THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable H.W. Funderburk, Jr., Administrative Law Judge

APPELLATE CASE NO.: 2019-000358
ADMINISTRATIVE LAW COURT CASE NO.: 16-ALJ-07-0386-CC

Trident Medical Center, LLC, d/b/a Trident Medical Center.....Respondent,

v.

South Carolina Department of Health and Environmental Control and Roper St. Francis Hospital-Berkeley, Inc. d/b/a Roper St. Francis Hospital – Berkeley ..... Respondents below,

Of Which South Carolina Department of Health and Environmental Control is a.....Respondent,

And Roper St. Francis Hospital – Berkeley, Inc. d/b/a Roper St. Francis Hospital - Berkeley is the.....Appellant.

BRIEF OF RESPONDENT TRIDENT MEDICAL CENTER, LLC

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STATEMENT OF THE CASE

On May 9, 2016, the Appellant Roper St. Francis Hospital–Berkeley, Inc. d/b/a Roper St. Francis Hospital-Berkeley ("Roper") submitted a Certificate of Need ("CON") application to establish a new diagnostic catheterization laboratory at its unopened hospital in Berkeley County ("Proposed Project"). **(R. pp. 753 – 935)**. On May 26, 2016, the staff of the Respondent South Carolina Department of Health and Environmental Control ("DHEC") accepted Roper's CON application and deemed it complete. **(R. p. 971; R. p. 974; R pp. 995 – 996)**.

On June 24, 2016, the Respondent Trident Medical Center, LLC, d/b/a Trident Medical Center ("Trident") timely notified DHEC of its status as an affected person opposing Roper's Proposed Project and requested that DHEC conduct a project review hearing on the matter. **(R. p. 939)**. On July 13, 2016, DHEC denied Trident's request for a project review hearing. **(R. p. 941)**. On July 21, 2016, Trident submitted a letter to DHEC from Trident's expert health planner, Daniel J. Sullivan of Sullivan Consulting Group, Inc., analyzing Roper's CON application and outlining Trident's reasons for opposing the Proposed Project. **(R. pp. 942 - 953)**.

On July 25, 2016, DHEC staff approved Roper-Berkeley's CON application. **(R. pp. 958 - 960)**. On August 9, 2016, Trident timely requested that the DHEC Board ("Board") conduct a final review conference on the matter. **(R. pp. 980 - 1011)**. On September 21, 2016, the Board formally declined to conduct a final review conference, thus rendering the DHEC staff decision the final agency decision for purposes of requesting contested case review by the Administrative Law Court ("ALC"). **(R. pp. 1345 - 1346)**.

On October 21, 2016, Trident petitioned the ALC for administrative review of DHEC's decision to approve Roper's CON application and requested a contested case hearing thereon. **(R. pp. 44 - 152)**. The ALC conducted a contested case hearing on this matter over two successive days beginning July 24, 2018. **(Amended Final Order, R. p. 21)**. Prior to the contested case proceeding, the parties stipulated to certain facts and agreed to limit the issue to be decided by the ALC to whether Roper's Proposed Project complied with Standard 3 of the *2015 South Carolina Health Plan* ("2015 State Health Plan"). **(Stipulation of Facts ¶ 9, R. p. 263)**.

On December 3, 2018, the ALC issued its order reversing DHEC's decision to approve Roper's Proposed Project. **(R. pp. 1 - 19)**. On December 13, 2018, Roper filed its Motion to Alter or Amend the Final Order and Decision of the ALC. **(R. pp. 153 – 186)**. On February 21, 2019, the ALC substituted an Amended Final Order and Decision ("Amended Final Order") for its prior decision. The Amended Final Order reiterated the court's original conclusion that DHEC's decision to approve Roper's Proposed Project should be reversed and Roper's CON Application should be denied. **(R. pp. 20 - 43)**.

On March 5, 2019, Roper filed its Notice of Appeal with this Court. On August 2, 2019, this Court issued its Order amending the caption of this case to clarify that DHEC appears as a party-Respondent in this matter.[1]

STATEMENT OF THE FACTS

In late April 2010, East Cooper Community Hospital, Inc. d/b/a East Cooper Medical Center ("East Cooper") contacted DHEC to discuss its plan to file a CON application to establish a new diagnostic catheterization laboratory (colloquially "cath lab") at its Mount Pleasant hospital facility. (**R. p. 1307**). Because the applicable State Health Plan prohibited the approval of a new diagnostic cath lab unless all other diagnostic cath labs in the service area, when averaged cumulatively, were performing at or above an established minimum threshold, the focus of East Cooper's outreach to DHEC was its concern that one underperforming cath lab would bar approval of its application. **(Id.)** Specifically, East Cooper sought guidance regarding the diagnostic cath lab at Bon Secours St. Francis Xavier Hospital ("St. Francis"), a Roper Healthcare System hospital located in the West Ashley area of Charleston County, which was underperforming to the extent that no new diagnostic cath labs could be approved in the service area. (**Id.**). East Cooper raised with DHEC St. Francis' failure to perform any procedures in its cath lab for the years 2007 through 2009 and requested a formal determination by DHEC whether the St. Francis diagnostic cath lab could be eliminated from East Cooper's calculation of the required utilization threshold. (**Id.**)

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[1] Because DHEC appears as a party-Respondent in this matter despite its alignment with Petitioner Roper on the merits, DHEC's initial brief will be filed concurrently with Trident's initial brief. Therefore, Trident in this brief addresses the arguments and issues as framed by Roper. Where possible, Trident attempts to anticipate and address DHEC's likely arguments on appeal, based on its positions stated during the contested case review process.

In response to its inquiry to DHEC, East Cooper first received input from Les Shelton, who at the time was DHEC's Director of Planning & CON. **(R. p. 1302)**. Mr. Shelton indicated that "We do not have the ability to 'close' the lab and remove it from the inventory. However, given that it has been out of operation for more than three years, it is certainly a fair question to ask whether it should be considered in the need calculations." **(Id.)** Mr. Shelton advised East Cooper that DHEC staff was going to discuss the question internally and provide a response to East Cooper's request. **(Id.)**

On May 27, 2010, Beverly Brandt, the Chief of the Bureau of Health Facilities and Services Development for DHEC, sent a formal response letter to East Cooper advising that, based on DHEC's review of the State Health Plan and CON law and regulations, "we do not currently have a mechanism in place that would allow the Department to discount the existence of the St. Francis cardiac cath lab when computing the average utilization for the service area." **(R. p. 1309)**. Ms. Brandt indicated that the appropriate way to address the issue would be to amend the draft 2010-2011 State Health Plan to "allow adjustments in the need calculations for 'unused' beds or equipment." **(Id.)**. Despite DHEC's acknowledgment of the problem in 2010 and its proposed appropriate solution, no amendments were ever made to the State Health Plan to address this issue.[2] **(Eubank Trial Tr.: R. p. 595, lines 2-16)**. Nevertheless, six years later, East Cooper decided to try again.

On February 4, 2016, East Cooper filed a CON application to establish diagnostic catheterization services at its Mount Pleasant hospital. **(R. pp. 1012 - 1078)**. In its need analysis,

[2] Although no amendments to the State Health Plan were made to address the underperforming diagnostic cath lab issue, other similar provisions exist for other services. For example, the failure to achieve a threshold volume of *therapeutic* catheterizations within a three year period can result in the loss of a CON to operate such a program. **(Sullivan Trial Tr.: R. p. 357, lines 4-22)**.

submitted to DHEC, East Cooper asserted that, because the St. Francis cath lab performed no procedures during 2007, 2008, and 2009, it should be considered unlawful and, therefore, non-operational and should be removed from the 2015 State Health Plan inventory and not used to calculate community need. **(R. p. 1035)**. East Cooper's argument for excluding the St. Francis cath lab was based on 3 S.C. Code Ann. Regs. 61-15 §102(1)(e)(Supp. 2019), which requires a healthcare provider to obtain a CON prior to "the offering of any health service . . . which has not been offered by the facility in the preceding twelve months and for which specific standards or criteria are prescribed in the South Carolina Health Plan." (**Id.**). As was the case in 2010, leaving St. Francis cath lab in the need calculation barred the approval of any new diagnostic cath labs in the service area. **(R. p. 1315)**.

In light of East Cooper's contention that the St. Francis cath lab should be considered in violation of CON law and non-operational, DHEC contacted St. Francis to discuss the matter. On February 22, 2016, Shannon Cantwell, the Regulatory Affairs Specialist for the Roper Healthcare System, provided DHEC with utilization data that contradicted East Cooper's assertion that the St. Francis cath lab had performed no procedures from 2007 through 2009. **(R. p. 1299)**. Ms. Cantwell advised that St. Francis cath lab had performed 21 procedures in 2007 but did confirm that no procedures were performed for 2008 and 2009 and only a minimal number of procedures were performed each year thereafter for 2010 through 2014.[3] (**Id.**). Ms. Cantwell also provided DHEC with the 2010 correspondence between DHEC and East Cooper, discussed above, in which DHEC concluded that it lacked the authority to close the St. Francis cath lab or to discount its low utilization when calculating community need. (**Id.**).

[3] The 2015 JAR for St. Francis indicated that it performed two inpatient catheterizations in 2015. **(Sullivan Trial Tr.: R. p. 345, lines 20-22)**.

On April 14, 2016, Louis Eubank, the then Director of the Certificate of Need Program[4], contacted Roper's attorney to update him on DHEC's intentions with regard to the St. Francis cath lab. (**R. p. 1314**). In his email Mr. Eubank advised:

> [T]he performance of 0 procedures in that lab during 2008 and 2009 is violative of SC Code Ann. Regs. 61-15, Section 102(1)(e).... Furthermore, the continued operation of the St. Francis Xavier cath lab at such low volume prohibits the entry of any additional cath labs in the service area as outlined in the SC Health Plan standards for such services. The low volume would also likely prohibit the transfer of that cath lab from one of the operator's facilities to another under the service transfer criterion which requires adequate historical utilization figures.

(R. p. 1315). Mr. Eubank goes on to notify Roper that DHEC is considering an enforcement action against St. Francis and asks Roper to propose a solution to the issue within ten days to avoid such action. (**Id.**)

On April 20, 2016, Roper's attorney responded to Mr. Eubank's email by filing a request with DHEC for Roper to be considered an "affected person" letter with regard to the East Cooper CON review. **(R. p. 1314)**. In this letter, addressed to Mr. Eubank, Roper denied East Cooper's contention that the St. Francis cath lab should be considered non-operational and discounted for purposes of determining community need and Roper reminded DHEC that it had rejected the same assertion by East Cooper in 2010. **(R. pp. 1080 - 1092)**. Further, Roper's attorney responded to Mr. Eubank's threat to take enforcement action against the St. Francis cath lab:

> [A]s we discussed on March 10 and again on April 19, 2016, Roper St. Francis has made the decision to open a new diagnostic catheterization laboratory at its hospital that is currently under development in Berkeley County. Roper St. Francis is currently preparing a CON application that will be filed with DHEC in the near future requesting approval for this cath lab at Roper St. Francis Berkeley Hospital. If Roper St. Francis' application is approved, Roper St. Francis intends to close its cath lab at Bon Secours St. Francis Hospital. This should allow DHEC to also approve the East Cooper Application consistent with the South Carolina

[4] At the time of trial, Mr. Eubank was the Chief of the Bureau of Healthcare Planning and Construction, which includes oversight of the CON Program. (**Eubank Trial Tr.: R. p. 527, lines 4-17**).

> Health Plan and the applicable CON laws. Until Roper St. Francis' CON application is approved, Roper St. Francis will continue to operate the cath lab at Bon Secours St. Francis Hospital.

(R. p. 1081). Roper concluded its affected person letter by requesting that DHEC consider both East Cooper and Roper's applications "in the same review cycle so that both can be approved consistent with the South Carolina Health Plan and the CON laws."[5] **(Id.)** Two days later, Mr. Eubank emailed East Cooper's health planning consultant a copy of Roper's affected person letter and indicated, "I think everything will work out just fine for everyone." **(R. p. 1329)**.

On May 9, 2016, as promised in its letter to Mr. Eubank, Roper filed its CON application to establish a new diagnostic cath lab at its then unconstructed Berkeley County hospital at a total project cost of $2,873,366. **(R. p. 753; R. p. 756)**. The application stated that "upon DHEC approval of the application, the diagnostic catheterization laboratory at its sister hospital, Bon Secours St. Francis Xavier Hospital, will close and the room will continue to be used as a special procedures lab." **(R. 758)**. Thus, in both its affected person letter filed in the East Cooper CON proceeding and in its own CON application, Roper indicated that it would close the St. Francis cath lab only if and when DHEC approved Roper's request for a new lab in Berkeley County. Otherwise, Roper stated that it would "continue to operate" the St. Francis lab. **(R. p. 1081)**.

Roper's CON application also classified St. Francis as an "existing" cath lab in the service area. In Exhibit 14 to the application, Roper lists the "Historical Utilization of Existing

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[5] Under S.C. Code Ann. § 44-7-210 (2018), unless a public hearing was requested, DHEC had to issue a decision letter on East Cooper's application no later than 120 days after the notice to affected persons was published in the *State Register*. No public hearing was requested and the notice to affected persons was published on March 25, 2016. **(R. p. 1123)**. Thus, the deadline for DHEC's decision in the East Cooper matter was July 25, 2016. Because Roper had to be approved before it was willing to close its underperforming St. Francis cath lab and because such approval had to occur prior to East Cooper's decision in order for DHEC to conclude that East Cooper met the Standard 3 requirement, Roper's decision had to be issued on or before July 25, 2018.

Labs in the Service Area." **(R. p. 782)**. Following this exhibit, Roper states that "while Bon Secours St. Francis **is operating** below 500 diagnostic equivalents per year, the lab **will be closed** upon the approval of this project. As a result **all labs that exist following the approval** of this project are currently operating well above 500 diagnostic equivalents per lab and meet the utilization requirements of this [Standard 3]." **(R. pp. 782 - 783)**. As correctly found by the ALC, "nowhere in the CON application does [Roper] state that the [St. Francis cath lab] is non-operational or non-existent, only that it **will close** and, therefore, **will not exist** after the approval of the CON application." **(Amended Final Order, R. p. 33)**(emphasis in original).

On May 26, 2016, DHEC advised Roper that its application was accepted and deemed complete and would be published in the next day's *State Register*. In his email to Roper's attorney, Mr. Eubank noted, "Everything is still looking good for the process you and Ashley [Biggers, DHEC's attorney] and I discussed previously." **(R. p. 1331)**.

When East Cooper filed its CON application to establish a new diagnostic cath lab in Mount Pleasant, Trident determined that East Cooper, which is approximately 45 minutes' drive time from Trident, would likely not draw many patients from Trident and, therefore, would not have a material impact on Trident's cardiac catheterization program. **(Sullivan Trial Tr.: R. p. 327, line 20 – p. 328, line 10; R. p. 454, line 10 – p. 455, line 11).** Thus, Trident decided not to appear as an affected person opposing East Cooper's CON application. **(Id.)**. At the time East Cooper filed in February, Trident was not aware of Roper's intention to file a CON application for a new Berkeley County diagnostic cath lab as Roper's affected person letter would not be filed until April 20, 2016. **(Sullivan Trial Tr.: R. p. 455, lines 1-7).** In contrast to East Cooper, Roper's Berkeley County hospital located in Goose Creek is only seven miles from Trident's facility that performs both diagnostic and therapeutic catheterizations. **(R. p. 946)**. Therefore, on

June 24, 2016, Roper filed an affected person letter with DHEC opposing Roper's Proposed Project. **(R. p. 939)**.

In support of its opposition to Roper's Proposed Project, Trident submitted an analysis from its health planning consultant, Dan Sullivan, on July 21, 2016. **(R. pp. 942 - 953)**. In his analysis, Mr. Sullivan stated as one of Trident's grounds of opposition that Roper did not meet Standard 3 of the applicable 2015 State Health Plan because "all existing labs in the service area have not performed a minimum of 500 diagnostic catheterization procedures per laboratory in 2015." **(R. p. 946)**. Standard 3 provides:

> New diagnostic catheterization services, including mobile services, will be approved only if all existing labs in the service area have performed a minimum of 500 diagnostic catheterization procedures per laboratory during the most recent year.

(R. p. 1171).[6]

Because Trident and Mr. Sullivan were unaware of the prior enforcement negotiations between DHEC and Roper[7], Mr. Sullivan also addressed in his analysis submitted to DHEC the Service Exception Standards of the 2015 State Health Plan. These standards provide for the transfer of services between related facilities. **(Sullivan Trial Tr.: R. p. 338, line 17 – p. 339, line 5).** As explained by Mr. Sullivan:

> It appeared to me this was some hybrid of a transfer that was being proposed . . . and so the service areas standards talk generally about what you have to do in order to comply when you're transferring services from one facility to the other.

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[6] As stipulated by the parties, "Standard 3 sets forth the historical utilization threshold for approval of a new diagnostic catheterization laboratory in a service area." **(Stipulation of Facts, ¶6(c), R. p. 262).**

[7] As discussed above, Mr. Eubank had advised Roper in April before it filed its CON application, that the low volume of the St. Francis lab would "likely prohibit the transfer of that cath lab from one of the operator's facilities to another under the service transfer criterion which requires adequate historical utilization figures." **(R. p. 1315)**

> And so, I wanted to at least look at those standards to see whether or not it would make sense for this application to be approved under these particular provisions.

(Id.). With respect to the service transfer standards, and only with respect thereto, Mr. Sullivan opined that the St. Francis cath lab was not functioning as a viable program that would support the transfer of diagnostic catheterization services to another facility because of the requirement that the applicant demonstrate need through historical utilization data. **(Sullivan Trial Tr.: R. p. 339, line 7 - p. 340, line 16).**

Roper submitted no response to Mr. Sullivan's analysis because, five days later on July 25, 2019, DHEC issued its decision letter approving Roper's application to establish a new diagnostic cath lab at its Berkeley County hospital. **(Platt Trial Tr.: R. p. 727, lines 10-13)**. In its decision letter, DHEC determined that Roper's CON application met the requirements of Standard 3 based on the following reasoning:

> A review of relevant Joint Annual Report (JAR) data for all diagnostic catheterization labs within the 45-minute drive time service area showed that all diagnostic catheterization labs met or exceeded the 500 procedure threshold outline in the Plan with one notable exception. The diagnostic cardiac catheterization lab located at Roper St. Francis Xavier Hospital in West Ashley performed no more than nine (9) procedures per year in any year from 2010 to 2014, according to available JAR data. The Department explained this inconsistency to the Applicant as an agent for both Roper St. Francis Hospital – Berkeley and Bon Secours St. Francis Xavier Hospital. As such an agent, **the Applicant agreed to shutter its diagnostic catheterization lab upon approval of the instant application**, regardless of the timing of the new lab installation or any potential opposition to the instant application, **thus allowing the department to discount the utilization figures of the lab at the Bon Secours St. Francis location**. As such, the Department concludes that other diagnostic catheterization labs within the service area operate at such equivalent capacity as to not preclude the addition of the diagnostic catheterization lab contemplated by the Applicant.

(R. pp. 958 - 959)(emphasis added). Nowhere in DHEC's decision letter approving Roper does DHEC indicate that the St. Francis cath lab did not "exist" for purposes of Standard 3 because of its failure to obtain a new CON after allowing its utilization to fall to zero during 2008 and 2009.

Upon issuance of the decision approving Roper's new cath lab, DHEC immediately issued its decision approving East Cooper's application for its new diagnostic cath lab. On the day the decisions were issued, Mr. Eubank transmitted East Cooper's healthcare consultant a copy of the East Cooper decision and included a copy of Roper's decision because "the two are tied together." **(R. p. 1332)**.

On July 26, 2016, the day following DHEC's decisions to approve East Cooper's and Roper's new cath labs, Mr. Eubank sent a letter to Roper requesting that Roper provide evidence of the closure of the St. Francis cath lab to DHEC within thirty days of the date of the letter. **(R. p. 978)**. The letter instructed Roper to include evidence of the removal of any print or web-based advertising and to submit "as well an affidavit signed by the appropriate individual within Roper St. Francis Healthcare which will attest to the closure of the aforementioned cath lab." **(Id.)**.

On August 17, 2016, Roper sent a letter from the CEO of St. Francis Hospital indicating that the St. Francis diagnostic cath lab was permanently closed on August 1, 2016, although the lab space itself would continue to be used for other services. **(R. p. 979)**. Other than the letter stating that the lab had been closed for diagnostic catheterization purposes, the record contains no evidence that Roper ever submitted the "evidence of closure" requested by DHEC or an affidavit attesting to the closure of the St. Francis cath lab.

STANDARD OF REVIEW

The ALC is an "agency and a court of record within the executive branch of the government of this State." S.C. Code Ann. § 1-23-500 (Supp. 2019). As such, the ALC heard this matter and issued its Amended Final Order containing its findings of fact and conclusions of law pursuant to its contested case review authority granted by S.C. Code Ann. §1-23-600 (Supp. 2019). Under that authority, the ALC sits as the fact finder in a de novo hearing with the

presentation of evidence and testimony and is, therefore, not restricted or confined by the findings of the administrative agency.[8] *See Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 512, 560 S.E.2d 410, 413 (2002); *See also Risher v. S.C. Dep't of Health & Envtl. Control*, 393 S.C. 198, 207-208, 712 S.E.2d 428, 433 (2011)(noting that the ALC is the ultimate fact finder in a contested case proceeding.).

As the ultimate fact finder, the ALC has the discretion to determine the weight and credibility to be assigned to the evidence before it, including assessing the weight and credibility of expert witness testimony. Thus, the ALC can accept all or part of any witness' testimony and can accept the testimony of one witness over that of another witness, including expert witnesses. *Maull v. S.C. Dep't of Health & Envtl. Control*, 411 S.C. 349, 359, 768 S.E.2d 402, 408 (2015).

In recognition of the ALC's role as the ultimate administrative fact finder in a contested case, the law limits the judicial review of an ALC's final decision as follows:

> The review of the administrative law judge's order must be confined to the record. The court may not substitute its judgment for the judgment of the administrative law judge as to the weight of the evidence on questions of fact. The court of appeals may affirm the decision or remand the case for further proceedings; or, it may reverse or modify the decision if the substantive rights of the petitioner have been prejudiced because the finding, conclusion, or decision is:
>
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

[8] As noted by this Court in *Dorman v. S.C. Dep't of Health & Envtl. Control*, 350 S.C. 158, 167, 565 S.E.2d 119, 123 (2002), "while the ALJD is an independent agency, it still functions as an arm of the agency for purposes of according the agency deference in interpretation."

S.C. Code Ann. § 1-23-610(B)(Supp. 2019). As summarized by the South Carolina Supreme Court, the standard of review on appeal is:

> In determining whether the ALC's decision was supported by substantial evidence, the Court need only find, looking at the entire record on appeal, that evidence from which reasonable minds could reach the same conclusion as the ALC. *Hill v. S.C. Dep't of Health & Envtl. Control,* 389 S.C. 1, 9-10, 698 S.E.2d 612, 617 (2010). However, the Court may reverse the decision of the ALC where it is in violation of a statutory provision or it is affected by an error of law. *Alltel Communc'ns, Inc. v. S.C. Dep't of Revenue*, 399 S.C. 313, 316, 731 S.E.2d 869, 870-71 (2012).

Kiawah Dev. Partners, II v. S.C. Dep't of Health & Envtl. Control, 411 S.C. 16, 28, 766 S.E.2d 707, 715 (2014).

ARGUMENT

I. THE ADMINISTRATIVE LAW COURT CORRECTLY DECLINED TO GIVE DEFERENCE TO DHEC'S INTERPRETATION OF A STATE HEALTH PLAN PROVISION ESTABLISHING A MINIMUM UTILIZATION FOR THE APPROVAL OF A NEW CARDIAC CATH LAB BECAUSE SUCH INTERPRETATION WAS ARBITRARY AND CONTRARY TO THE PLAIN LANGUAGE OF THE PLAN.

As its first issue for appeal, Roper contends in its brief that the ALC erred in declining to give deference to DHEC's interpretation of Standard 3 of the 2015 State Health Plan. As its second issue for appeal, Roper argued that the ALC erred in determining that DHEC's interpretation of Standard 3 was arbitrary and in violation of the plain language of the Plan. (**Brief of Appellant, p. 1**). Because these two issues are intertwined, Trident addresses Roper's Issues I and II together in this argument.

This case arises under the Certificate of Need program for health care facilities and services. The framework of the CON program is established by the State Certification of Need and Health Facility Licensure Act (the "CON Act") found at S.C. Code Ann. §§ 44-7-110, *et seq.* (2018 and Supp. 2019), the regulations set forth at 3 S.C. Code Ann. Regs. 61-15 (Supp. 2019), and the State Health Plan. The stated purpose of the CON program is to "promote cost

containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120 (2018). The goals of the CON Act are carried out through the requirement that a provider apply for, and receive, a CON from the Department prior to establishing a new health facility or service, adding beds, making large capital expenditures or acquiring medical equipment when the total project cost exceeds a certain threshold amount. S.C. Code Ann. §§ 44-7-120 and 44-7-160 (2018).

In determining whether to grant or deny an application for a CON, DHEC must evaluate the proposed project under the project review criteria found in the CON regulations and under the applicable policies and standards of the State Health Plan in effect at the time the application is filed, although it may consider a more current plan in making its decision. S.C. Code Ann. § 44-7-225 (2018). In this case, the parties have stipulated that the State Health Plan applicable to this matter is the 2015 State Health Plan. **(Stipulation of Facts, ¶ 2, R. p. 261).**

The State Health Plan is one of the primary methods DHEC uses to "guide the establishment of health facilities and services" under the CON Act. The State Health Plan is developed by the State Health Planning Committee, with the assistance and input of the DHEC staff, and approved by the DHEC Board. By law, the State Health Plan must be promulgated at least every two years through a process which requires public notice, public hearings, and a public comment period for both the original plan *and for any subsequent amendments*. S.C. Code Ann. § 44-7-180(C)(2018).

The CON Act mandates that the Plan contain an inventory of existing health care facilities, beds, and services in South Carolina, provide projections of the need for additional

facilities, beds, and services, and establish the standards to be followed by DHEC in reviewing applications for new or additional facilities, beds, and services. S.C. Code Ann. § 44-7-180(B)(2018). *See, Spartanburg Reg. Med. Center v. Oncology & Hematology Assocs of S.C., LLC*, 387 S.C. 79, 83, 690 S.E.2d 783, 785 (2010)("The purpose of the Health Plan is to outline the need for medical facilities and services in the State. The Health Plan is used as one of the criteria for reviewing projects under the CON program."). In this case, the 2015 Plan contains an inventory of cardiac catheterization services showing existing providers in various regions of the State, including St. Francis's cath lab in Region IV. **(R. p. 1244).** The inventory in the 2015 State Health Plan also shows the historical utilization of providers of cardiac catheterization services for the years 2011, 2012, and 2013. **(Id.).** At the hearing, Mr. Eubank admitted that the St. Francis cath lab reported the performance of procedures at least until 2015 and that, despite DHEC's having numerous opportunities to remove St. Francis from the inventory, it remained listed as an existing provider even during the period that it reported no procedures. **(Eubank Trial Tr.: R. p. 578, line 22 – p. 580, line 12).**

As explained below by Trident's expert at the hearing, the State Health Plan serves as the "roadmap" that the healthcare industry relies on in determining whether to apply for approval to add health services and facilities. **(Sullivan Trial Tr.: R. p. 389, lines 17-22).** Mr. Sullivan testified that for "every CON project in South Carolina, that would be my starting point to look at the South Carolina Health Plan." **(Sullivan Trial Tr.: R. p. 325, lines 11-19).** Indeed, the 2015 State Health Plan describes its formation and purpose as follows:

> In consultation with the Health Planning Committee, the Department formulated these standards to **guide medical providers throughout the State**. Inclusion of these standards in the application process is **designed to give applicants notice of its requirements and to elicit from them a commitment to incorporate these standards into both their applications and finished products**.

(**R. p. 1130**)(emphasis added).

The CON Act prohibits DHEC from issuing a CON to an applicant unless the application complies with the State Health Plan, Project Review Criteria, and other regulations. S.C.Code Ann. § 44-7-210(B)(2018). DHEC's regulations also mandate that "no project may be approved unless it is consistent with the State Health Plan." 3 S.C. Code Ann. Regs. 61-15, § 801(3) (Supp. 2019). *See, also, MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008)("Section 44-7-210(C) and the governing regulations are clear in establishing Plan standards and project review criteria as separate and distinct requirements that must be met as part of the CON application process.").

In this case the sole issue before the ALC was Trident's assertion that DHEC erred in finding that Roper's CON application complied with Standard 3 of the 2015 State Health Plan. The resolution of this issue turns on whether DHEC's interpretation of Standard 3 was arbitrary, capricious, or contrary to the plain language of the Plan. If so, the ALC was not required to defer to DHEC's interpretation of Standard 3 and could find, as he did, that Roper's CON application was not consistent with the State Health Plan. In the absence of a compelling reason to reject DHEC's interpretation, however, established case law requires the ALC to defer and accept DHEC's interpretation as correct.

In *Kiawah Development Partners II*, the Supreme Court discusses the parameters of the doctrine of deference by courts to administrative interpretations of the law. In that case, the Court articulated a two-step process for analyzing when such deference is appropriate. As summarized by the Court:

> [T]he deference doctrine properly stated provides that where an agency charged with administering a statute or regulation has interpreted the statute or regulation, courts, including the ALC, will defer to the agency's interpretation absent compelling reasons. We defer to an agency interpretation unless it is "arbitrary, capricious, or manifestly contrary to the statute."

Kiawah Dev. Partners, II, 411 S.C. at 34-35, 766 S.E.2d at 718 (2014), *citing Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). In response to the dissent in *Kiawah Development Partners, II*, the majority makes clear that its discussion of the deference doctrine does not change prior applications of the doctrine and is not meant to undermine any longstanding approach to the doctrine. *Kiawah Dev. Partners, II*, 411 S.C. at 67, n. 8, 766 S.E.2d at 735, n. 8. Indeed, throughout its opinion, the Court cites numerous prior cases that analyze whether there exists a compelling or cogent reason to decline to defer to an agency interpretation even when a regulation is ambiguous or silent.

The sole issue in this case involves DHEC's interpretation of Standard 3 of the 2015 State Health Plan. As discussed above, Standard 3 provides:

> New diagnostic catheterization services, including mobile services, **will be approved** only if **all existing labs** in the service area **have performed** a minimum of 500 diagnostic catheterization procedures per laboratory during the most recent year.

(R. p. 1171) (emphasis added).

At the hearing before the ALC, Mr. Eubank testified why he determined that Roper's Proposed Project compiled with Standard 3:

> Well my ultimate decision was that, given my firm belief that the Bon Secours St. Francis West Ashley lab had not offered the services for two years and would have required a CON to again be an existing lab that it was, in fact, not an existing lab for the purpose of review under Standard 3.

(Eubank Trial Tr.: p. 551, lines 6-12). This interpretation of Standard 3 – that St. Francis' failure to provide services for two years in 2008 and 2009 renders it "not existing" for purposes of Standard 3 – was DHEC's third known interpretation of Standard 3 in the long tortuous

history of this case. This most recent interpretation is the one that DHEC argues requires deferral.[9]

Roper, on the other hand, argues that the ALC should have deferred to DHEC's second interpretation of Standard 3, stated in DHEC's decision letter approving Roper. In that decision letter, Mr. Eubank does not find that St. Francis does not exist; rather Mr. Eubank indicates that Roper's promise to "shutter" St. Francis upon approval of its Goose Creek cath lab "allows the Department to discount the utilization figures of the lab at the Bon Secours St. Francis location." **(R. pp. 958 - 959)**. Mr. Eubank applied this same reasoning in approving East Cooper's application on the same day. **(R. p. 1100)**.

This interpretation, that St. Francis' low utilization could be discounted, was not a long-standing, consistent policy of DHEC. It was, however, an acknowledgement of the agreement between Roper and DHEC, which was arrived at in emails and conversations that occurred prior to the filing of Roper's application. As discussed above, under the agreement, in exchange for DHEC not pursuing an enforcement action against St. Francis, Roper agreed to cause the St. Francis cath lab to close if and when DHEC approved Roper's application for a new cath lab in Goose Creek. While no evidence exists that DHEC guaranteed approval of Roper's CON

[9] It should be noted that no enforcement action was ever taken against St. Francis because, as Mr. Eubank testified, that was "the intended result" of the agreement between DHEC and Roper. **(Eubank Trial Tr.: R. p. 633, lines 9-13)**. Thus, aside from Mr. Eubank's "firm belief", there has been no formal adjudication that St. Francis in fact was illegally operating its cath lab after 2009. Mr. Eubank admitted at the hearing that Roper disputes this conclusion because Roper continued to *offer* services during 2008-2009, even though no procedures were performed. **(Eubank Trial Tr.: R. p. 590, lines 13-18)**. *See also* 3 S.C. Code Ann. Regs. 61-15 §102(1)(e)(Supp. 2019), which requires a healthcare provider to obtain a CON prior to "the offering of any health service . . . which has not been **offered** by the facility in the preceding twelve months." (emphasis added). It is undisputed that St. Francis physically existed and was offering services at the time of Roper's CON review. In fact, St. Francis cath lab was open until August 1, 2016, six days after East Cooper's and Roper's CONs for new cath labs were approved. **(R. p. 979)**.

application, DHEC did agree, prior to the filing of Roper's CON, that Roper's stated intention to close the St. Francis lab upon approval would allow DHEC to discount St. Francis' extremely low utilization and find that Roper at least met the requirements of Standard 3 of the Plan. Roper essentially had nothing to lose (other than the potential costs of litigating an enforcement action by DHEC) because it made closure of its severely underutilized lab contingent on DHEC allowing it to open another lab in a potentially more promising location.

DHEC's first known interpretation of Standard 3 with regard to the St. Francis cath lab was set forth by Mr. Eubank's predecessor, Ms. Brandt, in her formal response to East Cooper's 2010 inquiry concerning whether East Cooper could discount St. Francis in its need calculations. In that letter, Ms. Brandt indicated that, after review of the applicable law and regulations, DHEC determined that it had no legal mechanism, during the course of CON review, to discount St. Francis' extremely low utilization when determining community need in the service area. **(R. p. 1309)**. DHEC's position in 2010 was that the proper way to address the issue would be to amend the State Health Plan to give DHEC the authority to allow adjustments in the need calculation for unused beds and services. Neither Roper nor DHEC urge deference by the ALC to this interpretation of Standard 3.

In its Amended Final Order, the ALC applied the two-step analysis set forth in *Kiawah Development Partners, II*, and examined first whether the plain language of Standard 3 addresses the issue of whether the St. Francis cath lab should be considered in calculating community need. This Court has previously determined that "[b]ecause the legislature has required these stringent requirements for State Health Plan implementation, it is clear the legislature intended for the State Health Plan to be an enforceable document" and, as such, the State Health Plan can be interpreted under the rules of statutory construction. *Trident Med. Ctr.*

v. S.C. Dep't of Health & Envtl. Control, 412 S.C. 341, 350-355, 772 S.E.2d 177, 182-184 (Ct. App. 2015).

In accordance with the rules of construction, the ALC was guided first by the plain language of Standard 3. *See Wade v. Berkeley County*, 348 S.C. 224, 229, 559 S.E.2d 586, 588 (2002) ("The first question of statutory interpretation is whether the statute's meaning is clear on its face...If a statute's language is plain and unambiguous, and conveys a clear and definite meaning, there is no occasion for employing rules of statutory interpretation and the court has no right to look for or impose another meaning.").

The ALC determined that, on its face, the plain and ordinary meaning of Standard 3 is that, in order for a new diagnostic cath lab to be approved, all cath labs in the service area that are open and offering diagnostic catheterization services at the time a CON application is being reviewed must have performed the required minimum 500 procedures during the year prior to the review period. **(Amended Final Order, R. p. 38)**. Again, Standard 3 states "[n]ew diagnostic catheterization services, including mobile services, **will be approved only if all existing labs** in the service area **have performed** a minimum of 500 diagnostic catheterization procedures per laboratory **during the most recent year**." **(R. p. 1171)** (emphasis added).

For assistance in confirming what "existing" means in its common usage, the ALC consulted the dictionary as many courts before it have. *See Lee v. Thermal Eng'g Corp.*, 352 S.C. 81, 91-92, 572 S.E.2d 298, 304 (Ct. App. 2002)("Where a word is not defined in a statute, our appellate courts have looked to the usual dictionary meaning to supply its meaning."). *See, also, e.g., Gibson v. Epting,* 426 S.C. 346, 353, 827 S.E.2d 178, 181 (Ct. App. 2019)(consulting Oxford English Dictionary for the meaning of "scintilla"); *Canal Ins. Co. v. Nat'l House Movers, LLC*, 414 S.C. 255, 262, 777 S.E.2d 418, 422 (Ct. App. 2015)(consulting Black's Law

Dictionary, American Heritage Dictionary and Webster's Third New International Dictionary for the meaning of "furnish"); *Estate of Chappell v. Gillespie*, 327 S.C. 617, 624, 491 S.E.2d 267, 270 (Ct. App. 1997)(consulting Oxford English Dictionary, American Heritage Dictionary, and Black's Law Dictionary for the meaning of "create").

Of the many choices of dictionaries available, the ALC chose to consult the Oxford English Dictionary, which defines "existing" as "in existence or operation at a current time." This definition is entirely consistent with the plain and commonly understood meaning of the word "existing". Further, this interpretation comports with the context of the use of the word in Standard 3.

As stipulated by the parties, "Standard 3 sets forth the **historical** utilization threshold for approval of a new diagnostic catheterization laboratory in a service area." (**Stipulation of Facts, ¶6(c), R. p. 262**)(emphasis added). As explained by Mr. Sullivan:

> The issue on Standard 3 is whether or not the capacity that exists **now** allows for existing labs to be well utilized. And whether or not you're not going to increase the number of labs, that still doesn't answer the question of **do we need all of the labs we have right now**. And Standard 3 really addresses that question. It's do we have enough capacity, too much capacity and simply saying, well we're not going to add any more labs doesn't really get to the community need aspect of Standard 3.

(Sullivan Trial Tr.: R. p. 371, line 23 – p. 372, line 9).[10]

Mr. Eubank testified that, in approving Roper's application, DHEC interpreted "existing" to mean those labs that exist at the time DHEC issues the CON for the new cath lab, an event which occurs only after the CON application is approved. **(Eubank Trial Tr.: R. p. 553, lines 8-**

[10] The parties also stipulated that "Standard 4 sets forth the minimum **projected** utilization for approval of a new diagnostic catheterization laboratory in a service area." **(Stipulation of Facts, ¶6(d), R. p. 262).** It is this Standard 4 and not Standard 3 which considers need in the market in a prospective manner. **(Eubank Trial Tr.: R. p. 621, line 18 – p. 622, line 21).**

15). This interpretation is plainly contrary to the language in Standard 3 that new diagnostic catheterization services will be approved "*only*" if all existing labs have historically performed a minimum number of procedures. Standard 3 requires that the determination of historical utilization of the "existing" cath labs in the service area be made before an application can be approved, not after such approval has taken place and a CON has been issued.

Roper also offers an interpretation of Standard 3 that is wholly inconsistent with its purpose and its plain language. Ms. Platt testified with regard to Roper's CON application that:

> A: [W]e state, while Bon Secours St. Francis Xavier Hospital is operating below 500 diagnostic equivalents per year, the lab **will be closed** upon the approval of the project. As a result **all labs which will exist following the approval of this project** are currently operating well above 500 diagnostic equivalents per lab and meet the utilization requirements of the standard....
>
> Q: And so you were including Bon Secours St. Francis as an existing cath lab in your discussion of Standard 3?
>
> A: No. I mean ...we presented it as a reporting lab but we said **it will not exist upon approval of the project. It will not continue to exist** to meet the needs of the population.

(Platt Trial Tr.: R. p. 673, line 9 – p. 674, line 1). Again, determining which labs will exist after approval is contrary to Standard 3's imposition of an historical threshold that must be met prior to approval.

Interpreting Standard 3 to require that all labs which are open and operating at the time of CON review must be performing a certain minimum threshold of procedures before any new labs are approved fulfills the purpose of Standard 3. As the ALC concluded, "the Department's forced construction by converting the term 'existing' and 'have performed' to 'will exist' and 'will perform' under the principle of agency deference completely negates the meaning and intent of

Standard 3 and circumvents the importance of historical utilization as a necessary tool for health planning."[11] **(Amended Final Order, R. p. 40).**

By using the St. Francis cath lab as a place holder for years, even when no procedures were being performed in the lab, Roper created a situation wherein the parties were obliged to engage in a theoretical debate over the meaning of the word "exist". It is undisputed that the St. Francis cath lab physically existed at the time that Roper submitted its CON application. It was operational and had performed procedures on patients during the prior year. It was listed in the inventory in the State Health Plan. Further, Roper acknowledged its existence and consistently asserted that the lab was operational. Finally, Roper refused to close, *i.e.* stop operating, the lab unless, and until, it was approved for a CON to establish a new cath lab at its Berkeley County hospital. All of the above observations are facts which are supported by the substantial evidence in the record. Based on these facts, the St. Francis cath lab plainly "existed" for purposes of Standard 3 of the State Health Plan.

Once the ALC correctly concluded that the plain language of Standard 3 addresses St. Francis' status in this case, the Court appropriately concluded that it could not defer to an agency's interpretation of the law that was in contradiction to the plain and ordinary meaning of the words contained therein. It is settled law that an agency is not entitled to the usual deference accorded in the construction of its laws and regulations when such construction contravenes the plain and unambiguous language of those laws and regulations. *See, Savannah Riverkeeper v. S.C. Dep't of Health & Envtl. Control,* 400 S.C. 196, 207, 733 S.E.2d 903, 908 (2012)("An

[11] Roper argues that Standard 3 contains no temporal requirements and that this is a "gap" that DHEC must fill by interpreting the word "existing". **(Brief of Appellant, p. 17).** As noted above, Standard 3 actually plainly contains two temporal requirements – that utilization from the most recent prior year be determined and that such determination must occur prior to approval of a new cath lab.

agency's interpretation of a statute or regulation that is erroneous or controlled by error of law presents a compelling reason not to defer to the agency's interpretation."); *Media Gen. Commc'ns, Inc. v. S.C. Dept. of Revenue*, 388 S.C. 138, 149–50, 694 S.E.2d 525, 530–31 (2010) ("An agency's long-standing interpretation of a statute is usually entitled to be given deference and should not be overruled by a reviewing court in the absence of cogent reasons, but the interpretation will not be sustained if it contradicts a statute's plain language.").

In addition to determining that DHEC's interpretation of Standard 3 violated the plain language of the Plan, the ALC also determined that DHEC's interpretation was arbitrary and, therefore, no deference would be required even if Standard 3 were determined to be "silent" on the issue. Roper contends that the ALC's conclusion that DHEC's interpretation is arbitrary was based on facts that are not relevant, clearly erroneous, and are not supported by substantial evidence. Roper raises three issues in furtherance of this argument.

First, Roper claims that the 2010 communications between DHEC and East Cooper are not prior interpretations of Standard 3 and are not relevant to DHEC's current interpretation of Standard 3. This contention lacks merit.

Under its deference analysis, in addition to addressing the plain language issue, the ALC was also required to consider whether there was any compelling or cogent reason to reject DHEC's interpretation of Standard 3. Among the compelling reasons recognized by the courts is whether the interpretation is not long-standing or is not consistent with the agency's prior actions and pronouncements on the regulation or policy in question. *See Media Gen. Commc'ns, Inc.*, 388 S.C. at 149, 694 S.E.2d at 531–32 ("An agency's longstanding interpretation of a statute is usually entitled to deference" in the absence of cogent reasons to overturn it.); *Bunch v. Cobb*, 273 S.C. 445, 452, 257 S.E.2d 225, 228 (1979)("A consistent mode of applying a statute by the

responsible governing agency has been given considerable deference in the construction of ambiguous statutes."). From a legal standpoint, the 2010 correspondence is relevant to the ALC's examination of the evolution of DHEC's interpretation of Standard 3.

This correspondence is also relevant from a factual standpoint. The 2010 correspondence between East Cooper and DHEC concerning the St. Francis cath lab is directly related to this matter. As discussed in the Statement of Facts, East Cooper's desire for a new diagnostic cath lab in 2010 started the chain of events that eventually led to the 2019 decision of the ALC in this case. Indeed, the early efforts of East Cooper represented by the 2010 correspondence to get DHEC to determine whether the St. Francis cath lab could be discounted for purposes of historical need and its subsequent filing of a CON application raising the same issues are what led Mr. Eubank to contact Roper to resolve the issue and enter into the agreement that forms the basis of the decision letters issued by DHEC to both Roper and East Cooper approving their respective cath labs. Finally, it should be noted that Roper itself cited the 2010 correspondence in its affected person letter submitted in the East Cooper matter and used it to remind DHEC that it had already rejected East Cooper's interpretation of Standard 3 in which it asserted that the St. Francis cath lab should be considered non-operational and discounted for purposes of determining community need. **(R. p. 1081).**

Roper also argues that the May 27, 2010 letter from Ms. Brandt, which concludes that DHEC does not have a "mechanism" to remove St. Francis from need calculations for a new cath lab simply based on its low volume, is not relevant because it is not an official DHEC interpretation of Standard 3. Specifically, Roper points to the lack of discussion of the use DHEC's enforcement powers in the letter.[12]

[12] Roper's focus on enforcement is yet another indication that DHEC's current interpretation of Standard 3 is neither long-standing or consistent. The reason DHEC needed to interpret

Roper's arguments assume a formality that is not required when considering prior interpretations of the law by an agency. In 2010, East Cooper asked DHEC to agree to discount St. Francis's cath lab when considering the historical need thresholds established by the State Health Plan. DHEC reviewed the applicable law and replied that it could not close St. Francis' cath lab or remove it from the State Health Plan inventory as a provider without addressing the issue in the Plan itself. DHEC's interpretation of Standard 3 in this case also does not arise in an enforcement action. It arises in the course of DHEC's application of the State Health Plan as part of a review of a CON application. In both cases, DHEC addressed whether or how to discount St. Francis in the course of the CON approval process so that other providers could be approved for new diagnostic cath labs. The ALC did not err in considering the 2010 correspondence and comparing it to DHEC's positions now.

In any case, even assuming that the 2010 correspondence cannot be considered to be an interpretation that is inconsistent with DHEC's current interpretation, the ALC correctly found that DHEC's interpretation of "existing" in Standard 3 as articulated at the hearing by Mr. Eubank changed from the one stated in the Roper and East Cooper decision letters in July 2016. **(Amended Final Order, R. pp. 40-41)**. *See Sierra Club v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 350-355, 772 S.E.2d 177, 182-184 (Ct. App. 2015)("Certainly, we are not required to give deference to an agency's interpretation of a regulation when that very interpretation has changed within the same litigation."). *See also MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 392 S.C. 314, 322, 709 S.E.2d 626, 630 (2011)(refusing to defer to a change in DHEC's prior allocation of costs policy developed by a new employee when

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"existing" in the first place was to accommodate a one-time "settlement agreement" of a threatened enforcement action. Standard 3 was plain and unambiguous as written. It just did not suit the needs of DHEC and Roper in this case. **(Amended Final Order, R. p. 40)**.

such change was inconsistent with legislative intent); *Gilstrap v. S.C. Budget & Control Bd.*, 310 S.C. 210, 215, 423 S.E.2d 101, 104 (1992)("[T]he Board previously construed the Act as limiting its authority to making proportionate across the board cuts. The Board's current interpretation...appears to be based solely on the effect it would have on the various state agencies and, at best, has been in existence only since February of 1991. Deferring to this interpretation would be inappropriate.").

As its second issue contesting the conclusion of the ALC that DHEC's interpretation of Standard 3 is arbitrary, Roper takes issue with the ALC's description of the 2016 email correspondence between Mr. Eubank and Roper which resulted in the agreement by Roper to close the St. Francis cath lab upon approval of a new Roper cath lab in Goose Creek. Roper specifically alleges that the ALC's reference to this agreement as a "plan" is an indication of bias on the court's part. This argument is meritless. At various times, DHEC and Roper have referred to the effort to address St. Francis's cath lab as a "mechanism" **(R. p. 1309)** or a "process" **(R. p. 1331)**. Neither of these terms is any more pejorative than the ALC's use of the word "plan" to describe a negotiated resolution to a problem. This argument lacks merit and further was not raised by Roper at any time below.

Roper cites as further evidence of "bias" the court's rejecting the Merriam Webster definition of "existing," which Roper's attorney referenced in her opening statement and Roper's expert agreed with in her testimony, and instead, choosing the Oxford English dictionary definition. This claim is meritless. As this Court has recognized, the use of a dictionary or multiple dictionaries can aid a court's understanding of a term but it is by no means the determining factor in construing the plain meaning of a statute or regulations. *See Ex Parte Traveler's Home & Marine Ins. Co. v. Stringfellow,* 427 S.C. 238, 803 S.E.2d 718 (Ct. App.

2019)("[M]eaning can be obscured rather than revealed if words are isolated and cut off from content. We are interpreting a rule, not a dictionary entry, and how words are arranged often determines meaning."). *See also Heilker v. Zoning Bd. of Appeals for City of Beaufort*, 346 S.C. 401, 552 S.E.2d 42 (Ct. App. 2001)(discussing the disadvantages of using dictionary definitions to determine the meaning of words used in statutes and regulations). The ALC's choice of a dictionary commonly and recently used by this Court to aid in its analysis is not an error of law.

Finally, Roper contends that the State Health Plan provides substantial evidence to support Roper and DHEC's interpretations of Standard 3. Specifically, Roper points to Standard 2 of the 2015 State Health Plan, which defines the service area as "all facilities" within 45 minutes' one way automobile travel time of the proposed project. **(R. p. 1170).** Standard 2 was not at issue before the ALC. Nevertheless, Roper's argument is that the use of "all facilities" in Standard 2 and the use of "all existing labs" is an intentional distinction, which precludes interpreting "all existing labs" to mean "all facilities." This argument is meritless.

In this case, the ALC did not interpret "existing" to simply mean "all." The ALC interpreted existing to mean all labs that were open and offering services to the public during the CON review period. Sometimes that interpretation will result in "all facilities" being included in "all existing labs" but that result is not a foregone conclusion. These terms do not lose their distinct nature under the ALC's interpretation of Standard 3.

Furthermore, Roper's own expert offered a perfectly reasonable explanation of why the Plan might use the two different terms in addressing two different criteria:

> Q. Are those phrases the same? All facilities and … all existing labs?
>
> A. No. **[W]hen it's talking services, …it's…the program as a whole** – is there a cardiac care program and it just uses the word all. That's the service area definition. And then the Standard 3 focuses specifically on labs and **a service may have more than one lab**. And then it also distinguishes all existing labs.

(Platt Trial Tr.: R. p. 659, lines 3-13)(emphasis added). Standard 3, which requires review of the historical utilization of a service includes all existing labs and sets the threshold "per laboratory." **(R. p. 1171)**.

Roper's contention is that the use of two different terms addressing two different concepts – service area and historical utilization – creates "flexibility" that justifies interpreting Standard 3's plain language. As noted by Mr. Sullivan:

> [F]lexibility doesn't mean that you have objective standards that change from project review to project review. I think there needs to be a common understanding of what is the inventory of services. Those inventories can change with approvals of new projects, and obviously you have to factor that in. If externally someone closes a cath lab you would factor that in to the analysis. But that's a whole different type of flexibility than what they're proposing here and that is[,] let's figure out a way to get rid of this meddlesome, underutilized lab. Here's a solution, we can let them close it after the fact and say we don't have to consider it. But the standard is pretty clear and I think there are good health planning reasons why the standard is what it is. So, I think flexibility is appropriate, but I don't' think it is appropriate in this particular instance.

(Sullivan Trial Tr.: R. p. 743, line 13 – p. 744, line 7).

The ALC thoroughly considered the State Health Plan and the testimony of all the witnesses in making his decision, which is supported by the substantial evidence in the record. "In determining whether the ALC's decision was supported by the substantial evidence, the Court need only find, looking at the entire record, on appeal, evidence from which reasonable minds could reach the same conclusion as the ALC." *Kiawah Dev. Partners, II*, 411 S.C. at 29, 766 S.E.2d at 715.

II. THE ADMINISTRATIVE LAW COURT CORRECTLY CONCLUDED THAT OTHER PROVIDERS LACKED ADEQUATE NOTICE OF APPELLANT'S AGREEMENT WITH DHEC TO CLOSE APPELLANT'S UNDERPERFORMING CARDIAC CATH LAB UPON APPROVAL OF A NEW CATH LAB.

In its order, the ALC briefly discusses the negative effects of allowing DHEC to discount the existence of the St. Francis cath lab as part of an agreement initially arrived at in emails between DHEC and Roper. In this discussion, the ALC concludes that other providers in the service area lacked adequate notice of the agreement that, in effect, required DHEC to interpret Standard 3 of the State Health Plan to remove a provider from the mandated inventory set forth in the 2015 State Health Plan. Roper argues that other providers had knowledge of the closure of the St. Francis lab from the public notices published by DHEC in the State Register, from Roper's affected person letter in the East Cooper matter and from statements in Roper's own CON application. This argument misapprehends the Court's findings on the lack of notice.

The mere filing of a CON application and the publication of notice of such filing in the State Register would not give providers any reason to believe that DHEC would overlook the requirements of the State Health Plan, including the plain language of Standard 3 and the published inventory listing St. Francis as an existing, albeit underperforming, cath lab, to approve an application that was clearly non-compliant. In fact, Mr. Sullivan testified that he assumed that East Cooper's CON application for the establishment of a new diagnostic cath lab would be denied, given its failure to comply with CON Standard 3. **(Sullivan Trial Tr.: R. p. 416, lines 10–16).**

The ALC's findings reflect that none of the public notices on which Roper expected providers to rely would put providers on notice that DHEC and Roper had an agreement to discount an underperforming lab, on the promise that it would close, in order to approve a new

diagnostic cath lab upon which such closure was conditioned.[13] As ALC concluded "a service provider should be able to rely on publicly available information, such as the State Health Plan and the most recent JARs, to find accurate and reliable data upon which to make business decisions in government-regulated areas such as those administered by DHEC. **(Amended Final Order, R. pp. 42-43)**.

Furthermore, the issue of whether all providers in the service area had notice of the agreement between DHEC and Roper, which resulted in the closure of the St. Francis cath lab is not relevant to the sole issue before the Court. DHEC cannot unlawfully waive State Health Plan provisions, in contravention of the plain language thereof, in order to approve a certain CON application, even if all other providers are on notice of the agreement. Roper's arguments to the contrary are meritless and do not justify overturning the ultimate decision of the ALC. See *S.C. Dep't Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 265, 725 S.E.2d 480, 485 (2012)(If the agency has an issue with how a regulation defines a term, then it may promulgate a new regulation as appropriate upon proper notice to the public. Until then, "other businesses which follow the unambiguous language of the regulation should not be punished as a result.").

[13] Roper also argued that Trident could have submitted Freedom of Information Act requests to DHEC to obtain the 2016 emails between Roper and DHEC in order to determine what agreements the parties had made outside the four corners of the CON application.

III. THE ADMINISTRATIVE LAW COURT CORRECTLY WEIGHED AND CONSIDERED THE ARGUMENTS TRIDENT MEDICAL CENTER RAISED DURING DHEC REVIEW.

Roper contends that the ALC failed to weigh and consider its assertion that Trident made inconsistent statements with regard to Roper's Proposed Project and argues that it is "inequitable and unfair" to "ignore and disregard" these alleged inconsistent positions. **(Brief of Appellant, p. 28)**. As its only evidence of Trident's alleged inconsistent position, Roper points to Mr. Sullivan's analysis submitted to DHEC on July 21, 2016, four days before DHEC issued its decision letter approving Roper's CON application. As discussed above, Mr. Sullivan addressed all the ways in which Roper's Proposed Project failed to comply with the State Health Plan, including its failure to meet the CON Standards specific to the transfer of health care services between affiliated facilities.

In his analysis Mr. Sullivan notes at the outset:

> Given the Roper-Berkeley application is proposing a new diagnostic cardiac cath service, the relevant standards for review are those for Cardiac Catheterization Services and specifically the criteria relating to Diagnostic Cardiac Catheterization. Roper-Berkeley does not address the Exceptions to Service Area Standards, which are considered when an applicant seeks to transfer beds or services between two related facilities. Given that these Exceptions are not addressed by the applicant, there is no basis to approve the project under these criteria, however, this letter will address the reasons why the Roper Berkeley project fails to satisfy these Exceptions as well.

(R. p. 943). Mr. Sullivan's statement that "[DHEC] should not recognize [St. Francis'] diagnostic catheterization program as an existing service" was part of an argument made specifically with regard to the requirements for the transfer of health care services in anticipation that, at some point in the process, Roper might attempt to utilize the transfer standards to gain approval of its new lab. **(R. p. 951)**. Nevertheless, Roper seizes on this statement as evidence that Trident somehow agreed with DHEC's interpretation of the word "existence" in Standard 3, which is a completely different standard.

At the hearing before the ALC, Mr. Sullivan testified that he addressed both the CON standards for new diagnostic cardiac catheterization services and the CON standards related to the transfer of health care services because of the unusual nature of Roper's proposal to close Bon Secours' cath lab upon approval (and only upon approval) of the CON Application:

> Q: And you listed both Standard 3 and the transfer exception in your letter?
>
> A: I did.
>
> Q: And why did you do that again?
>
> A: Again, because it was such an unusual structure to this application in terms of the applicant talking about conditioning the closure of a lab upon the approval of another lab. That's in effect what transfers usually are, we're going to shut down one program and then open it somewhere else. The applicant never said it was going to be a transfer but I've been surprised before when an applicant presents an application one way and then amends it late in the process to make a different argument and so that was just, sort of, if the applicant tries to say, this is a transfer rather than a new program, then I don't believe they meet this transfer standard.
>
> Q: You were hedging?
>
> A: I was.

(Sullivan Trial Tr.: R. p. 510, line 21 – p. 511, line 16). Again, the discussion of St. Francis's program being underutilized to the point that Roper could not justify its transfer to another location under the Plan's transfer standards occurs only in the section of Mr. Sullivan's analysis dealing with the transfer standards. Furthermore, Mr. Sullivan's opinion in this regard matches the same advice that DHEC gave to Roper in Mr. Eubank's April 14, 2016 email to Roper's attorney.[14] **(R. p. 1315)**.

[14] Mr. Eubank's advice was that "[t]he low volume [at St. Francis cath lab] would also likely prohibit the transfer of that cath lab from one of the operator's facilities to another under the service transfer criterion which requires adequate historical utilization figures." **(R. p. 1315)**.

Roper asserts that Trident did not raise noncompliance with Standard 3 as an issue until the hearing before the ALC. This assertion is patently incorrect.[15] Mr. Sullivan unequivocally addressed the application's noncompliance with CON Standard 3 in his written analysis submitted to the DHEC staff during the CON review period. **(R. pp. 946 – 947)**. With respect to his discussion of Standard 3 and Roper's inability to comply because of the low-volume St. Francis cath lab, Mr. Sullivan explained Trident's position that St. Francis was an "existing lab" for purposes of the Standard 3 community need threshold:

> [F]rom a Standard 3 perspective, I think there was little question that Bon Secours St. Francis was an existing provider that provided volume during the year, the 12 months most recent to the application. But I did not believe that for purposes of transferring, that this was really a program that merited transferring because it had been one that had been kept alive by performing only a handful of procedures every year.

(Sullivan Trial Tr.: R. p. 339, lines 10-20). When asked whether he believed that St. Francis was offering diagnostic catheterization services in the year before Roper's application was filed, Mr. Sullivan responded, "They clearly were offering the service. They reported actual patients who received catheterizations there." **(Sullivan Trial Tr.: R. p. 340, lines 12-16)**.

Mr. Sullivan further testified that he addressed the service transfer standards precisely because he assumed that DHEC would conclude that Roper did not meet Standard 3 and, therefore, could not be approved on that basis:

> Q: Turn over to your letter at Joint 1-194. And, Ms. Hollingsworth [Roper's attorney] asked you a few questions about this diagnostic cath lab. She said that there was no mention about existing labs but could you please read the very first line under Standard 3?

[15] Even if Trident had failed to raise Roper's noncompliance with Standard 3 because of the presence of St. Francis in the market, which it did not, the ALC could still consider the issue under S.C. Code Ann. § 44-7-210(E)(2018), which provides that "The issues considered at the contested case hearing considering a Certificate of Need are limited to those presented **or** considered during the staff review." (Emphasis added). DHEC most certainly considered Standard 3 and St. Francis' effect thereon in its review of Roper's CON application.

A: All existing labs in the service area have not performed a minimum of 500 diagnostic catheterization procedures per laboratory in 2015.

* * *

Q: And then, you provided a table on Joint 1, 195 that states – that presents what information?

A: Utilization of existing labs and showing that, among other things, that the Bon Secours St. Francis lab was underutilized.

Q: As a health planner, did you feel like you needed to give The Department any more information than that?

A: It seemed pretty straight forward to me, but, you know, the standard wasn't met which was why later on I went into the transfer standards. My assumption was well, they can't possibly be approved under Criteria 3, so they would have to be approved under some other mechanism.

(Sullivan Trial Tr.: R. p. 515, line 13 – p. 516, line 14).

There is nothing disingenuous, inequitable, or unfair about presenting all available arguments against a project that fails to comply with the CON requirements. Trident's arguments with regard to the service transfer standards, which were never invoked by Roper and which did not form the basis of DHEC's decision to approve Roper's CON application, are wholly irrelevant to the issue of whether Roper's project complied with the requirements of CON Standard 3, which was the sole issue before the Court. Nevertheless, the ALC did consider Mr. Sullivan's analysis and he accepted Mr. Sullivan's explanation of Trident's positions before DHEC as to Standard 3 and as to the service transfer standards.[16] **(Amended Final Order, R. pp. 32-33)**. These findings are supported by the substantial evidence in the record and are within the discretion of the ALC as the finder of fact to make. Roper's contention that the ALC failed to

[16] Mr. Eubank testified that he was not confused or befuddled by Mr. Sullivan's statements concerning Roper's noncompliance with Standard 3 because all cath labs in the service areas were not performing the minimum required number of procedures to justify approval of a new lab. **(Eubank Trial Tr.: R. p. 629, line 12 – p. 630, line 6)**.

give proper weight to its incorrect assertion that Trident took inconsistent positions on Standard 3 before DHEC and the ALC are untrue and without merit.

CONCLUSION

The Administrative Law Court's decision reversing DHEC's approval of Roper's CON application is supported by the substantial evidence in the whole record and is not affected by error of law. Therefore, Trident respectfully requests that the Court uphold the decision of the Administrative Law Court.

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February 3, 2020
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable H.W. Funderburk, Jr., Administrative Law Judge

APPELLATE CASE NO.: 2019-000358
ADMINISTRATIVE LAW COURT CASE NO.: 16-ALJ-07-0386-CC

Trident Medical Center, LLC, d/b/a Trident Medical Center ..... Respondent,

v.

South Carolina Department of Health and Environmental Control and Roper St. Francis Hospital-Berkeley, Inc. d/b/a Roper St. Francis Hospital – Berkeley ..... Respondents below,

Of Which South Carolina Department of Health and Environmental Control is a ..... Respondent,

And Roper St. Francis Hospital – Berkeley, Inc. d/b/a Roper St. Francis Hospital - Berkeley is the ..... Appellant.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Final Brief of the Respondent Trident Medical Center, LLC in the above-referenced matter complies with Rule 211(b), SCACR.

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