

For Respondent South Carolina Department of Health and Environmental Control

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I. STATEMENT OF THE CASE

This consolidated matter is before the South Carolina Administrative Law Court (ALC or Court) pursuant to requests for contested case hearings filed by Petitioners Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center (Trident) and CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital (Roper St. Francis). Petitioners challenge a decision by Respondent South Carolina Department of Health and Environmental Control (Department or DHEC) approving a Certificate of Need (CON) application filed by Respondent Medical University Hospital Authority, d/b/a MUSC Health Emergency Services (MUHA) to establish a freestanding emergency department in Berkeley County, South Carolina. A contested case hearing was held from July 22, 2019 through August 2, 2019. After careful consideration of extensive testimony, more than two-hundred exhibits including deposition designations, the applicable law, and the parties' arguments and proposed orders, the Court denies MUHA's CON application for a freestanding emergency department.

II. BACKGROUND

On April 12, 2017, Trident submitted a CON application for the construction of a 12,200 square foot freestanding emergency department (FED or FSED) in Berkeley County at a cost of \$13,079,900. On June 6, 2017, MUHA submitted a CON application for the construction of a 15,300 square foot FED in Berkeley County at a cost of \$13,584.161. Both FEDs were to be located near the Nexton Community accessible from I-26 via Exit 199.¹ Roper St. Francis timely notified the Department of its status as an affected person, and its opposition to MUHA's project; Trident similarly opposed MUHA's project. Pursuant to Regulation 61-15 § 802 of the South Carolina Code of Regulations, and by letter dated July 10, 2017, the Department advised MUHA

¹ A new exit, Exit 197, was to be developed later.

of the specific review criteria that would be used in reviewing its project: (1) Community Need Documentation; (2) Distribution (Accessibility); (3) Medically Underserved Groups; and (4) Financial Feasibility. S.C. Code Ann. Regs. § 61-15 § 802 (Supp. 2019); (Joint Ex. 001-545). On August 24, 2017, the Department held a project review meeting and all parties to this action participated. On September 25, 2017, the Department issued decisions concluding that MUHA and Trident's CON applications for FEDs were not competing; the Department approved both applications. The Department's letter to MUHA stated that MUHA had "presented substantial evidence that the Project complies with the relevant project review criteria and with the *South Carolina State Health Plan*, enacted August 13, 2015 ..."

On October 6, 2017, Roper St. Francis filed a written request for the Department's Board to conduct a final review of the staff decision approving MUHA's CON. On October 10, 2017, Trident likewise asked the Department to conduct a final review. On November 15, 2017, the Department declined to conduct a final review conference thereby rendering its staff decision approving MUHA's project as a final agency decision. *See* S.C. Code Ann. § 44-1-60(F) (2018).

On December 14, 2017, Trident filed a Petition for Administrative Review and Request for a Contested Case Hearing. In its Petition, Trident argued that MUHA's application and its own application for FEDs were competing,² and that the Department incorrectly found otherwise. Trident posited that the Department was required to grant the application that most fully complied with the requirements, goals, and purposes of the CON Act, the State Health Plan (Plan), and the established project review criteria, and that Trident's application most fully complied. On December 15, 2017, Roper St. Francis also filed a Request for a Contested Case Hearing asking the Court to reverse the Department's decision to approve MUHA's CON for a FED. On April 18, 2018, the Court issued an order consolidating these cases.³ On May 4, 2018, MUSC's motion to lift the automatic stay was denied.

² The Department's regulations define "competing applicants" as "two or more persons and/or health care facilities ... who apply for Certificates of Need to provide similar services and/or facilities in the same service area and whose applications if approved would exceed the need for this facility or service." S.C. Regs. 61-15 § 103(6) (Supp. 2019). The regulation further provides: "Any application received by the Department later than the fifteenth day following publication of the Notice of Affected Persons in the State Register for the first application(s) will not be considered to be competing with the(se) application(s)."

³ This statement is somewhat of an oversimplification of what occurred. There was also a third related case filed under Docket No. 17-ALJ-07-0433-CC in which Roper St. Francis filed a Request for a Contested Case Hearing challenging the Department's approval of Trident's CON application for a FSED. MUHA's Motion to Intervene in that case was denied but its request to consolidate all three cases including Docket Nos. 17-ALJ-07-0441-CC and 17-ALJ-07-0444-CC, was granted by Order of this Court on April 18, 2018. The case filed by Roper St. Francis under Docket No. 17-ALJ-074-0433-CC contesting the Department's approval of Trident's CON application for a FSED was dismissed by consent of Roper St. Francis, Trident and the Department.

On June 6, 2018, the parties agreed to a Consent Scheduling Order which established a hearing date of November 26, 2018. On November 7, 2018 and per request of the parties, the Court issued an Amended Consent Scheduling Order providing that discovery be completed by February 8, 2019 and scheduling the trial to commence on March 18, 2019. On April 23, 2019, the parties requested, and the Court issued a Second Amended Scheduling order providing that discovery be completed by June 14, 2019, and that trial commence on July 22, 2019. *See* S.C. Code Ann. § 44-7-210(G) (2018) (“Notwithstanding any other provision of law, in a contested case arising from the department’s decision to grant or deny a Certificate of Need application, grant or deny a request for exemption under Section 44-7-170, or the issuance of a determination regarding the applicability of Section 44-7-160, the Administrative Law Court shall file a final decision no later than eighteen months after the contested case is filed with the Clerk of the Administrative Law Court, unless all parties to the contested case consent to an extension or the court finds substantial cause otherwise).⁴ S.C. Code Ann. §§ 44-7-160 and -170 (2018 and 2019 Supps.).

Prior to the merits hearing, this Court entertained multiple discovery motions, and three motions for summary judgment. Over the course of the approximately ten-day hearing, the Court received direct testimony from twelve witnesses, seven of whom were qualified as expert witnesses:

1. Gregory A. Hall, MD testified on behalf of MUSC and was qualified as an expert in emergency medicine and in the administration and operation of emergency departments;
2. Stephen D. Porter testified on behalf of Roper St. Francis as its former Chief Executive Officer;
3. Joy Huntington testified on behalf of Roper St. Francis and was qualified as an expert on emergency service operations in the tri-County area (Charleston, Berkeley, and Dorchester Counties);
4. Kathryn M.T. Platt testified on behalf of Roper St. Francis and was qualified as an expert in healthcare planning and finance, and the State Health Plan;
5. Lisa Valentine testified on behalf of Trident as Summerville Medical Center’s Chief Executive Officer;

⁴ The parties also requested an extension of time within which to provide the Court with proposed orders in this matter following receipt of the transcript.

6. Joan Eccleston testified on behalf of Trident and was qualified as an expert in emergency department administration, leadership, and nursing care;

7. R. Preston Wendell, MD testified on behalf of Trident and was qualified as an expert in emergency medicine and in the administration and operation of emergency departments.;

8. Daniel Sullivan testified on behalf of Trident and was qualified as an expert in healthcare planning and finance, and the South Carolina CON Program;

9. Margaret P. Murdock testified on behalf of the Department as its Director of the CON Program, the primary reviewer of MUHA's application for a FED, and the developer of the Department's decision;

10. Patrick J. Cawley, MD testified on behalf of MUHA as the Chief Executive Officer of MUSC Health;

11. David S. Louder, III, MD testified on behalf of MUHA as the Executive Director of the MUSC Health Alliance; and

12. David Levitt testified on behalf of MUHA and was qualified as an expert in healthcare planning and finance, and the South Carolina CON Program.

More than two-hundred exhibits were entered into evidence, many of which had multiple pages.

III. STANDARD OF REVIEW

In reviewing contested case actions involving Certificates of Need, the Court uses a *de novo* standard. *Marlboro Park Hosp. v. S.C. Dep't of Health and Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004). While the issues that can be raised in a contested case involving a CON are limited to those presented to or considered by the Department during its review and decision-making process, this Court may receive and consider new evidence during the contested case. *Id.*; S.C. Code Ann. 44-7-210(E) (2018). Petitioners bear the burden of proof by a preponderance of the evidence. *Nat'l Health Corp. v. S.C. Dep't of Health and Envtl. Control*, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989).

IV. FINDINGS OF FACT

Having carefully considered the evidentiary record developed in these consolidated proceedings, and taking into account the credibility of the witnesses and reliability of the evidence, I make the following Findings of Fact by a preponderance of the evidence:

A. The Parties

1. Trident consists of the following inpatient facilities and FEDs:

- a. Trident Medical Center:⁵ 296-bed tertiary care hospital in North Charleston, South Carolina (Charleston County), which includes an emergency department with 46 treatment spaces;
- b. Summerville Medical Center: 124-bed acute care hospital in Summerville, South Carolina (Dorchester County), which includes an emergency department with 46 treatment spaces;
- c. Moncks Corner Medical Center: freestanding emergency department in Moncks Corner, South Carolina (Berkeley County) with 8 treatment spaces;
- d. Centre Pointe Emergency: freestanding emergency department in North Charleston, South Carolina (Charleston County) with 12 treatment spaces;
- e. Summerville FED: freestanding emergency department under construction in Summerville, South Carolina (Berkeley County) with 12 treatment spaces; and
- f. Berkeley Medical Center: 50-bed acute care hospital approved to be developed in Moncks Corner, South Carolina (Berkeley County) that will include an emergency department with 13 treatment spaces.

2. At the time of the hearing, the Department had approved a CON for both Trident's Summerville FED and Berkeley Medical Center but construction had not commenced for either. It was unknown as to when or whether construction would commence for the Berkeley Medical Center. (Tr. 941:9-942:9).

3. In its emergency departments, Trident has demonstrated efficient operation which the parties referred to as "throughput,"⁶ as measured by no more than 2% of patients who leave without treatment; average door-to-doctor time of eight minutes or less; door-to-discharge times of 155 minutes in its hospital emergency department and 80 - 90 minutes in its freestanding emergency departments. (Tr. 1034:10-1035:24).

4. Roper St. Francis is a non-profit healthcare system comprised of the following inpatient facilities and FEDs:

- a. Roper Hospital: 316-bed tertiary care hospital located in downtown Charleston, South Carolina (Charleston County), which includes an emergency department with 27 treatment spaces;
- b. Bon Secours-St. Francis Xavier Hospital: 204-bed acute care hospital located in the West Ashley area of Charleston, South Carolina (Charleston County), which

⁵ Trident Medical Center is a Level II trauma center.

⁶ Throughput means the ability to move a patient through the emergency department, from the time the patient arrives at the facility until the patient leaves after receiving needed services. (Tr. 122:18-21; 480:4-8).

includes an emergency department with 30 treatment spaces;

- c. Roper Mount Pleasant Hospital: 85-bed acute care hospital in Mount Pleasant, South Carolina (Charleston County), which includes an emergency department with 12 treatment spaces;
- d. Roper St. Francis Berkeley Hospital: 50-bed acute care hospital in Summerville, South Carolina (Berkeley County), which includes an emergency department with 15 treatment spaces;
- e. Roper Hospital Diagnostics & ER – Berkeley: freestanding emergency department located in Moncks Corner, South Carolina (Berkeley County) with 12 treatment spaces; and
- f. Roper Hospital Diagnostics & ER – Northwoods: freestanding emergency department located in North Charleston, South Carolina (Charleston County) with 15 treatment spaces.

5. At the time of the hearing, the Department had approved a CON for Roper St. Francis Berkeley Hospital and construction had commenced.

6. Roper St. Francis has demonstrated efficient throughput in its emergency departments, as indicated by 1.5% of patients who leave without treatment from hospital departments, and fewer than 1% of patients who leave without treatment from freestanding emergency departments; average door-to-doctor time of six minutes or less; and door-to-discharge times of 120 - 180 minutes in the hospital emergency departments and sixty minutes in freestanding emergency departments. (Tr. 480:1-2; 519:15-24; 521:1-13; Tr. 521:23- 522:4).

7. MUSC⁷ is not a party to this case but it is relevant for purposes of identifying the Medical University Hospital Authority, d/b/a MUSC Health Emergency Services. MUSC is a State entity that consists of three main bodies: an academic medical school, the hospital, and a physician practice group. In 2000, MUHA was established by the South Carolina General Assembly as a separate State agency. Through powers enumerated in its enabling legislation, MUHA has the authority to manage, regulate, and operate the healthcare functions of MUSC. MUHA is authorized to establish not-for-profit entities as the board finds necessary to facilitate the healthcare operations of MUSC. S.C. Code Ann. § 59-123-60(E)(13) (2020). MUSC includes the following inpatient facilities:

- a. MUSC Medical Center: 656-bed tertiary/quaternary care hospital in downtown

⁷ MUSC is the State's highest ranked hospital by *U.S. News and World Report*. (Tr. 2380: 17-20); (Joint Ex. 01-008). It is a Level I trauma center and has more than one-hundred outreach locations and operates a Medicare Accountable Care Organization (ACO). (Tr. 1460:12-16; 1876:6-8); (Joint Ex. 001-008).

Charleston, South Carolina (Charleston County), which includes an adult “main” emergency department with 41 treatment spaces although 12 are reserved for mental health patients, and a separately located emergency department in the Ashley River Tower with 10 treatment spaces designated the Chest Pain Center; and

- b. MUSC Children’s Hospital (Shawn Jenkins Women and Children’s Hospital): a newly constructed replacement facility for the MUSC Children’s Hospital specializing in pediatric and women’s care that is soon to open on the peninsula of downtown Charleston, South Carolina (Charleston County) and will include an emergency department with 20 treatment spaces. At the time of the hearing, the pediatric emergency department had 16 treatment rooms although four treatment rooms were used only for pediatric mental health patients.

In short, at the time of the trial, MUSC’s emergency department consisted of 67 treatment rooms but 16 were reserved for mental health patients.

8. MUSC’s adult and pediatric emergency rooms are Level I trauma centers, the highest level of trauma. MUSC’s emergency rooms are the only Level I trauma centers in Charleston, Berkeley, or Dorchester counties, and have the ability to treat the most acute patients and complex cases. (Tr. 136:19-137:6); (Joint Ex. 001-008).

9. MUSC’s emergency department has experienced negative efficiency indicators, as measured by 5% of patients who leave without treatment; average door-to-doctor time in excess of forty-five minutes; and door-to-discharge times above 200 minutes. (Tr. 158:12–160:25). Typically, twenty to thirty patients are “boarders” at any given time, meaning they are awaiting a bed for inpatient admission or awaiting discharge from the emergency department. (Tr. 1776:14-18). MUSC’s existing downtown emergency department has design and physical plant challenges that decrease treatment efficiency and frustrate treatment providers. (Tr. 170:4-12; 324:3-325:1).

10. MUSC has neither redesigned nor renovated its emergency department in at least seven years partly because of the exorbitant cost. (Tr. 301:3-8; 329:1-23). MUSC has applied for a CON to add additional inpatient beds to alleviate some of its boarding problems in its emergency department. (Tr. 1810:16-19; 1812:4-7). Inpatient capacity has had a significant effect on emergency department wait times and throughput. (Tr. 221:23-222:15).

11. All of the hospital parties to this contested case are subject to the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which requires on and off-site emergency departments to perform an emergency medical screening examination on any person who presents requesting such assistance. *See* 42 U.S.C.A. § 1395dd *et seq.* EMTALA prohibits emergency departments from conditioning an emergency screening examination on a patient’s ability to pay.

(Tr. 1206:6-20). Emergency services at all emergency departments operated by all parties to this case do so with competent, qualified emergency service professionals. (Tr. 332:2-9; 404:3-5; 538:18-22).

12. Lastly, the Department is the State agency charged with implementing South Carolina's CON program and includes promulgating the Plan, reviewing and approving CON applications, issuing CONs, and monitoring the implementation of CON projects. S.C. Code Ann. § 44-7-140 (2018). By statute, the Department is "the sole agency for control and administration of the granting of [CONs] and licensure of health facilities." *Id.*

B. The Regulatory Process and State Health Plans

13. The purpose of the State Certificate of Need and Health Facility Licensure Act (CON Act) 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 South Carolina. S.C. Code Ann. § 44-7-120 (2018).

14. The primary vehicle by which the CON program is implemented, and its stated goals achieved, is the requirement that a certificate of need be obtained by a person or health care facility before undertaking "the offering of a health service by or on behalf of a health care facility 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." S.C. Code Ann. § 44-7-160(5) (2018). In determining whether to grant or deny an application for a CON, the Department evaluates the proposed project as provided for in the CON Regulations, including the project review criteria, and considers the policies and standards set forth in the applicable Plan. *See* S.C. Code Ann. § 210(B) and (C) (2018).

15. The Plan is a document that the Department is required to promulgate in furtherance of the CON Act's purpose. S.C. Code Ann. § 44-7-120(3) (2018). The Plan which the Department is required to publish at least once every two years, contains specific standards and criteria for the review and approval of covered services, including as relevant here the establishment of outpatient facilities such as the FED proposed by MUHA. *See* S.C. Code Ann. § 44-07-180(C) (2018).

16. Project review criteria are adopted by the Department in regulations and "must be used in reviewing all projects under the Certificate of Need process." S.C. Code Ann. § 44-7-190(B) (2018). There are thirty-three project review criteria: Need; Community Need Documentation; Distribution (Accessibility); Acceptability; Financial Entries and Assumptions;

Projected Revenues; Projected Expenses; Beginning Cash Flow; Net Income; Debt Service; Methods of Financing; Ability to Obtain Capital; Record of the Applicant; Ability to Complete the Project; Financial Feasibility; Cost Containment (Minimizing Costs); Efficiency; Physical Design; Alternative Methods; Staff Resources; Support Services and Equipment; Distribution; Adverse Effects on Other Facilities; Adverse Effects on Training Programs; Access; Zoning; Utilities; Site Size; Environmental Hazard; Square Footage; Medically Underserved Groups; Other Entities; Elimination of Safety Hazards. S.C. Code Ann. Regs. 61-15 § 802 (Supp. 2019).

17. The Department must advise an applicant which of the Project Review Criteria it considers to be most important, and in what priority order those Project Review Criteria will be evaluated. S.C. Code Ann. Regs. 61-15 § 304 (Supp. 2019). “When an application has been appealed, the Department may not change the weight of the importance of the project review criteria.” *Id.*

18. The Plan contains an inventory of existing health services, the projections of need for additional services and facilities, and the standards for distributing the facilities and services across the state’s regions, known as “service areas.” *See* S.C. Code Ann. § 44-7-180(B) (2018).

19. FEDs are hospital-based outpatient facilities that serve patients who do not require hospitalization. (Tr. 599:12-20); (Roper St. Francis Ex. 55-019).⁸ The Standards applicable to FEDs are located in the Outpatient Facilities Chapter of the South Carolina Health Plan. (Roper St. Francis Ex. 55-019).

20. FEDs do not have “service areas” defined in the Plan, so applicants seeking to provide freestanding emergency services must define the geographic bounds, or “service area” which they intend to serve. (Tr. 1340:7-12).

21. Need calculations for freestanding emergency services differ from calculations for hospital beds because freestanding emergency services do not have a facility-specific need calculation within the Plan. (Tr. 1486:12-1487:9).

22. In determining whether to grant or deny a CON Application, the Department evaluates a proposed project under the review criteria found in the CON regulations, and under the policies and standards set forth in the applicable Plans. *See* S.C. Code Ann. § 44-7-210 (2018); S.C. Code Ann. Regs. 61-15 (2018 and Supp. 2019). The Department must consider the policies and standards of the Plan in effect at the time a CON Application is filed, and the Department may

⁸ Roper St. Francis Ex. 55 is the 2015 State Health Plan.

consider the policies and standards of a subsequently promulgated Plan. *See* S.C. Code Ann. § 44-7-225 (2018).

23. Even if an application complies with the State Health Plan, the Department can refuse to issue a CON based on the Project Review Criteria and other regulations it identifies. *See* S.C. Code Ann. § 44-7-210(B).

24. The CON Act dictates that “[t]he department **may not** issue a Certificate of Need **unless** an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations.” S.C. Code Ann. § 44-7-210(B) (2018) (emphasis added). *See also MRI at Belfair LLC v. S.C. Dep’t of Health and Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008) (holding that compliance with the State Health Plan and the Project Review Criteria are independent requirements for approval of a CON).

25. MUHA’s CON Application to construct a FED in Berkeley County was filed on June 6, 2017, when the *2015 South Carolina Health Plan* was still in place (2015 Plan). The Outpatient Facilities Chapter, and therein the Standards for Freestanding Emergency Services, are found at Chapter XI of the 2015 Plan. (Roper St. Francis Ex. 55-021). The *2017-2018 South Carolina Health Plan* (2017-2018 Plan) was enacted on June 9, 2017, three days after MUHA’s CON Application was filed. (Roper St. Francis Ex. 56). The Department’s decision letter states that the CON Application was reviewed under the 2015 Plan.⁹ (Joint Ex. 001-551).

26. The 2015 Plan contains the following six Standards that must be satisfied in order to establish services in a FED:

1. A Certificate of Need is required to establish a freestanding emergency service (also referred to as an off-campus emergency service).
2. All off-campus emergency services must be an extension of an existing hospital’s emergency service in the same county unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.
3. Regulation 61-16 will be used to survey off-campus emergency services, specifically including 24 hour/7 day per week physician coverage on site.

⁹ The CON Act states: “The department, the Administrative Law Court, and the Court of Appeals shall consider the South Carolina Health Plan in place at the time the application was filed and may consider the current South Carolina Health Plan when making its decision.” S.C. Code Ann. § 44-7-225 (2018).

4. An off-campus emergency service must have written agreements with Emergency Medical Services providers and surrounding hospitals regarding serious medical problems, which the off-campus emergency service cannot handle.
5. The physical structure must meet Section 12-6 of the Life Safety Code, New Ambulatory Health Care Centers, and must specifically have an approved sprinkler system.
6. The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area.

The only standards that were disputed in this case were Standards 2 and 6.

27. The 2015 Plan also provides that the following project review criteria are considered to be the most important in evaluating CON applications for this service:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Resource Availability; and
5. Financial Feasibility.

(Roper St. Francis Ex. 55-023).

28. Finally, the 2015 Plan provides that the “benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating [CON] applications for this service.” *Id.*

29. On June 9, 2017, the 2015 Plan was replaced by the 2017-2018 Plan. (Tr. 597:21-25). Standards 5 and 6 outlined in the 2015 Plan were not restated. Instead, the following new paragraph was added:

The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.

(Roper St. Francis Ex. 56-026).

30. The project review criteria for FEDs were also changed in the 2017-2018 Plan and the following were considered to be the most important in evaluating CONs for FEDs:

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Medically Underserved Groups;
4. Record of the Applicant; and
5. Staff Resources.

(Roper St. Francis Ex. 56-026).

31. The 2017-2018 Plan further provided that “Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for [freestanding emergency hospital services].” (Roper St. Francis Ex. 56-026).

32. The 2018-2019 Health Plan standards and requirements for Freestanding Emergency Hospital Services are unchanged from the 2017-2018 Health Plan. (Roper (St. Francis Ex. 56-026; 57-026)).¹⁰

C. MUHA’s CON Application

33. On April 12, 2017, Trident filed a CON application for the Summerville FED to be located in front of the Nexton community development in Summerville, (Berkeley County), South Carolina. (MUSC Ex. 8 at M08.001; M08.034). On June 6, 2017, MUHA filed an application for a FED in order to meet the deadline for the Department to review its application comparatively with Trident’s FED application in the event the Department determined the applications to be competing. MUHA’s FED was to be located in the Nexton community development in Berkeley County, South Carolina on a medical campus under development by Palmetto Primary Care Physicians that would also include primary care, specialty care, imaging, and lab services. (Joint Ex. 001-010 through -022). At the time both applications were filed, the 2015 Plan was in effect. (Tr. 1333:4-8).

34. MUHA’s CON application described the project as a FED totaling 15,300 square feet to include ten private treatment areas, one isolation treatment area, and one resuscitation area. Space for a Clinical Decision Unit (CDU) for purposes of observation was also included. MUHA’s proposed FED was also to have a helipad which MUHA stated would enable it to serve higher acuity patients. The land on which MUHA’s FED was to be built and its building were to be funded and developed by Nexton FED, LLC. (Joint Ex. 001-081). MUHA’s application described the need for the project as being to “increase access to care for service area residents while alleviating capacity constraints at the hospital-based ED.”¹¹ (Joint Ex. 001-010; -022). MUHA

¹⁰ Roper St. Francis Ex. 57 is the 2018-2019 State Health Plan.

¹¹ The evidence indicates that MUSC’s emergency department has seen fewer rather than more patients since MUHA’s CON application for a FED was filed. (Tr. 740:3-11); (MUSC Ex. 34; 60-23). In fact, the 2017 Joint Annual Report

also represented that the FED would improve access for MUSC patients residing in the North Area. (Tr. 158:2-7; 1711:23-1712:6; 1977:14-1979:23); (MUSC Ex. 60-3). It also stated that both would improve operations and help further MUSC's mission as a teaching hospital. (Tr. 158:2-7; 1711:22-1712:6; 1977:12-1979:23); (MUSC Ex. 60-3).¹²

35. MUHA's application provided that as an academic medical center and Level I trauma center, MUSC's emergency department must manage complex cases and deliver specialized care in a teaching environment. (Joint Ex. 001-008; -009). At the hearing, MUHA represented that MUSC is different from other providers and sees fewer patients per emergency room bed because it is in an academic medical center that treats many high acuity patients. (Tr. 2102:16-19).

36. MUSC's hospital-based emergency department consists of three separately identified departments: the adult emergency department in the main hospital, the Chest Pain Center emergency department in Ashley River Tower, and the pediatric emergency department in the Children's Hospital, the latter of which is soon to be relocated to the Shawn Jenkins Women and Children's Hospital. (Tr. 210-213). In MUHA's CON application, the historical volume used as the baseline to project emergency room utilization was all emergency room visits for all patient types (including pediatric and trauma) seen at the hospital-based emergency rooms downtown. (Joint Ex. 001-025); (Tr. 617:22-619:21). MUHA's CON application proposed that "a portion of MUSC's hospital-based ED patients from the service area will shift to the FED for services." (Joint Ex. 001-025). MUHA stated "the majority of patients shifting to the FSED originate from Berkeley and Dorchester Counties." (Joint Ex. 001-026). MUHA's utilization methodology resulted in an overall assumption that 21% of all emergency visits to MUSC's tertiary, quaternary Level I trauma center downtown will shift to the FED in Berkeley County. (Joint Ex. 001-026); (Tr. 621:7-622:11). In the first year of the proposed project which was anticipated to be 2019, MUHA represented that 15,129 patient visits were projected to shift to the FED. (Joint Ex. 001-026).

37. In addressing impact on existing facilities, MUHA's application stated "MUSC's proposed project will not represent unnecessary duplication of services and will not adversely

indicates that Trident's emergency department visits declined despite the population growth in the proposed service area. (Tr. 1467:24-1468:4).

¹² MUSC's mission as a teaching hospital is laudable but is not a criterion listed in any Plan or regulation. See (Tr. 2288:18-2289:1; Tr. 2289:10-13).

affect existing facilities in the service area ... [T]he proposed project will serve to address the existing challenges at MUSC, and will have no adverse impact on the programs of competitors in the area. Existing patient volume will shift to the freestanding ED. The existing patient population and population growth can fully support the proposed project.” (Joint Ex. 001-028).

38. In further addressing impact on existing facilities, MUHA’s application stated that the proposed project “will not represent unnecessary duplication of services and will not adversely affect existing facilities in the service area ... The proposed project will serve to address the existing challenges at MUSC [as] existing patient volume will shift to the freestanding ED.” (Joint Ex. 001-028). The application additionally provided that “The proposed freestanding ED will alleviate capacity constraints and enhance access.” (Joint Ex. 001-028). MUHA also represented that the existing patient population and population growth could fully support the proposed project. (Joint Ex. 001-028). MUHA expounded on the unique nature of MUSC’s downtown hospital-based emergency departments stating that because it “[was] an academic medical center and Level I trauma center, the emergency department at MUSC Health [was] unique compared to other providers.” (Joint Ex. 001-028).

39. In response to being asked to discuss alternative facilities and/or services considered as required by Regulation 61-15 § 202(2)(b)(12), MUHA stated that under the status quo, MUSC patients and physicians would continue to experience capacity challenges associated with the existing emergency department, and that expansion or renovation were not viable options for a myriad of reasons including that the cost of renovation “far outweigh the costs of developing the proposed project.” S.C. Code Regs. 61-15 § 202 (Supp. 2019); (Joint Ex. 001-029).

D. The Department’s Staff Review and Approval of MUHA’s CON Application

40. By letter dated July 10, 2017, the Department advised MUHA that the CON application was deemed complete, and listed the following project review criteria as the most important:

The specific criteria to be used [in reviewing the application] are set forth below and are ranked according to their relative importance, with the most important being listed first. All other relevant criteria will be given equal importance.

- a. Community Need Documentation;
- b. Distribution (Accessibility); and
- c. Medically Underserved Groups; and
- d. Financial Feasibility.

(Joint Ex. 001-545 through 546).

41. The Department did not identify “Compliance with Need Outlined in [the] Plan or “Resource Availability,” which are set forth in the 2015 Plan as project review criteria considered the most important in evaluating CON applications for FEDs. (Roper St. Francis Ex. 55-023).

42. On July 6, 2017, Trident notified the Department of its status as an affected person and opposition to MUHA’s CON application. (Joint Ex. 001-440 through -441). On July 21, 2017, Roper St. Francis provided similar notice to the Department. (Joint Ex. 001-442 through -443).

43. Trident’s opposition to MUHA’s application, as outlined in its letter of July 6, 2017 to the Department, focused on the absence of community need for the proposed FED, the lack of improvement in access, the lack of a detailed patient origin zip code analysis, and the belief that MUHA’s motivation was to capture market share from existing providers of similar services and not simply redirect existing patient volume. (Joint Ex. 001-440). Trident also addressed the adverse impact its multiple emergency departments in the service area would experience if the CON application was approved. *Id.*

44. By letter dated July 21, 2017 and on behalf of Roper St. Francis, Ms. Platt provided a health planning analysis identifying a number of problems with MUHA’s application, which generally included that: (a) the CON application did not satisfy Standards 2 or 6 of the 2015 Plan; (b) there was no community need to be addressed by the proposed FED given the abundance of capacity in the proposed service area; (c) the methodology and assumptions used to support the proposed Project were unreasonable and flawed; and (d) the proposed Project did not improve access and failed to promote cost containment. (Joint Ex. 001-442).

45. At the request of the affected persons, the Department conducted a project review meeting on August 24, 2017. All three parties appeared to present their positions. Copies of presentation materials are included in the Department’s record. (Joint Ex. 001-0457 through -490; 001-512 through -543).

46. At the project review meeting, MUHA identified by zip code, the number of historical patient visits it assumed would shift to the proposed Project; its data evidenced that of the 14,366 patient visits it projected to shift to the FSED, 5,020 would originate from Berkeley County, 3,603 would originate from Charleston County, and 5,749 from Dorchester County. (Joint Ex. 001-530). Thus, 35% of the emergency department visits are Berkeley County residents, compared to 40% from Dorchester County and 25% from Charleston County. (Joint Ex. 001-530).

47. MUHA represented that the FED's helipad would enable it to serve a higher acuity patient base and that its FED was unique because its CDU would "eliminate bottlenecks in the ED and result in more efficient usage of treatment rooms."¹³ (Tr. 1641:19-23; 1643:12-17; Tr. 1653:19-1654:5; Tr. 1777:11-21; Tr. 2175:20-2176:12; Tr. 2176:2-16) (Joint Ex. 001-011; -020 through 021; -516).

48. Written submissions were made to the Department following the project review meeting. (Joint Ex. 001-493 through 495; 001-496 through 504; 001-506 through 511).

49. The post project review meeting submissions included a letter dated September 7, 2017 from Mr. Levitt on behalf of MUHA to the Department in response to opposition and included data addressing the acuity level of MUSC's emergency department patients. (Joint Ex. 001-507). The acuity level was explained at the contested case hearing as the severity of a patient's condition upon presenting to an emergency department. (Tr. 474:2-23). The data provided by Mr. Levitt categorized MUSC's 2016 historical emergency room volume by six types, which MUHA asserted was evidence that "high acuity trauma visits are less than one percent of MUSC's total ED volume." (Joint Ex. 001-507). The figure shown was that 712 of 81,260 visits (or 0.9%) were "HB ER VISIT CRITICAL CARE." *Id.*

50. Ms. Murdock served as the primary reviewer of MUHA's CON Application and developed the staff decision. (Tr. 1316:24; 1328:22-1329:1). She testified that she reviewed MUHA's proposal in the application and conducted her own analysis of the effect the FED proposed by MUHA would have on existing and approved projects in the area. (Tr. 1347:21-1348:19).¹⁴ Ms. Murdock additionally testified that she identified the project review criteria for the deemed complete letter that she believed were "most important based on [the CON Program's] mission." (Tr. 1331:1-1332:6). According to Ms. Murdock, the Department interprets Regulation 304 as giving Department staff the authority to identify project review criteria for a project that may or may not include all of the project review criteria identified in the Plan for that particular facility or service. (Tr. 1426:1-11; 1431:17-21; 1433:5-1434:5).

51. On September 25, 2017, the Department approved MUHA's application finding that the application "sufficiently complies" with the Standards in the 2015 Health Plan and the

¹³ MUHA's application stated that "A unique aspect of the proposed project is the proposed inclusion of a clinical decision unit (CDU)." (Joint Ex. 001-021).

¹⁴ The Court questions Ms. Murdock's analysis as she was unaware of several relevant projects as they "were not [her] cases" and while capacity was an issue in this matter, she was unaware of the number of beds at Centre Pointe FED which is located in the proposed service area. (Tr. 1348:11-19; 1455:7-1457:6; 1446:18-1147:1).

identified relative importance of the project review criteria. (Joint Ex. 001-551 through -0555). No other project review criteria were discussed. The Department summarily stated, “that the opposition has not provided evidence sufficient to require denial of a CON for the Project.” (Joint Ex. 001-552).

E. Changes to the Project after Review

52. After the Department approved MUHA’s CON application but prior to the contested case hearing, MUHA made changes to its project. Roper St. Francis and Trident argued that the changes were so substantial as to constitute a new project requiring a new application. The Court disagrees.

53. It is not uncommon for CON projects to change after Department approval. (Tr. 1984:20-23; 1396:24-1398:4). The Department requires a CON applicant to certify the veracity of the statements in the application, but the certification is limited to the time the application is submitted to the Department. (Tr. 1395:25-1396:23). For example, by letter dated February 24, 2017 (which served as its quarterly report to the Department), Roper St. Francis identified several changes to the Roper St. Francis Berkeley Hospital project. (Roper St. Francis Ex. 5). These changes included reducing the size of the lobby, eliminating an atrium, moving administrative offices and infusion space out of the hospital, adding ultrasound equipment, reducing the number of emergency treatment rooms and operating rooms, changing the configuration of the post-anesthesia care unit, adding a special procedures lab, eliminating 12 medical-surgical beds and four LDRP (labor, delivery, recovery, and post-partum) beds, adding 16 postpartum gynecological rooms, and reducing the overall size of the hospital from 138,750 to 115,194 square feet. (Tr. 1999:21-2002:90); (MUSC Ex. 60-4); (Roper St. Francis Ex. 5) .

54. The primary changes to MUHA’s proposed FED are a relocation of the site, a reduction in size and cost, and the elimination of the CDU and helipad. (MUHA Ex. 60:5). Relocation changes are not uncommon for CON projects. (Tr. 1374:4-5). MUHA’s new location is less than one mile from the original site. (Tr. 2003:21-22); (MUSC Ex. 60-6). The original and new location sites are in the same zip code. (Joint Ex. 001-004); (MUSC Ex. 42); (Trident 056-005). Both sites are in the Town of Summerville and in Berkeley County. (Tr. 1330:10-12; 2033:1-2); (Joint Ex. 001-004). The original site was on the edge of the Nexton development, while the new site is on the other side of I-26 on Summerville’s North Main Street (Highway 17A).

(Tr. 2005:17-19; 2008:20-22; 2009:12-13).¹⁵ When MUHA submitted its application, the original site was within a planned medical campus with several different medical services. (Tr. 2021:8-15). Since then, however, many of these planned projects have been abandoned or are not moving forward. *Id.* The new site is in a shopping center and has greater visibility and access than the original site. (Tr. 1867:2-6; 2009:9-2010:2; 2011:6-20); (MUSC Ex. 60-6). No evidence was presented showing that MUHA's relocation will have any impact on the FED project from a clinical, operational, or patient safety perspective.

55. The decision to relocate has resulted in some additional changes. The original site was owned by an Ohio company called Nexton FSED, LLC. (Joint Ex. 001-005). The new site is owned by a company called Luco Realty, with whom MUHA has negotiated and executed a new lease.¹⁶ (Tr. 2014:2-5); (MUSC Ex. 59). The Department's practice is to permit flexibility with respect to lease changes. (Tr. 1373:6-1374:5). Here, the original lease was for ten years, while the Luco lease is for five, and both contain multiple renewal options. (Tr. 2014:6-18); (Trident Ex. 72-006). The acreage leased is slightly smaller on the new lease. (Tr. 2015:8-20). After MUHA eliminated the CDU and helipad, not as much acreage was needed. (Tr. 1794:6-17).

56. The changes also affected the project's financing. Under the original proposal, the financing was to be the joint responsibility of Nexton FSED, LLC and MUHA. (Joint Ex. 001-081 and -082). As Nexton FSED, LLC is no longer involved in the project, MUHA plans to finance the project through a new developer, a loan, or MUSC's operational cash flow. (Tr. 1755:6-9). If the CON is issued, MUHA will commit to a funding mechanism, based on current interest rates. (Tr. 1755:17-1756:2). The funding mechanism proposed by MUHA at the hearing is not materially different from the financing options it outlined in its CON application. MUHA's application included a letter from the chief operating officer that provides "MUHA may fund the project through operating income, cash reserves, existing lines of credit or through issuance of debt. If necessary, MUHA will fund the project through operations and existing reserves." (Joint Ex. 001-082). Although MUHA's 2018 unaudited interim financial statement shows an operating

¹⁵ In its recently approved FED application, Summerville Medical Center stated that its FSED was "ideally situated near I-26 and along Highway 17A to enhance access." (MUSC Ex. 8-24). Summerville Medical Center and MUHA's FED sites are slightly over a mile away from each other. (Tr. 2160:8-14). The two sites are equally close to Highway 17A and I-26. (MUSC Ex. 42). The MUHA site is as ideal as the Summerville Medical Center site.

¹⁶ The parties to the new ground lease are Luco Realty and MUSC-Strategic Ventures (MUSC-SV). The lease provides that MUHA shall be automatically substituted for MUSC-SV as a party in the event a final, non-appealable order is issued holding that MUSC-SV is *ultra vires* or must be dissolved. (MUSC Ex. 59).

loss of \$2,888,383 million,¹⁷ Dr. Cawley testified that MUSC has sufficient capital or debt capacity to fund the project. (Tr. 1874:2-16); (Roper St. Francis Ex. 47-003). The same financial statement shows that MUHA has \$18,584,383 million in operating income. (Tr. 2159:2-6); (Roper St. Francis Ex. 47-004).

57. Finally, the relocation has affected the project's zoning. The original site would have been zoned as part of the Nexton planned unit development. (Tr. 2016:8-11). The best evidence presented to the Court on the new site's zoning is a local draft ordinance showing the site would be B-3, which includes hospitals, medical clinics/urgent care, and other health care facilities. (MUSC Ex. 60-12 and -13; Tr. 2016:12-2017:8; 2191:17-2193:12).

58. The second principal change to MUSC's project is a size and cost reduction. MUHA reduced the size of the FED building from approximately 15,000 to 10,700 square feet and the project cost from approximately \$13.6 million to \$11 million. (Tr. 2004:1-5); (MUSC Ex. 29). The FED still contains 12 emergency treatment rooms. (Tr. 2024:5-12; MUSC Ex. 29). Five of the treatment rooms will be "fast track" rooms, which are designed primarily for lower acuity patients. (Tr. 2026:12-23). The Department does not usually focus on changes in schematic designs or layouts, as such aspects of the project will be examined in detail later by the Department's Construction and Licensing Division to ensure regulatory compliance. (Tr. 1372:6-19). There was no evidence that the design changes would affect patient safety.

59. MUHA's application stated that its FED would have a helipad and a CDU. (Joint Ex. 000-011). Interestingly, Petitioners originally criticized both features. *See, e.g.*, Trident's Petition for Administrative Review at Page 8, ¶28 ("the construction of a helipad ... creates serious questions as to the financial feasibility of MUSC's Proposed Project"); at P. 9, ¶30 ("MUSC presented no evidence of any clinical benefits ... from the establishment of the CDU because there are none"). MUHA decided that the costs of the CDU and helipad outweighed their benefits and eliminated both from the project. (Tr. 198:7-200:10; 1725:18- 1726:8; 2028:5-17). The decision to eliminate the CDU and helipad was the primary reason for the over \$2 million decrease in project costs. (Tr. 1725:8-11).

60. Roper St. Francis argued that the Department based its decision to approve the application partially on MUHA's assertions that the CDU and helipad were critical factors differentiating MUHA's project from other FEDs. (Tr. 784:2-785:2). MUHA entitled one section

¹⁷ The operating loss of \$2.8 million is based upon pension liabilities. (Tr. 2159:2-8). While there is a loss, MUHA still has \$18 million in operating income and a positive cash flow is being produced. (Tr. 2159: 6-10).

of its application “MUSC Emergency Services and Differentiating Factors.” (Joint Ex. 001-008 through -009). The section references many aspects of the project that differentiate it from other FEDs, but no mention is made of the CDU or helipad. *Id.*; (Tr. 2028:22-2030:24); *see* (Tr. 2031:1-20). Also, the Department’s decision letter approving the project did not mention either the CDU or the helipad. (Joint Ex. 001-551 through -555). Without objection, the Department’s director testified that neither the CDU nor the helipad affected the Department’s decision. (Tr. 1366:7 – 1367:5). *See also* (Tr. 1371:7-9; 1372:25-1373:4). Trident’s expert testified that he did not believe the CDU or helipad were necessary or important parts of the project and did not know what weight the Department may have ascribed to them in its evaluation. (Tr. 1273:13-21). For these reasons, I find that the proposed CDU and helipad had little influence on the Department’s decision to approve the application and were not important aspects of the project. Also, MUHA can still conduct the same functions of a CDU within the 12 beds at the FED. (Tr. 2028:14-17).

2015 STATE HEALTH PLAN

F. Standard 2 of the 2015 State Health Plan

61. Pursuant to Rule 201, SCRCP, Roper St. Francis and Trident have asked that the Court take judicial notice that as of October 4, 2019, Roper St. Francis Berkeley Hospital opened. The Court declines to do so. Roper St. Francis Berkeley Hospital was not open at the time of the filing of MUHA’s application or at the conclusion of the hearing on August 2, 2019, and no party filed a motion to re-open the record and supplement it with the same.

62. The Court views this request as a veiled attempt by the parties to circumvent this Court’s ruling denying Roper St. Francis and Trident’s Motion for Summary Judgment as to Standard 2 in the 2015 Plan, and to further bolster any argument as to Standard 2 on appeal of this case.¹⁸ However, as detailed below, the Court finds that Roper St. Francis and Trident have established by a preponderance of the evidence that MUHA’s proposed FED does not meet Standard 6 of the 2015 Plan; does not meet all of the project review criteria deemed most important for evaluating a FED application; and is inconsistent with the CON Act. Thus, there is no need to address Standard 2 of the 2015 Plan.

¹⁸ Also, MUHA’s CON application in this case was submitted on June 6, 2017 and approved on September 25, 2017. The parties should not benefit as a result of their own lack of diligence in aggressively pursuing discovery and the hearing of this matter which did not commence until July 2019.

G. Standard 6 of the 2015 State Health Plan

63. Standard 6 of the 2015 Plan requires that an applicant demonstrate a need for a FED by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area.

1. Patient Origin and Utilization

64. MUHA defined the service area for its FED as the tri-county area of Berkeley, Dorchester, and Charleston counties. (Joint Ex. 001-022). The Department considered this to be a very large service area as did Ms. Platt who said it was too broad. (Tr. 738:23-739:3; 1515:7-20). According to Mr. Porter, a former chief executive officer of Roper St. Francis with more than 30 years of health care experience, most patients of a freestanding emergency department originate from a relatively close proximity such as a five to seven-mile radius of the freestanding emergency department. (Tr. 379:9-17). Ms. Huntington, a registered nurse with 35 years of nursing services experience and the director of emergency services for Roper St. Francis, testified that a six to ten-mile radius was appropriate. (Tr. 441:24-442:4; 447:13-17; 458:2-4; 463:24-464:1; 477:21-478:3; 479:1-6; 2343:16-18). The Department considered Trident's use of a four zip code primary service area for Trident's Summerville FED to be reasonable. (Tr. 1465:2-16).

65. MUHA's expert's approach was to identify seven zip codes from which MUHA's proposed FED would expect to draw almost 80 (78.4) percent of its patients, with the remaining 20 (21.6) percent to in-migrate from eighteen other zip codes in the service area. (Tr. 2059:10-2060:1); (MUSC Ex. 44).

66. MUHA submitted patient origin information for its FED to the Department at the project review meeting. (Tr. 733:13-16); (Joint Ex. 001-530). MUHA estimated that Dorchester County would supply 40% of the project's patients, more patients than either Berkeley or Charleston Counties. MUHA further projected that the FED would draw the most patients by number from a zip code in Charleston County; specifically, zip code 29406. (Joint Ex. 001-0530); (Tr. 1478:7-24).

67. Additionally, MUHA represented to the Department that the FED would serve only patients who previously drove to MUSC's downtown location, saying "existing patient volume will shift to the freestanding ED" and calculated proposed patient visits based on "volume shift from MUSC only." (Joint. Ex. 001-0026; 001-0028). At the contested case hearing, MUHA assumed its patients would "choose the shorter travel time" and utilize the FED rather than travel to MUSC's hospital-based emergency department in downtown Charleston. (Tr. 2043:21-2044:8).

68. MUHA provided no basis, insight, or information for its assumption as to why some of its patients who resided in Berkeley, Charleston, and Dorchester Counties were already bypassing other hospital-based emergency rooms as well as FEDs to seek treatment at MUSC on the peninsula. (Tr. 1663:1-24).¹⁹ While pertinent to Standard 6's requirement that an applicant demonstrate why patients are not being adequately served by existing services in the area, the fact that a patient chooses to bypass an existing provider does not mean that existing health resources in the service area are inadequate. (Tr. 1664:14-24).

69. Roper St. Francis and Trident asserted that the utilization set forth in MUHA's application which used the historical patient utilization of MUSC's downtown emergency departments as the basis for its projected utilization (and proposed three-county service area of Berkeley, Charleston and Dorchester Counties) for the FED, was unreasonable and flawed. Petitioners' experts stated that MUHA's projections did not account for the acuity or age of the patient populations treated at MUSC downtown before making assumptions as to redirection to the FED in Berkeley County. (Tr. 635:12-19; 734:1-10; 7431-25; 1185:3-8; 1185:21-25; 2263:21-2264:7); (Roper St. Francis Ex. 59-011).

70. Acuity refers to the severity of a patient's condition upon presenting to an emergency department. (Tr. 474:1-12). The "emergency severity index" or "ESI" is a five-level index where level one is the most critical and level five is the least critical. (Tr. 474:24-475:8). Ms. Huntington testified that the ESI level is based on the anticipated resource utilization for a patient's needs, with the level ones and twos being the most acute patients that likely require hospitalization. (Tr. 475:1-8). Dr. Hall, MUSC's Medical Director for the main emergency department similarly testified that "three, four and fives" were the acuity levels of the patients that would show up at the FED. (Tr. 270:6-12).

71. As noted above, after the project review meeting, MUHA's expert witness submitted a letter to the Department in response to the opposition and included data addressing the acuity level of MUSC's emergency patients. (Joint Ex. 001-507). The data provided by Mr. Levitt categorized MUSC's 2016 historical emergency room volume by six types, which MUHA asserted was evidence that "high acuity trauma visits are less than one percent of MUSC's total ED volume." (Joint Ex. 001-507).

¹⁹ Mr. Sullivan testified that "[I]f patients are traveling downtown now to the Medical University, they're not doing it because of lack of access to emergency care, they're doing it for other reasons." (Tr. 1205:16-22).

72. However, at the hearing, Dr. Hall testified that these six codes were actually billing codes and stated that “[b]illing codes don’t necessarily accurately reflect the patient that’s coming in through the door. How sick patients are when they show up and how quickly you need to see them is usually reflected in your ESI level.” (Tr. 267:16-268:4). Ms. Huntington corroborated that emergency department nurses are focused on triage acuity (ESI) or the severity of the level with which a patient presents. (Tr. 474:1-23). After the patient has been treated, medical coding for billing may be completely different than how the patient presented at the facility. *Id.* Roper St. Francis’ health planning expert, arrayed data for MUSC’s 2018 emergency department patients to show the disconnect between acuity levels at triage versus emergency department billing codes. (Tr. 742:11-743:17); (Roper St. Francis Ex. 59-17).

73. While there is some overlap in that the most acute patients tend to have a need for utilization of higher-level resources, and therefore, would appear at the uppermost billing level,²⁰ MUHA’s utilization of billing codes does not depict the most accurate reflection of the acuity levels of patients. It follows that MUHA’s shift projections based on billing codes are inaccurate even though a FED must be equipped to stabilize all acuity levels.²¹ *See* (Tr. 2260:9-2264:7).

74. Additionally, Ms. Platt’s analysis of MUSC’s historical patient data evidences that the three-year trend in patient acuity showed a decline in all but Level II, which increased by 22% over the three-year period. (Roper St. Francis Ex 59-018).

75. While a FED can stabilize a patient of any age or acuity level, the testimony rendered indicated that “three, four and fives” were the acuity levels of the patients that would seek services at the FED. (Tr. 270:6-12; 272:23-25; 2065:24 – 2066:19; 2093:9-18).

76. Actual experiences of Roper St. Francis’ freestanding emergency services contradict MUHA’s prediction that patients in a FED and patients in a main hospital emergency department will be similar in acuity. (Tr. 2261:6-14; 2262:16-23). A freestanding emergency department is more likely to serve lower acuity patients and unlikely to simply serve a subset in similar proportion to all acuities seen at the main campus. (Tr. 2263:11-18). All of the parties’ experts agreed that freestanding emergency services provide care to proportionally more low-acuity patients than emergency departments located on a hospital campus. (Tr. 382:10-21; 888:11-

²⁰ (Tr. 2260:24-226:4).

²¹ MUHA noted that in prior CON applications, neither Roper St. Francis nor Trident included calculations for age or acuity adjustments in their shift projections. Those applications are not before the Court.

13; 1062:16-20). Ideally, the most seriously ill patients bypass a freestanding emergency room and go directly to a hospital. (Tr. 475:23-476:2; 832:20-834:4; 2383:13-15).

77. This is consistent with Dr. Hall's testimony that the admission rate for the adult main emergency room downtown is approximately 25-26%, which is higher than the national average of 20%, reflecting in his opinion that MUSC's ED patients "tend to be a little more complicated and the admission rate shows that." (Tr. 141:19-142:4); *see also* (Tr. 214:23-215:4). The rate of admission for the Chest Pain Center is even higher at 40%, reflecting a patient population with a much higher rate of converting to an inpatient admission from the emergency department visit. (Tr. 215:5-19). In contrast, the admission rate of a freestanding emergency department is very low, more like 2-3%. (Tr. 419:2-7; Tr. 1187:5-11; 2347:3-6).

2. Whether Patients Adequately Served by Existing Services in the Area – Capacity

78. MUHA's initial application did not identify any other providers of emergency services in the proposed service area although there are several and did not address capacity constraints or lack of access in the area to be served. (Tr. 1463:3-1464:9). Following the project review meeting and after Petitioners objected to the approval of the application given the existing and approved emergency room capacity in MUHA's proposed service area, Mr. Levitt submitted a chart asserting to be a "much more realistic capacity volume" for pending and approved emergency departments in the planning area, than was that of Roper St. Francis. (Joint Ex. 001-449; -465; -509; -510).

79. In materials submitted after the project review, Roper St. Francis represented that 3,000 patients per treatment space was the appropriate number to use for determining capacity in existing and proposed emergency departments in Berkeley County. (Joint Ex. 1-454; -465).²² Mr. Levitt stated that this was extremely high and concluded that 1,500 visits per bay was a more realistic capacity volume for evaluating emergency department capacity in the market "which is extremely conservative for facilities like MUSC which experience visits from more complex, higher acuity patients." (Joint Ex. 001-509). Mr. Levitt maintained a similar position at the hearing opining that 1,250²³ to 1,500 visits per treatment bay was accepted as capacity for an emergency room department. (Tr. 2102:7-2104:15). Mr. Levitt's opinion was based upon (1) the

²² At the hearing, Roper St. Francis' health care expert posited that 2,000 visits per space should be utilized for purposes of determining capacity. (Roper St. Francis Ex. 59-007).

²³ Mr. Sullivan testified that he believed 1,250 was a low number for purposes of measuring capacity even for an academic medical institution, and particularly for MUSC which has separate emergency departments for pediatric and adult patients, and then another dedicated to chest pain patients. (Tr. 1155:2-23).

fact that MUSC is an academic medical center and treats much higher acuity patients, (2) MUSC's experience with a significant volume of behavioral health patients that had long lengths of stays in the emergency department (boarders); and (3) emergency room planning and guidelines published by Jon Huddy. *Id.* For planning purposes,²⁴ or for a new facility that has no actual data on its capacity, the use of 1,500 visits per bed may be within the range of what is appropriate for assessing capacity, particularly in MUSC's experience on the peninsula (including its negative efficiency indicators in its emergency department).

80. While the parties presented testimony estimating what anticipated capacity might be for an emergency department similar to that proposed by MUHA,²⁵ I find that substantial evidence at the contested case hearing establishes that a threshold of 1,500 visits per treatment space understates the capacity for FEDs and community hospital-based emergency departments when there is actual historical data indicating otherwise. Similarly, the utilization of 2,000 visits per treatment space is improper for purposes of planning when there is historical data that indicates otherwise.

81. Freestanding emergency rooms typically see patients of lower acuity than hospital-based emergency rooms. (Tr. 382:10-18; 908:13-18; 1067:25-1068:8). Because of the difference in acuity between patients, hospital-based emergency departments typically see fewer patients per bed than freestanding emergency departments. (Tr. 377:14-378:17). An average community hospital emergency room capacity is 1,200-1,500 patients per space per year. (Tr. 481:11-13). MUSC's downtown hospital location reports a capacity of 1,250 per room per year. (Tr. 312:5-20). There are valid reasons for different facilities to adopt different capacity measures based on actual and historical experiences. (Tr. 2352:1-22). Thus, Mr. Levitt's use of 1,500 and Ms. Platt's use of 2,000²⁶ (or any figure) for visits per treatment bed for purposes of calculating capacity for

²⁴ (Tr. 2352:4-22).

²⁵ Dr. Hall testified it was possible that the volume capacity for a FSED such as the one proposed by MUHA could see greater than 2,000 patients per treatment space per year which was consistent with the number of patients seen per treatment space at the community hospital where he was formerly employed. (Tr. 269:17-270:2; 297:5-298:6). Ms. Huntington testified that a FED treating patients with ESI levels of 3, 4 and 5 would have capacity expectations of 2,500 to 3,000 per treatment space per year, with that number reducing in proportion to more complicated patients being treated, thereby reducing the facility's efficiency. (Tr. 482:16-25). Joan Eccleston, Trident's Nurse Director of Emergency Services, testified to a conservative capacity of 2,200 ED visits per treatment space per year but at a community-based hospital. (Tr. 996:6-17; 997:21-23).

²⁶ During the project review process and for purposes of calculating capacity, Ms. Platt on behalf of Roper St. Francis, utilized the figure of 3,000 visits per treatment bed. (Joint Ex. 001-465). At the hearing and during her direct testimony, Ms. Platt used 2,000 visits per space in calculating capacity during her direct testimony. (Roper St. Francis Ex. 59-007). She then utilized a third set of figures later in the trial after Mr. Levitt's direct testimony. (Roper St. Francis Ex. 63-006 and -008).

all facilities (existing and proposed) irrespective of their actual historical experience, is improper. Capacity and utilization can be easily manipulated depending upon the number of visits assigned per treatment bed, as well as the number of treatment beds one considers (e.g., beds for which CON applications have been approved versus only operational facilities).

82. When determining compliance with the Plan, the Department stated that it looked at both facilities that were operational and projects that had been approved. (Tr. 1521:3-7).

83. Ms. Murdock testified that while certain project review criteria address “existing” facilities, the Department looked at approved facilities for purposes of planning: “as part of our general purposes of CON and guiding establishment where these services are needed, I think we need to look towards what will exist in the future [e.g., approved facilities] in addition to what exists now.” (Tr. 1353:11-1354:5). Ms. Platt concurred with this approach. (Tr. 726:1-18; Tr. 2240:14-2241:25.)²⁷ The Court concurs with the Department and Roper St. Francis that approved facilities should be considered for purposes of health care planning as it is consistent with the stated purpose of the CON Act outlined in Section 44-7-120 of the South Carolina Code:

[The purpose of the CON Act 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 high quality services are provided in health facilities in this State.

S.C. Code Ann. § 44-7-120 (2018).

84. At the time MUHA’s application was submitted and approved and as of the date of the conclusion of the hearing, the following projects and facilities that provide similar services and are within a 20-mile radius of MUHA’s proposed service area²⁸ were operational, under construction, and/or had been approved by the Department.²⁹ After consideration of all of the facts and expert witness testimony from each of the parties regarding their own experiences and capacities, the Court finds the following a reasonable measure of capacity of patients per bed for each existing facility:

²⁷ Mr. Levitt testified that it depended upon the project and standards and opined that one should only consider existing providers. (Tr. 2203:7-21).

²⁸ (Tr. 726:19-727:9); (Roper St. Francis Ex. 59-007).

²⁹ While Berkeley Medical Center, a 50-bed acute care hospital had likewise been approved and was scheduled to be developed in Moncks Corner, South Carolina (Berkeley County) and was to include 13 treatment spaces, the Court did not consider it. At the hearing, testimony was rendered that the project was stalled with the Army Corps of Engineers because of a wetlands issue and it was unknown as to when, if ever, construction would commence. Should the facility open, it would result in additional capacity in the proposed service area. (Tr. 941:9-942:6). Similarly, the Court did not include MUHA’s Berkeley Hospital; while its CON application was approved, the parties did not provide information regarding the number of emergency room beds during the course of the trial. (Tr. 2146:9-130; (Trident Ex. 101.006). If either or both had been included, there would be additional service capacity in the area.

Facility	Capacity	Source
Trident Medical Center	1,850 ³⁰	Tr. 995:9-20
Summerville Medical Center	2,200 ³¹	Tr. 250:19-21; 995:23-996:8; 997:21-23
Roper Northwoods FED	2,500	Tr. 482:16-22
Trident Moncks Corner FED	2,200	Tr. 996:6-11
Trident Centre Pointe FED	2,200	Tr. 996:6-8
Roper Moncks Corner FED	2,500	Tr. 482:16-22
Roper St. Francis Berkeley Hospital ³²	1,500 ³³	Tr. 2352:4-22
Trident Summerville FED ³⁴	1,500 ³⁵	Tr. 2352:4-22

85. Multiplying these capacity values by the number of treatment areas, the total capacity for the service area defined by MUHA is 338,300, calculated as follows:

Facility	Capacity	Spaces	Total
Trident Medical Center	1,850	48 ³⁶	88,800
Summerville Medical Center	2,200	46	101,200
Roper Northwoods FED	2,500	15 ³⁷	37,500
Trident Moncks Corner FED	2,200	8	17,600

³⁰ Ms. Eccleston testified as to 1,850 emergency room visits per bed. Ms. Valentine, the chief executive officer for Summerville Medical Center, testified that Trident Medical Center is seeing about 2,500 patients per emergency room bed. (Tr. 985:14-25). The Court placed more credibility on the testimony of Ms. Eccleston who is directly involved in the daily operations and oversight of emergency services.

³¹ Ms. Eccleston testified as to 2,200 emergency room visits per bed. Ms. Valentine similarly testified that Summerville Medical Center is seeing about 2,500 patients per emergency room bed. (Tr. 889:4-14). The Court placed more credibility on the testimony of Ms. Eccleston who is directly involved in the daily operations and oversight of emergency services.

³² At the time of the hearing, Roper Berkeley Hospital was under construction and scheduled to open in October 2019. (Tr. 279:22-24; 701:16-19; 825:2-6; 954:16-18).

³³ The Court used a capacity number of 1,500 visits per bed in the approved but not completely constructed or utilized facilities. Testimony was rendered by Mr. Sullivan that 1,500 was a number that was routinely used for planning purposes. (Tr. 2352:4-22). Also, there is no historical data for these specific facilities. While the Court could utilize higher capacity numbers as demonstrated by similar facilities in the proposed service area, the Court declines to do so to demonstrate that even erring on the conservative side, there is still additional capacity in the area.

³⁴ At the time of the hearing, ground was scheduled to soon be broken for the construction of Trident Summerville FED, and it was expected to be open within a year. (Tr. 1238:20-:1239:3).

³⁵ *Id.*

³⁶ At the hearing and in its proposed order, MUHA indicated that it believed that Trident had only 36 emergency department beds. Ms. Eccleston on behalf of Trident testified to that same number. (Tr. 993:22-994:4; 2129:1-59; 2132:24-2133:3; 2134:13-18). Mr. Sullivan, however, was provided with a copy of the floor plan of Trident's existing emergency department treatment areas and arrived at a figure of 48 indicating that both MUHA and Ms. Eccleston were incorrect. (Tr. 2353:2-2354:17); (Trident Ex. 103).

³⁷ This includes five additional beds that will be opening in April of 2022. (Tr. 485:23-486:1).

Trident Centre Pointe FED	2,200	12	26,400
Roper Moncks Corner FED	2,500	12	30,000
Roper St. Francis Berkeley Hospital	1,500	15	22,500
Trident Summerville FED	1,500	12	18,000
Total		168	342,000

86. Roper St. Francis and MUHA's experts testified that in 2018, the current providers of emergency services in MUHA's self-defined service area had an actual utilization of between 220,000 and 225,000 visits. (Roper St. Francis Ex. 6-008); (MUSC Ex. 60-30). Based on the testimony presented, actual utilization of emergency services for the above facilities was 34% ($225,000 \div 342,000 = .66$) below the existing capacity for emergency services in the proposed service area.

87. Using these facilities, there is capacity in the service area to treat an additional 117,000 ($342,000 - 225,000 = 117,000$) patients without adding another FED or hospital-based emergency room.

88. Standard 6 of the 2015 Plan uses the word, "existing," as in "The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by existing services in the area"³⁸ (emphasis added). Even if the Court were to exclude (1) Roper St. Francis Berkeley Hospital (which was scheduled to open in October of 2019),³⁹ (2) Trident's Summerville FED (which was approved simultaneously with MUHA's FED and was not appealed and scheduled to open within a year of the contested case hearing on MUHA's FED), and (3) Roper Northwoods FED's five additional beds that will be online in April 2022, from its capacity calculations on the basis that they were not "existing" and operational as of the conclusion of the contested case hearing, there would still be sufficient capacity in the service area to treat an additional 64,900 ($289,900 - 225,000 = 64,900$) patients without adding another FED or hospital-based emergency room. As an aside, there was also no evidence regarding excessive wait times at the facilities in MUHA's proposed service area. *See also* (Tr. 2244:3-2246:1).

³⁸ Standard 6 has been omitted from the 2017-2018 Plan, and the following language which still includes the word, "existing," was added: "The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area."

³⁹ (Tr. 465:14-18).

89. Although Ms. Murdock testified that she independently assessed capacity and utilization of emergency department services in the proposed service area, she was unaware of the number of treatment spaces in several of the existing FEDs, including Trident Centre Pointe FED. (Tr. 1455:13-1457:6). Without knowing the capacity of the emergency departments and FEDs in the proposed service area, I find that the Department's assessment of utilization of emergency services could not have been complete or reliable.

90. Roper St. Francis and Trident have additional capacity to provide emergency services in their presently operating emergency department locations to patients in the tri-county service area of Berkeley, Charleston, and Dorchester counties. (Tr. 467:5-11; 486:2-4; 1000:17-22).

91. Capacity cannot be evaluated in a vacuum, and the Court must consider not only the number of beds available for emergency visits but also, how population growth and growth in emergency room visits may affect capacity. Roper St. Francis' health care planner and former chief executive officer did not disagree that the tri-county area and particularly Berkeley County was rapidly growing and was the third fastest growing county in the state. (Tr. 401:22-402:3; 767:23-768:10). *See also*, (Tr. 1978:7-9; 2118:1324); (MUSC Ex. 36). The Department testified that the utilization of emergency services had been "exploding" over the last five years in the area in which the proposed FED was to be located but provided no supporting data as to whether such growth would continue. (Tr. 1348:1-11).

92. In response to Roper St. Francis and Trident's demonstration of existing additional capacity in the proposed service area, and in support of its proposed FED, MUHA presented extensive testimony regarding the population growth (including patient origin growth) and emergency department growth in the proposed service area (particularly in Berkeley County, the county in which MUHA's FED was proposed to be located). (Tr. 401:22-402:3; 1978:7-9; 2115:15-2121:5); (MUSC Ex. 30, 31, 32, 34, 35, 36, 37). The other parties did not dispute that there was population growth. Tr. 767:23-768:10; 2359:6-15). While the population and number of emergency room visits have grown in the tri-county area (and particularly in Berkeley County), statistical information alone can be misleading and does not support a need for an additional FED in the proposed service area given the existing capacity.

93. As an example, MUHA noted that there was a 23.1% (or 75,974 visits) increase in emergency room visits in the tri-county area from 2012 which exceeds the statewide average. (MUSC Ex. 37). This information does not necessarily lend support for an additional FED in the

proposed service area. While the Court does not dispute population and emergency room visit growth in the tri-county area, the trend in the growth of emergency department visits indicates that it slowed in 2016, and that it actually declined in 2017. (Tr. 2359:16-2361:16); (MUSC Ex. 37). There is no indication that there is going to be a consistent dramatic increase in emergency department visits going forward. (Tr. 2361:1-11). Moreover, there are additional facilities that will soon be coming online such as Roper St. Francis Berkeley Hospital and Trident Summerville FED.

94. MUHA stated that one of the reasons it was seeking the FED in the proposed service area was to alleviate constraints in its own emergency department. (Joint Ex. 001-022). MUHA's application projected growth in its emergency department visits. (Joint Ex. 001-0127). At the hearing, however, MUHA acknowledged that the total emergency department visits to MUSC from the tri-county area had slightly declined in 2016, and then again in 2017 and 2018. (Tr. 1467:10-21).⁴⁰ MUHA reported growth in the number of Berkeley County residents traveling to MUSC's downtown emergency department from 2015-2018, but the vast majority of its patients were still coming from Charleston County, even though the number of visits originating from Charleston County declined during the same time period. (Tr. 2107:25-2108:23); (MUSC Ex. 34). MUHA had a decline in the total number of emergency department visits. *Id.*

95. MUHA's market share of tri-county emergency department patients for Berkeley County has declined by 1.6 % and for Dorchester County by 2.2%. (Tr. 741:1-742:10); (Roper St. Francis Ex. 59-016). This undermines one of MUHA's argument that serves as the basis for its FED: that it wants to create better accessibility for its existing patients in the proposed service area (which again, is not a criterion for project review), as its market share in the proposed service area appears to be declining.

96. Finally, Ms. Platt testified that there was sufficient existing capacity for future growth by taking into account both existing and approved projects. (Tr. 727:20-729:25). To establish that there was sufficient capacity for future growth, Ms. Platt applied a rate of 1.7% of annual growth in emergency department visits in the proposed service area which was also the percentage of growth used by MUHA in its application. (Tr. 729:1-25); (Joint Ex. 001-026); (Roper St. Francis Ex. 59-008). Ms. Platt applied that to the service area emergency department

⁴⁰ In fact, MUHA acknowledged a slight decline in Trident's emergency department visits between 2016 and 2017. (Tr. 4167:24-4168:4).

patient volume continuing to 2024 which she believed would likely encompass the time at which MUHA's proposed FED would become operational. (Tr. 729:7-12). The Court has adopted a growth rate of 1.7% per year in service area emergency department patients.

97. While the Court has utilized different numbers than did Ms. Platt for purposes of service area emergency department capacity, the Court finds that based upon the following, there exists sufficient capacity for additional emergency department visits even with ongoing population growth in MUHA's proposed service area.

	Service Area ED Patients	Service Area ED Capacity ⁴¹	Percent of Capacity Utilization in Service Area
FY 2016 Actual	204,226	289,900 342,000	70.4% 59.7%
FY 2017 Actual	200,701	289,900 342,000	69.2% 58.6%
FY 2018 Projected	204,113	289,900 342,000	70.4% 59.7%
FY 2019 Projected	207,583	289,900 342,000	71.6% 60.7%
FY 2020 Projected	211,112	289,900 342,000	72.8% 61.7%
FY 2021 Projected	214,701	289,900 342,000	74.1% 62.6%
FY 2022 Projected	218,351	289,900 342,000	75.3% 63.8%
FY 2023 Projected	222,063	289,900 342,000	76.6% 64.9%
FY 2024 Projected	225,838	289,900 342,000	77.9% 66%

98. While MUHA stated that the exploding population growth in the proposed service area provided a basis for its need of the FED, this contradicts MUHA's position that it would only (or even primarily) be serving or redirecting patients who are already being treated by MUSC at its downtown emergency departments. *See* (Tr. 1977: 12-23; 2161:19-22). If MUHA was only

⁴¹ 289,900 represents the capacity of emergency room beds in the proposed service area that were operational at the conclusion of the contested case hearing. 342,000 includes the additional capacity for facilities approved as of the conclusion of the hearing and that would be coming online including Roper St. Francis Berkeley Hospital (which was scheduled to open in October of 2019), Trident Summerville FED (which was approved simultaneously with MUHA's FED and was not appealed), and Roper Northwoods FED's five additional beds that will be online in April 2022.

seeking to redirect its own patients to the new FED for its stated purposes of providing better access for its existing patients and alleviating capacity constraints at its downtown emergency departments, the growth in population and emergency department visits in Berkeley County would seem irrelevant.

99. Based on the foregoing, the Court finds that there is sufficient capacity in MUHA's proposed service area not only to meet the existing need but also, the projected growth without the need for MUHA's proposed FED.

H. 2015 Plan's Relative Importance of Project Review Criteria

100. The 2015 Plan sets forth the following project review criteria as being the most important:

1. Compliance with the Need Outlined in this Section of the Plan;
2. Community Need Documentation;
3. Distribution (Accessibility);
4. Resource Availability; and
5. Financial Feasibility

The 2015 plan also provides that the "benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating [CON] applications for this service."

- Compliance with Need Outlined in the Relevant Section of the 2015 Plan and Community Need Documentation

101. The requirement for Community Need Documentation is addressed both in the 2015 Plan's Standards (*i.e.* Standard 6) and project review criterion 802.2. The Community Need Documentation criterion has five subparts although criterion 2(d)⁴² does not apply. Community Need Documentation requires in part that the target population be clearly identified and that the projections of anticipated population changes be reasonable and based upon accepted demographic or statistical methodologies clearly presented in the application. S.C. Code Ann. Regs. 61-15 § 802.2(c) (Supp. 2019). A "proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing body." *Id.*

⁴² "In the case of a reduction, relocation, or elimination of a facility or service, the applicant should address the need that the population presently has for the service, the extent to which that need will be met by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination, or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other underserved groups, to obtain needed health care."

102. MUHA stated that the proposed FED “will enhance access and convenience, promote quality of care and increase patient satisfaction,” but does not address an identified (documented) need of the target population as required by project review criterion 802.2(c). (Joint Ex. 001-028). I find that the need asserted by MUHA in the CON Application to “attempt to address the continued growth and space constraints” at its existing emergency departments downtown is not the community need required to satisfy Standard 6 or project review criterion 802.2. (Joint Ex. 001-021).

103. At trial, MUHA explained that “seeing our patients where they want to be seen and when they want to be seen is the most important thing.” (Tr. 1816:15-17). MUHA further explained that what it would “like to offer – is the alternative that if [patients who choose MUSC for primary care] are seeking emergency room care in the North Charleston, Summerville area that we have something that is in network that can be offered to them.” (Tr. 1915:18-25). Neither patient choice nor convenience is included in the Plan or encompassed by project review criterion 802.2. (Tr. 1507:2-12; 2276:8-2278:10; 2290:9-12; 2307:10-14).

104. While MUHA identified the target population, MUHA’s methodology and the assumptions (including those relating to patient shift) used to support the proposed FED are unreasonable and flawed. As an example, MUHA utilized billing codes (rather than ESI levels) for purposes of shift projections, and failed to provide any information as to why its patients in the proposed service area were already driving past several other providers to seek treatment at MUSC on the peninsula.

105. As discussed above in more detail, Roper St. Francis and Trident have proven by a preponderance of the evidence that: (1) there is no community need for MUHA’s proposed FED as there is no lack of access given the capacity in the proposed service area even with continued population growth; and (2) MUHA’s methodology and assumptions including those relating to patient shift used to support the proposed FED are unreasonable and flawed as discussed herein.

- Distribution (Accessibility)

106. The Distribution (Accessibility) project review criterion addresses both duplication of services and the need to locate services in medically underserved areas. S.C. Code Ann. Regs. 61-15 § 802.3(a) and (b) (Supp. 2019). MUHA’s presentation to the Department’s staff at the project review meeting specifically addressing the Distribution (Accessibility) project review criterion, stated “the proposed project is solely based on MUSC’s existing ED patient base and space constraints at the hospital-based ED.” (Joint Ex. 001-534). Ms. Murdock acknowledged at

the hearing that MUHA was not proposing to serve a medically underserved group; “[t]hey were proposing to serve the patients that they were already serving.” (Tr. 1482:4-11; 2161:19-22).

107. As to duplication of services, evidence at the contested case hearing was that the location of MUHA’s proposed FED is less than 10 miles of multiple providers of emergency services, including Trident Medical Center and Summerville Medical Center. (Roper St. Francis Ex. 59-006). Neither of these were mentioned in MUHA’s original CON application, and while they were mentioned in information submitted during or after project review, the information contained “very general conclusory statements about other providers and that there [would] be no effect or adverse effect on other providers.” (Tr. 1463:10-1464:2; 2279:15-2280:17). While not operational at the time of trial, the proposed FED is only five miles from Roper St. Francis Berkeley Hospital, and less than one mile from Trident’s Summerville FED, the latter of which was simultaneously approved by the Department along with MUHA’s application for a FED. (Tr. 863:20-25; 1142:6-25); (Roper St. Francis Ex. 59-006). The existing and approved capacity for emergency services within 20 miles of MUHA’s proposed FED location is approximately 342,000 visits per year in 168 treatment spaces, which does not include Berkeley Medical Center or MUHA’s Berkeley Hospital. Trident’s health planning expert testified “it would be hard to envision a part of the state of South Carolina where there would be less need for a freestanding emergency department than where the Medical University is proposing to put theirs,” and that there is an abundance of access to emergency services for residents in the service area without the need of an additional FED. (Tr. 732:20-733:9; 1142:1-6). I find that MUHA’s CON application does not comply with project review criterion 802.3 because it is both unnecessarily duplicative and is admittedly intended to serve patients who are already served by MUSC and thus, those patients cannot be considered to be medically underserved. To allow such unnecessary duplication would be contrary to the purpose of the CON Act in promoting cost containment.

108. While MUSC provides services to low income patients as well as those receiving Medicare⁴³ and Medicaid and represented that it would do so at its FED, there was no evidence that other facilities in the proposed service area do not treat similarly situated patients. In fact, EMTALA mandates that any patient (indigent, medically underserved and otherwise) who presents at an emergency department requiring treatment must be treated. (Tr. 1070:12-1071;2; 1071:23-1072:10; 1483:2-6; 2369:9-16). This includes any FED that would serve as an extension

⁴³ Not all Medicare patients are medically underserved. (Tr. 2369:17-2370:3).

of MUSC. (Tr. 1279:24-1280-6; 1358:3-12; 1483:7-12; Tr. 2384:8-16). Thus, the medically underserved, indigent, and others already have access to the same emergency services through the providers in MUHA's proposed service area. (Tr. 732:24-733:9; 1206:9-1207:2; 1483:2-12). There is nothing about MUHA's FED that will have any material impact, if any, on the medically underserved population. *Id.*

109. The Court also notes that while Mr. Levitt testified that it was irrelevant because it is not a criterion utilized by the Department, the site on which MUHA's proposed FED is located is not within a medically underserved area (MUA) as defined by the United States Department of Health and Human Services, although a zip code next to the proposed site is. (Tr. 1203:9-1204:10; 2154:25-2155:7; Tr. 2280:19-2281:2).

- Resource Availability

110. Resource availability⁴⁴ is set forth in the 2015 Plan as being one of the five criteria considered the most important in evaluating CON applications for FEDs yet the Department elected not to include it in the deemed complete letter of July 10, 2017, or address it in its decision granting a CON to MUHA for the FED. (Tr. 707:1-14); (Joint Ex. 001—551; -545); (Roper St. Francis Ex. 55-023).

111. Ms. Murdock testified that she did not include Resource Availability because it did not correspond to an actual project review criterion listed in Regulation 61-15, and that the closest criterion to "Resource Availability" set forth in the 2015 Plan was the "Staff Resources" criterion. (Tr. 1335:4-19; 1335:25-1336:3; 1336:17-1337:4; 1434:16-22);⁴⁵ See S.C. Regs. 61-15 § 802.20 (Supp. 2019). Additionally, Ms. Murdock stated that she did not include it among the priority criteria for MUHA or Summerville Medical Center's proposed FEDs because there was nothing particularly concerning or unique about MUHA's staffing plans. (Tr. 1337:5-1338:3).

112. While there is no specific criteria titled, "resource availability," several other project review criteria address resource availability including project review criterion 3(h), 20, 21, and 23(b). S.C. Code Ann. Regs. 61-15 § 802 (Supp. 2019). In 2015, the Department identified the same project review criteria set forth in the 2015 Plan in review of a CON application for a FED in Horry County, and defined "Resource Availability" to include project review criterion

⁴⁴ The 2017-2018 State Health Plan substitutes "Staff Resources" for "Resource Availability." (Roper St. Francis Ex. 57-026).

⁴⁵ Ms. Murdock testified that the Department interprets Regulation 304 as giving Department staff the authority to identify project review criteria for a project that may or may not include all of the project review criteria identified in the Plan for that particular facility or service. (Tr. 1426:1-11; 1431:17-21; 1433:5-1434:5).

20(a), 20(b), 20(c), 21(a), 22, 23(a), 23(b) and 24. (Roper St Francis Ex. 62-001; -002). Section 802.23 of Regulation 61-15 which is captioned, “The Adverse Effects on Other Facilities” provides in part that, “The staffing of the proposed service should be provided without unnecessarily depleting the staff of existing facilities or services or causing an excessive rise in staffing costs due to increased competition.” S.C. Code Ann. Regs. 61-15 § 802.23(b) (Supp. 2019).

113. Concerns about the project’s impact on staffing and staffing shortages were raised by Roper St. Francis during the Department’s staff review. (Tr. 1536:25-1537:5); (Joint Ex. 001-490); (Trident Ex. 020-003). While Ms. Murdock’s notes from the project review meeting document that Roper St. Francis brought up “staffing problems” during the presentation, she testified that she did not conduct any research or do any analysis on staffing specifically, as she was “already aware of the – the general concern nationwide regarding nursing shortages.” (Tr. 1537:10-15; 1537:25-1538:5).

114. At the hearing, both Roper St. Francis and Trident’s nursing experts testified extensively as to nursing shortages both in South Carolina and throughout the United States. (Tr. 499:20-21; 514:11-18; 885:6-12; 885:25-886:11; 942:16-24; 1045:13-15). Concern was expressed about the competition for experienced and qualified clinical staff and how additional facilities exacerbate the difficulty. (Tr. 885:1-886:7; 2284:22-2285:25).

115. Contrary evidence was presented that despite a national nursing shortage, the addition of a FED such as the one proposed by MUHA would not significantly impact the nurse staffing needs of other facilities in the area. (Tr. 1305:11-14; 1617:10-14; 1617:22-1618:4). Neither Roper St. Francis nor Trident offered evidence quantifying the effect MUHA’s proposed FED would have on nursing staff. (Tr. 545:3-6). Moreover, despite claims of a nursing shortage, Trident has not ceased its emergency department expansions in the tri-county area. (Tr. 943:19-944:4; 1109:1-9; 1298:4-12). Trident’s expert healthcare planner testified that with regard to the current Summerville FED, Trident would “ultimately be able to staff it.” (Tr. 1305:9-14). Similarly, Summerville Medical Center’s chief operating officer testified that although some nurses were being targeted for recruitment by other facilities, she could not confirm any actual losses, particularly with regard to emergency department nurses. (Tr. 953:24-954:13). Roper St. Francis’ director of emergency services only knew of two or three current vacancies at Roper Northwoods FED. (Tr. 545:10-21). MUHA’s expert testified that Roper St. Francis and Trident’s CON applications reported no staffing issues for their proposed projects. (Tr. 2199:6-2200:6).

Lastly, the Department's CON director testified that a reasonable staffing plan by MUHA should not exacerbate any nursing shortage. (Tr. 1617:19-1618:4).

116. Based upon all of the testimony presented at the hearing on the issue, Roper St. Francis and Trident have not demonstrated by a preponderance of the evidence that MUHA's project will have any significant effect on existing providers' staff or staffing costs.

- Financial Feasibility

117. "Financial Feasibility" is set forth in the 2015 Plan as being one of the five criteria and is included in the criteria for project review in Section 802.15 of Regulation 61-15. (Tr. 601:5-20; (Joint Ex. 001—551; -545); (Roper St. Francis Ex. 55-023). The pro forma budget for MUHA's FED is set forth in the CON application. (Tr. 2033:18-20); (Joint Ex. 001-0087). It projects annual net operating revenue for the FED's first four years of operation as ranging from \$8.27 – \$8.71 million. (Tr. 2157:4-5); (Joint Ex.001-0087). Net income is projected at over \$2.7 million each year. (Tr. 2157:5-8); (Joint Ex. 001-087). All projections on the pro forma in the application remain the same with the exception of capital costs in that rent will be replaced by depreciation. (Tr. 2033:20-2034:9). The cost reductions as a result of the changes to the project including the deletion of the CDU unit and helipad⁴⁶ will result in decreased costs and improved net income. (Tr. 2034:2-12; 2157:2-2158:9). I find the pro forma projections and the assumptions on which they are based to be reasonable and based upon accepted accounting procedures. *See* (Joint Ex. 0001-084 through -088). The project remains financially feasible. *See* (Tr. 2156:12-2160:1).

- Equally Weighing the Benefits of Improved Accessibility with the Adverse Effects of Duplication in Evaluating [CON] Applications for this Service

118. MUHA stated that the primary motivation behind the FED project is to improve access for its own patients (those residing in the north area) "to get to a more convenient site." (Tr. 1711:23-1712:3; 1977:14-23); (MUSC Ex. 60-3). Improved access for a facility's own patient base is not a criterion included in the CON Act, the 2015 Plan, or the relevant Departmental regulations which this Court may consider in determining whether to approve a project.

⁴⁶ One of the criticisms contained in paragraphs 26-28 of Trident's Petition for Administrative Review and Contested Case Hearing filed on December 14, 2017 was the cost associated with the construction of a helipad and operation of a helicopter making the project inconsistent with the CON Act and project review criteria governing cost containment and financial feasibility.

119. Roper St. Francis and Trident have shown by a preponderance of the evidence that the proposed FED will not improve access to emergency department services as the proposed service area has sufficient availability of comparable emergency department services.

120. The Court finds that while MUHA's FED would not adversely affect staff resources at other facilities, the construction of another FED in the proposed service area when there is additional capacity in existing facilities would result in a waste of health care dollars and an unnecessary duplication of services.

121. Roper St. Francis and Trident have shown by a preponderance of the evidence that MUHA's FED does not comply with the 2015 Plan as there is no community need even with the increasing population growth, and the project is unnecessarily duplicative of existing services, and it is not located in a medically underserved area. Even if this Court were to apply the criteria set forth in the Department's letter of July 10, 2017, or the 2016-2017 Plan, MUHA would still not meet the requirements for approval of its application.

I. Criteria Utilized by the Department in Evaluating the Project

122. Despite the 2015 Plan having set forth five criteria as being the most important for purposes of evaluating CON applications for FEDs as required by Section 44-7-180(B)(4), the Department advised MUHA of the following four review criteria by letter dated July 10, 2017, that would be used in reviewing its project:

1. Community Need Documentation
2. Distribution (Accessibility);
3. Medically Underserved Groups; and
4. Financial Feasibility.

(Joint Ex. 001-545). The Court's factual findings as to these criteria are the same as discussed above including, "Medically Underserved Groups." "Medically Underserved Groups" was addressed above under the heading of "Distribution (Accessibility)" which included a discussion of both duplication of services and the need to locate services in medically underserved areas. S.C. Code Ann. Regs. 61-15 § 802.3(a) and (b) (Supp. 2019).

2017-2018 STATE HEALTH PLAN⁴⁷

J. 2017-2018 State Health Plan

1. Need and Capacity Constraints

123. The 2017-2018 Plan includes the following in its need projections and standards section: “The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.” (Roper St. Francis Ex. 56-026). As discussed herein, Roper St. Francis and Trident have demonstrated by a preponderance of the evidence that there is no need for another FED in the proposed service area. While MUSC’s downtown emergency department is constrained, it is not a criterion that the Court may consider.

2. Travel Time

124. Roper St. Francis and Trident presented testimony and evidence establishing by a preponderance of the evidence that the patients proposed to be served by MUHA’s FED already reside within fifteen minutes travel time of an existing emergency department including Trident Medical Center and Summerville Medical Center, both of which are hospital based. (Tr. 725:8-726:1; 731:22-732:19); (Roper St. Francis Ex. 7-005). This is consistent with the statement under the 2017-2018 Plan’s project review criteria which provides that the majority of South Carolina residents should have access to emergency medical services within fifteen (15) minutes’ travel time. (Roper St. Francis Ex. 56-026).

125. While not critical to this determination, additional facilities (including Roper St. Francis-Berkeley Hospital, Trident’s Summerville FED, and MUSC’s Berkeley Hospital) have been approved and (one of which was under construction at the time of trial and was expected to be online in October 2019) will provide even more availability and capacity within the window of a fifteen-minute drive time. (Tr. 2255:3-2257:10); (Roper St. Francis Ex. 7-004; 7-005; 63-014). *See also*, (Roper St. Francis Ex. 63-015).

K. 2017-2018 Plan’s Relative Importance of Project Review Criteria

126. The project review criteria considered the most important in evaluating CONs for FEDs no longer include “Compliance with the Need Outlined in this Section of the Plan,”

⁴⁷ The Court exercises its discretion to consider the 2017-2018 State Health Plan in reviewing the proposed project. *See* S.C. Code Ann. § 44-7-225 (2018). Neither party asked the Court to consider the 2019 Plan and the Court declines to do so.

“Resource Availability,” or “Financial Feasibility,” and instead identify “Medically Underserved Groups,” “Record of the Applicant,” and “Staff Resources.” The 2017-2018 Plan’s criteria are as follows:

1. Community Need Documentation;
2. Distribution (Accessibility);
3. Medically Underserved Groups;
4. Record of the Applicant; and
5. Staff Resources.

(Roper St. Francis Ex. 56-026).

127. The 2015 Plan provided that “The benefits of improved accessibility will be equally weighed with the adverse effect of duplication in evaluating [CON] applications for this service,” while the 2017-2018 Plan provided that “The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for [freestanding emergency department services]. (emphasis added).” (Roper St. Francis Ex. 55-023; 56-026). The 2017-2018 Plan also added that “Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. (Roper St. Francis Ex. 56-026).

128. The Court need not revisit “Community Need Documentation,” “Distribution (Accessibility),” “Medically Underserved Groups,” or “Staff Resources.”⁴⁸ The Court’s findings of fact relative to these “most important criteria” are set forth above. (Roper St. Francis Ex. 56-026). MUHA meets the applicable project review criterion titled, “Record of the Applicant” as outlined by Section 802.13 of Regulation 61-15, and no evidence was presented to the contrary. S.C. Regs. 61-15 § 802.13 (Supp. 2019).

129. Based upon the findings of fact set forth above, the Court finds that MUHA’s project does not provide increased accessibility and even if it did, it would be outweighed by the unnecessary duplication.

L. Intuitive Health

130. In the fall of 2017, MUHA began communicating with Intuitive Health, a company located in Texas that operates and manages emergency department services. (Tr. 1728:2-23). Over a 12-14-month period, representatives of MUHA and Intuitive Health exchanged information and participated in several telephone calls. (Tr. 1728:-13; 1732:11-15). MUHA officials made a

⁴⁸ As to “Staff Resources,” the hearing testimony was that “Resource Availability” criterion in the 2015 Plan was equivalent to the Staff Resources” criterion in the 2017-2018 Plan. *See* (Tr. 1335:25-1336:3; 1336:17-1337:4; 2283:1-10); Roper St Francis Ex. 62-001; -002).

site visit to an Intuitive Health facility in the fall of 2018. (Tr. 1728:18-22; 1731:11-1732:15). During these communications, the topics of discussion included potential sites, size, and layout of MUHA's Berkeley County FED; use of a CDU and helipad; and a "hybrid," urgent care model used by Intuitive. (Tr. 1730:1-15). Intuitive provided MUHA with a "joint venture package" of proposals and information related to the Berkeley County FED. (Trident Ex. 68). This package included site information, a market analysis, a pro forma budget, staffing recommendations, a billing methodology, and a proposed joint venture legal structure between MUSC and Intuitive. *Id.*; (Tr. 1730:16-1731:7). MUHA eventually rejected Intuitive Health's proposal for a joint venture or any form of business venture. (Tr. 1732:16-21; 1737:15-18). MUHA also rejected Intuitive Health's proposed staffing plan, pro forma budget, and market analysis, which was based on a smaller service area. (Tr. 1443:5-22). Instead, MUHA decided to rely on the staffing plan, pro forma budget, and service area set forth in its application. (Tr. 1743:13-1744:5; 1744:20-1745:7). In late 2018 or early 2019, MUHA informed Intuitive Health that the two would not be working together on the Berkeley County FED. (Tr. 1734:14 – 1735:8); (Intuitive Health Rule 30(b)(6), *SCRCF* Depo. Tr. 78:8-13).

131. In February 2019, Dr. Cawley submitted an affidavit in support of MUHA's Memorandum in Opposition to Trident's Motion for Summary Judgment that was filed on February 19, 2019. (MUSC's Memo. in Opp. to Trident Motion for Summary Judgment, Ex. A.). In his February affidavit, Dr. Cawley stated that MUSC would consider retaining Intuitive or another company to provide management services for the Berkeley County FED. *Id.* ¶ 10. At the July trial, however, Dr. Cawley testified that MUSC had not entered into a management agreement with anyone, had no plans to do so, and that any decision about a management agreement would be his to make. (Tr. 1738:8-23). He further testified that MUSC would not enter into any management agreement under which the management company could determine elements of the nature and quality of medical services, select the physicians who would provide services, or change its charity care policies. (Tr. 1738:24 – 1739:12).

132. In his affidavit on February 19, 2019, Dr. Cawley stated MUSC intended to provide urgent care services in the FED. MUSC's Memorandum in Opposition to Trident's Motion for Summary Judgment, Ex. A ¶ 8:

Another change to the Project that MUSC intends to make is to provide urgent care services (which are not subject to CON requirements) in the same building as the FED. Many people who come to an Emergency Department do not need emergency services, only urgent care services. Rather than providing such patients with

unnecessary emergency-level services, MUSC will instead provide them with urgent care services. When urgent care services are provided, payors will be billed for urgent care services, rather than for the more expensive emergency services.

Id. This paragraph describes the Intuitive Health “hybrid” model. (Tr. 1739:24–1740:1). In June, however, the Department notified MUHA that the Department’s licensing and certification divisions might have concerns about providing urgent care in the FED. (Tr. 1576:21-1577:1; 1578:1-6; 1580:6-1582:3). As a result, MUHA reverted to the original proposal set forth in the application, that only emergent services would be provided in the FED. (Tr. 1741:7-21; 1744:6-10). On July 2, 2019, the day before Dr. Hall’s deposition, Dr. Cawley sent him an email, which MUHA forwarded to Petitioners, clarifying that the Berkeley County FED would use the traditional FED model, as described in the CON application, and would not provide urgent care services. (Tr. 204:19-205:14; 1741:3-21); (Trident Ex. 76).

133. Dr. Cawley testified that MUHA benefitted from the discussions with Intuitive Health by learning about and adopting some best practices in FED operations and management. (Tr. 1746:1-4). However, Intuitive Health has not made any changes to MUHA’s project and MUHA only adopted suggestions after conducting its own review and analysis. (Tr. 1742:4-23). Intuitive will not be a joint venture party with MUHA in this project, will not have any ownership interest in the project, and will not provide capital or financing for the project. (Tr. 1737:15-24).

134. The Court finds that while MUHA consulted⁴⁹ with Intuitive Health (an entity that has no experience in developing or operating a FED or one affiliated with an academic medical center similar to MUSC) as to the proposed FED, MUHA rejected most of Intuitive Health’s proposals including the latter’s proposed service area, and proposal for a joint venture. Intuitive Health will not be participating in MUHA’s proposed FED. It is somewhat disconcerting that MUHA engaged in discussions with a third party as late as it did that could have *potentially* resulted in significant modifications that affected the manner in which the project complied with the Act, the Plan, and the project review criteria. However, as discussed herein, the project remained substantially the same. While these communications may have altered the manner in which the parties elected to proceed with discovery, the Court places little weight on documents and testimony relating to Intuitive Health including its representative’s deposition.

⁴⁹ It appears that most of the communications occurred after MUHA’s application had been submitted and after the project was approved by the Department.

M. MUHA's Communication with the Department

135. MUHA and the Department staff communicated several times about the Berkeley County FED application after the contested case was filed. MUHA first contacted the Department about potential changes to the FED project in February 2018. (Tr. 1534:2-4); (Roper St. Francis Ex. 22). *See also*, (Tr. 1534:4-11). In December 2018, MUHA's attorney and expert health care planner along with other MUHA representatives met with the Department to discuss possible changes to the project and the Department's position. (Tr. 1991:22-1992:25; 1993:17-1994:10). Roper St. Francis and Trident were not apprised of the communications or the meeting. (Tr. 1534:19-21).

136. During the meetings, MUHA asked the Department whether it would consider the potential project changes in location, size, and cost to be substantial and were told that such changes would not generally be considered substantial.⁵⁰ (Tr. 1993:20-1994:15).

137. The Department's practice is to encourage communication between interested parties and Department staff regarding CON applications. (Tr. 1392:2-6). When considering changes to a CON project during the pendency of contested case litigation, Mr. Levitt testified that his practice has been to advise clients to notify the Department. (Tr. 1990:23-1991:7).

138. On Monday, July 29, 2019, the sixth day of trial, and in response to questioning by counsel for Roper St. Francis, Ms. Murdock stated that she had communicated with MUHA since her deposition. (Tr. 1544:20-23). When asked about the purpose of the communication, the Department's attorney objected on the basis that the Department and MUSC had entered into an oral joint defense agreement and answering questions about their communication would violate the attorney-client privilege. (Tr. 1545:25-1546:5-10). The Court asked the parties to brief the issue as to the propriety of the agreement and adjourned for the day. (Tr. 1547:8-16). On July 30, 2019, the Court reconvened at which time the Department's attorney stated that MUHA and the Department's interests were aligned and that they had a common interest in preparing Ms. Murdock for her testimony; MUHA concurred. (Tr. 1548:17-1549:2; 1150:1-5; 1551:15-19). Upon further questioning by the Court as to the propriety of the agreement, the Department offered to allow Ms. Murdock to answer questions subject only to the privilege that existed between the Department's attorney and Ms. Murdock. (Tr. 1550:22-1551:11). Questioning resumed. (Tr. 1560:5-10).

⁵⁰ Mr. Levitt was uncertain whether elimination of the CDU and helipad was discussed. (Tr. at 1994:3-7).

139. Ms. Murdock testified that a few days before trial, one of MUHA's attorneys met with the Department's CON director and one of its attorneys. (Tr. 1560:17-1561:7). During the twenty minute or less meeting, Ms. Murdock was asked what she thought about the FED project and some of the proposed changes including the relocation and possibly whether the helipad and CDU were significant. (Tr. 1561:1-19; 1562:16-20; 1563:1-3).

140. Ms. Murdock then testified to a final meeting between MUHA and the Department that took place on July 26, 2019, after several days of trial testimony but before Ms. Murdock took the stand. (Tr. 1565:10-14). The meeting took place in the offices of MUHA's attorneys and lasted no more than 30 minutes. (Tr. 1566:1-8; 1565:12-13). Those attending were MUHA's two hearing attorneys, the Department's hearing attorney, and Ms. Murdock. (Tr. 1565:15-16). Mr. Levitt was also there at the beginning of the meeting but stayed less than five minutes. (Tr. at 1566:17-20). The stated purpose of the meeting was to discuss the trial testimony that had already been rendered including Ms. Murdock's interpretation of Roper St. Francis and Tridents' experts' testimony. (Tr. 1566:18-24; 1569:19-1570:1). She was also asked what she thought about the case moving forward.⁵¹ *Id.* Per Ms. Murdock's testimony, none of the attorneys made any suggestions or advised her about her testimony. (Tr. 1567:11-15). Ms. Murdock did not review any documents during the meeting. (Tr. 1569:14-16). Ms. Murdock testified that nothing that was said during the meeting caused her to change her testimony.⁵² (Tr. 1567:11-19).

V. CONCLUSIONS OF LAW

Based upon the above findings of fact, the Court concludes the following as a matter of law:

A. Legal Overview

1. The Administrative Law Court has jurisdiction over contested cases arising from Department final agency decisions, including CON decisions. S.C. Code Ann. §§ 1-23-600; § 44-1-60(F); 44-7-210(D) (2018 and 2019 Supp.). A contested case challenging a Department CON decision is tried de novo before the Administrative Law Court. *Marlboro Park Hosp., supra*. A

⁵¹ When Ms. Murdock was first questioned on cross examination about the meeting, the Department's counsel objected on grounds the meeting was subject to an oral joint defense agreement but withdrew the objection subject to Department not waiving the attorney-client privilege with respect to communications solely between the Department's in-house counsel and Department staff. *Id.* at 1545:25-1546:5; at 1551:4-11.

⁵² At trial, Roper argued that, although Ms. Murdock's trial testimony was the "same as it was at her deposition," it was "not consistent to the information we were provided at the deposition." (Tr. at 1590:3-8). Roper submitted designated portions of Ms. Murdock's deposition transcript to support its position, but they do not show any material inconsistencies between her deposition and trial testimonies.

de novo contested case hearing is one where the “whole case is tried as if no trial whatsoever had been had in the first instance.” *Id.* (internal citation omitted). The Court makes both factual findings and conclusions of law in contested cases challenging Department CON decisions. *Spartanburg Reg. Med. Center v. Oncology and Hematology Assocs.*, 387 S.C. 79, 98, 690 S.E.2d 783, 788 (2010); *Brown v S.C. Dep't of Health & Envtl. Control*, 248 S.C. 507, 512, 560 S.E.2d 410, 413 (2002); S.C. Code Ann. § 1-23-600(B) (Supp. 2019).

2. The CON Act regulates the establishment of health care facilities and services in South Carolina. *See* S.C. Code Ann. § 44-7-120 (2018). “The purpose of [the CON Act] 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.” *Id.*

3. Parties are required to obtain CONs from the Department before establishing certain health care facilities and services. S.C. Code Ann. § 44-7-160 (2018). Freestanding emergency medical services are health services subject to standards or criteria in the South Carolina State Health Plan. S.C. Regs. Ann. § 65-15 § 103(14) (Supp. 2019).

4. To obtain a CON, a party must submit a CON application to the Department for approval on the form established by regulation. *See* S.C. Code Ann. § 44-7-200(A) (2018). “The application must address all applicable standards and requirements set forth in departmental regulations, Project Review Criteria of the Department, and the South Carolina Health Plan.” *Id.* The Department determines whether to approve or deny the CON application by evaluating the proposed project’s compliance with the State Health Plan and applicable project review criteria. “The [D]epartment may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations.” S.C. Code Ann. § 44-7-210 (B) (2018).

5. While the Department and a later reviewing court must consider the Plan in place at the time of the application, both retain discretion to consider a later-adopted Plan when evaluating an application. *See* S.C. Code Ann. § 44-7-225 (2018).

6. Project review criteria are adopted as regulations, and “[t]he project review criteria promulgated in regulation must be used in reviewing all projects under the Certificate of Need process.” S.C. Code Ann. § 44-7-190 (2018). From among the thirty-three project review criteria listed in the Department’s regulations the Department chooses the most important and advises the

applicant in writing of the “relative importance of the project review criteria” that will be used to evaluate the application. S.C. Regs. Ann. 61-15 §§ 304(1) and 801 (Supp. 2019).

7. A proposed project may be approved despite failing to satisfy every project review criterion, but the Department has no discretion to approve a proposed project that is inconsistent with the Plan. *See* S.C. Regs. Ann. 61-15 § 801(3) (Supp. 2019).

8. Affected persons may request that the Department’s Board review a Department staff decision approving or denying a CON application and, thereafter, may challenge the final Department decision by filing a contested case. S.C. Code Ann. § 44-1-60(G) (2018 &); S.C. Code Ann. § 44-7-210 (2010).

9. At the contested case hearing before this Court, the issues to be considered are limited to those presented to or considered by the Department during the staff review and decision-making process. S.C. Code Ann. § 44-7-210(E) (2018). As long as no new issues are considered in these contested case proceedings, any evidence pertinent to the issues considered by Department staff may be considered by this court. *Marlboro Park Hosp.*, 358 S.C. at 578-79, 595 S.E.2d at 854.

B. Burden of Proof

10. A petitioner challenging the Department’s approval of a CON application bears the burden of proving, by a preponderance of the evidence, that the CON application does not satisfy the relevant CON standards and project review criteria. *See Leventis v. S.C. Dep’t of Health & Envtl. Control*, 340 S.C. 118, 132-33, 530 S.E.2d 643, 651 (Ct. App. 2000) (citations omitted). Here, Roper St. Francis and Trident bear the burden of proof by establishing by a preponderance of the evidence that a CON should be denied.

C. Evidence

11. The weight and credibility assigned to evidence presented at the hearing of a matter is within the province of the trier of fact. *See S.C. Cable Television Ass’n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992). Furthermore, a trial judge who observes a witness is in the best position to judge the witness's demeanor and veracity and to evaluate the credibility of his testimony. *See, e.g., Woodall v. Woodall*, 322 S.C. 7, 10, 471 S.E.2d 154, 157 (1996).

12. Under Rule 702 of the South Carolina Rules of Evidence, “[i]f scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience,

training, or education, may testify thereto in the form of an opinion or otherwise." An expert is granted wide latitude in determining the basis of his opinion, and where an expert's testimony is based upon facts sufficient to form an opinion, the trier of fact must weigh its probative value. *Small v. Pioneer Mach., Inc.*, 329 S.C. 448, 470, 494 S.E.2d 835, 846 (Ct. App. 1997).

13. In general, "expert opinion evidence is to be considered or weighed by the triers of the facts like any other testimony or evidence ... [;] the triers of fact cannot, and are not required to, arbitrarily or lightly disregard, or capriciously reject, the testimony of experts or skilled witnesses," and make an unsupported finding to the contrary of the opinion." 32A C.J.S. *Evidence* § 966 (2020). However, the trier of fact may give an expert's testimony the weight he or she determines it deserves. *Florence County Dep't of Soc. Servs. v. Ward*, 310 S.C. 69, 72-73, 425 S.E.2d 61, 63 (Ct. App. 1992). Further, the trier of fact may accept the testimony of one expert over that of another. *See SC. Cable Television Ass'n v. S. Bell Tel. & Tel. Co.*, 308 S.C. 216, 222, 417 S.E.2d 586, 589 (1992).

14. As the fact-finder, the Court "must make sufficiently detailed findings supporting the denial [or grant] of a permit application." *Marlboro Park Hosp.*, 358 S.C. at 578, 595 S.E.2d at 854. During the contested case hearing, the ALC can "weigh the evidence and assess each witness's testimony and credibility prior to ruling on whether [the] changes [are] substantial enough to constitute a new project." *MRI at Belfair*, 394 at 577, 716 S.E.2d 116 (citing *Spartanburg Reg'l Med. Ctr. v. Oncology & Hematology Assoc. of S.C.* 387 S.C. 79, 89, 690 S.E.2d 783, 788 (2010)).

D. Changes to the Project

15. Roper St. Francis and Trident contend that MUHA's project modifications subsequent to the Department's review are substantial such that it constitutes an entirely new project. The Court disagrees.

16. "The Certificate of Need, if issued, is valid only for the project described in the application including location, beds and services to be offered, physical plant, capital or operating costs, or other factors as set forth in the application, except as may be modified in accordance with these regulations ..." S.C. Code Ann. Regs. 61-15 § 311 (2018). Consequently, "If an applicant amends or alters his project after receipt of a Certificate of Need, the Department will decide whether or not the amendment is substantial and thereby constitutes a new project." S.C. Code Ann. Regs. 61-15 § 605 (Supp. 2018); *see also*, Black's Law Dictionary, *Substantial* (11th ed.

2019) (defining substantial as “[i]mportant, essential, and material; of real worth and importance.”).

17. If an applicant makes changes to a project during the contested case proceedings, the Court may weigh the evidence and testimony on the alleged changes made to the project before determining, “whether these changes were substantial enough to constitute a new project under [S]ection 605.” See *MRI at Belfair, LLC v. S.C. Dep’t of Health and Env’tl. Control*, 394 S.C. 567, 577-588, 716 S.E.2d 111, 116 (Ct. App. 2011) (citing *Spartanburg Reg. Med. Ctr.*, 387 S.C. 79, 89, 690 S.E.2d 783, 788 (2010)).

18. Review of this issue requires a comparison of the amended project to the original project proposed in the CON application to determine whether the amendment is substantial. See *MRI at Belfair, LLC*, 394 S.C. at 573-574, 716 S.E.2d at 114; see also *Providence Hosp. v. S.C. Dep’t of Health and Env’tl. Control & Palmetto Richland Mem’l Hosp.*, 2002 WL 31423801 *2 (S.C.Admin.Law.Judge.Div. September 11, 2002).⁵³ In making that determination, the court may consider whether the amendments to the project substantially change the project’s compliance with the relevant project review criteria. See *MRI at Belfair, LLC*, 394 S.C. at 574, 716 S.E.2d at 114. Accordingly, if MUHA’s amended project meets the “same project review criteria it originally met *in substantially the same way*,” this Court may find that the changes were not “substantial” under Section 605 of the CON Act. See *id.* (emphasis in original).

19. Due to the *de novo* nature of a contested case hearing, the Court was permitted to take new evidence, including expert testimony, on core issues presented to or considered by the Department during the review process, which it did in the instant case. Accordingly, Roper St. Francis and Trident spent considerable time during the hearing highlighting each change made to MUHA’s project since the initial determination.

20. Conversely, MUHA presented ample evidence suggesting that the changes did not substantially impact the manner in which the project complies with any of the project review criteria. MUHA’s new site is less than a mile away from its original proposed site and located in the same county, city, and zip code. Its target population, population and emergency department visit projections, need and utilization projections, methodologies, and assumptions, and pro forma budget statement remain the same as they were during the Department’s staff review. (Tr. 2149:17-23; 2153:16-2154:12; 2156:16-21). There is no evidence MUHA’s historical

⁵³ This case may also be found at Docket No. 02-ALJ-07-0155-CC.

commitment to serving medically underserved groups has changed although the project is not located in a medically underserved area. See (Tr. 2150:9-17; 2155:24-2156:8). There is no evidence MUHA's project changes will impact the market share or staffing of existing providers any more than the approved project. (Tr. 2161:3-2162:3; 2167:1-11). Based on these and other facts, Mr. Levitt testified persuasively that the project changes would not substantially affect compliance with any criteria. (Tr. 2149:17-24; 2150:9-17; 2153:16-2154:12; 2155:24-2156:8; 2156:16-21; 2161:3 – 2162:3; 2167:1-11). Petitioners have offered no compelling argument as to how the amendments to MUHA's project substantially change its compliance with any of the project review criteria.

21. The *Belfair* Court analyzed other factors in addition to the project review criteria. First, the Court noted that the change in location for the MRI at issue was not substantial because the change “would not reduce the standard of care of emergency room patients.” *MRI at Belfair, LLC*, 394 S.C. at 575, 578, 716 S.E.2d at 115-17 (“the change in location of the MRI project ... and the overall layout of the implemented MRI project did not substantially change the project from a clinical, operational, or patient safety perspective”). The location of MUHA's project was changed to improve accessibility and will have no impact on the project from a clinical, operational, or patient safety perspective; no evidence was produced to the contrary. Second, the *Belfair* Court specifically held that a decrease in project costs, such as in MUHA's project, is permissible and not a substantial change since it would not negatively affect compliance with cost containment or financial feasibility criteria. *Id.* at 578, 716 S.E.2d at 116. Third, the *Belfair* Court accepted the ALC's determination that the physical layout changes to the amended project were not relevant because they did not affect patient safety. *Id.* at 575, 716 S.E.2d. 115. Here, changes to the size and floor plan of the FED will have no impact on patient safety. Fourth, just as in *Belfair*, “the scope of the services is the same under both the original and amended project.” *Id.* at 578, 716 S.E.2d. 116.

22. After weighing all of the evidence, I find that while MUHA made a number of changes to the project, the changes are not substantial so as to require a new application. The changes do not materially change the way in which the project complies with the project review criteria.

E. The Department May Not Reorder Review Criteria Set in State Plan

23. The project review criteria in the Department's letter are not identical to the priority project review criteria for freestanding emergency services found in either the 2015 Plan or the

2017-2018 Plan. The Department believes that pursuant to Section 44-7-180(B)(4), it has the discretion to not utilize all of the criteria deemed most important (as outlined in the Plans) in evaluating a proposed FED, as well as reorder the criteria. (Tr. 1389:17-22; 1418:14-1419-4; 1426:12-24; 1427:5; 1429:2-1430:23; 1431:4-22; 1622:9; 1624:2-11). The Court disagrees.

The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature. *Charleston County Sch. Dist. v. State Budget and Control Bd.*, 313 S.C. 1, 437 S.E.2d 6 (1993). Under the plain meaning rule, it is not the court's place to change the meaning of a clear and unambiguous statute. *In re Vincent J.*, 333 S.C. 233, 509 S.E.2d 261 (1998) (citations omitted). Where the statute's language is plain and unambiguous, and conveys a clear and definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning. *Id.* at 233, 509 S.E.2d at 262 (citing *Paschal v. State Election Comm'n*, 317 S.C. 434, 454 S.E.2d 890 (1995)). "What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will. Therefore, the courts are bound to give effect to the expressed intent of the legislature." Norman J. Singer, *Sutherland Statutory Construction* § 46.03 at 94 (5th ed. 1992) ...

Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000).

Statutes dealing with the same subject matter must be reconciled, if possible, so as to render both operative. *Id.* "It is presumed that the Legislature is familiar with prior legislation, and that if it intends to repeal existing laws it would ... expressly do so; hence, if by any fair or liberal construction two acts may be made to harmonize, no court is justified in deciding that the later repealed the first." *Justice v. Pantry*, 330 S.C. 37, 43-44, 496 S.E.2d 871, 874 (Ct. App. 1998) (*quoting State v. Hood*, 181 S.C. 488, 491, 188 S.E. 134, 136 (1936)).

Id. at 88-89, 533 S.E.2d at 583.

This Court will not construe a statute in a way which leads to an absurd result or renders it meaningless. *See Lancaster Cnty. Bar Ass'n v. S.C. Comm'n on Indigent Defense*, 380 S.C. 219, 670 S.E.2d 371 (2008) (in construing a statute, this Court will reject an interpretation which leads to an absurd result that could not have been intended by the General Assembly); *Gordon v. Phillips Utils., Inc.*, 362 S.C. 403, 608 S.E.2d 425 (2005) (it is presumed that the General Assembly intended to accomplish something by its choice of words and would not do a futile thing); *Denene, Inc. v. City of Charleston*, 352 S.C. 208, 574 S.E.2d 196 (2002) (this Court must presume the General Assembly did not intend a futile act, but rather intended its statutes to accomplish something); *Hinton v. S.C. Dep't of Probation, Parole and Pardon Servs.*, 357 S.C. 327, 592 S.E.2d 335 (Ct.App.2004) (the Court should seek a construction that gives effect to every word of a statute rather than adopting an interpretation that renders a portion meaningless).

Florence Cnty. Democratic Party v. Florence Cnty. Republican Party, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012).

24. The Court generally defers to an administrative agency's interpretation of an applicable statute or its own regulation but will reject the agency's interpretation if it is arbitrary, capricious, or manifestly contrary to the statute, regulation, or law. *See Sierra Club v. S.C. Dept. of Health & Envtl. Control*, 426 S.C. 236, 256, 826 S.E.2d 595, 606 (2019).

25. As required by Section 44-7-180(B)(4), the criteria set forth in the Plan have been determined to be the most important, and a CON may not be issued absent compliance with the Plan. The Department does not have discretion to choose whether to include the most important criteria listed in the Plan when considering an application for a FED, although it may add additional criteria listed in Section 802 and reorder those. *See* S.C. Code Ann. § 44-7-210(B) (2018) ("The Department may not issue a Certificate of Need unless an application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations."). *See also*, S.C. Code Regs. § 802.1 (Supp. 2019) ("The proposal shall not be approved unless it is compliance with the South Carolina Health Plan."). To hold otherwise, would render the criteria set forth in the applicable Plan meaningless, and render its enactment futile.

26. I find that the Department erred in failing to include "Resource Availability" in the Department's deemed complete letter as one of the most important review criteria as mandated by the 2015 Plan. Likewise, the Department should have evaluated the proposed project's impact on staffing resources and included it in its letter approving the project. Nevertheless, upon consideration of all the testimony presented at the hearing on the issue, Roper St. Francis and Trident have not demonstrated that MUHA's project will have any significant effect on existing providers' staff or staffing costs.

27. The Department also does not have discretion to choose whether to include compliance with the Plan as a project review criterion. (Tr. 1334:20-22).

F. MUHA's Proposed FED Does Not Comply with the CON Act, the 2015 or 2016-2017 Plans, or the Project Review Criteria Chosen by the Department

1. MUHA's Proposed FED does Not Comply with Standard 6 of the 2015 Plan

28. Roper St. Francis and Trident demonstrated by a preponderance of the evidence and I conclude as a matter of law that MUHA's FED does not comply with Standard 6 of the 2015 Plan.

29. Roper St. Francis and Trident demonstrated that MUHA failed to sufficiently establish the origin of its potential patients for its proposed FED. MUHA has shown that an unknown number of patients⁵⁴ travel past other existing providers of emergency services to receive care at MUSC's emergency department at its hospital in Charleston, but MUHA could not adequately describe why this was occurring. Without basis, insight, or information to support its assumption, MUHA posits that the majority of those patients will self-redirect to its freestanding emergency room if given the opportunity simply because it is more convenient.

30. Additionally, MUHA's shift projections are flawed. MUHA utilized billing codes versus acuity levels and did not take acuity into account in making its projections. Also, MUHA's representation that it assumed no (or even little) market shift and intended only (or even primarily) a shift of its existing patients,⁵⁵ is unrealistic.

31. The Court is unconvinced that patients from the tri-county and beyond, who presently obtain services at MUHA's downtown Level I trauma center, which includes a robust specialty practice, will necessarily seek services at MUHA's FED (and be satisfied with telemedicine). MUHA assumed a percentage would shift but presented no information regarding why the patients from its proposed zip codes will transition to a satellite FED other than it was more convenient.⁵⁶

32. Roper St. Francis and Trident have also proven by a preponderance of the evidence and I conclude as a matter of law that there is sufficient existing capacity in MUHA's proposed service area not only to meet the current need but also for projected population growth without the need for an additional FED. There is no evidence that patients who seek treatment at MUHA's downtown campus but who are originating from locations within the tri-county area, are not able to be adequately served by existing providers. These existing facilities have medical personnel that are competent and qualified and have demonstrated efficient operation.

33. The capacity constraints of MUSC's emergency department is not a factor included in any of the Plans.

⁵⁴ The testimony established that over 20,000 visits were made from the proposed service area to MUSC's emergency department. MUHA was not able to demonstrate whether this was 20,000 individuals, since some individuals may present for more than one visit. Patients and visits were used interchangeably by MUHA's expert. (Tr. 2076:19-25).

⁵⁵ "We are seeking to treat our patients at a location closer to their residence. We're relying on only our patients. We're not assuming a market share shift and therefore it won't have any impact on existing providers." (Tr. 2161:17-22).

⁵⁶ "It is a guess." (Tr. 1181:3).

2. MUHA's Proposed FED Does not Satisfy Relevant Project Review Criteria Under the 2015 or 2016-2017 Plan, or Those Selected by the Department

34. The 2015 Plan lists the following project review criteria as the most important in evaluating CON applications for freestanding emergency department services: (1) Compliance with the Need Outlined in [the freestanding Emergency Services] Section of the Plan; (2) Community Need Documentation; (3) Distribution (Accessibility); (4) Resource Availability;⁵⁷ and (5) Financial Feasibility.

35. The 2016-2017 Plan altered this list slightly, ranking the following criteria as the most important in evaluating an application for a FED: (1) Community Need Documentation; (2) Distribution (Accessibility); (3) Medically Underserved Groups; (4) Record of the Applicant; and, (5) Staff Resources.

- Community Need

36. The proposed FED does not comply with the “Community Need Documentation” criterion. S.C. Code Ann. Regs. 61-15 § 802.2 (Supp. 2019). Through fact and expert testimony, Roper St. Francis and Trident have proven, by a preponderance of the evidence, that there is adequate emergency department capacity in MUHA’s defined service area to meet the needs of the proposed population in that service area. MUHA incorrectly focused on the population it currently serves in the community and suggested that a portion of that population would patronize its new FED in Berkeley County simply because they would choose a shorter travel time. However, MUHA could not reasonably explain why these same patients were not choosing a shorter travel time already, as the targeted patients are currently bypassing existing hospital-based and other FEDs in favor of MUSC’s downtown location. Without an understanding of why its patients are seeking emergency services downtown at MUSC’s tertiary/quaternary level hospital, MUHA cannot reasonably expect those same patients to redirect to another lower acuity emergency facility simply because it is located in closer proximity to where they live. This is especially the case when there are already lower acuity emergency options in the area with far better emergency department service metrics.

37. Even though they were not operational at the time of the contested case hearing, Roper St. Francis Berkeley Hospital which was scheduled to open in October 2019 and Trident

⁵⁷ Curiously, “Resource Availability” was listed in the 2015 State Health Plan but does not appear in the CON Act or in the controlling regulations. See S.C. Code Ann. Regs. 61-15 § 802. The Department considered “resource availability” in the State Plan to refer to “staff resources,” although the Court need not make this determination to reach a decision.

Summerville's FED (which is located less than one mile from MUHA's proposed project) which was scheduled to open within a year of this contested case hearing, will provide even more capacity thereby reducing the need for an additional FED in this location.

- Distribution (Accessibility)

38. The proposed FED does not comply with the "Distribution (Accessibility)" criterion. S.C. Code Ann. Regs. 61-15 § 802.2 (Supp. 2019). "Duplication and modernization of services must be justified," and "[u]nnecessary duplication of services and unnecessary modernization of services will not be approved." S.C. Code Ann. Regs. 61-15 § 802.3(a) (Supp. 2019). No modernization is involved.

39. Increased accessibility and convenience to MUHA's existing patients who reside in the service area and are currently seeking treatment at MUSC in downtown Charleston, are not relevant to the Court's inquiry. These factors do not appear in the CON Act, the regulations, or Plans.

40. Roper St. Francis and Trident have proven by a preponderance of the evidence that MUHA's proposed FED would result in unnecessary duplication because residents in MUHA's defined service area, including the medically underserved, currently have easy access to both freestanding and hospital-based emergency room services within a fifteen-minute drive time. MUHA's FED would not increase access or otherwise improve it.

41. Roper St. Francis and Trident have also proven by a preponderance of the evidence that MUHA's FED is an unnecessary duplication of services given that there are no capacity constraints in the proposed service area for emergency department services now or in the near future. While the decision in this matter does not rest upon the following, the Court notes that additional facilities are scheduled to open in October 2019 (Roper St. Francis Berkeley Hospital) and within the year (Trident Summerville FED), the latter of which is less than one mile from MUHA's project.

42. While MUHA has established that it has efficiency challenges in its own emergency department as a result of several factors (e.g., design, boarding as a result of an insufficient number of admission beds) which have led to capacity constraints at its facility on the peninsula, neither the Plan nor regulations consider facility-specific needs in evaluating applications for FEDs.

- Medically Underserved Groups

43. Roper St. Francis and Trident have proven by a preponderance of the evidence that MUHA's proposed project does not comply with project review criterion 802.3 because it is both

unnecessarily duplicative and is admittedly intended to serve patients who are already served by MUSC.

44. I find as a matter of law that the medically underserved, indigent, and others who reside in the proposed service area already have access to the same emergency services through the providers in MUHA's proposed service area. There is no evidence of excessive wait times at existing facilities in the proposed service area and EMTALA ensures public access to emergency services irrespective of the ability to pay. MUHA's proposed FED is not within a MUA. There is nothing about MUHA's FED that will have any material impact, if any, on the medically underserved population.

- Resource Availability/Staff Resources

45. The 2015 Plan used the term, "Resource Availability" but there was no specific project review criteria heading titled, "Resource Availability." Even though, the Department cannot exclude and fail to consider it because the 2015 Plan lists it as among the most important review criteria in evaluating an FED.⁵⁸

46. The 2017-2018 Plan substituted "Resource Availability" for "Staff Resources," and lists "Staff Resources" as among the most important criteria in evaluating an application for a FED. There are project review criteria that are specific to resource availability. See S.C. Code Ann. Regs. 61-15 § 802.20 (Supp. 2019).

47. The Court finds as a matter of law that Section 304 does not give the Department the discretion to exclude (substitute, or reorder) any of the criteria set forth in a Plan, or to change the weight of the project review criteria set forth in the Plan. S.C. Code Ann. Regs. 61-15 § 304 (Supp. 2019).

48. Consistent with the Department's and other testimony, the Court concludes that "Resource Availability" generally refers to staffing plans.

49. While a nursing shortage exists in South Carolina, under either the 2015 Plan or the 2017-2018 Plan, the greater weight of the evidence is that Roper St. Francis and Trident have not demonstrated that MUHA's project will have any significant adverse effect on existing providers' staff or staffing costs; especially considering that Petitioners continue to add emergency department services requiring additional nursing staff.

⁵⁸ Roper St. Francis established by a preponderance of the evidence that historically, the Department has used the following project review criteria to evaluate resource availability: Subsections 20(a), 20(b), 20(c), 21(a), 22, 23(a), 23(b) and 24 of Section 802 of Regulation 61-15. Other criteria are also relevant to "Resource Availability" including 3(h) and 23(b).

- Financial Feasibility

50. The “Financial Feasibility” criterion provides: “The applicant must have projected both the immediate and long-term financial feasibility of the proposal. Such projection should be reasonable and based upon accepted accounting procedures.” S.C. Code Ann. Reg. 61-15 § 802.15 (Supp. 2019). MUHA’s pro forma budget projects both the immediate and long-term financial feasibility of the FED, and even increased feasibility with the changes made to the project. The pro forma’s projections are reasonable and based on accepted accounting procedures, and Roper St. Francis and Trident have failed to establish otherwise by a preponderance of the evidence. For these reasons, MUHA complies with this criterion.

- Record of the Applicant

51. MUHA’s record is one of successful operation and adequate management experience. S.C. Code Ann. Regs. 61-15 § 802.13(a) (Supp. 2019). No evidence was produced to the contrary. While Roper St. Francis and Trident elicited testimony that suggested that MUHA may have difficulty funding the proposed project, the Court concludes as a matter of law that they failed to meet their burden of proof. I conclude as a matter of law that MUHA has a demonstrated ability to obtain necessary capital financing. S.C. Code Ann. Regs. 61-15 § 802.13(b) (Supp. 2019).

3. MUHA’s Proposed FED Does Not Satisfy the Drive Time and Access Standards in the 2017-2018 Plan that Replaced Standard 6 in the 2015 Plan

52. Standard 6 of the 2015 State Health Plan was not included in the 2017-2018 South Carolina Health Plan that became effective three days after MUSC’s CON Application was filed. A new requirement, not numbered but appearing at the end of the list of Standards, was added, providing:

The applicant must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area.

(Roper St. Francis Ex. 56-026).

53. This standard does not address instances where a particular patient chooses to travel more than 15 minutes to see a particular or preferred provider. The purpose of this provision is not to ensure that a **specific** provider will be easily accessible, but rather to ensure that a provider is easily accessible.

54. Roper St. Francis and Trident have demonstrated by a preponderance of the evidence that there are no capacity constraints in existing emergency departments. Their emergency departments that were operational at the time of the hearing have additional capacity to provide emergency services and are not experiencing capacity constraints. While not critical to this determination, additional facilities that were scheduled to come online upon the conclusion of the hearing will provide additional capacity.

55. Additionally, Roper St. Francis and Trident have established by a preponderance of the evidence that patients in MUHA's proposed service area do not experience a "travel time of greater than 15 minutes to an existing emergency department in the service area." Ms. Platt demonstrated that all of the patients proposed to be served by MUHA already reside within fifteen minutes of an existing emergency services provider. (Roper St. Francis Ex. 63-014).

56. The Court did not base its decision upon the following but notes that while the standard speaks in terms of time, there are four existing and one approved FED within twenty miles of MUHA's proposed location. (Roper St. Francis Ex. 63-005).

4. The Balancing Test Under the 2015 and 2017-2018 Plans

57. Both the 2015 and the 2017-2018 Plans require the Department to weigh the benefits of improved accessibility and the adverse effects of duplication. The 2015 Plan which this Court is required to consider, provides that the benefits of improved accessibility "will be equally weighed" with the adverse effects of duplication for the service. The 2017-2018 Plan mandates that "the benefits of improved accessibility will outweigh the adverse effects of duplication" with accessibility having been determined to be the fifteen-minute travel time standard set forth in the Plan.

58. The persons in the proposed service area will not experience improved accessibility as result of the FED. As a result, MUHA has identified certain persons who live in the proposed service area and who have received emergency services at its main campus in the past. There is no evidence that those individuals lack access to emergency medical services, or that they lack access to emergency medical services within a fifteen-minute travel time.

59. The persons projected to shift from MUSC's downtown campus emergency department to MUHA's proposed FED in Berkeley County already have robust emergency service options within a fifteen-minute travel time window.

60. It is uncontroverted that MUHA has efficiency challenges in its own emergency departments at MUSC. However, neither the regulations nor the Plans consider facility-specific needs when evaluating applications to add freestanding FED services.

61. The Court has already concluded that the proposed project would not adversely affect other facilities as to staffing. *See* S.C. Code Ann. Regs. 61-15 § 802.23 (Supp. 2019). No evidence was presented that the FED would adversely affect the occupancy or use rates of the existing facilities in the proposed service area. *Id.*

62. As the proposed project would not result in increased accessibility and there are no adverse effects in terms of staffing, the Court cannot engage in a meaningful balancing test as specifically set forth in the 2015 and 2017-2018 Plans. “Adverse Effects” is not defined in the CON Act. *See* S.C. Code Ann. § 44-7-130 (2018 and 2019 Supp.)

63. If one expanded the meaning of “adverse effects” beyond the parameters of Section 802.23 of Regulation 61-15 to an ordinary and every day meaning, wasted health care dollars that would be expended if an unnecessary duplicative facility was approved would qualify as an adverse effect. Accordingly, the adverse effects of an unnecessary duplication resulting in wasted health care dollars would handily outweigh improved accessibility as there is none.

64. Irrespective of the balancing test, the project fails to comply with other significant project criteria contained in the Plans, the regulations, and the CON Act, and therefore the CON application must be denied.

5. MUHA’s Proposed FED Does Not Comply with the CON Act

65. The purpose of the CON Act 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.” S.C. Code Ann. § 44-7-120 (2018).

66. Even though a project does not have to satisfy every criterion to be approved, no project may be approved unless it is consistent with the State Health Plan. S.C. Code Ann. Regs. § 801.3 (Supp. 2019).

67. MUHA’s FED violates the purposes of the CON Act. It is unnecessarily duplicative of facilities and services that exist in the proposed service area for which additional capacity exists. The proposed project does not promote cost containment and will not best serve the public need.

G. MUHA'S Communication with the Department⁵⁹

68. At trial, Roper St. Francis' counsel argued that the mid-trial meeting between the Department and MUHA influenced Ms. Murdock's testimony in a way that "cannot be undone." (Tr. 1588:25-1591:15). The South Carolina Administrative Procedures Act prohibits "members or employees of an agency **assigned to render a decision or to make findings of fact and conclusions of law in a contested case**" from communicating "directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate." S.C. Code Ann. § 1-23-360 (2005) (emphasis added).

69. While Section 1-23-360 does not appear to specifically prohibit the communications between the Department and MUHA, the Court is troubled by the surreptitious oral⁶⁰ joint defense agreement into which the Department and MUHA entered at the conclusion of the first week of trial for the purposes of securing Ms. Murdock's thoughts on testimony rendered by witnesses who previously testified and to prepare her for her hearing testimony. It violates the spirit of Section 1-23-360 and smacks of unfairness.

70. The Court considered the credibility of and assigned such weight to Ms. Murdock's testimony in light of the circumstances that preceded her testimony. Thus, there has been no resulting prejudice.

H. The Parties' Discovery Motions

71. Throughout the pendency of this matter, the parties engaged in a very active motion practice including Roper St. Francis' filing of discovery motions against MUHA alleging various

⁵⁹ The Court need not decide the issue as pertains to the joint defense agreement as the Department agreed to waive whatever privilege existed. The Court finds, however, that the Department and MUHA do not share a "common and singular public-private interest"⁵⁹ in this matter and is unpersuaded by their arguments to the contrary including that there is public interest in the CON being approved.⁵⁹ See *Hunton & Williams v. U.S. Dept. of Justice*, 590 F.3d 272, 281 (4th Cir. 2010). As noted by Roper St. Francis, all parties to this case have a shared interest in insuring that the purposes of the CON Act are accomplished. (Tr. 1556:2-4). While both have an interest in the approval of the CON application, their underlying interests and motivations are not the same. *Hunton v. Williams*, 590 F.3d at 281. (In evaluating agency participation in a common defense agreement, the court inquired into "whether a singular public-private interest is present).

⁶⁰ The Court is aware that joint defense agreements need not be in writing to be enforced although a written agreement is the most effective method of establishing the existence of one. See, e.g., *United States v. Gonzales*, 669 F.3d 974, 979 (9th Cir. 2012) ("[I]t is clear that no written agreement is required, and that a JDA may be implied from conduct and situation, such as attorneys exchanging confidential communications from clients who are or potentially may be codefendants or have common interests in litigation."); *Minebea Co., Ltd. v. Papst*, 228 F.R.D. 13, 16 (D.D.C. 2005) ("Obviously, a written agreement is the most effective method of establishing the existence of a joint defense agreement, although an oral agreement whose existence, terms and scope are proved by the party asserting it, may be enforceable as well.").

discovery abuses including that MUHA withheld and failed to timely produce relevant information pertaining to changes to the proposed FED. Other motions (for summary judgment, to compel, to quash, and for a protective order) were filed prior to the contested case hearing and ruled upon. The outstanding motion pertains to a discovery motion filed on July 16, 2019; Roper St. Francis filed it against MUHA alleging in part that MUHA violated this Court's order of April 11, 2019.

72. On January 28, 2019, Roper St. Francis filed a discovery motion stating that MUHA's discovery answers and responses were materially deficient. Roper St. Francis stated that MUHA untimely supplemented its discovery and "withheld and failed to produce highly relevant and probative information regarding the Project for an unreasonable period of time" thereby prejudicing Roper St. Francis. Roper St. Francis stated that the documents withheld and/or produced late related to MUHA's plans for changes to the project. Roper St. Francis requested that the Court order MUHA to fully and immediately supplement its discovery. On February 7, 2019, Trident filed its "Response in Support and Consent to CareAlliance's Motion for Discovery Order." On February 19, 2018, MUHA submitted a memorandum opposing the motion.

73. After a hearing on Roper St. Francis' discovery motion, the Court issued an order on April 11, 2019 requiring all parties to immediately supplement their discovery answers and responses and continue to timely do so. The Court declined to assess costs or issue sanctions against MUHA⁶¹ but reserved the right to revisit matters raised in Roper St. Francis' motion should any discovery violation be committed by MUHA or any other party during the remainder of the case.

74. On July 16, 2019 and days before the commencement of the contested hearing on July 22, 2019, Roper St. Francis filed another discovery motion against MUHA alleging that MUHA violated the Court's order of April 11, 2019. In particular, it was alleged that MUHA: (1) failed to fully and timely supplement its answers and responses primarily pertaining to project changes; and (2) deliberately withheld responsive, discoverable information as evidenced by documents subpoenaed from third parties including Intuitive Health, LLC,⁶² Health Facilities

⁶¹ In its order, the Court noted the delay in the parties' commencement and participation of discovery. While Roper St. Francis and Trident filed a request for a contested case hearing in December 2017, the party seeking relief served no written discovery in this case until August 30, 2018. As of February 27, 2019, no party had taken any depositions which resulted in a postponement of the contested case hearing.

⁶² On January 7, 2019, Roper St. Francis issued a subpoena to third party Equity, LLC, with a compliance date of January 25, 2019. When the documents were not forthcoming, Roper St. Francis filed a motion on June 17, 2019 (almost five months after the compliance date and approximately four weeks before the commencement of the hearing) to enforce the subpoena. On June 27, 2019, MUHA filed a motion to quash the subpoena. On July 5, Roper St.

Planning Partners, LLC, and Equity, LLC. Roper St. Francis requested an order sanctioning MUHA to include the entry of an adverse disposition against MUHA. Roper St. Francis requested that it be awarded costs and fees associated with the filing of this motion and its motion of April 11, 2019. Alternatively, Roper St. Francis requested a continuance of the contested case hearing. Trident orally joined in Roper St. Francis' motion. (Tr. 12:23). On July 19, 2019, MUHA filed its response to Roper St. Francis' discovery motion asking that the motion be denied.

75. On July 22, 2019, the first day of the contested case hearing, the Court heard from both parties on Roper St. Francis' motion. (Tr. 7:5-49:4). The Court stated that the motion would be considered as she heard testimony, and that she would render a determination later. (Tr. 49:5-13).

76. On October 24, 2019, MUHA filed a supplemental memorandum in response to Roper St. Francis' motion for discovery. On November 1, 2019, Roper St. Francis filed a reply to MUHA's supplemental memorandum reiterating MUHA's alleged discovery abuses including the failure to comply with discovery rules, the failure to produce requested data, and misplaced reliance upon the "anticipation of litigation" as exception to document production.

77. After having carefully reviewed and considered all materials pertaining to Roper St. Francis' discovery motion of July 16, 2019 (including materials received from MUHA), and after listening to all of the testimony in the contested case, the Court denies Roper St. Francis' motion.


Francis filed a response to MUHA's motion stating MUHA had no standing to object to Roper St. Francis' subpoena to Equity, LLC, and that its motion was untimely. On July 8, 2019, the Court issued an order finding that MUHA had no standing to object to Equity LLC's production and ordered that the documents be produced by July 16, 2019.

ORDER

After careful review of the evidence presented in this matter and based upon the findings of fact and conclusions of law stated above, **IT IS HEREBY ORDERED** that the South Carolina Department of Health and Environmental Control's decision is **REVERSED** and the Medical University Hospital Authority, d/b/a MUSC Health Services' application to establish a freestanding emergency department in Berkeley County is **DENIED**.

IT IS FURTHER ORDERED that the discovery motion filed by CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital is **DENIED**.

AND IT IS SO ORDERED.



SHIRLEY C. ROBINSON
Administrative Law Judge

May 28, 2020
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Ti'a Smith, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof in the United States mail, postage paid, or by electronic mail, to the address provided by the party(ies) and/or their attorney(s).



Ti'a Smith
Judicial Law Clerk

May 28, 2020
Columbia, South Carolina

RECEIVED
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SC Court of Appeals