So I understand you just wanted to provide some bullet points or some sort of high-level overview of your prefile; is that correct?

THE WITNESS (Schwab): Yes. And I'll be brief.

HEARING OFFICER CSUKA: Okay. Thank you.

THE WITNESS (Schwab): I appreciate the time. And good morning to the Hearing Officer and the OHS staff. I also apologize for not being able to have my testimony notarized. I'm traveling for a work conference, so it's a little difficult to get that done, but I do adopt the prefile testimony as my own.

HEARING OFFICER CSUKA: Thank you.

THE WITNESS (Schwab): I'm Jerry Schwab, the president and CEO of High Watch Recovery Center. We are the oldest substance abuse treatment center in the country. We've been operating in Connecticut for 83 years. We are a residential treatment center located in Kent, Connecticut. I'm not going to read my whole testimony. I'm sure that it's on file and will be read by yourself and the staff, so I appreciate you taking the time to review that. I'm going to keep it kind of brief and simple from our perspective.

We see about over 1,000 patients a year. We receive a lot of calls. We've been operating in Connecticut for a long time. And my understanding of a bit of this process is the demonstration and need. And quite simply, you

know, we operate with the, contrary to what the applicant had said, we work with the providers in Connecticut all the time. We have a very good working relationship with providers that are contracted through DMHAS or DSS or commercial nonprofits, for-profits. Most of the treatment providers in Connecticut work very well together, and there's a lot of cross-referral back and forth based upon, you know, a number of different factors.

But I can say, you know, from the people that we work with on a regular basis that we don't see this overwhelming need for additional bed availability, number one. Number two, if there was, there are existing providers in the state that can provide those services, I think, at more cost effective and less impactful ways. And also, there's a bunch of pending, you know, beds in the system that are online to come, you know, open within, you know, a shorter period of time here.

You know, basically, if you look at the -- I understand the DMHAS website changes on a regular basis. I'm not an expert on that historical data, but I'm sure the office has

access to those type of numbers. But we use that system on a regular basis, you know, to refer people. You know, High Watch currently doesn't have a detox. It should hopefully be open in the next week or two. And we added that service as a need with regards to completing our continuum of care as opposed to the necessity of detox beds across the state.

But, you know, there's, you know, a lot of heart. I also want to say that I'm a person in long-term recovery. This isn't a competition on who cares about addiction treatment patients more than the other. But I do want to point out that a lot of these arguments are very, you know, emotional with regards to the clients that we serve and the people that we're trying to help, but they don't necessarily equate to the need for additional beds. At any given time across the State of Connecticut, and Connecticut is a small state, it's the size of many counties in other states, actually, you know, we haven't had the significant issue of finding beds. You know, sometimes, you know, we do, you know, High Watch is full at times, as are other facilities. As pointed out by the DMHAS website, you know, things

kind of ebb and flow with regards to censuses. But, you know, on average, our census runs about 72 beds for the year. We're currently licensed for 78 residential beds. So, on average, we have six open beds.

And, you know, there's not a direct correlation between, you know, overdose deaths and the need for residential beds. You know, there's many, many, many different factors that go into this, a lot of it being the potency, unfortunately, of drugs and whatnot that are on the streets, but, you know, people in the State of Connecticut, you know, unfortunately die of coronary artery disease all the time. It doesn't mean every hospital needs a cath lab or three cath labs.

So one of the things that we're trying to focus on is, you know, reaching those people that don't necessarily want treatment or treatment adverse and getting them the appropriate level of care, whether it be outpatient, intensive outpatient, residential that those people might need. But as far as the detox and the residential bed need, you know, it could have a negative impact on the system as a whole specifically, you

know, I think it would be an inaccurate assertion that commercial insurance providers don't pay more than Medicaid providers.

One of the things I just want to address super quickly, and I didn't plan on it in my testimony today is, you know, the segregation of patients based upon payer, something I've never heard of. I think, you know, all the reasons given, you know, it's basically segregating people based upon socioeconomics. It's not something that's done by the providers in Connecticut currently. And, you know, I think that the reasons listed were things that as an operator, I've never heard of those challenges before.

I just want to make sure I hit all my points here. You know, just the last thing, and it doesn't necessarily equate, you know, literally, but it's, you know, a staffing issue. Everybody in the State of Connecticut has had a -- all of our colleagues, you know, we all work together and try hard not to take staff from each other, but it does happen at times -- is the, you know, lack of mental health addiction medical providers in the state. Nurses are very difficult to get. Nowadays everybody has staffing

shortages. So adding another provider to the mix, you know, obviously that increases those demands significantly in an environment that, quite frankly, you know, I don't see as having a significant bed void that's been asserted. So I think that's it.

HEARING OFFICER CSUKA: Thank you, Mr. Schwab.

Attorney Feldman, did you have any direct questions for your witness?

MS. FELDMAN: Sure. I do. Thank you.

DIRECT EXAMINATION

BY MS. FELDMAN:

Q. Mr. Schwab, are you aware of any allegations being made by Landmark regarding High Watch's activity in trying to hold itself out as a Landmark employee trying to recruit staff?

A. Yes.

Q. And has High Watch held itself out as -- and you're under oath -- has High Watch held itself out as Landmark to try to recruit staff from other providers in the primary service area?

A. Absolutely not.

MS. FELDMAN: Thank you. No further questions.

HEARING OFFICER CSUKA: Okay. Attorney Volpe, do you have any cross-examination for Mr. Schwab?

MS. VOLPE: I do. Just one, really one question.

CROSS-EXAMINATION

BY MS. VOLPE:

Q. How are you, Mr. Schwab?

A. Good. How are you?

Q. Good. I appreciate your testimony and and respect all that you've accomplished professionally and personally.

I just have one question for you, or actually one subject but a couple of followups. Are you familiar with the waiver that the state has applied to for CMS?

A. Yes, I am.

Q. Okay. Great. And are you aware that states who have the ability under the waiver to treat the population do have -- you said you noted in Connecticut there isn't a distinction in the patient population -- but are you aware that in other states that have been granted the waiver that there is this distinction in facilities in other states?

A. I don't operate in other states, so I couldn't answer specifically with regards to that. I do know that the waiver process is somewhat new, and I think that, you know, even if it's done in other states, I think one could very honestly make a very good argument that, you know, and it's been done in the mental health arena for sure, is that segregating based on socioeconomics is a form of discrimination. You know, minorities have a much higher rate of Medicaid usage in socioeconomics. So I think that if that's going on in other states, I think it is unethical, and I think that, you know, those cases might come to bear that it is a form of discrimination.

MS. VOLPE: Okay. I don't have any further questions for Mr. Schwab. I just want to make sure my client doesn't have any questions.

Chris, do you have any questions for Mr. Schwab?

THE WITNESS (Kang): I do not.

MS. FELDMAN: Excuse me, I'm not sure what's happening now.

HEARING OFFICER CSUKA: As I informed Attorney Kang that although he is an attorney, he's not licensed to practice in this state. So

certainly if you would like to take a break and see if all of his questions were answered, we can come back in a couple minutes.

MS. VOLPE: We're good. He doesn't have any questions.

HEARING OFFICER CSUKA: Okay. So we're actually going to take another five-minute break anyway because I want to speak with Annie and Steve and make sure we're all set to go with the OHS questions. So assuming there's no objection to that, we will come back at 12:12. Sound good?

MS. VOLPE: That's sounds good. Thank you.

MS. FELDMAN: Thank you.

(Whereupon, a recess was taken from 12:06 p.m. until 12:12 p.m.)

HEARING OFFICER CSUKA: We are going to need a few more minutes, so let's say 12:17, if that's okay.

MS. VOLPE: Yes, that's fine with us. No worries.

HEARING OFFICER CSUKA: I apologize.

MS. FELDMAN: It's fine with the intervenor. Thank you.

HEARING OFFICER CSUKA: Thank you.

(Whereupon, a recess was taken from 12:12 p.m. until 12:26 p.m.)

HEARING OFFICER CSUKA: So we're going to move on to questions from the OHS staff. I believe we're going to start with Annie. So Annie, you can ask your questions of the applicant, and then if you have separate questions for the intervenor we can ask those as well. So let's start with the applicant first though.

MS. FAIELLA: Good afternoon, everyone. Okay. I will be muting myself when I receive answers so that I can type just so you're not confused.

So my first question is regarding the first completeness letter response for Question No. 16. The applicant said that only 1 to 2 percent of the population in the PSA will be seeking the care that they are going to provide. So my question is, please explain why Landmark believes that 1 to 2 percent is an example of a clear public need.

THE WITNESS (Kang): Yes. So the 1 to 2 percent of the population would basically mean in the overall general population, the numbers are specifically stated there, but that is a lot of

annual patients per year. And so, in other words, when we calculate the 1 to 2 percent population, we're not saying that there's only 1 to 2 percent population in a given year and that's the extent of the SUD crisis. This is the total number of patients that most likely will be going to come to our facilities on any given year. So I apologize if the phrasing of that wasn't particularly correct. But in many ways I guess a different way to phrase it is that the 1 to 2 percent population estimate has to do with a patient who would be willing to seek treatment suffering from an SUD.

MS. FAIELLA: So then I have a follow-up question. Do you believe that this shows a need for additional beds or does it really show a need to educate the population and those in need of the service where they can actually receive these services?

THE WITNESS (Kang): We believe that there is additional need for beds. And the rationale for that is reasonable people can disagree on what the solution for the SUD crisis is. Some people may say the best way to do it is outpatient. Some people say inpatient is good. There's a lot of conflicting data. But what we do

know and likely what, especially for Landmark from our perspective, what we are good at is letting people know that we are available and trying to get them to our doors. And so just to repeat what I meant, I am not saying that all the other outpatient patients -- outpatient facilities in the area are doing something wrong, no, I think outpatient services can be extremely effective. However, we are good at providing from a continuum of care currently we're about 45 to 60 days. Eventually we're going to get to 180 days, and that kind of service is ultimately what Connecticut needs.

MS. FAIELLA: Okay. And then also in the data that you had provided, the graphs, when you add a trend line, there's actually -- and especially for the 2022 data, the data actually shows that the trend is going down. Can you speak to that at all regarding the data that you provided?

THE WITNESS (Kang): Is that the overdose death data?

MS. FAIELLA: Yes.

THE WITNESS (Kang): Yes. So that's an interesting question. If you look at the footnote

that is attached to that data point, it says that they don't -- so again, I can't speak from, directly for the collector of the data, but if you look at the footnote, it typically says something, it says something along the lines of the data is incomplete at this time and updates will come in as time passes by. So in the first three months where I believe that report was published in June or May, I can't recall off the top of my head, but if you look at the data, it's typically not unusual for the coroner's report and more data to come months after the death has occurred. So again, it's hard to say. If there is a drop, that's certainly an encouraging sign for Connecticut, but based on the first three months it seems like it's going to be about the same.

HEARING OFFICER CSUKA: I'm sorry, where would that data be found?

MS. FAIELLA: This is in their first completeness letter -- sorry, rather, their prefile testimony they submitted a graph showing a line graph with multiple years.

HEARING OFFICER CSUKA: Okay. Thank you.

MS. FAIELLA: So I understand that this

data for 2022 is not complete which might show a skewed slope, for lack of a better term. However, if you look at 2020 and 2021 as well, it's relatively average and it's not increasing that dramatically. So again, I guess my question is still can you speak to that data and really kind of explain why you believe that there is a clear public need when the data is relatively flat.

THE WITNESS (Kang): So, in other words, I would assume that from a health care perspective what we want to do is decrease it. So even if, let's say, this year we have, I don't know, let's say, 100 less beds or 200 less beds, it's just a reality of the situation that compared to 2016 it has doubled. So, in other words, I would make the argument that even in 2016 Connecticut did not have enough SUD treatment options available, and our job is to lower that number. Obviously, zero is probably an impossible number, but we need to get back to a manageable rate because, as OHS is very well aware, visits to the emergency department in high acute level inpatient care is one of the highest, easiest ways to drive up the cost of health care system, and that is what we're trying to prevent. And if it's

using inpatient beds, that's great. If it's outpatient services, that's great. It's truly an effort that the entire village has to take together.

MS. FAIELLA: Thank you. So then another question that I had was regarding the plans for the Praxis facility. There has been discussion now of using this facility or this building as the Praxis facility, and then there has also been discussion about opening up a new one. Can Landmark state whether they would be looking to keep this current CON proposed building as a Praxis facility or as a Landmark Recovery facility?

THE WITNESS (Kang): That is a fascinating question. I wish I would have a very good answer for that question. So yesterday I had a meeting with representatives from DMHAS. And based on -- ultimately the answer to that question, as a practical matter, will be determined by the rates set by DMHAS. Landmark Recovery, just because of the fact that we have, you know, I feel safe saying this, we're one of the leading providers of Medicaid beds, we are very experienced in this field, and we know what

the target, approximately what the target allowed amount needs to be on a daily basis. So if -- but I don't think DMHAS is quite ready yet to publish the rates yet, if I understand it correctly. So if that rate can come out before, let's say, the CON is granted, then absolutely we'd be willing to take a look, but that's a little bit outside our control at this very second.

MS. FAIELLA: So if then CON is -- if a decision has been made on CON, would it be Landmark's intention then to, so it goes one way or the other, would it be Landmark's intention to open up another facility in Connecticut to do the opposite?

THE WITNESS (Kang): Right. So, in other words, one of the promises that we were willing to make after we discussed with the executive team -- again, the Section 1115 process is so extensive that there are a lot of different parts to it. But assuming the rates are there, what we are willing to do, and I believe this is the most likely scenario, is to convert this current facility to a Praxis facility, as everybody pointed out, the City of New London does have more patient pool who are on the lower income

side, and open another facility that could accommodate our commercial patients which in turn would allow us to offer more long-term continuum of care services.

MS. FAIELLA: Okay. And then speaking of the commercial payers, so on page -- or Question 23 of the main application, we asked you to fill out OHS Table 3 and Table 4. And I know you did discuss it in this, in your testimony. Could you please provide me with the average cost per day?

THE WITNESS (Kang): Average cost per day, I may need to run the calculations again. It's not something, I don't know if I can provide at this time. When you say out of -- when you say "cost per day," do you mean out-of-pocket costs or total cost?

MS. FAIELLA: So we're looking for the average cost of services per self-pay patient and for the commercially insured patient and the cost, minus the total dollar amount paid by the insurer, plus patient out-of-pocket costs.

THE WITNESS (Kang): Yeah, that's all data we can provide. And most likely, if we provided one before, it's probably changed by now,

so we'll be happy to share that with you.

MR. LAZARUS: We can collect that as a Late-File. Would that be reasonable?

HEARING OFFICER CSUKA: That's what I was going to suggest.

MS. VOLPE: Just so we're clear, absolutely. So the Late-File, just to be clear, we're talking about not reimbursement collected, you're talking about cost. I just want to, I think that was maybe Chris's hesitation. We want to make sure we're responsive to the question. So what is your specific question that you want answered in the Late-File?

MR. LAZARUS: Annie --

MS. FAIELLA: Go ahead. I'm sorry.

MR. LAZARUS: I was just going to read what I have written down. It says the average cost per day for commercial and self-pay for your facility, for the proposed facility, and it's the cost for the service per day.

THE WITNESS (Kang): Right.

MS. FAIELLA: It's -- sorry, go ahead.

THE WITNESS (Kang): So for the commercial side, again, this is, I can't give you an exact rate, but I know for the commercial side

it's going to be anywhere between 550 and 580. That's typically what we find. And the reason I cannot speak to it is, let's say we had a payer and we just recently opened three facilities. So depending on the rates that they are getting, it's going to change. Again, payer amounts are interesting because it's actually not something that Landmark Recovery has direct control over because each single state has different needs, and the insurance payers ultimately dictate the rate, but it's something we can find.

MS. VOLPE: And that's what I'm trying -- are you asking for the rate? Are you asking for like what it's going to cost to deliver the service? I mean, I know they're supposed to be equivalent. But are you talking about the rate that is proposed for commercial and self-pay at the facility?

MR. LAZARUS: Yes, yes.

MS. VOLPE: And certainly we can do a Late-File. That data was provided during his testimony, and we can provide a written copy of Chris's testimony. And it had -- I think, Chris, you cited some of the specific rates in your testimony today, if you want to go back and look

at it, that were well below the current Connecticut average rates.

THE WITNESS (Kang): Correct. So --

MS. VOLPE: And below --

THE WITNESS (Kang): Right. Sorry, I apologize. So the data that I cited was the budgeted amount for each of the facilities. And generally speaking, our facilities, I mean, once in a while we'll see somebody, a facility that may be better than our budget, but generally it's slightly lower. So one of the reasons why I'm hesitating is, so in other words, each facility does not have the same number of beds. So if one facility, let's say, has 100 beds while the other facility has, you know, 30, then it's not as simple as taking those two rates and dividing by half. I need to go and actually look into the data and see how have the patients been charged what rate, if that makes sense.

MR. LAZARUS: Well, I think we're asking more specifically for this proposed facility.

THE WITNESS (Kang): Okay. For the proposed facility the average revenue patient per day that we are targeting is 585.

MS. VOLPE: I don't think we need a Late-File because that is the rate that's going to be proposed, and it was stated in the testimony. So that's why I wanted to clear up --

THE WITNESS (Kang): I apologize, I misunderstood the question.

MS. VOLPE: Yeah.

MR. LAZARUS: Okay. I think that will -- go ahead.

HEARING OFFICER CSUKA: Attorney Volpe, you suggested that you also provide a written copy of his testimony that was given today. I don't know, Annie, Steve, do you think that would be beneficial? I don't know.

MS. VOLPE: I mean, you'll have the transcript, but to the extent you want it, we can certainly provide it.

MR. LAZARUS: I think the transcript should be sufficient.

HEARING OFFICER CSUKA: I just wasn't sure if there was additional data in there that has citations that we don't currently have, because if there are citations, then that might be beneficial; if there aren't, then --

MS. VOLPE: The citations were to the

Statewide Health Plan. The citations were to --

HEARING OFFICER CSUKA: Okay.

MS. VOLPE: -- to DMHAS data. It's all -- no new data points, if you will.

HEARING OFFICER CSUKA: Okay. Annie, I think you have a couple more questions.

MS. FAIELLA: Yeah, just a couple more, yeah.

So in the main application the answer to Question 9A states that the key to achieving cost effectiveness in health care is early prevention. My question is, if this proposal is for a detox/residential facility, how is this considered early prevention? I understand that the emergency department is considered not early prevention, but how is a detox/residential early prevention?

THE WITNESS (Kang): That's an excellent question. So I suppose there is that distinction there. So when we think about early intervention, a lot of times the way we think about it is we want to get to the patient before they have to go into a hospital inpatient system or the emergency department. However, as I stated, as I alluded to in my testimony today and

I believe there have been reference to it, one of the things that Landmark Recovery takes pride in is our, for lack of a better word, let's call it marketing program. And one of the things that we do is that we have a dedicated team. If you visit our website, or unfortunately despite my age I'm an elder millennial so I'm not really that familiar with social media apps, but if you go to Instagram, TikTok, Facebook, whatever the case may be, we generate a lot of content, but that content that we generate is not really, I mean, yes, there's advertisement purposes there, but really the reality of the situation is that oftentimes substance use disorder targets younger individuals. And we want to basically be there to constantly let people know like, hey, like substance abuse is a serious issue. So oftentimes if you look at our marketing materials, it often says something to the effect that, hey, before, like warning signs for, let's say, addiction. So if you are drinking when you are stressed out, that might be a sign. So along with this particular facility, if we were to come to Connecticut, there would be a massive, kind of marketing campaign that goes with it that we have

no doubt that the Connecticut citizens will benefit from.

MS. FAIELLA: So you alluded to the idea that the marketing campaign is really more for millennials and younger generations. What kind of early prevention strategies will Landmark take for veterans or for other populations that TikTok won't be reaching?

THE WITNESS (Kang): Absolutely. So the veterans are, let me answer with the veterans because that's actually a very unique relationship. Landmark Recovery over the years had developed a relationship with key partners in the VA community. So one of the reasons why in my testimony I alluded to the fact that the veterans, we may look into a facility dedicated for them, is that under their health care plan they can actually receive, and this is what my recollection is, they can receive anywhere between 90 to 120 days of continued inpatient residential program. That's amazing except we don't really know what to do with all those hours. It's an incredible amount of opportunity.

So like the short answer to that is, aside from the fact that we have the marketing

campaign which leads to more of like an organic reach, we do have what we call community liaison and strategic partner liaisons, and their job is to basically go around the community, introduce ourselves and let them know like what kind of resources are there available. So oftentimes that fact and being able to talk to the key decision-makers in community groups allows us to basically send out the message to let people know, hey, you know, if you are having a hard time, please come to us and we will try to see what we can do to help.

MS. FAIELLA: Thank you. So Question 26, first completeness letter, stated that this will be the second smallest location. What sort of teams are available for each location; and if it's so small, will it actually be able to survive? And also, if another facility -- you mentioned that recruitment is national. If another facility is in desperate need for additional staff, is there any potential that Landmark will take away Connecticut staff members and relocate them to another facility that might be bigger?

THE WITNESS (Kang): No, generally

speaking, that does not happen because of a hundred different reasons for logical reasons. But at the end of the day, so currently at 48 beds they will be, there's about -- let me just look at the count here. There is one, two, there's three other facilities that have 48 beds, and the smallest facility, which is actually part of our flagship location in Kentucky, is only 38 beds.

So without going into all the background stuff that happens at Landmark Recovery, one of the reasons why we have been able to kind of grow at the rate that we are growing in and kind of one of the secrets to our success is that we have a very large headquarter base here in Franklin, Tennessee. And so oftentimes, let's say, the admission team, the UR team, all these different folks necessary to run the facility, they're in a consolidated location.

So because of that, we historically have never transferred, let's say, a provider from one facility to another unless they said, you know, like, hey, I'm moving to a family can I go be closer to in Nevada, in those situations, sure, we'll try to accommodate them. But as a general rule, we don't pull employees from one facility to

another. Generally speaking, each facility stands on its own.

MS. FAIELLA: Thank you. And I just have a couple more questions regarding the readmission rate. If a patient in a facility nearby is discharged from that one facility but comes to Landmark, is that considered a readmission or do they track them separately?

THE WITNESS (Kang): No. So in other words, our readmission rate, and this is where it gets tricky when you use the term readmission rate, our readmission rate, the last time I provided the data, is for the entire history of Landmark. So if a patient, let's say, came to us three years ago and they have been readmitted to our facility, their information is in our patient database so we would mark that as a readmission. So oftentimes this is where it gets tricky because when you see the publicly available studies, the readmission rate is measured by 30 days, 90 days, a year. So it's a very technical discussion, but that number that we provided is from time beginning.

MS. FAIELLA: And then so I just wanted to clarify the 16.59 percent readmission rate does

not include those who leave the facility or have graduated, you use the term "graduated," who have graduated from the facility but then actually ended up overdosing on, actually end up having an overdose related death, correct, those are separate numbers?

THE WITNESS (Kang): Yes, I would say that is true. We can try to pull our data point to see if we can find a different data point on there, but that is a very challenging statistic to find because, so, for example, if we had a graduate and for some reason we lost touch with them and they have an overdose, it's very hard for us to track that, which is one of the reasons why, and it was not relevant to this particular CON application, but one of the projects that we're working on is forming a nonprofit that will be exclusively dedicated to what we call alumni services. And the whole purpose behind that is build a community around our graduate, and that doesn't necessarily have to be our graduates, but about the community around it where we would encourage them to share data with us. Because if they relapse five years from graduating from our facility, we would like to know because that helps

us make decisions. And it's a very, frankly, ambitious data project, but it's something that we're looking forward to. And we hope that one day we can come back and give you guys precise measured outcomes for our facilities.

MS. FAIELLA: Thank you. And then the last question I have is that the applicant did state that the lack of space is going to affect the possibility of operating an outpatient program. Does Landmark expect to outgrow the facility; and if yes, how fast?

THE WITNESS (Kang): That is an interesting question. So at this moment in time, I believe the current arrangement at 48 beds would not allow for outpatient from day one. So unless we can do some kind of rearranging the facilities, which we have spoken about, but if we can't find the rearrangement, it might be possible to offer outpatient services, but ideally probably the more likely scenario is just have one other facility. And I alluded to it on the original application in other responses, but one of the new strategic projects we have is what we call OBOT facilities. And so our OBOT facility is going to be a little bit different than what's mostly available in the

market where oftentimes OBOT focuses mainly on MAT whenever providing suboxone to the patients. Our program is going to combine that with IOP or PHP.

And so it's an idea where we launched in, I believe, in Indiana and Kentucky as a test model. And our hope is that we can bring that to Connecticut as well because being able to tie, let's say, the benefits and the ease of administration of OBOT with a substantial amount of therapy, I think, can only do good for the patient population.

MS. FAIELLA: Thank you. Steve, did you have any follow-up questions?

MR. LAZARUS: Yes.

HEARING OFFICER CSUKA: I'm sorry, I didn't realize you were done, Annie.

MR. LAZARUS: I was just waiting for you to finish up. All right. Thank you.

Steve Lazarus, OHS staff. So I just have a couple of questions Mr. Kang. You had testified today earlier that -- well, first let's start with, can you talk a little about the number of facilities Landmark has. I think you had said you had four, but I thought I heard 15 somewhere in there, but you also said you have five Praxis

facilities and a couple other that are sort of coming up.

THE WITNESS (Kang): Yes.

MR. LAZARUS: But as far as the existing facilities, could you just kind of talk about those number and what is the actual number and types of facilities?

THE WITNESS (Kang): Yes. Let me just pull up the data just to make sure I'm providing you with the correct information. We are actually in the season of opening new facilities, and so every month is slightly a little bit different, but give me just one second, please. Correct, so right now at this very second we have 11 facilities in our system. So it would be five commercial facilities. The one that was not included -- well, there's two facilities that were probably not included in the application. There's one in Seymour, Tennessee for 48 beds. There's one facility that we just opened yesterday in Denver that has 80 beds, Denver, Colorado. Other commercial facilities include one facility, a 72-bed facility in Indianapolis. Louisville is 64. There's a 64-bed facility in Las Vegas. And a 60-bed facility in Oklahoma City, which is a

little bit unique because there are many tribal members there, so it's not necessarily a pure commercial facility, but it's kind of its own unique situation.

From the Praxis side at Willard, Ohio we have 48. And Euclid, Ohio we have 60. And Louisville, Kentucky we have a 38-bed facility. And Bluffton, Indiana we have a 90-bed facility and a 48-bed facility in Carmel, Indiana.

And in the next upcoming few months we'll have 160-bed facility in Mishawaka, Indiana. We will have a 60-bed facility in Norfolk, Virginia. We will have a commercial facility in Wisconsin. And then a 64-bed facility in Ladova, Indiana. And finally 80-bed facility in Wintersville, Ohio.

MR. LAZARUS: Thank you.

HEARING OFFICER CSUKA: Have those all been approved, the ones that are upcoming?

THE WITNESS (Kang): Yes. The only other state currently that we are in that requires a CON for our purposes is South Carolina. And there's a lot of activity happening there regarding the CON laws. But that's not going to be, we're not looking into opening those until mid

to end of 2023.

HEARING OFFICER CSUKA: Thank you.

MR. LAZARUS: Thank you. So today you mentioned, you know, and as you were testifying and responding that you use data that, you know, your facility, Landmark's data, national data to show that the majority of the patients tend to come from a 30-mile radius, here you're also using Connecticut 60 mile, and then you have the PSA. So how is the PSA towns developed using your data?

THE WITNESS (Kang): How does a --

MR. LAZARUS: How did you develop the primary service area towns?

THE WITNESS (Kang): Yeah. So I'm really simplifying it. Ultimately, I would probably need one of our data analysts to really provide the correct calculations because that's a little bit outside my expertise. But the way I've understood it and what I've been told is that we have, when we pick a metropolitan statistical area, let's say we just pick the one for here, when you pick that data, our experience has been that we have not seen a situation where the available patients, because we do some market research with other facilities around the area, it

has never gone below one and it typically does not go over two. So it's a loose approximation, and this is somewhat of a little bit of sad reality, but we have yet to find a market, or it's very rare for us to find a market where there's already a critical mask of inpatient residential treatment areas.

So one area would be, let's say, South Florida. South Florida, there's no doubt that they have enough facilities there. Every market data or market research we have done there suggest that they're at capacity. Even here in Nashville, if you look at all the beds and compare to population size, given the fact that this is supposed to be kind of the behavioral health care hub, there is no doubt that there is enough beds right in the Nashville metropolitan area. So when we make decisions to expand, I mean, that is one factor we look at. The precise nature of it is a little bit outside my expertise, but that's kind of the -- that would be what they would tell me to understand.

MR. LAZARUS: But I guess I'm looking for some sort of evidence to understand why this location was picked in Connecticut when you have a

two hour, you know, radius, so specifically for a Connecticut location.

THE WITNESS (Kang): I mean, when we looked at different facilities, so the way this project came about, it's actually a put facility, and unfortunately I was not there at this time. I started working for Landmark Recovery in November of 2020. I believe these discussions were being done at the end of '18 or early '19. So what ended up happening was we have a financial partner with us who do a lot of projects, Sabra Health Care, and they were publicly traded. I believe they have owned this property since, for several, several years and during that time I cannot recall what the previous use exactly was, but that said operator ended and this was when we were starting our partnership with them, and they said, hey, we have a facility here in the City of New London, we don't know what to do with it, would you be able to come in and take a look to see if it would be a fit. And so really the practical answer to that is, we found the property first before we determined the PSA location, let's say.

MR. LAZARUS: All right. Thank you. That's helps. I understand a little better. This

is kind of going back. I think it's one of the questions that was asked. But are you aware of if there is any laws in Connecticut that prevent discrimination against payer status?

THE WITNESS (Kang): Again, I don't know if I know the statute off the top of my head, but my guess is that such law exists in every single state because what constitutes, for example, what constitutes discrimination typically in a Medicaid setting is, let's say, a patient shows up and you're a health care provider. If they accept, let's say, Medicaid and they're unwilling to treat the patient for whatever reason and discriminate against another the patient, then I believe that could be a basis for discrimination, but again, I'm not a hundred percent sure what exactly the Connecticut statute specifically states.

MR. LAZARUS: All right. Thank you. One question I have left. You had mentioned in your testimony earlier that when you go, your practice, Landmark's practice is when you go into a certain service area you tend to partner with other providers. Can you talk a little bit more about that, what type of partnership are you

alluding to, and have you approached any of the providers in the area in Connecticut?

THE WITNESS (Kang): At this moment, I believe Annie Mooney from our team has spoken to some. Unfortunately, I did not directly, I was not the person who directly spoke with them. So Annie Mooney has done, I believe, some outreach on there. Typically speaking, our outreach process really happens after this point in time. So we have a fairly regimented process for opening a facility. So typically the community outreach portion of it would be done, let's say, between four to three months before opening a schedule, and that's typically when we -- typically around the time when we look to hire staff for that particular facility, and that includes our outreach folks. And so when they come in they will be doing most of the outreach there.

MR. LAZARUS: So you mentioned community outreach. So are you talking about, are you just talking about the community outreach, or are you talking about reaching out to other --

THE WITNESS (Kang): To providers. So when you say "community outreach," we actually don't mean, let's say, nonprofit or the

individuals. We mean other providers, hospitals in the area, other health care providers.

MR. LAZARUS: And what is the goal of this outreach?

THE WITNESS (Kang): One of the goals of outreach is simply to let them know that we are there and we are happy to collaborate. So oftentimes what ends up happening is, let's say, in Kentucky our legal department gets hundreds may be too much, but on any monthly basis we get anywhere between, let's say, 20 to 40 what we call memorandums of understanding. And what essentially happens, let's say a provider comes to another, I don't want to even use the word competing, but another provider in the area, and for whatever reason they don't have space or they can't provide the services because their ASAM level service is lower than ours, they will basically say, like, hey, if we have to refer patients to you guys, like here's what we would expect.

And it's not anything to do with, you know, like finances or anything like that. It's typically just simple things like, hey, you guys, if we refer a patient, you guys promise to provide

transportation or something along those lines. So there's a lot of kind of those little minor details to work out with other providers. But it's really, the idea basically behind it is to make sure that they are aware of our presence and we are aware of what they do so that in case a patient needs additional services upon graduation, we would be able to refer them out.

MR. LAZARUS: All right. Thank you very much. I think that's all the questions I have for the applicant. I have one question for the intervenor, Mr. Schwab.

So Mr. Schwab, you had testified today and I think in your testimony you mentioned that you certainly expect some sort of an impact from this particular facility opening. Could you discuss that a little bit more? What type of impact do you expect if this facility opens? And if you can give some examples, specific examples of that.

THE WITNESS (Schwab): Yeah, I mean, I think, you know, based upon, you know, bed availability, you know, there's X amount of patients that are seeking services in the state in a given year and there's X amount of beds in the

state in a given year. And the more providers that you add and the more beds you add, the lower the census is for the existing providers which impacts the providers' revenue, so not only myself, but the other providers, you know. And there's a bunch of CONs pending besides this one. So, you know, you get a couple hundred beds that are kind of dumped into the system all at once, and, you know, people's, you know, average daily census drops by, you know, 10 or 15 or 20 percent, whatever that might be, that will have a negative impact on everybody's bottom line and their ability to provide services.

MR. LAZARUS: All right. Thank you. I think that's all the questions I have. Thank you very much.

HEARING OFFICER CSUKA: Annie, did you have any questions for the intervenor?

MS. FAIELLA: No, I do not.

HEARING OFFICER CSUKA: Okay. Attorney Volpe, did you have any followup for Attorney Kang based on the questions that were asked?

MS. VOLPE: No, no, I do not.

HEARING OFFICER CSUKA: Okay. And Attorney Feldman, do you have any followup for

your witness based on the questions that were asked?

MS. FELDMAN: Yes, I do have one question to ask Mr. Schwab. He talked about what would happen if you added 4,800 beds and added all the beds in the queue. I would like to ask him right now what is his understanding of bed availability in this state at this very point in time.

THE WITNESS (Schwab): I mean, I could speak for us. You know, I think as of yesterday, I haven't checked them this morning. But as of today, our census that I know of is 71, so that would mean we have 7 open residential beds. I looked at the DMHAS website today. It looked like there was 10 at SCADD, and there was a dozen or so, I think, at the retreat in New Haven. They're peppered throughout as they typically are.

MS. FELDMAN: Thank you.

HEARING OFFICER CSUKA: Okay. So I think that's sort of the close of the technical portion of the hearing. We're going to have closing arguments and comments after the public comment period which is scheduled to begin at 3. The sign-up will take place from between 2 and 3.

I don't expect there to be any additional questions for the witnesses, but I would like them to be available for a brief period of time in the event there are any additional questions.

And are there any questions or concerns from Attorney Volpe or Attorney Feldman before we sign off for now?

MS. VOLPE: No. Just logistically, they are going to be signing up between 2 and 3. Are you not going to convene the hearing again until 3?

HEARING OFFICER CSUKA: Correct.

MS. VOLPE: Okay.

MS. FELDMAN: No further issues.

HEARING OFFICER CSUKA: And actually, Attorney Feldman, I should have followed up with you. In one of your statements you made reference to the Connecticut Law that prohibits discrimination. What law specifically were you referring to?

MS. FELDMAN: I will have to submit that as a Late-File, if I will, because I don't have the statutory cites. And I will say also that the Medicaid program provider agreements prohibit discrimination against Medicaid patients

or discrimination on any basis. So if you are going, looking to participate in the waiver program, Section 1115, which is slated to begin in perhaps another year, I'm not sure, you are prohibited from any sort of discrimination against Medicaid patients. And I would be very surprised with respect to how this proposal would be received and whether or not it would be viewed as filing provider agreement requirements.

THE WITNESS (Kang): Actually, would I be able to speak on that?

HEARING OFFICER CSUKA: Sure.

THE WITNESS (Kang): So as one of the largest providers of Medicaid services, that's not actually quite exactly correct. The way Medicaid contracts work under Section 1115 system is that they are facility contracts. So when you open a facility and you basically tell Medicaid, hey, we comply with, and there's hundreds of pages of requirements about how you can become qualified, once you tell them that you are qualified, the Medicaid entity whether it's directly through the state or managed care issues a contract to the facility saying for these facilities you have to accept Medicaid patients. That has been our case

in, again, this is not -- I don't want to pull rank, but ultimately at the end of the day we operate more Medicaid beds than most other providers, and that has been our experience.

MS. FELDMAN: I would like to respond to that, if I may.

MS. VOLPE: I don't really want the attorney testifying. I mean, if there are questions, I think we've already had that opportunity. If the Hearing Officer or OHS staff has questions. I think we're done with our cross.

MS. FELDMAN: So I was just trying to respond to the Hearing Officer's question. I'll let him decide whether he wants me to finish the response.

HEARING OFFICER CSUKA: I think we're all set for now.

MS. FELDMAN: Okay. Thank you. But I guess do you want a Late-File with respect to that issue?

HEARING OFFICER CSUKA: I would, yes, and I'll give it whatever value it is due. I'm an attorney, I'll review it, and I'll see to what extent it applies in this particular circumstance. Is there anything else?

(No response.)

HEARING OFFICER CSUKA: Okay. So we are going to go offline until 3 o'clock. As I mentioned, public sign-up will take place between 2 and 3. And I will see everybody back here at 3 o'clock.

(Whereupon, a recess was taken from 1:09 p.m. until 3:03 p.m.)

HEARING OFFICER CSUKA: Thank you. Welcome back. For those of you just joining us, this is the second portion of today's hearing concerning a CON application for Landmark Recovery of Connecticut, docketed as 22-32515-CON. We had the technical portion this morning and early afternoon, and this is now going to transition into the public portion. We will call the names of those who have signed up to speak in the order in which they are registered. If we miss anyone, please feel free to make yourselves known and we will be happy to let you speak. Speaking time is limited to three minutes. Please do not be dismayed if we stop you at the conclusion of your time. We want to be fair to anyone who wants to present their comments.

Additionally, we strongly encourage you

to submit any further written comments to OHS by email or mail no later than one week, that is seven calendar days from today. Our contact information is on our website and on the public information sheet which you were provided at the beginning of the hearing. Thank you for taking the time to be here today and for your cooperation. We are now ready to hear statements from the public. Mayda Capozzi from our office has been kind enough to keep a list of individuals who have submitted their names, so I may need her assistance with that. Anyone speaking, I would remind you to turn your video and microphone on.

As of a few minutes ago, my understanding is that Stacey Lawton was the only one who had provided her name.

Mayda, has anyone else also submitted?

MS. CAPOZZI: No. At this time only Stacey.

HEARING OFFICER CSUKA: Okay. Thank you.

MS. CAPOZZI: You're welcome.

HEARING OFFICER CSUKA: So Ms. Lawton, I may not have pronounced your last name correctly, but please pronounce your name, spell

your last name, and then you can proceed with your testimony.

STACEY LAWTON: Good afternoon and thank you. My name is Stacey Lawton, L-A-W-T-O-N. And you got it exactly correct, it is pronounced "Lawton." So thank you very much for the opportunity to speak this afternoon. I am the chief executive officer for the Southeastern Council on Alcoholism and Drug Dependence, more commonly known as SCADD. We are a nonprofit agency that has provided mental health and substance abuse treatment to individuals in Southeastern Connecticut who are primarily indigent or else covered by Medicaid, and we've been doing that since 1966. This our 56th year of service and operation in Connecticut.

We are the agency that will be most affected by the introduction of an out-of-state for-profit entity seeking to profit at the expense of the existing nonprofit provider infrastructure. SCADD provides a continuum of treatment services that includes 176 beds ranging from detox to residential treatment, recovery housing, outpatient services, community outreach, case management and drug education. Our mission

includes serving individuals regardless of their ability to pay, and this represents the vast majority of persons served in Connecticut.

It is with great pride that I share with you that I have been an employee with this agency for 29 years. Other staff at SCADD have had similar longevity due largely to their personal commitment and loyalty to an organization whose mission is focused on helping others rather than on making a profit. The community nonprofits in Connecticut provide essential services in every town in every city serving people in need and employing tens of thousands. They have been the backbone of Connecticut's treatment infrastructure serving approximately 85 percent of the state's substance use disorder treatment clients.

I come before you today to express my firm opposition to the applicant's proposal to establish a 48-bed facility in New London. While we all recognize the impact of the current opioid epidemic, pointing to overdose and emergency department data that sparked public attention does not in any way identify the actual need, or more importantly, the true demand for additional beds. The applicant has failed to demonstrate the need

for additional beds and has failed to recognize and acknowledge the highly detrimental effect its presence would have on the current infrastructure in the area.

The applicant has correctly cited in its application that there are 22 existing programs in the surrounding area and that there are 224 beds available within its proposed primary service area. It should be noted that while not licensed as residential treatment beds, the program operated by Stonington Institute provides over 100 silver living beds that are attached to a Partial Hospitalization Program. This would be the equivalent to a residential ASAM 3.5 level program.

While the applicants suggest that the New London area is lacking in services, the opposite is true. In fact, with over 1,600 treatment beds across the state, Connecticut has one bed for every 2,200 residents. In the applicant's proposed service area of 286,000 residents, there are the equivalent of over 324 beds when you include the beds in the Stonington model. This means that there is one bed for every 884 residents in our area, almost three times the

density of the State of Connecticut. Even if you discount the Stonington numbers, there are still about twice as many beds per capita here as there are across the state.

At the same time, reports by the Department of Mental Health and Addiction Services suggest that there is an underutilization of existing beds. For example, detox or 3.7 WM level of care beds are only 71 percent utilized statewide for the six-month period ending December 31, 2021. And the 3.1 level of care beds are only 84 percent utilized. So the actual utilization data for the state does not support the suggestion that more beds are needed. This morning our agency had 6 open detox beds and 23 open residential beds.

I'd like to now shift and speak about the struggle to find qualified staff.

HEARING OFFICER CSUKA: Ms. Lawton, you've gone well over the three minutes that we typically allot for public comment. And you're also, you know, testifying at length about specific data points and things of that nature. So I am going to swear you under oath. And then if Attorney Volpe and Attorney Feldman have some

questions for you, I'm going to allow them to ask you questions as well. And I'm going to allow you to finish your testimony, but certainly it sounds like you may have wanted to submit something in writing as well. And in fairness to the applicant, I am also going to allow the applicant to respond to that if you do decide to submit something in writing.

So you can continue. Just let me swear you in first. Let's see, sorry, I have to find the prompt. I haven't committed it to memory yet.

MS. FELDMAN: What is the significance of Ms. Lawton being sworn in? Does that mean that her testimony goes on the record?

HEARING OFFICER CSUKA: I just want to be able to rely on it in terms of -- it's just my understanding that this is sort of what has been done in the past when things begin to veer into --

MS. VOLPE: I mean, it is beyond a public comment. I mean, if she's concluded her testimony, you know, I mean, if she's not prepared to take cross-examination from us, I don't know that she has counsel, how comfortable we are with that, but, you know, perhaps our preference would be that, you know, she's concluded her remarks.

If she hasn't and she is going to submit something in writing, obviously we'd like an opportunity to respond because there's lots of precedent that this is just a public comment period, not testimony.

MS. FELDMAN: My understanding, and I've been to many hearings where sometimes there are a hundred people providing public testimony, and sometimes there's only one. And typically my experience, I don't know whether Mr. Lazarus will confirm it or not, but that there is some, you know, leniency regarding three minutes, especially if there's one witness. I have never seen somebody who's providing public testimony being subject to cross. I thought that whatever testimony she provides does not go on the record and doesn't get weighed as evidence. So I'm a little confused by what direction we're going here, what the precedent is for this detour.

MR. LAZARUS: Hearing Officer, can I just jump in for a second? Steve Lazarus.

HEARING OFFICER CSUKA: There is precedent for it, but yes, Steve, you can.

MR. LAZARUS: So basically I think in the past practice when somebody veers -- you know,

time is up to the Hearing Officer, that's totally up to the Hearing Officer's discretion. But as far as the testimony goes, I think when it veers into the area of expert when you're, you know, beyond just the opinion matter, now you're talking about an agency that's coming in that's directly affected, that is up to the -- and if the agency wants to use any of this information beyond just the public comment, we have in the past upgraded the status to be some sort of an intervenor status.

MS. FELDMAN: Okay.

MR. LAZARUS: So we can use it.

MS. FELDMAN: Okay.

MR. LAZARUS: But I think if both parties agree, and it's up to the Hearing Officer, if you just want to keep it as a public comment, that's fine.

MS. FELDMAN: I am more than happy to have Ms. Lawton's testimony be part of the record. And if there is precedent for doing that and if it becomes part of the record and there is an opportunity for cross, I have no objection. I just didn't ever witness that so --

MS. VOLPE: Okay. I'd like to be

heard, Hearing Officer, I'd like to be heard. This is the public comment portion of the proceeding, okay. Now, we have providers who are well aware of the process, the regulatory process. They've had opportunities to ask for a hearing. We have one that's intervening. It's not appropriate to offer testimony unless they've been issued status in the proceeding. So I am going to object. They are providers. They've noted themselves they've been provided for decades. I think they understand what the process is in Connecticut.

And this is a public comment period. I mean, we have lots of public comment that were submitted as part of the application. We have public comments that came from the Mayor. We have public comments that came from representatives, Representative McCarthy, Representative Somers. So there's lots of opportunity for public comment. This, rightly so, as you noted, is veering in the form of testimony, and they haven't been designated a party in this proceeding, so we're going to object.

MS. FELDMAN: And I'd like to respond to that. It's interesting that that's the

position. It's completely consistent with the position they took with us, which was to object to our testimony as an intervenor. So I think that what we have here is an attempt, once again, to muffle testimony. So whatever the Hearing Officer decides whether to treat this as public testimony and let her finish or swear her in and be subject to cross, you know, my preference is if it's valuable to the Hearing Officer have her sworn in. I don't think she's represented by counsel.

HEARING OFFICER CSUKA: That was my concern. So what I am going to do is I'm just going to allow her to finish her testimony. Ms. Lawton, how much longer do you expect?

STACEY LAWTON: Another two minutes.

HEARING OFFICER CSUKA: Okay. So I'll allow her to finish. And then certainly, Ms. Volpe and Ms. Feldman, if you would like an opportunity to -- well, since she's in opposition to the application, Attorney Volpe, I'm going to allow you an opportunity to respond to her testimony once the transcript comes in.

MS. VOLPE: Yeah, once the transcript comes in, I appreciate that. I mean, ethically she's not represented by counsel, so I don't feel

comfortable approaching her during this proceeding.

HEARING OFFICER CSUKA: And I could be wrong, but my recollection is that when people providing public comment have been sworn in in the past, it's because they are essentially an employee of either the applicant or an intervenor, so they do sort of have an attorney present at the time that they are providing public comment. So I agree with that position. So I'm going to allow Ms. Lawton to proceed and then, as I said, you'll have an opportunity to respond.

MS. VOLPE: Great. Thank you.

MS. FELDMAN: Well, I have a question about that. Since she's not getting sworn in and it's not going to be part of the record, I don't understand, you know, the opportunity to respond to something that's not going to be in the record.

HEARING OFFICER CSUKA: The agency has the ability to look to public comment in connection with making their decision. If you would like, I can swear her in and then just not permit cross-examination since she's not represented by counsel. At least, if we do that, then, you know, we have her under oath attesting

to the truth and veracity of her statements. That would seem to make sense to me.

MS. FELDMAN: That's fine. And I think that's really up to Ms. Lawton.

STACEY LAWTON: I'm telling the truth whether I'm sworn in or not, so I'm happy to be sworn in.

HEARING OFFICER CSUKA: Okay. So Ms. Lawton, please raise your right hand.

S T A C E Y L A W T O N,

having been first duly sworn (remotely) by the Hearing Officer, testified on her oath as follows:

HEARING OFFICER CSUKA: Thank you.

STACEY LAWTON: Would you like me to proceed?

HEARING OFFICER CSUKA: Yes, you may proceed.

STACEY LAWTON: Thank you. So I was saying that I'd like to now shift and talk about the struggle to find qualified staff. At our agency our 20-bed detox has recently been at about 50 percent capacity largely due to staffing shortages. If Landmark is allowed to open in the same city, our chances of filling positions will

be critically impacted. This will mean, at best, 10 open beds for the Medicaid population will remain empty, and as many as 700 Medicaid clients per year will no longer be served. At worst, should Landmark be successful in obtaining approval and open, they fulfill their promise to hire locally, the only option they will have is to hire professionals away from the pool -- away from our pool. We would be facing the possibility of having to close our detox facility resulting in an additional 700 Medicaid clients per year that would be without services.

The point here is that Landmark's application would result in not only a significant destruction of the existing service provider system, but would reduce the number of Medicaid recipients who will receive services in Connecticut. We suggest that OHS investigate and fully research the facts and data in Connecticut rather than accepting the applicant's estimates of need based on corporate projections from other states.

SCADD has been providing the proposed level of care for over five decades in Southeastern Connecticut. The pool of qualified

applicants is abysmally scarce all over Connecticut, but especially so in Southeastern Connecticut. We have position vacancies for RNs and licensed clinicians, and we've had them for over nine months. With the current implementation of the Medicaid Section 1115 Waiver, we are going to be trying to fill about 17 licensed clinician positions and about 6 licensed nursing positions over the next 20 months. With the Paramount Wellness Retreat now open in Haddam, the pool of candidates for SCADD and for the applicant will be even further diminished.

Last week on the evening news it was reported that OHS received an application by Johnson Memorial Hospital to close their maternity ward. The reason, they couldn't staff it. It was additionally reported that Windham Hospital has made a similar request. The professional labor shortage is not limited to the behavioral health sector.

My organization has identified the introduction of Landmark into New London as a serious threat to our survival due largely to their ability to entice our staff with more money. This concern turned to reality as I became aware

of the applicant's clandestine and unethical recruitment efforts when several of my employees reported being contacted at work by individuals associated with Landmark. This solicitation, as reported by one employee, goes back as far as November of last year. Never in my 29 years at this agency have I experienced such a brazen and unethical tactic. Our team under the leadership of our volunteer board of directors works proudly and perhaps naively within the charitable arena rather than the profit-centered world. We are focused on helping people in need, not on making profits.

I trust that OHS will seriously and thoroughly investigate the facts related to this application and look beyond the dramatic suggestion that overdoses and emergency room visits have anything more to do than a tangential connection to clients who are actually seeking treatment. Accurate data are available and do suggest that there is an unmet need for outpatient treatment for the Medicaid population, but this is not the client population that the applicant is proposing to serve. The insurance and self-pay clients they propose to serve have options, and

they can chose where they wish to receive treatment. They currently choose places like Malibu or Palm Beach. And I'm not sure what would change their mind to receive services in New London.

I want to thank you for your time and for allowing me to speak, and I request respectfully that you deny the approval of the applicant's request for the certificate of need.

HEARING OFFICER CSUKA: Thank you. Attorney Volpe, I am going to, if you want to respond to that, I will give you an opportunity to do that, but I did want to see first whether there was anyone else from the public who wanted to make a comment today.

Mayda, has anyone else shown up?

MS. CAPOZZI: No, not at this time.

HEARING OFFICER CSUKA: Okay. And is there anyone else here who would like to be heard?

(No response.)

HEARING OFFICER CSUKA: Okay. So Attorney Volpe, if you did want to respond to that, feel free, but as I mentioned, you'll have an opportunity to do so in writing as well.

MS. VOLPE: Yes. So we will reserve

our right to do so in writing. I mean, there's been an accusation that, you know, Landmark has solicited staff. And that was subject to a full investigation within their organization and there is no validity to that whatsoever. And in fact, my client is prepared to engage law enforcement to look into it because of these accusations and impersonations. So, you know, they did take that very seriously. That did get back to us. And they do all of their recruiting internally, and they have not approached anyone at SCADD. And so that is something that they are going to be looking into with outside law enforcement agency as they already investigated it internally. So there isn't any truth to that.

MS. FELDMAN: Well, I would just like to say that I received an email from Mr. Kang accusing my client of posing itself as Landmark and calling SCADD to try to recruit their employees. And Attorney Kang wrote me an email saying that he's very tempted to refer to his friends at the FBI and US Department of Justice for wire fraud, would I like to discuss it with him. So, you know, I wasn't going to bring that up, but the fact that there is this statement

about referring it to outside sources, this is not news. And whoever --

MS. VOLPE: I'm addressing it because there was a specific allegation of Landmark during the public comment period. I have the floor. The Hearing Officer allowed me to respond to the statements. We're also going to have an opportunity to respond in writing, but that one had to be addressed because of the seriousness of the accusation.

Some of the other comments which were, you know, numbers were thrown around, I think we are going to address those specifically because a detailed analysis was done on the need and specific for New London County. So we walked through that with our application.

So, yes, Hearing Officer Csuka, we would like an opportunity to respond in writing as a Late-File based on the public comment period, as you noted.

HEARING OFFICER CSUKA: Okay.

MS. FELDMAN: Hearing Officer, if Ms. Lawton retains counsel -- and I've never spoken to her before. I have no idea whether she will or won't -- I'm just wondering if she would have an

opportunity to respond to their response to her public testimony.

HEARING OFFICER CSUKA: I think we're thinking pretty far off at this point. So maybe, maybe not. I can issue an order on that specific point.

MS. VOLPE: And we would object. Again, these are providers who understand the process, had an opportunity to ask for a hearing, did not, had an opportunity to seek status, were allowed to cure deficiencies in doing so. This is a public comment period for a reason. So I'd like to continue with the proceedings.

HEARING OFFICER CSUKA: Thank you. So I believe that concludes the public comment period. We're going to move on to Late-Files which there were not many.

Steve, do you have the very short list?

MR. LAZARUS: Yes. So according to my notes, there's only two Late-Files. So the first one is the Hearing Officer's request to Attorney Feldman to provide the Connecticut law regarding anti-discrimination related to the payer source, if that's the correct description. I will leave it at that as general. Does that cover that,

Hearing Officer?

HEARING OFFICER CSUKA: Yes.

MR. LAZARUS: Okay.

HEARING OFFICER CSUKA: Attorney Feldman made specific reference to a state law.

MR. LAZARUS: Yes.

MS. FELDMAN: Are you not interested in the federal law either as it relates to Medicaid?

HEARING OFFICER CSUKA: Certainly, if there's a federal law that's also implicated.

MR. LAZARUS: Connecticut, so state as well as federal law.

HEARING OFFICER CSUKA: Uh-huh.

(Late-File Exhibit 1, noted in index.)

MR. LAZARUS: And the second item, actually, which we would like to request of the applicant, and that's something we discussed afterwards was that the applicant during my questioning referred, detailed some of the facilities for Landmark in other states, and he was referring to a document. We were wondering if we could get a copy of that document as a Late-File.

MS. VOLPE: Yeah, I think he may have just been referring to their website, but I'll let

him respond directly. I mean, their website does have all of their facilities on it as well.

MR. LAZARUS: If that's the case, if you can just provide the citation to that particular page, that would be sufficient.

MS. VOLPE: Sure.

THE WITNESS (Kang): Just to clarify that, we just have like an Excel sheet that shows the recent schedules. We can provide that. That's easy.

MR. LAZARUS: Okay. That will be Late-File 2.

(Late-File 2, noted in index.)

HEARING OFFICER CSUKA: So in terms of when you think you could submit these, Attorney Feldman, how long do you think it would take for the statutes to be provided?

MS. FELDMAN: A week.

HEARING OFFICER CSUKA: Okay. And Attorney Volpe, it sounds like he has that Excel sheet ready to go, so I guess let's just say a week for both.

MS. VOLPE: Yeah. I guess, you know, we definitely want the record to be closed within the seven days. So I guess, you know, we would

ask that the record be closed within seven days so that the applicant and intervenors, if to the extent they're required to produce Late-Files, do so in time so that you can close the record within the week.

HEARING OFFICER CSUKA: I understand your position, but you're also requesting that you have an opportunity to respond to the transcript, and I don't know how long it will take for the transcript to come in. So I guess what I can do is I can close the record after a week and then reopen it for the limited purpose of accepting that Late-File once we have the transcript.

MS. VOLPE: Great. That's great. That works. Thank you.

HEARING OFFICER CSUKA: But the statutory time period within which to issue a decision would run from, actually, I don't know whether it would run from a week from now or after you've submitted that Late-File. My guess is it would be a week from now, but I would have to confirm that. And I can issue an order in writing that explains this.

MS. FELDMAN: Right. I guess, Hearing Officer, again, I just want to emphasize the

possibility that Ms. Lawton would retain her counsel to file a rebuttal to the testimony that is submitted by the applicant responding to her sworn testimony.

MS. VOLPE: And I would object that they don't have standing in this proceeding. They offered public comment. We're the applicant.

HEARING OFFICER CSUKA: I understand both of your positions. I'll issue an order on that at a later date once I've seen what comes in from the applicant in terms of a response.

So with that said, we will move on to closing arguments. I'm going to start with Attorney Feldman first on behalf of the intervenor.

MS. FELDMAN: Okay. Thank you. I guess I will start my closing comments by stating that based on my belief and knowledge many providers, especially not-for-profit providers, do not have financial resources to engage counsel to obtain standing in a proceeding like this. So to the extent that, you know, I don't know whether that's the reason why Ms. Lawton has not petitioned to become an intervenor, but I did want to say that that's a reality for lots of my

not-for-profit clients.

But most importantly, I think, you know, focusing on the application before us, I really do not believe that the applicant has proven the need for the services in this application. To reference information about national statistics, and I think as Mr. Schwab gave the example, there are people having heart attacks all over this country. That does not mean that every hospital needs to have an angioplasty program. And in this instant case, the applicant has failed to show or demonstrate that in this PSA there is, in fact, a need for these additional 48 additional beds when there are vacancies in that same service area, when folks with commercial insurance have mobility and resources to go to many other places than individuals who don't have those resources.

And the most that I've gotten out of the entire application, based on testimony today is, if you build it, they will come. So we heard that there's a building in New London and it seemed like a good place to occupy it, it seemed like a good way to occupy it given the opioid crisis nationally speaking. But, you know, given

the demographics of that geographic area and the fact that the applicant has been very straightforward about planning on drawing patients from all over the state and patients who can get to their facility within a half hour to an hour drive or two mile -- two-hour radius, it's not entirely convincing to me that the real reason the applicant is proposing this facility is to address a need in the primary service area.

With respect to the Medicaid waiver that is in the works, and it is DSS that sets the rates for the Section 1115 Waiver, not DMHAS, although DMHAS and DCF will have some sort of a role in terms of guidance regarding credentialing and programmatic issues and ASAM issues. Under that waiver there is a waiver of the IMD rules. So there's really no need whatsoever to separate Medicaid patients from the facility that is being proposed here with 48 beds. So we find it somewhat ironic. We really don't know what the reasons are. And we heard from Mr. Schwab who is an experienced operator that he himself opined that it was unethical.

So they failed to prove that they are going to provide any meaningful services to those

who are marginalized such as the underinsured and uninsured. As we have stated in our testimony, we do believe that this will have a significant impact on providers in the state and their ability to find talent and to be able to compete with the competitive wages that Landmark is likely to be able to offer given the large size of this company and the plans for it to quote, unquote have a trillion whatever, patients, facilities, whatever.

So the impact is real. It will primarily impact the not-for-profits because they are providing significant charity care. And I can tell you that High Watch provides ten times the amount of 1 to 2 percent of charity care every year to its patients. So for all those reasons that you've heard today, we urge you to take our concern seriously as the consequences will undermine the integrity and fabric of the state's health care system of residential SUD providers. Thank you. And I appreciate your time and listening.

HEARING OFFICER CSUKA: Thank you, Attorney Feldman.

Attorney Volpe, do you have a closing statement?

MS. VOLPE: Yes, I do. But the applicant would like to make the statement directly as a closing statement. So I think he should be afforded the opportunity to make a closing statement as the applicant, and then I can just offer some procedural lawyer closing remarks, okay?

HEARING OFFICER CSUKA: Sure.

THE WITNESS (Kang): All right. Thank you for the opportunity to speak today. I would just like to provide a brief closing statement on behalf of our team at Landmark Recovery.

Ultimately, our ask here is simple. We ask that you grant our CON application so that Landmark Recovery can save lives in Connecticut, especially our primary service area, New London County. In that regard, I want to speak again to why New London needs us.

In its 2012 Statewide Health Care Facilities and Services Plan, Connecticut estimated that out of 2.75 million of its citizens, around 280,000 of them needed treatment. Out of the 280,000 individuals, only 47,000 or so would seek treatment. Differently stated, Connecticut estimates that around 10.2 percent of

the given population suffers from SUD, and only about 1.7 percent of them seek treatment. Using theses estimates and applying it to the PSA area, one could estimate that the New London County area has 27,000 individuals suffering from SUD and only around 4,500 of them seeking treatment.

When asked by our financial partners, this was back in 2019, 2020, we jumped on the opportunity to open a facility in the City of New London since all metrics and all the research we did indicated that there was a severe need. As discussed on page 20 of our application, New London County has the highest ratio of overdose deaths between the years 2015 to 2021. Despite this, our review shows that there were only 162 beds available in the New London County area with 50 of them being for detox and 112 being for inpatient residential care.

We can run some numbers based on this, based on this data. Assuming a 90 percent occupancy and some optimism, we would expect that each bed could successfully treat about 11 patients a year. This means, even if we included all 162 beds, they can only serve about 1,800 patients each year. Using the estimates from

Connecticut, this is about 2,700 patients without adequate access to service just in New London County. The proposed facility can close that gap. Indeed, this staggering need is why Landmark committed over $4 million for the proposed facility. In our mind to suggest that the PSA does not need our services would be a great injustice.

Along those lines, there are a few other points I want to address. First, I strongly believe that the SUD community, treatment community must refuse to accept the status quo. This is something brand new given that this is our first certificate of need state, but this is especially true when it comes to encouraging patients to seek help. Landmark believes that for the community to combat the SUD crisis, all providers, all three providers who are on this call must engage in community outreach to encourage people to seek help. It's not good enough that Connecticut says only 1.7 percent of the population will seek help but 10.2 percent needs it.

Differently stated, our goal here at Landmark Recovery is not to only help those 4,700

patients who are statistically likely to seek help, we want to help and motivate all 27,000 individuals in the PSA area to seek early intervention on SUD, substance use disorder issues and behavioral health issues at large. Every single provider in Connecticut should be working together on this mission encouraging people to seek help. Instead, everyone seems to just accept the status quo that only a certain percentage of the population will seek help. Vacancy cannot be an excuse when it comes to need and when it comes to saving lives.

The same thing could be said about the fear about not being able to find qualified providers. Landmark Recovery currently has explored, aside from Connecticut, 15 other states. This is not a problem unique to Connecticut. We have a health care worker shortage that's a nationwide crisis. When we were faced with a challenge we didn't say we can't do it. We didn't say we're going to give up. We found a solution to the problem. The solution to the problem partially is the fact that we operate more efficiently than most health care providers and therefore we can pay higher salary and benefits.

That in turn allows people to come in the areas where, if you look at our geographic locations, a lot of our areas are in remote places, much more remote than say the City of New London, but they come there because we offer not only quality care and opportunity to make a difference but also practical salaries and benefits.

That last point, and I think we touched on that at the last second, but one other point I would like to address. While I enjoyed my time today listening from everyone, one insinuation I heard was frankly disappointing. Granted, I'm not a clinician, but having been around a lot of clinicians, no clinician would ever disagree with the premise that a personalized curriculum is the best for the patient. This is why we create our Praxis facilities. We have found that individuals who have Medicaid insurance often experience different life circumstances and experience than those who do not. As such, we have a customized program around both populations needs with curriculum and services customized around their experience and alleviating those identified barriers for treatment which for Medicaid patients could include severe legal issues and even

homelessness. This should not be a controversial point. It is indisputable that shoving the same curriculum in someone's face without (inaudible) background and experiences simply does not work.

To sum up the hearing, reasonable people can disagree what the optimal solution for this crisis is, but the following fact is indisputable. As noted by the Connecticut Department of Social Services, Connecticut is experiencing one of the most significant public health crises in its history, and the mind blowing fact here is that even if Landmark could save one million lives in the next 100 years, it's not enough. Even if that impossible goal, seemingly impossible goal is met, it is not enough. The entire community needs to work together, not against each other, to win this battle.

Again, I feel much more strong -- I feel very strongly about this mission, especially given that Connecticut recently received the Section 1115 waiver. Serving Medicaid patients is part of Landmark's mission, it's core to our mission. Our core mission is to provide quality, evidence-based care to everyone. By end of this year, we will have somewhere between 650 to 720

beds available for Medicaid patients at our Praxis facilities. All these patients will receive distinguishable care from our award winning commercial facilities. We would love to discuss with OHS, DMHAS and any other interested parties about how we can bring the same level of care to Connecticut.

Again, I'd like to thank everyone for their time. We really look forward to the opportunity to come to Connecticut and save lives with everyone. Thank you.

HEARING OFFICER CSUKA: Thanks. Attorney Volpe.

MS. VOLPE: Okay. Thank you. And we appreciate everyone's time today. I think Attorney Kang said it best. I mean, and DSS succinctly said we're in the midst of one of the most significant public health crises that Connecticut has seen. Today Landmark walked through in detail how it meets each and every statutory criteria under the CON laws. It walked through and it explained how it meets in detail by each prong.

We have a provider who has the quality and clinical know-how and financial resources and

is willing to come to Connecticut to New London County to service the population. For providers to just stand up and offer no data or support for their speculations and opinions that somehow they're going to be harmed, we should have an overwhelming amount of providers willing to service the Medicaid population, willing to service commercial payers. Not every resident in Connecticut who has insurance can afford to run off to Malibu or somewhere else to get treatment. They're going to serve patients who have commercial coverage. These are the working class patients of Connecticut. They deserve access to the same types of treatments that they could get if they did have the resources to run out to Malibu. You have an established proven provider with a quality record. They should be permitted to come to Connecticut.

The other thing we want to talk about is Landmark is dedicated to meeting the needs of all patients, including the Medicaid population. That's been stated time and time again. Because they're willing to do it with a targeted curriculum, this is not discrimination. And if you look at the CMS waiver that everyone has

pointed to, they understand that the Medicaid population is unique, and Landmark has experience and history in servicing that population.

We also want to point out there wasn't a lot said today, it is in the record, about the overwhelming public support from the New London community for this application. They want Landmark to be able to come in and service this community. There's letters of support from the Mayor from the City of New London, he wrote in. State Representative McCarthy, State Senator Somers. We have letters of support from the director of human services from the City of New London. We have letters of support from Tony Sheridan, president and CEO of The Chamber. We have support from the executive director of the New London Homeless Hospitality Center, and the list goes on. There are a lot of people in support of letting Landmark come and service the patients of Connecticut.

What the intervenors have presented today is unsupported by any real data. They've made just blanket assertions that they're going to lose staff or they're going to lose money. I think Connecticut could stand with more

competition. And that, you know, to use the CON laws to keep out a viable, knowledgeable quality clinical-proven provider would be a shame. That's not what the CON laws are intended to in Connecticut. I know that can't be what OHS wants. There's criteria for applying whether or not a provider should be allowed to implement a service. That's what we should be looking at. And the Department of Public Health will also have its say because it has to issue a license. There will be a lot of regulatory bodies looking at whether or not this is the right provider.

So obviously the intervenors themselves realize there's a clear public need. They've looked to add additional beds. So again, we implore OHS to use its authority to allow Landmark to come into the state. And to the extent that you've noted any deficiencies in their application, which we don't believe exist, we think that we've met every standard, but to the extent that you note deficiencies, let them be known and let us address them and provide us with that same deference that the intervenors were allowed to in curing their application to be part of this proceeding.

So again, we appreciate your time today. We know how much work goes into having to hold hearings. We know how much is on the docket and before the Office of Health Strategy. And we appreciate your time today. And we respectfully request that you approve the CON before you. Thank you.

HEARING OFFICER CSUKA: Thank you, Attorney Volpe. I believe that's it for the day. I did want to thank everyone, Attorney Volpe, Attorney Feldman, Attorney Kang, Mr. Schwab and Ms. Lawton for being here. And this hearing is hereby adjourned, but the record will remain open until closed by OHS. And thank you, everyone.

MS. VOLPE: Thank you.

MS. FELDMAN: Thank you.

(Whereupon, the witnesses were excused and the hearing adjourned at 3:55 p.m.)

CERTIFICATE FOR REMOTE HEARING

STATE OF CONNECTICUT

I, Lisa L. Warner, L.S.R. 061, a Notary Public duly commissioned and qualified, do hereby certify that on July 20, 2022, at 10:06 a.m., the foregoing REMOTE HEARING before the CONNECTICUT OFFICE OF HEALTH STRATEGY IN RE: DOCKET NO. 22-32515-CON, LANDMARK RECOVERY OF CONNECTICUT, LLC ESTABLISHMENT OF A NEW HEALTH CARE FACILITY, was reduced to writing under my direction by computer-aided transcription.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which these proceedings were taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

In witness whereof, I have hereunto set my hand this 26th day of July, 2022.

Lisa L. Warner, CSR 061
Notary Public
My commission expires:
May 31, 2023

I N D E X

I n d e x: (Cont'd)

EXHIBITS ADDED TO TABLE OF RECORD

LATE-FILE EXHIBITS