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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Ralph King Anderson II, Administrative Law Court Judge

APPELLATE CASE NO.: 2020-001610
ADMINISTRATIVE LAW COURT CASE NO.: 20-ALJ-07-0108-CC

Lexington County Health Services District, Inc.,
d/b/a Lexington Medical Center, ... Petitioner/Respondent,

v.

South Carolina Department of Health and Environmental Control, Prisma Health-Midlands,
Providence Hospital, LLC d/b/a Providence Health, Providence Health Northeast,
Providence Health Fairfield, and Kershaw Hospital, LLC
d/b/a Kershaw Health Medical Center, ... Respondents,

OF WHICH

Prisma Health-Midlands and Providence Hospital, LLC d/b/a Providence Health, Providence
Health Northeast, Providence Health Fairfield, and Kershaw Hospital, LLC
d/b/a Kershaw Health Medical Center the Appellant are the Appellants/Respondents.

**PETITIONER/RESPONDENT'S RETURN TO MOTIONS TO CERTIFY CASE FOR
REVIEW BY THE SUPREME COURT AND TO EXPEDITE THE PROCEEDING**

Pursuant to Rule 240(e), SCACR, Petitioner/Respondent, Lexington County Health Services District, Inc., d/b/a Lexington Medical Center (LMC), submits this return to Respondent/Appellant Prisma Health – Midland's (PHM) Motions to Certify Case for Review by the Supreme Court and to Expedite the Proceeding filed in the Court of Appeals on December 28, 2020, and forwarded to the Supreme Court on Monday, January 4, 2021. While LMC agrees that matters involving Certificates of Public Advantage ("COPA") and acquisitions among competing health systems are important, the issues in this appeal are not of such significant public or legal

interest as to justify removing this case from the jurisdiction of the Court of Appeals prior to a decision or severely curtailing the time period in which the parties are permitted to brief and argue the facts and applicable law. As such, LMC respectfully requests that the Court deny PHM's Motions.

PROCEDURAL BACKGROUND

PHM and Respondents/Appellants Providence Hospital, LLC d/b/a Providence Health, Providence Health Northeast, Providence Health Fairfield (Providence Health), and Kershaw Hospital, LLC d/b/a Kershaw Health Medical Center (Kershaw Health) have each appealed¹ a decision of the Administrative Law Court (ALC) in a contested case proceeding that arose from the Respondent South Carolina Department of Health and Environmental Control's (DHEC or the Department) decision dated February 28, 2020, that amended the ongoing conditions of an existing COPA² issued to Baptist Healthcare System of South Carolina, Inc. (BHS), and Richland Memorial Hospital (RMH), on October 6, 1997 ("COPA-97-01"). DHEC's decision, which is attached as Exhibit 3 to PHM's Memorandum, purports to allow for PHM's proposed acquisition of acute care facilities owned and operated by LifePoint Health (LPNT), a health provider operating in the same market area as PHM, to be included under the COPA issued in 1997 to BHS and RMH. DHEC's decision identifies the assets PHM proposes to purchase from LPNT as the Providence Health acute care hospitals (Providence Health (HTL-0928), Providence Health –

¹ PHM's Memorandum refers to the Providence Health and Kershaw Health entities collectively as "LPNT." Providence Health and Kershaw Health's Notice of Appeal was consolidated with PHM's appeal by the Court of Appeals, although LMC has not been served with any notice that the LPNT Appellants have joined or consented to PHM's request to certify and expedite.

² The Health Care Cooperation Act defines a certificate of public advantage to mean "the formal approval, including any conditions or modifications, by the department of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health provider networks, or health care purchasers that might be construed to be violations of state or federal antitrust laws." S.C. Code Ann. § 44-7-510(2).

Northeast (HTL-0929), and a freestanding emergency department in Fairfield County operating under HTL-0929), as well as the Kershaw Health acute care hospital (HTL-0101). (PHM Mem., Exhibit 3 at 1 & n.1).

LMC sought a Final Review Conference by the DHEC Board of the DHEC staff decision, which was denied, and LMC thereafter commenced a contested case proceeding in the ALC by Petition for Administrative Review and Request for Contested Case Hearing filed May 14, 2020. (LMC Pet. Admin. Review, attached as **Exhibit A**). The City of Columbia, Kershaw County, and Fairfield County and Fairfield Memorial Hospital also sought administrative review of the DHEC staff decision by the DHEC Board and contested case review in the ALC³; however, those petitioners each dismissed their contested case prior to the merits hearing for unknown and undisclosed reasons. LMC, PHM and DHEC engaged in written discovery in the contested case proceeding and the ALC heard several motions prior to ruling on the cross-motions for summary judgment, including a Motion to Expedite filed by PHM and a Motion to Intervene filed by the LPNT entities. The ALC denied PHM's Motion to Expedite by Order dated July 14, 2020 (Order Denying Mot. Expedite, attached as **Exhibit B**) and granted the Motion to Intervene by Order dated September 4, 2020 (Intervention Order, attached as **Exhibit C**). PHM and the LPNT entities filed their appeals following the ALC's Order Denying Cross-Motions for Summary Judgment (Summ. J. Order, Exhibit 1 to PHM's Mem.) and the subsequent Order clarifying the finality of that decision (Clarification Order, Exhibit 2 to PHM's Mem.).

³ The Procedural Background provided in PHM's Motions omits the existence of these three public bodies that also appealed the February 28, 2020 decision.

STANDARD OF REVIEW

PHM moves “[p]ursuant to S.C. Code Ann. § 14-8-210(b) (Supp. 2020) and Rules 204(b) and 244, SCACR,” for certification of its appeal to the Supreme Court of South Carolina “for direct review and an expedited hearing.” (PHM Mem., 1⁴). South Carolina Code Section 14-8-210(b) is nearly identical to the language of Rule 204(b), SCACR, providing for the manner in which cases may be certified for review by the Supreme Court prior to a decision of the Court of Appeals, which both clearly explain, “[c]ertification is normally appropriate where the case involves an issue of significant public interest or a legal principle of major importance.” Rule 204(b), SCACR. PHM does not offer any procedural rule or other authority to support the request for expedited hearing. (PHM Mem. at 1, 18). As noted earlier, LMC has not been served with any notice that the LPNT Appellants have joined or otherwise consent to PHM’s request to certify and expedite these consolidated appeals.

REGULATORY AND FACTUAL BACKGROUND

This matter arises under the regulatory scheme by which COPAs are issued by the State of South Carolina. In enacting the Health Care Cooperation Act, codified at S.C. Code Ann. § 44-7-500, *et seq.*, the General Assembly expressly found “that competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects

⁴ Rule 244, SCACR, provides for the Supreme Court’s discretion to “answer questions of law certified to it by any federal court of the United States or the highest appellate court or an intermediate appellate court of any other state” Rule 244(a), SCACR. There is no provision in the Rule that empowers PHM as an aggrieved party seeking appellate review from an administrative tribunal to certify questions of law to the Supreme Court, and thus PHM is not entitled to any relief under that Rule. *See* Rule 244(b), SCACR.

on competition.” S.C. Code Ann. § 44-7-505(4). The General Assembly also clearly stated the intent of the HCCA is to afford certain immunities to health care providers who “negotiate, enter into, and conduct business pursuant to a cooperative agreement” S.C. Code Ann. § 44-7-520(A). The HCCA does not, however, “create[] immunity for a person for conduct in negotiating or entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.” *Id.* § 520(B).

As part of the statutory framework for approval of cooperative agreements and issuance of COPAs, the HCCA provides that “[p]arties to a cooperative agreement may apply to the department for a certificate of public advantage,” which applications shall be reviewed by DHEC with advisement by the Attorney General. S.C. Code Ann. §§ 44-7-530 & 550(A). DHEC is required by the Act to promulgate regulations “to implement the provisions of [the HCCA] including any fees and application costs associated with the monitoring and oversight of cooperative agreements approved under this article.” *Id.* § 570(D). COPA-97-01 was issued by DHEC following its review of an application submitted by BHS and RMH seeking approval to develop “a locally controlled nonprofit health care system with continuing supervisory responsibility over the jointly operated hospitals by the Sponsoring Boards [of BHS and RMH].” (LMC Prehr’g Stmt.⁵ at Exhibit A (LMC DHEC FOI 0809), attached as **Exhibit D**). In late 2003, DHEC updated the conditions of COPA-97-01 because “[m]any of the conditions set forth in the COPA were targeted for the first five (5) years of operations and have either been satisfied or are no longer applicable.” (DHEC Ltr. to Palmetto Health Alliance at 1, Exhibit 7 to PHM Mem.). Notably, Condition No. 12 of the updated conditions to COPA-97-01 provides,

⁵ PHM’s Memorandum included LMC’s Prehearing Statement as Exhibit 11 but failed to include the exhibits. The complete Prehearing Statement as filed in the ALC is at **Exhibit D**.

That the System will adhere to the commitments it has outlined in its ‘Summary of System Commitments and Proposed DHEC Monitoring’ in its application and all other representations made in the [COPA] application and all of its subsequent submissions, to the extent they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.

Id. at 4.

In late 2017, Palmetto Health notified DHEC of its intent to enter an affiliation agreement with Greenville Health System, the result of which created a new company that was added as a member of Palmetto Health “with certain rights and powers reserved to it.” (L. Crum Ltr. to DHEC at 2, Exhibit 8 to PHM Mem.). Prisma Health is the company formed by the merger of Palmetto Health and Greenville Health System, and is that company “with certain rights and powers reserved to it” over PHM (formerly Palmetto Health). (*See id.*; *see also* PHM Mem., 8). In the COPA application submitted by BHS and RMH in 1996, the assurances made by those Sponsoring Organizations included that “[t]he System will remain non-profit” and “[i]ts control will remain with local Boards,” as well as that “[c]ompetition from Lexington and Columbia/HCA hospitals, as well as from other hospitals in the System’s core service area, will help to ensure that the hospitals continue to be efficient, low-cost, high quality hospitals.” (BHS/RMH COPA App., LMC Prehr’g Stmt. at Exhibit A (LMC DHEC FOI 0809), **Ex. D**).

DHEC’s decision of February 28, 2020, purporting to amend the conditions of COPA-97-01, is directed to Mark S. O’Halla, President and Chief Executive Officer of Prisma Health, whose business address is in Greenville, South Carolina.⁶ (DHEC Ltr. to Prisma Health at 1, Exhibit 3 to PHM Mem.). The ALC’s Summary Judgment Order correctly finds, “the COPA sanctioned the cooperative agreement between Richland Memorial Hospital and Baptist Hospital to merge their

⁶ Indeed, the communications to DHEC in December 2019 describing the proposed transaction and requesting amendments to COPA-97-01 are from Prisma Health, not PHM. PHM included the first two pages of the December 13, 2019 communication as Exhibit 10 to its Memorandum, the entire letter is found as an attachment to Exhibit C of LMC’s Petition for Administrative Review.

assets and operate jointly as a single entity.” (Summ. J. Order, 10). In rejecting PHM’s request to amend COPA-97-01 to include the proposed purchase of the LPNT facilities, the ALC found “PHM is acquiring the assets of a competitor who is being removed from the market but with whom no cooperative agreement was negotiated or established.” (Summ. J. Order, 11).

In support of certification, PHM claims the application of the HCCA and Regulation 61-31 to a healthcare entity such as PHM “is of significant public importance and to the timely, cost effective and efficient delivery of health care services in the Midlands Area of South Carolina.” (PHM Mem., 2). To be clear, while true that DHEC has never before purported to amend the ongoing conditions of an existing COPA so as to allow for the subsequent acquisition of a competitor’s healthcare facilities after a private internal review, what is at issue in this appeal is simply PHM’s desire to purchase existing hospital assets (the Providence and Kershaw facilities), which are currently owned by its market competitor, LPNT. (PHM Mem., 2). While PHM’s Memorandum would revise the history of COPA-97-01 and includes inaccurate and supported allegations as fact (PHM Mem., 6-9), a factually accurate description of COPA-97-01’s history⁷ is found in the ALC’s Summary Judgment Order at pages 1 through 3, including that “[p]ursuant to the cooperative agreement for which the COPA was sought, Baptist Hospital and Richland Memorial Hospital would enter into a joint operating agreement to create a locally controlled non-profit health care system.” (Summ. J. Order, 3). COPA-97-01 was delivered to BHS and RMH on October 6, 1997, authorizing the incorporation of “BR Health System, Inc.” (PHM Mem. at Exhibit 6). The certificate itself clearly states that DHEC determined the applicants demonstrated the likely

⁷ LMC’s Response in Opposition to Summary Judgment and Cross-Motion for Summary Judgment details the public review by DHEC and the Attorney General of BHS and RMH’s COPA Application in 1996 and 1997, and attaches excerpts of the Department’s record obtained through the Freedom of Information Act. (See LMC Cross-Mot. Summ. J., 5-7 & Exhibit A at **Ex. E**).

benefits outweighed the likely disadvantages of the arrangement, and the reduction in competition likely to result was reasonably necessary to obtain the likely benefits - findings required by Section 44-7-560 of the Act. *See id.*

PHM's "Factual Background" does not disclose that, quite unlike the public review process that occurred prior to the issuance of COPA-97-01, the review undertaken by DHEC in response to PHM's request to add new assets to COPA-97-01⁸ was a private internal review without any public notice or opportunity for participation by affected persons. (DHEC Resp. Req. Admis. No. 4, Exhibit D to LMC Cross-Mot. Summ. J. **Ex. E**; Order Denying Mot. Expedite at 2 & n.3, **Ex. B**). Moreover, the DHEC decision did not "determine[] that despite the addition of the LPNT assets, the benefits of the COPA would continue to outweigh any potential competitive disadvantages due to the loss of competition" as claimed by PHM. (PHM Mem., 9). To the contrary, DHEC's Responses to LMC's Requests for Admission admit that "DHEC did not make a determination in its staff decision dated February 28, 2020, that the likely benefits resulting from the transaction proposed by Prisma Health – Midlands outweighed the likely disadvantages." (DHEC Resp. Req. Admis. No. 2, Exhibit D to LMC Cross-Mot. Summ. J., **Ex. E**). DHEC further admits that "DHEC did not make a determination in its staff decision dated February 28, 2020, that the reduction in competition likely to result from the transaction proposed by Prisma Health – Midlands is necessary to obtain the benefits likely to result." *Id.* at No. 3. While clearly PHM desires to obtain the benefits of a COPA for the proposed acquisition of its competitor's assets, PHM and LPNT did not avail themselves of the process set forth in the HCCA to obtain a COPA and the ALC properly denied PHM's attempted end-run around the statutory and regulatory

⁸ Neither PHM nor LPNT submitted an application for a COPA. (DHEC Resp. to Req. Adm. No. 4, Exhibit D to LMC Cross-Mot. Summ. J., **Ex. E**).

requirements that are required for such significant protections. “Indeed, to find otherwise, would allow PHM to claim its acquisition of practically any assets fits within the spirit of the COPA between Richland Memorial Hospital and Baptist Hospital.” (Summ. J. Order, 12).

GROUND FOR CERTIFICATION

***Sua Sponte* Rulings by the ALC**

PHM’s first reason for certification claims that certain *sua sponte* rulings by the ALC amount to “a question of first impression and is of significant public importance and involves a legal principle of major importance.” (PHM Mem., 10). This is simply not so. As addressed in the ALC’s Clarification Order responding to PHM’s reconsideration request, the issues PHM claims were *sua sponte* were instead “necessary and vital considerations to the Court’s analysis of the issues raised by the parties in their summary judgment motions.” (Clarification Order, 3). The ALC further explained, “a court is not required to choose one of the legal interpretations advocated by the parties in resolving a legal issue.” *Id.* at 4. Regardless of PHM’s continued pursuit of these allegations of error on appeal⁹, there is nothing unique or unusual about a disgruntled appellant asserting that issues ruled on below were “without notice” to the parties so as to support certification under Rule 204(b), SCACR.

LMC’s Vagueness Challenge to Regulation 61-31 § 508

PHM is correct that LMC challenged the validity of Section 508 in Regulation 61-31, but given that the ALC did not reach and therefore did not rule on the claim, it is unclear why PHM suggests certification is warranted. (Summ. J. Order, 12). While PHM’s Memorandum continues

⁹ To the extent the Court considers any of the six “issues” enumerated in PHM’s Motion in more detail, LMC’s Response to PHM’s Motion to Clarify and Reconsider addresses each of PHM’s claims at pages 5 through 7. (LMC Resp. Mot. Clarify & Mots. Recon., **Exhibit F**).

to misstate the nature of LMC's "as-applied" challenge to Section 508¹⁰ and ignores the ALC's express authority to decide such claims¹¹, the *absence* of a ruling necessarily means that any important legal principle is undisturbed and certification is thus unnecessary. "It is this Court's firm policy to decline to rule on constitutional issues unless such a ruling is required." *Riverwoods, LLC v. Cty. of Charleston*, 349 S.C. 378, 387, 563 S.E.2d 651, 656 (2002). LMC submits the Court should find agreement with the ALC and similarly "decline to engage in an analysis of § 508 that would merely be an exercise in dicta." (Clarification Order, 6).

Acquisition and Operation of New Assets Under an Existing COPA

Finally, PHM asserts that its desire to purchase the LPNT assets with the "antitrust immunity" provided for BHS and RMH to jointly operate as BR Health System in 1997 "is of significant public interest as it raises a novel question of law." (PHM Mem., 17). PHM brazenly asserts "not only is the PHM acquisition and operation of the LPNT Assets important for the overall health of the Midlands Area long term, it is of grave public importance for health care services especially during the COVID-19 pandemic to have the ability to manage depleted and exhausted health care resources and personnel and provide patients access to care." (PHM Mem., 18). PHM's bold claims of public benefit and patient access are facially inconsistent with its plans for the Providence and Kershaw facilities once acquired. As told to DHEC, PHM plans to pillage the more lucrative services lines from Providence Hospital to benefit its existing operations¹² before ceasing operation of the acute care facility, and only committed to maintaining seven

¹⁰ See LMC Cross Mot. Summ. J. at 28-29, **Ex. E**; see also Summ. J. Order, 6.

¹¹ *Travelscape, LLC v. S.C. Dept. of Revenue*, 391 S.C. 89, 108-09, 705 S.E.2d 28, 38-39 (2011).

¹² For example, according to page 6 of Prisma's December 13, 2019 letter to DHEC, PHM intends to transfer from Providence Hospital to Prisma Richland Hospital one of four open heart surgery suites and two of seven cardiac catheterization laboratories before closing the remaining open heart and cardiac catheterization rooms. Prisma's letter is *Exhibit 5* to the DHEC Staff Response to Requests for Final Review. (Exhibit C to LMC Pet. Admin. Rev., **Ex. A**).

emergency departments for a period of five years after closing. (Prisma Ltr. to DHEC, Exhibit C to LMC Pet. Admin. Review at pp. 6 & 9, **Ex. A**). Given that PHM currently owns four EDs in the greater Midlands Area and proposes to purchase the four owned by LPNT for a total of eight EDs, PHM can immediately close one of the EDs (presumably Providence Hospital) and after five years can abandon two more (which for Fairfield County and Kershaw County, the LPNT facilities are the only hospital providers of emergency services in the entire county).¹³

PHM's motivation for acquiring a competitor's assets is its own self-interests, and suggesting that the havoc wreaked by the COVID-19 pandemic on all hospital providers supports a public significance to the proposed transaction is hypocritical. As correctly noted by the ALC in response to a similar argument below, "COVID-19 is affecting all hospitals across the State" and the issues faced by PHM "and those of patients are not unique to it and are common to all hospitals at this troubled time." (Order Denying Mot. Expedite at 5, **Ex. B**). And given PHM's plans and limited commitments to continue operating the facilities, access to these long-standing critical health services as exists today under LPNT's ownership appears to be in jeopardy and would seem to be contrary to the public's best interest.

GROUND FOR EXPEDITED TREATMENT

Approaching Closing Date Set by PHM and LPNT

Inexplicably, PHM waited three weeks after serving its Notice of Appeal to file these motions, a significant amount of time given the rapidly approaching deadline by which PHM demands a decision. In the Motion to Expedite, PHM asks for "expedited treatment" of its appeal, but does not propose or request a schedule by which the issues could be fully briefed, and the

¹³ It is also unclear how the Fairfield County freestanding ED would continue to operate once PHM stopped operating Providence Hospital as an acute care facility, as the freestanding ED operates under Providence Hospital's license as an outpatient department of that hospital.

record on appeal prepared and disseminated, in time for meaningful review and decision by an appellate court before the March 2, 2021 date agreed to by PHM and LPNT. (PHM Mem., 18). Rather, PHM restates arguments previously made to the ALC for expedited treatment; although again inexplicably, PHM does not address the questions raised by the ALC as to why the deadlines agreed to in the purchase documents cannot be adjusted or why the transaction cannot be consummated without the COPA:

At the outset, PHM failed to demonstrate that the contractual deadline it willingly agreed to merits a determination of good cause to expedite this case. In other words, PHM argues good cause exists to expedite this case based upon its own actions that created the need to expedite this case. Although even under these circumstances there could conceivably be a need to expedite this case, PHM does not explain why it was necessary to enter into a contract with this specific closing date or why the contract and/or closing date cannot be amended to accommodate this litigation. In fact, as PHM itself admits, a COPA is not necessary for it to purchase the Assets. If a COPA is not necessary, then PHM has no need to expedite this case to complete the sale. Rather, it is PHM's decision to voluntarily pursue a COPA that put itself in this position.

(Order Denying Mot. Expedite at 3-4¹⁴, **Ex. B**). There is no justification for a severely truncated appellate review process, and PHM's conduct in pursuit of this appeal does not demonstrate that time is of the essence. *See* Rules 208(a)(1) & 209(a), SCACR. PHM not only waited three weeks after serving its Notice of Appeal to file these motions, but apparently is also using all of the time allotted for preparing its initial brief and designation of matter, yet seemingly suggests that the other parties should be faced with reduced time for briefing or preemptive denial of extensions in order to meet the March 2, 2021 deadline. Neither the courts nor LMC had any part in negotiating the payment terms or performance deadlines in the transaction sought by PHM. The consequences of PHM and LPNT's strategic business decisions do not justify expediting a hearing in this appeal.

¹⁴ The ALC's Order then quotes Regulation 61-31 § 103, which provides for the voluntary nature of the COPA program, meaning that PHM certainly has the option to proceed with the transaction without an amendment to COPA-97-01. *See* Order Denying Mot. Expedite, n.5, **Ex. B**; *see also* S.C. Code Ann. Regs. 61-31 § 103.

The Court should refuse to expedite this appeal where the request is “based upon [PHM’s] own actions that created the need to expedite this case.” (Order Denying Mot. Expedite at 4, **Ex. B**).

COVID-19 Pandemic

As discussed above, PHM attempts to capitalize on the public fears associated with COVID-19, while ignoring that its plans for the LPNT assets will further strain “the Midlands hospitals and patients[’] ability to access treatment.” PHM’s discussion of COVID-19 as support for expedited treatment is not and cannot be supported by evidence in the record, and presumably because of which PHM attaches two new affidavits and includes new documents¹⁵ that were not part of the record before the administrative tribunal. Setting aside that the circumstances of COVID-19 and health provider’s responses and financial assistance policies are irrelevant to the issues on appeal, PHM has not sought permission nor consent to supplement the record, and therefore the Court should disregard these factual allegations and PHM’s Exhibits 9 and 13, the former of which attaches a recently adopted financial policy for “Prisma Health” not part of the record below. *See* Rules 212 & 210(h), SCACR; *see also Doe 2 v. Citadel*, 421 S.C. 140, n.5, 805 S.E.2d 578, n.5 (Ct. App. 2017) (noting facts alleged by appellant as support for appeal do not appear in the record and therefore are not considered); *Spreeuw v. Barker*, 385 S.C. 45, 68, 682 S.E.2d 843, 854 (Ct. App. 2009) (explaining that evidence not appearing in the record cannot be considered on appeal, citing Rule 210(h), SCACR)).

Because it would appear that PHM has every ability to proceed with a transaction to acquire LPNT’s assets in a manner compliant with the laws applicable to such transactions, including federal and state antitrust laws (*see* Order Denying Mot. Expedite at 4 & n.5, **Ex. B**), there is no

¹⁵ The Affidavits are both dated after the Notice of Appeal was filed, which is clear evidence they were not a part of the record below. *See* PHM Mem., Exhibits 9 & 13.

reason to afford such expedited treatment as would necessarily impair a full and fair review of these appeals. LMC submits that it was at PHM's peril that the parties chose not to follow the procedures laid out in the law for cooperative agreements and applications for certificates of public advantage, instead seeking DHEC's approval in a process outside the public view and without the opportunity for affected persons to participate and be heard. The wisdom or folly of these strategic decisions are not justification for the compromises PHM seeks here.

CONCLUSION

For the reasons set forth herein, LMC respectfully requests that this Court deny PHM's Motion to Certify and Motion to Expedite.

Respectfully submitted,

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Dated: January 8, 2021

EXHIBIT A

To LMC's Return

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SC Court of Appeals

*LMC's Petition for Administrative Review and Request for
Contested Case Hearing*

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

v.

South Carolina Department of Health and
Environmental Control and Prisma Health –
Midlands,

Respondents.

Docket No.: 20-ALJ-07-____-CC

**PETITION FOR ADMINISTRATIVE
REVIEW AND REQUEST FOR
CONTESTED CASE HEARING**

Pursuant to Article 1, § 22 of the South Carolina Constitution, the South Carolina Code of Laws at Sections 1-23-600(A) and 44-1-60(G), the South Carolina Health Care Cooperation Act, codified at S.C. Code Ann. § 44-7-500, *et seq.*, as well as the Department of Health and Environmental Control's Regulation 61-31 and SCALC Rule 11, Petitioner Lexington County Health Services District, d/b/a Lexington Medical Center (LMC), files this Request for Administrative Review and Contested Case Hearing challenging the South Carolina Department of Health and Environmental Control's (DHEC or the Department) (i) February 28, 2020 Decision that purports to amend the ongoing conditions of an existing Certificate of Public Advantage (COPA) originally issued nearly 24 years ago to Richland Memorial Hospital (RMH) and Baptist Healthcare System of South Carolina, Inc. (BHS), to approve a proposed transaction whereby Prisma Health – Midlands (PHM) will acquire acute care facilities owned and operated by LifePoint Health (LPNT), a competing healthcare provider operating in the same service area, which consists of Providence Health (HTL-0928), Providence Health – Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department (FED) in Fairfield County operating under HTL-0929 (**Exhibit A**); and (ii) the DHEC Board's April 21, 2020 decision to not

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hold a final review conference on the matter, rendering the Department Staff's Decision the final agency decision (**Exhibit B**) (collectively, the "Department Decision").

I. BACKGROUND

A certificate of public advantage or "COPA" is a tool used by states to review and oversee proposed combinations involving health care providers that may create or strengthen otherwise illegal monopoly powers. South Carolina's Health Care Cooperation Act (HCCA or the Act) was enacted in 1994 by Act No. 437, Section 1, and provides the opportunity for health care providers in South Carolina to seek to qualify for certain immunity for proposed transactions otherwise subject to significant federal and state scrutiny under various antitrust laws. The General Assembly's intent in enacting the HCCA is expressly stated in the Act:

(A) It is the intent of this article **to require the State to provide direction, supervision, regulation, and control over approved cooperative agreements through the department and the Attorney General.** This state direction, supervision, regulation, and control of cooperative agreements will provide immunity for health care providers, health provider networks, or purchasers who participate in discussions or negotiations authorized by this article from civil liability and criminal prosecution under federal or state antitrust laws.

(B) A health care provider, health provider network, or health care purchaser may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any state antitrust law. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith is immune from challenge or scrutiny under state antitrust laws, regardless of whether a certificate is issued. It is the intention of the General Assembly that this article immunizes covered activities from challenge or scrutiny under federal antitrust laws. **Nothing in this subsection creates immunity for a person for conduct in negotiating or entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.**

S.C. Code. Ann. §44-7-520 (emphasis added). COPA protection is available only for agreements that "would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural

hospitals can remain open.” S.C. Code Ann. 44-7-505(2). In addition to requiring a transparent agency review process to include publication of public notice and the right to public hearings, the HCCA requires DHEC to seek the advice of the Attorney General on the propriety of approving a COPA application. *See* S.C. Code Ann. §§ 44-7-540, -550.

The HCCA provides for the right to judicial review under the Administrative Procedures Act of a Department decision to approve or deny a COPA. *See* S.C. Code Ann. § 44-7-550; *see also* S.C. Code Ann. Regs. 61-31 § 311. The right to review is afforded both to applicants for a COPA and “affected persons” aggrieved by an agency decision. S.C. Code Ann. § 44-7-550(B). Because LMC is a health care provider “who provides or purchases the same or similar health care services in the geographic area served or to be served by” PHM under the existing COPA purportedly amended by the Department Decision, LMC is an “affected person” under the Act. S.C. Code Ann. § 44-7-510(1)(a); *see also* S.C. Code Ann. 44-1-60(G).

II. LEGAL ARGUMENTS

Subject to and without waiving the right to address any issues presented or considered by the Department during review of PHM’s request for COPA protection of the LPNT transaction, LMC submits that the Department’s Decision should be reversed, or remanded to DHEC for the administrative review required by the HCCA, for the following reasons:

1. The Department lacks the authority to “amend” the ongoing conditions of a previously issued COPA to approve a proposed transaction involving two health care providers in which the assets of one health care provider are acquired by the other health care provider in a manner that otherwise may be construed to violate state and/or federal antitrust laws. *See* S.C. Code Ann. § 44-7-510(2)-(3).

manner that otherwise may be construed to violate state and/or federal antitrust laws. *See* S.C. Code Ann. § 44-7-510(2)-(3).

2. The COPA affected by the Department Decision, and purportedly “updated” with additional conditions, is that certain COPA issued by DHEC in 1997, formally approving a cooperative agreement between RMH and BHS, under which the two competing health care providers merged “into a new single healthcare system.” DHEC Staff Resp. to Req. for Review, p. 1 (attached as **Exhibit C**) (“DHEC RFR Response”).

3. The Department Decision sanctions and grants the benefits of a COPA to a new and different agreement between new and different health care providers² without first requiring PHM to submit an application as required by the HCCA. *See* S.C. Code Ann. § 44-7-530. The HCCA is abundantly clear: there is no immunity for health care providers who negotiate and enter cooperative agreements “for which an application for a certificate of public advantage is not filed.” S.C. Code Ann. § 44-7-520.

4. The Department Decision purporting to amend the existing COPA issued to RMH and BHS to approve a different cooperative agreement, without first receiving and reviewing the required documentation, coupled with its finding “that the proposed changes resulting [from PHM’s acquisition of three hospitals and a FED] might materially impact the benefits or disadvantages to the community to be served,” was an abdication of the responsibility placed on the Department by the General Assembly. Because there is no evidence PHM submitted the required application, to include responses to the questionnaire, submission of programmatic documents, or even written assurance as required by DHEC’s own regulation, DHEC could not

² Notably, upon information and belief, the COPA issued to RMH and BHS had previously been rendered ineffective by amendment. “The certificate of public advantage, if issued, is only valid for the project described in the application including the parties involved.” S.C. Code Ann. Regs. 61-31 § 309.

have (and LMC and this Court cannot now) appropriately evaluated any potential benefits to the proposed transaction as necessary to outweigh the obvious disadvantages.³ See S.C. Code Ann. Regs. 61-31 § 202. Given the clear language of the Act, DHEC lacks the authority to approve a new transaction in the manner of the Department Decision.

5. LMC is informed and believes that PHM presently has a leading share, perhaps as high as nearly sixty percent, in the Midlands primary service area with its existing acute care facilities comprised of Prisma Health Baptist, Prisma Health Baptist Parkridge, Prisma Health Richland, and Prisma Health Tuomey. With the addition of the four hospital facilities PHM proposes to acquire from LPNT (Providence Health, Providence Health – Northeast, Kershaw Health, and the Fairfield County FED), PHM will own and control every acute care/hospital-based facility in the contiguous Midlands counties of Richland, Kershaw, Fairfield and Sumter, with the only proximate competitor being LMC's single hospital facility in Lexington County (a county contiguous only to Richland and more distant from Kershaw, Fairfield and Sumter counties).

6. There is no evidence DHEC considered the cumulative effect of PHM's existing dominance in its service area plus the increased presence of Prisma Health, South Carolina's largest health system with twelve hospitals throughout the Upstate and Midlands of South Carolina. It is incumbent on DHEC to engage in the proscribed review process called for in the HCCA and Regulation 61-31, and consider not just the perceived benefits and disadvantages from the biased perspective of the applicant, but also the views and opinions of affected persons who stand to be adversely impacted by the proposal.

7. In the alternative, should the Court believe the existing COPA issued to RMH and BHS can be amended to address the LPNT transaction, the Department Decision should be

³ In significant contrast, just the narrative portion of the application submitted by RMH and BHS in 1996, in accordance with Regulation 61-31, spanned 79 pages.

remanded with the instruction that DHEC engage in the review process necessary to evaluate the “amendment” sought by PHM of the COPA. Once issued, a COPA “is only valid for the project described in the application including parties involved, services to be offered, mergers or consolidations approved, or other factors as set forth in the application, except as may be modified in accordance with these regulations.” S.C. Code Ann. Regs. 61-31 § 309. As further proscribed by regulation, “[i]f an applicant amends, alters, or otherwise changes the agreement after receipt of a [COPA], the Department will decide whether or not the amendment is substantial and thereby requires another review.” *Id.* at § 508. It is expressly stated in the HCCA and comprehensively detailed in Regulation 61-31 – a proscribed review with rights of public participation and advice of the Attorney General are essential components to evaluation of a cooperative agreement before issuance of a COPA. DHEC’s interpretation of Regulation 61-15 § 508 to allow for the inadequate and incomplete review that occurred here is manifestly erroneous and contrary to the plain meaning of Section 508.

8. It is undisputed that DHEC determined the transaction proposed by PHM, *to the extent disclosed to DHEC by PHM*,⁴ was a “substantial” change to the COPA issued to RMH and BHS. *See Exhibit A*, p. 1 (“[T]he Department determined that the proposed changes resulting from the transaction might materially impact the benefit or disadvantages to the community to be served. The Department therefore undertook another review of the COPA.”) Nonsensically, DHEC then undertook a limited, one-sided, secretive “review” of the proposed transaction before issuing the

⁴ While the partial FOIA response received from DHEC is obviously incomplete, it does not appear from the documents that were produced and the Staff Response to the Requests for Review that DHEC was provided all of the documentation necessary under the HCCA for review and approval of a cooperative agreement. At a minimum, and by statute, PHM is required to provide “an executed written copy of the cooperative agreement and describe the nature and scope of the cooperation in the agreement and any monetary or other consideration passing to a party under the agreement” S.C. Code Ann. § 44-7-530. The significance of this required disclosure is evidenced by the Department’s separate statutory obligation to “maintain on file all cooperative agreements for which certificates of public advantage remain in effect.” S.C. Code Ann. § 44-7-580.

DHEC Staff Decision, arbitrarily ignoring the proscribed, detailed, and transparent review process outlined both in the HCCA and Regulation 61-31 (which notably was the nature of the review undertaken in 1996 and 1997). *See e.g.*, S.C. Code Ann. §§ 44-7-540, -550, -560; S.C. Code Ann. Regs. 61-31 §§ 302, 303, 304, 305, and 307.

9. DHEC need look no further than the HCCA to understand what “review” is required for cooperative agreements. Where parties desire the benefit of a COPA, such request to DHEC must be in an application, and the General Assembly has instructed that DHEC “**shall review** the application in accordance with the standards set forth in Section 44-7-560 and if requested by an affected person within thirty days of the department’s receipt of a completed application, may hold a public hearing in accordance with regulations promulgated by the department.” S.C. Code Ann. § 44-7-540 (emphasis added).

10. Of greatest concern, in acquiescing to PHM’s demands for a limited and one-sided review, DHEC did not develop the record necessary to reasonably evaluate the benefits and disadvantages that will result from combining the only providers of acute and emergency care services in Richland, Kershaw, Fairfield and Sumter Counties. *See* S.C. Code Ann. Regs. 61-31 §§ 401, 402, 403. In fact, Regulation 61-31 specifically requires DHEC to consider “written and verbal comments by affected persons and other persons concerning the application.” S.C. Code Ann. Regs. 61-31 § 307. By interpreting Section 508 to allow for something other than the review process set forth in the HCCA and Regulation 61-31, DHEC “denied contemporaneous notice and participation opportunities that DHEC’s own regulations required be provided to both the public and [affected persons].” *Pickens Cty. v. S.C. Dept. of Health and Envtl. Control*, 429 S.C. 92, 105, 837 S.E.2d 743, 750 (Ct. App. Jan. 8, 2020), *reh’g denied*.

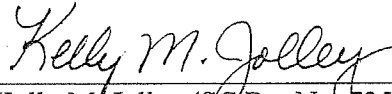
11. Rather than the proscribed, detailed, and transparent review process, the Department inexplicably “conducted a review without public notice or hearing” based only on the “persuasive” writings of PHM and its representations as to the benefits of the transactions and dire consequences should the Department’s conduct not comport with the demands made by PHM. *See* Staff Response to RFR at p. 5 (“PHM represented to the Department that the seller of the assets would not proceed with the proposed transaction if the review included public notice and review and provided information to the Department regarding the potential consequences if the transaction were not consummated.”) Such obvious manipulation of agency action, particularly given the matters at stake, cannot go unaddressed.

III. RELIEF SOUGHT

LMC respectfully requests this Court reverse the Department Decision and deny PHM’s request to “amend” the conditions of a previously issued COPA to protect the proposed acquisition of LPNT’s health care facilities without first demonstrating compliance with the application and undergoing the attendant review process required by the HCCA and Regulation 61-31. In the alternative, LMC requests that the Court remand this matter to the Department with an instruction that the amendment proposed by PHM to the existing COPA be reviewed under the HCCA and Regulation 61-31, including the requirements of public notice, provisions for public participation and hearing, and advice of the Attorney General.

Signature blocks appear on following page.

Respectfully submitted,



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*Counsel for Petitioner Lexington County Health
Services District, d/b/a Lexington Medical Center*

Dated: May 14, 2020

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February 28, 2020

VIA CERTIFIED MAIL

Mr. Mark S. O'Halla
President and Chief Executive Officer
Prisma Health
300 East McBee Avenue
Suite 300
Greenville, SC 29601

Re: Review of the Certificate of Public Advantage ("COPA") held by Prisma Health – Midlands (Formerly the Palmetto Health Alliance) and update to the conditions as set forth therein.

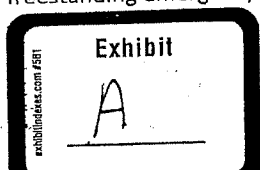
Dear Mr. O'Halla:

In December 2019, your organization submitted to the South Carolina Department of Health and Environmental Control ("Department") notice of a proposed transaction wherein Prisma Health – Midlands ("PHM") would acquire certain assets currently owned by LifePoint Health ("LPNT")¹ in the Richland County, Fairfield County, and Kershaw County market area. The Department received additional documentation from PHM in support of this transaction in February 2020. Pursuant to S.C. Code Regs. 61-31,§ 508, the Department determined that the proposed changes resulting from the transaction might materially impact the benefits or disadvantages to the community to be served. The Department therefore undertook another review of the COPA.

As a result of that review, and having given substantial consideration to all information provided by PHM to the Department regarding the proposed transaction, the Department has determined that the ongoing conditions of the COPA shall be amended as follows to provide for the addition of the LPNT assets:

1. PHM will provide a full report to the Department every other year which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial

¹ To include Providence Health (HTL-0928), Providence Health – Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department in Fairfield County operating under HTL-0929.



S.C. Department of Health and Environmental Control
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statements; and information which will enable the Department to evaluate each of the conditions listed below. In years when a full report is not required, PHM will provide the Department an abbreviated report which will include, at a minimum, an annual audited financial statement plus a description of the programs and services PHM provides through its Community Outreach Programs as described in Condition 2, as well as the required reporting as described in Conditions 17 and 19. All reports, full and abbreviated, may require additional information the Department feels is necessary to adequately evaluate PHM's compliance with the COPA and the COPA conditions. These annual reports are due to the Department no later than 120 days after the end of each fiscal year. In addition, PHM will provide a revised three (3) year forecasted financial statement, which may be based upon its most recently Board approved budget and Board accepted audited financial report, and which projects three (3) years forward from the end of the most recent fiscal year. PHM will also make available to the Department all of its managed care contracts for inspection, if necessary, which will be considered proprietary and not subject to disclosure.

2. PHM will provide fifteen percent (15%) of its "excess revenues over expenses" to fund public health initiatives and community outreach programs. Efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits, changes, and/or accomplishments that occur because of the activities and services provided by the programs and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive such services without the Certificate of Public Advantage.
3. For twenty-four (24) months following the date of closing of the transaction, PHM will report major operational savings that can be documented as they relate to the acquisition of the LPNT assets. Costs used to document the above savings must be specific to the acquisition, that is, savings that occurred because of the acquisition and not savings that would have been realized even if the acquisition had not occurred.
4. PHM will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, PHM will give them terms and conditions equal to the average of the amount which would be received from patients insured by any of PHM's commercial payers. That PHM will continue this access for which it is the sole provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable. Additionally, PHM must make available to the Department, upon

request, names of any facilities, to include terms and conditions, to which services have been offered.

5. PHM will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Prisma Richland Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one PHM facility, the medical, graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.
6. Should PHM change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.
7. As part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied, but excluding extraordinary revenue and expenses, losses on extinguishments of debt and the impact of any mark to market adjustments on derivative instruments, will be used to calculate net of revenues over expenses in the annual report for determining the 15% public health commitment and that such financial statements will be certified by an independent auditor. However, should any of these other items result in cash gains or losses, they may be included in net revenues over expenses.
8. Neither PHM, nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is competitive.

However, it must be the decision of the payer and not be required as a condition of a contract with PHM or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

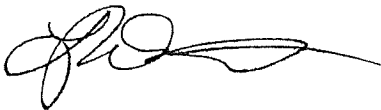
In addition, PHM will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require PHM to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will, as a part of its ongoing monitoring process, investigate consistent complaints from employers and managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

9. Except to the extent required by vendors, suppliers or Group Purchasing Organizations ("GPOs"), neither PHM, nor its subsidiaries, shall condition any contracts with suppliers, vendors, or GPOs that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the PHM.
10. The Department may amend these conditions to include, but not be limited to, the lowering of prices should unexpected events lead to abnormally high margins from operations.
11. PHM will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.
12. PHM will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring these conditions.
13. Prior to the final execution of the Asset Purchase Agreement ("APA") by and between PHM and LPNT regarding those assets outlined the December 2019 and February 2020 submissions to the Department by PHM, PHM shall submit to the Department evidence that the Board of PHM is aware of the transaction.
14. PHM will conduct a comprehensive study of access to emergency, urgent, and/or extended primary care services within the northern City of Columbia or other disadvantaged area of Richland County. Based upon this study, PHM will develop a plan to address those issues identified in the study for presentation to, and input from, the Department. Such a study will be completed within eighteen (18) months of the closing date of the transaction.
15. Within twenty-four (24) months of the closing date of the transaction, PHM will begin provision of primary care, and/or extended-hours primary care, and/or urgent care services to the Lower Richland community.
16. Prior to closing or permanently reducing the number of licensed facilities or beds held by PHM, PHM shall submit to the Department a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such a change. This requirement shall be in addition to those requirements set forth in S.C. Code 44-7-110 *et seq.*, and the *South Carolina Health Plan*.

17. All acquired facilities will be subject to the charity care policy of PHM. The current charity care policy in force at the time of submission will be included in PHM's annual COPA report. In the event PHM determines to close a licensed general hospital, PHM will provide the Department with a plan that addresses how indigent care patients will be accommodated.
18. PHM will maintain Level 1 trauma services and serve as a Regional Perinatal Center for at least five (5) years following the date of closing of the transaction, subject to no material change in program requirements, state law or regulations, and federal law or regulations. Further, PHM will commit to operating no less than seven (7) emergency departments, unless otherwise approved to do so by the Department, for at least five (5) years following the date of closing of the transaction.
19. In addition to the requirements set forth in the *Health Care Cooperation Act*, S.C. Code Ann. Sections 44-7-500 through 44-7-590, the *Health Care Cooperative Agreements Regulation*, S.C. Code Ann. Regs. 61-31, and these Conditions, PHM shall notify the Department through its annual COPA report of any acquisitions or dispossessions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance use and treatment facilities.
20. These Conditions will be evaluated for necessity and compliance on an annual basis. Those Conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance, and PHM and the Department may mutually agree to adjust the specified time period.

Your continued cooperation and compliance is greatly appreciated. Please do not hesitate to contact me with any questions you might have.

Very Respectfully,



Louis Eubank, Chief
Bureau of Healthcare Planning & Construction

cc: Malcolm Isley (via email)
Liz Crum, Esquire (via email)

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SC ADMIN LAW COURT



Mark R. Elam, Chairman
Jim P. Creel, Jr., Vice-Chairman
Charles M. Joye, II, P.E., Secretary
J.B. (Sonny) Kinney

Board:
Seema Shrivastava-Patel
Richard V. Lee, Jr.
Alex A. Singleton

April 21, 2020

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S.C. Department of Health and Environmental Control

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Exhibit

B

**RE: Docket Nos. 20-RFR-15, 20-RFR-16, 20-RFR-17, 20-RFR-18, Prisma Health – Midlands
(Formerly Palmetto Health Alliance)**
Review of Certificate of Public Advantage (COPA) and update of Conditions

Dear Counsel of Record:

The South Carolina Board of Health and Environmental Control will not conduct a Final Review Conference on the above-referenced matter.

CONTESTED CASE GUIDANCE

S.C. Code Section 44-1-60 provides that if the Board declines in writing to schedule a final review conference, the staff decision becomes the final agency decision, and an applicant, permittee, licensee, or affected person may request a contested case hearing before the Administrative Law Court (ALC) within thirty calendar days after notice is mailed to the applicant, permittee, licensee, and affected person that the Board declined to hold a final review conference.

A request for a contested case hearing before the Administrative Law Court must be filed within the time allowed and in accordance with the Rules of the ALC, including payment of the ALC's filing fee, at the following address:

Clerk's Office
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

The ALC's Notice of Request for Contested Case Hearing form and the Rules of the ALC can be found at the ALC's website: <http://www.scalc.net>. Further information on filing a request for a contested case hearing before the ALC may be obtained by calling the Clerk's Office at the Administrative Law Court (803-734-0550).

If a party files a request for a contested case hearing with the ALC, the party must serve a copy of the request on DHEC and any other parties at the same time the request is filed with the ALC. A copy of the request for a contested case hearing must be delivered or mailed to DHEC at the address at the top of this memorandum.

Sincerely,



M. Denise Crawford
Clerk
S.C. Board of Health and Environmental Control

cc: Derial Ogburn, The Health Services District of Kershaw County (via Electronic Mail sharrell@healthdistrictkc.org)

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APR 15 2020

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL CONTROL
STAFF RESPONSE TO REQUESTS FOR FINAL REVIEW

Clerk, Board of Health
and Environmental Control

Requestors: The City of Columbia
Kershaw County
Fairfield County and Fairfield County Memorial Hospital by and through the
Fairfield County Memorial Hospital Board of Trustees
Lexington County Health Services District, Inc., d/b/a Lexington Medical Center

In Re: Docket No. 20-RFR-15
Docket No. 20-RFR-16
Docket No. 20-RFR-17
Docket No. 20-RFR-18

Review of the Certificate of Public Advantage (COPA) held by Prisma Health –
Midlands (formerly the Palmetto Health Alliance) and update to the conditions as
set forth therein

Staff of the South Carolina Department of Health and Environmental Control (DHEC or
Department) respectfully submit the following response to the above-referenced Requests for Final
Review (RFRs).

I. Summary

Prisma Health – Midlands (PHM)¹ received a COPA from the Department in 1997. The
COPA provided state approval pursuant to the *Health Care Cooperation Act* (HCCA or Act), S.C.
Code Ann. §§ 44-7-500, *et seq.*, and Regulation 61-31, *Health Care Cooperative Agreements*, of
a cooperative agreement between Richland Memorial Hospital (RMH) and Baptist Healthcare
System of South Carolina, Inc., (BHS) for the merger the two separate entities into a new single
healthcare system. Since issuance of the COPA in 1997, the Department has provided monitoring
and oversight of PHM's activities under the COPA conditions, as originally imposed in 1997 and
as updated in 2003.²

In December 2019, DHEC received notice from PHM of a proposed transaction wherein
PHM would acquire certain assets from LifePoint Health (LPNT), including three hospitals and a
freestanding emergency department located in Richland, Fairfield, and Kershaw Counties. In
accordance with applicable regulations, DHEC reviewed the information provided by PHM in
light of the existing COPA and issued a letter dated February 28, 2020, updating the COPA's
conditions.³

¹ PHM has undergone name changes since its initial incorporation. At the time the COPA was issued, it
was incorporated under the name BR Health System, Inc. (BRHS). It later changed its name to Palmetto
Health Alliance (Alliance), and more recently changed its name to PHM.

² Copies of the 1997 Department decision approving the COPA application with conditions, the 1997
COPA, and the 2003 update to the COPA conditions are attached as Exhibits 2, 3, and 4, respectively.

³ A copy of the February 28, 2020, letter updating the COPA conditions is attached as Exhibit 1.

Exhibit

C

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On March 13, 2020, the requestors listed above filed RFRs requesting Board review of staff's February 28, 2020, update to PHM's COPA conditions. The requestors raise legal questions related to the process by which the COPA conditions were updated. They allege the proposed transaction required the filing of a new COPA application. Alternatively, they allege the Department should have provided an opportunity for a public hearing prior to modifying the COPA conditions. The HCCA and Regulation 61-31 require neither. Changes occurring after issuance of a COPA are addressed in Section 508 of Regulation 61-31, which does not require submission of a new COPA application or repetition of the review processes applicable to a COPA application. Staff therefore requests the Board decline the RFRs.

II. The COPA Statutory and Regulatory Framework⁴

The HCCA is designed to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition. The Act is predicated upon legislative findings "that cooperative agreements among hospitals health care purchasers, and other health care providers would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open," and "that federal and state antitrust laws may prohibit or discourage cooperative agreements that are beneficial to South Carolinians" and "should be supplanted by a regulatory program to permit and encourage cooperative agreements . . . when the benefits outweigh the disadvantages caused by their potential adverse effects on competition." Sections 44-7-505(2), (3), and (4). The intent of the HCCA is to require the State to provide direction, supervision, regulation, and control over approved cooperative agreements. Section 44-7-520(A). This state direction is intended to "provide immunity for health care providers, health provider networks, or purchasers who participate in discussions or negotiations authorized by [the HCCA] from civil liability and criminal prosecution under federal or state antitrust laws." *Id.*

DHEC is the state agency authorized to implement and enforce the HCAA and is authorized to promulgate regulations pursuant to the Act. Sections 44-7-510(4) -570(D). Parties to a cooperative agreement⁵ may apply to the Department for a COPA. A COPA is "the formal approval, including any conditions or modifications, by the department of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health provider networks, or health care purchasers that might be construed to be violations of state or federal antitrust laws." Section 44-7-510(2) (Emphasis added). The issuance of a COPA not required in order for health care providers to enter into cooperative agreements. Reg. 61-31

⁴ Copies of the HCCA and Regulation 61-31 are attached as Exhibits 8 and 9, respectively.

⁵ "Cooperative agreement" is defined as "an agreement between two health providers, health provider networks, or purchasers or among more than two health care providers, health provider networks, or purchasers for the sharing, allocation, or referral of patients or the sharing or allocation of personnel, instructional programs, support services and facilities, medical, diagnostic or laboratory facilities, procedures, equipment, or other health care services traditionally offered by health care facilities or other health care providers or the acquisition or merger of assets among or by two or more health providers, health provider networks, or health care purchasers, provided the agreement does not involve price-fixing or predatory pricing or illegal tying arrangements." Section 44-7-510(3).

Section 103. The issuance of a COPA does not exempt health care providers or purchasers from complying with Certificate of Need (CON) and licensing requirements. Section 44-7-590.

Upon completion of an initial application process and review, the Department must issue a COPA if it determines that (1) the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement, and (2) reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result. Section 44-7-560(A). "The [D]epartment may also establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with the HCCA and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure that the activity is appropriately supervised and regulated by the State." Section 44-7-560(B).

Following issuance of a COPA, the Department provides active supervision and monitoring of activities conducted pursuant to the COPA to determine compliance with the conditions of approval. See Section 44-7-570(A) and Reg. 61-31 Sections 501 and 502. The Department is authorized to revoke a COPA if it finds the agreement is not in substantial compliance with the terms of the application or the conditions of approval, or the likely benefits resulting from the agreement no longer outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement, or if a party to a cooperative agreement terminates the agreement. Section 44-7-570(A) and -580; Reg. 61-31 Sections 503 and 506.

Section 508 of Regulation 61-31 specifically addresses changes after receipt of a COPA and provides:

If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires another review. A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.

Section 508, which appears solely in regulation and does not have a similar provision in statute, is directly applicable to the Department's February 28, 2020, letter and the RFRs submitted by the requestors.

III. Response to Grounds Stated in Requests for Review:

As background, DHEC issued a COPA to PHM in 1997. The application for the COPA was submitted to the Department in 1996 by RMH and BHS, which were the parties to the cooperative agreement for which the COPA was sought. Pursuant to the agreement and COPA application, RMH and BHS proposed to merge and form a new nonprofit corporation, currently known as PHM, to jointly operate as a single unit their systems and hospitals serving the Midlands area of South Carolina. The COPA application process included public notice, a public hearing,

review of the application by the Attorney General, and review by the Department. DHEC decided to approve the COPA application after determining that the likely benefits resulting from the agreement outweighed the likely disadvantages from the agreement, and that the reduction in competition likely to result from the agreement was reasonably necessary to obtain the benefits likely to result. DHEC's May 8, 1997, decision approving the COPA application established conditions for approval to ensure the COPA's consistency with the COPA Act and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure appropriate supervision and regulation by the State. After a legal challenge to the Department's decision, DHEC issued the COPA on October 6, 1997. DHEC has actively monitored and regulated the COPA since its issuance to ensure compliance with the conditions of approval. The conditions were updated in 2003.

On December 13, 2019, DHEC received an 18-page written submission from PHM, with five exhibits attached, noticing its intent to acquire three South Carolina hospitals, and other related assets and operations, from LPNT. The assets include include Providence Health hospital in downtown Columbia, Providence Health-Northeast hospital in Columbia, KershawHealth hospital in Camden, and a freestanding emergency department in Fairfield County. PHM referenced its COPA, specifically the conditions in place for the COPA, and asked the Department to acknowledge that the assets purchased from LPNT would be subject to the COPA conditions and asked the Department to make any updates or modifications to the COPA conditions as the Department deemed necessary in light of the proposed acquisition. PHM submitted an updated version of its written submission on December 16, 2019, correcting clerical errors in the December 13, 2019, 18-page document. Both versions of the document contained redactions to certain proprietary and confidential information.⁶ See Section 44-7-530 and Reg. 61-31 Section 310 (providing that information obtained by DHEC related to cooperative agreements under the HCCA and Reg. 61-31 is publicly available unless proprietary and protected from disclosure). On December 20, 2019, DHEC received approval from the South Carolina Revenue and Fiscal Affairs Office (RFA) of an application to receive certain encounter data containing restricted data elements, and executed an agreement with RFA allowing DHEC to receive and review restricted RFA data, and maintain such data in accordance with the agreement's confidentiality provisions, for purposes of carrying out DHEC's obligations pursuant to the COPA program. On December 23, 2019, PHM submitted an updated version of its December 16, 2019, document to the Department without redactions with new supplemental information attached as Appendix 1 and Appendix 2.

The Department reviewed PHM's December 19, 2019, submissions and determined the changes resulting from the proposed transaction might materially impact the benefits or disadvantages to the community to be served and thereby required another review pursuant to Section 508 of Regulation 61-31. The Department submitted a letter to the Attorney General seeking an opinion as to the Department's interpretation of "another review" under Section 508 – specifically, that it is within the Department's "discretion to conduct the review it deems appropriate based on the facts and circumstances involved including, but not limited to, the significance of the proposed change, and any exigent circumstances as found by DHEC or as represented to DHEC by the parties to the cooperative agreement." See Exhibit 6 (DHEC's

⁶ A copy of PHM's December 16, 2019, 18-page submission (without exhibits) is attached hereto as Exhibit 5.

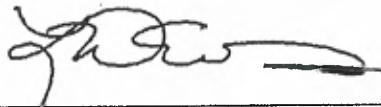
February 20, 2020, letter requesting an Attorney General opinion). By letter dated February 25, 2020, the Attorney General's office opined that DHEC's interpretation "would likely be given considerable deference by the courts as a reasonable interpretation." *See* Exhibit 7 (February 25, 2020, Attorney General Opinion). Staff hereby incorporates by reference the legal arguments set forth in the Department's February 20, 2020, request for an Attorney General opinion. As described in more detail therein, and as supported by the response from the Attorney General's Office, changes after issuance of a COPA do not require submission of a new COPA application or the public notice and hearing requirements applicable thereto.

PHM submitted additional information to the Department regarding the proposed asset acquisition in February 2020. Information contained in a February 2020 submission, while proprietary, was persuasive to the Department in conducting its review pursuant to Section 508 without a public notice or comment period. PHM represented to the Department that the seller of the assets would not proceed with the proposed transaction if the review included public notice and review and provided information to the Department regarding the potential consequences if the transaction were not consummated. PHM's representation to the Department of the possible increase in additional staff layoffs without the transaction as opposed to with the transaction, as well as the potential impact on PHM's ability to provide certain safety net services to the South Carolinians within its service area absent the proposed transaction, were persuasive to the Department. The Department conducted a review without public notice or hearing. Staff gave substantial consideration to all information available to it regarding the proposed transaction and determined that the COPA conditions should be modified to foster compliance with the HCCA and Regulation 61-31. As a result, the Department issued its February 28, 2020, letter to PHM updating the COPA conditions, imposing additional requirements upon PHM as described therein.

V. Requested Action

Staff respectfully requests the Board decline to conduct a final review conference and uphold staff's February 28, 2020, letter modifying the conditions of PHM's COPA.

Respectfully submitted,



Louis Eubank, Chief
Bureau of Healthcare Planning & Construction

// Ashley Biggers

Ashley C. Biggers
Chief Counsel for Healthcare Quality

Attachments:

Exhibit 1 – February 28, 2020, Letter Updating COPA Conditions

Exhibit 2 – May 8, 1997, Letter Approving COPA Application with Conditions

Exhibit 3 – October 6, 1997, Issuance of COPA
Exhibit 4 – November 18, 2003, Letter Updating COPA Conditions
Exhibit 5 – December 16, 2018, Submission from PHM
Exhibit 6 – February 20, 2020, Request for Attorney General Opinion
Exhibit 7 – February 25, 2020, Attorney General Opinion
Exhibit 8 – Health Care Cooperation Act
Exhibit 9 – Regulation 61-31

EXHIBIT 1



February 28, 2020

VIA CERTIFIED MAIL

Mr. Mark S. O'Halla
President and Chief Executive Officer
Prisma Health
300 East McBee Avenue
Suite 300
Greenville, SC 29601

Re: Review of the Certificate of Public Advantage ("COPA") held by Prisma Health - Midlands (Formerly the Palmetto Health Alliance) and update to the conditions as set forth therein.

Dear Mr. O'Halla:

In December 2019, your organization submitted to the South Carolina Department of Health and Environmental Control ("Department") notice of a proposed transaction wherein Prisma Health - Midlands ("PHM") would acquire certain assets currently owned by LifePoint Health ("LPNT")¹ in the Richland County, Fairfield County, and Kershaw County market area. The Department received additional documentation from PHM in support of this transaction in February 2020. Pursuant to S.C. Code Regs. 61-31, § 508, the Department determined that the proposed changes resulting from the transaction might materially impact the benefits or disadvantages to the community to be served. The Department therefore undertook another review of the COPA.

As a result of that review, and having given substantial consideration to all information provided by PHM to the Department regarding the proposed transaction, the Department has determined that the ongoing conditions of the COPA shall be amended as follows to provide for the addition of the LPNT assets:

1. PHM will provide a full report to the Department every other year which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial

¹ To include Providence Health (HTL-0928), Providence Health - Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department in Fairfield County operating under HTL-0929.

statements; and information which will enable the Department to evaluate each of the conditions listed below. In years when a full report is not required, PHM will provide the Department an abbreviated report which will include, at a minimum, an annual audited financial statement plus a description of the programs and services PHM provides through its Community Outreach Programs as described in Condition 2, as well as the required reporting as described in Conditions 17 and 19. All reports, full and abbreviated, may require additional information the Department feels is necessary to adequately evaluate PHM's compliance with the COPA and the COPA conditions. These annual reports are due to the Department no later than 120 days after the end of each fiscal year. In addition, PHM will provide a revised three (3) year forecasted financial statement, which may be based upon its most recently Board approved budget and Board accepted audited financial report, and which projects three (3) years forward from the end of the most recent fiscal year. PHM will also make available to the Department all of its managed care contracts for inspection, if necessary, which will be considered proprietary and not subject to disclosure.

2. PHM will provide fifteen percent (15%) of its "excess revenues over expenses" to fund public health initiatives and community outreach programs. Efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits, changes, and/or accomplishments that occur because of the activities and services provided by the programs and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive such services without the Certificate of Public Advantage.
3. For twenty-four (24) months following the date of closing of the transaction, PHM will report major operational savings that can be documented as they relate to the acquisition of the LPNT assets. Costs used to document the above savings must be specific to the acquisition, that is, savings that occurred because of the acquisition and not savings that would have been realized even if the acquisition had not occurred.
4. PHM will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, PHM will give them terms and conditions equal to the average of the amount which would be received from patients insured by any of PHM's commercial payers. That PHM will continue this access for which it is the sole provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable. Additionally, PHM must make available to the Department, upon

request, names of any facilities, to include terms and conditions, to which services have been offered.

5. PHM will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Prisma Richland Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one PHM facility, the medical, graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.
6. Should PHM change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.
7. As part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied, but excluding extraordinary revenue and expenses, losses on extinguishments of debt and the impact of any mark to market adjustments on derivative instruments, will be used to calculate net of revenues over expenses in the annual report for determining the 15% public health commitment and that such financial statements will be certified by an independent auditor. However, should any of these other items result in cash gains or losses, they may be included in net revenues over expenses.
8. Neither PHM, nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is competitive.

However, it must be the decision of the payer and not be required as a condition of a contract with PHM or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

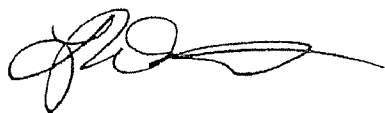
In addition, PHM will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require PHM to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will, as a part of its ongoing monitoring process, investigate consistent complaints from employers and managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

9. Except to the extent required by vendors, suppliers or Group Purchasing Organizations ("GPOs"), neither PHM, nor its subsidiaries, shall condition any contracts with suppliers, vendors, or GPOs that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the PHM.
10. The Department may amend these conditions to include, but not be limited to, the lowering of prices should unexpected events lead to abnormally high margins from operations.
11. PHM will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.
12. PHM will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring these conditions.
13. Prior to the final execution of the Asset Purchase Agreement ("APA") by and between PHM and LPNT regarding those assets outlined the December 2019 and February 2020 submissions to the Department by PHM, PHM shall submit to the Department evidence that the Board of PHM is aware of the transaction.
14. PHM will conduct a comprehensive study of access to emergency, urgent, and/or extended primary care services within the northern City of Columbia or other disadvantaged area of Richland County. Based upon this study, PHM will develop a plan to address those issues identified in the study for presentation to, and input from, the Department. Such a study will be completed within eighteen (18) months of the closing date of the transaction.
15. Within twenty-four (24) months of the closing date of the transaction, PHM will begin provision of primary care, and/or extended-hours primary care, and/or urgent care services to the Lower Richland community.
16. Prior to closing or permanently reducing the number of licensed facilities or beds held by PHM, PHM shall submit to the Department a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such a change. This requirement shall be in addition to those requirements set forth in S.C. Code 44-7-110 *et seq.*, and the *South Carolina Health Plan*.

17. All acquired facilities will be subject to the charity care policy of PHM. The current charity care policy in force at the time of submission will be included in PHM's annual COPA report. In the event PHM determines to close a licensed general hospital, PHM will provide the Department with a plan that addresses how indigent care patients will be accommodated.
18. PHM will maintain Level 1 trauma services and serve as a Regional Perinatal Center for at least five (5) years following the date of closing of the transaction, subject to no material change in program requirements, state law or regulations, and federal law or regulations. Further, PHM will commit to operating no less than seven (7) emergency departments, unless otherwise approved to do so by the Department, for at least five (5) years following the date of closing of the transaction.
19. In addition to the requirements set forth in the *Health Care Cooperation Act*, S.C. Code Ann. Sections 44-7-500 through 44-7-590, the *Health Care Cooperative Agreements Regulation*, S.C. Code Ann. Regs. 61-31, and these Conditions, PHM shall notify the Department through its annual COPA report of any acquisitions or dispossessions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance use and treatment facilities.
20. These Conditions will be evaluated for necessity and compliance on an annual basis. Those Conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance, and PHM and the Department may mutually agree to adjust the specified time period.

Your continued cooperation and compliance is greatly appreciated. Please do not hesitate to contact me with any questions you might have.

Very Respectfully,



Louis Eubank, Chief
Bureau of Healthcare Planning & Construction

cc: Malcolm Isley (via email)
Liz Crum, Esquire (via email)

EXHIBIT 2



2600 Bull Street
Columbia, SC 29201-1708

May 8, 1997

CERTIFIED MAIL

Mr. Charles D. Beaman, Jr., President
Baptist Healthcare System of South Carolina, Inc.
Taylor at Marion Street
Columbia, South Carolina 29220

Mr. Kester S. Freeman, Jr., Chief Executive Officer
Richland Memorial Hospital
Five Richland Medical Park
Columbia, South Carolina 29203

Re: Certificate of Public Advantage
BR Health System, Inc.
Columbia, South Carolina

Dear Messrs. Beaman and Freeman:

Pursuant to Section 307 of Regulation No. 61-31, Health Care Cooperative Agreements, this is to advise that it is the decision of this Department that a Certificate of Public Advantage be issued to BR Health System, Inc. (the System) for the incorporation of a nonprofit entity to operate the hospitals of the Sponsoring Organizations as a single unit, where the Sponsoring Organizations will develop, implement, and fund new initiatives to improve public health and community outreach programs, and to expand the counseling centers of the Pastoral Institute. The Sponsoring Organizations include (1) Baptist Healthcare System of South Carolina, Inc., Columbia and Easley, South Carolina and (2) Richland Memorial Hospital, Columbia, South Carolina.

The decision to approve the Certificate of Public Advantage is based on the following reasons:

- (1) The Department has determined that the applicant has demonstrated that the likely benefits resulting from the cooperative agreement outweigh the likely disadvantages from the cooperative agreement; and

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- (2) The Department has determined that the reduction in competition likely to result from the cooperative agreement is reasonably necessary to obtain the benefits likely to result.

The Department's decision to approve the Certificate of Public Advantage is made subject to the following conditions pursuant to Section 312 of Regulation 61-31, Health Care Cooperative Agreements:

1. That the System will provide an annual report to the Department, which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial statements; information which will enable the Department to evaluate each of the conditions listed below; and any additional information the Department feels is necessary to adequately evaluate the compliance of the Certificate of Public Advantage. This annual report is due to the Department no later than 120 days after the end of each fiscal year after the System's Joint Operating Agreement is consummated.
2. That the System will provide 10% of its "excess revenues over expenses" to fund public health initiatives and community outreach programs, and the System will provide no less than fifteen million dollars to be allocated over the first five years of the System's existence. This 10% or \$15 million, whichever is greater, will be over and above the current annual effort of \$3,370,700 for cancer and maternal and child health efforts and any current fiscal year expenditures for other community health benefits. However, in addition to maternal and child health and cancer programs, the fifteen million additional dollars may be used for other approved community benefits. Any efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits /changes/ accomplishments that occur because of the activities /services provided by the program and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive these services without the Certificate of Public Advantage.
3. That as a part of the information required in Condition Number 1, the System will report on the nature, source and amount of operational savings and depreciation and interest expense reductions from the capital expenditures avoided during the preceding fiscal year. Costs used to document the above savings must be merger specific, that is, savings that occurred because of the merger and not savings that would have been realized even if the merger had not occurred.
4. That the System, as a part of the information required in Condition Number 1, will provide a revised five year budget projection based on the independently audited financial report.

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5. If seventy one million dollars in operational savings and capital cost avoidance is not achieved after five years, that the System will transfer to the public health initiatives budget an amount equal to the difference between the actual amount of operational savings and capital costs avoided during the first five years and 71 million dollars. Should indigent /charity care substantially exceed the average indigent/charity care provided by the parties in FY95 and FY96, the System may request the Department to review this condition to determine the necessity of an adjustment.
6. That the System will provide medically necessary services to individuals regardless of their ability to pay. Because of this commitment, the System will continue to provide one level of care to patients regardless of their ability to pay. This commitment is absolute, predicated on no assumptions, and unconditional. The System will identify the amount of indigent/charity care provided during the fiscal year as part of the information required by Condition Number 1.
7. That the System will adjust its charges to non-governmental payers for the first five years, so that after adjustments for changes to the medical consumer price index (Southeast region or the South Carolina medical consumer price index, whichever is lower), new services, and governmentally imposed requirements, the System will not realize a higher case mix adjusted net inpatient revenue from non-governmental payers per admission than that realized by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital in combination in 1995.
8. That the System will reduce its gross charges to all payers during each of the first five years of the operation of the System. The System will report, as part of the information required in Condition Number 1, any rate changes (increase or decrease, inpatient or outpatient) to the Department in enough detail to assure the Department that any growth in gross revenue over the five year period is due strictly to changes in patient volume.
9. As part of the information provided in Condition Number 1, the System will report its prospective plans for changes of clinical services between the Sponsoring Organizations' facilities for the upcoming year. That the System, prior to changing, will receive approval from the Department of the change. The changes required to be reported are any consolidations, mergers, deletions, or other change or alteration of clinical services that may significantly affect patients' access to care; or medical, graduate medical, and allied health education program's access to the clinical service.
10. That the System will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any

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competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, the System will give them terms and conditions no less favorable than that covering state employees who have selected the standard non-HMO coverage that is in effect at the time the competing licensed facility requests access to a service. That the System will continue this access for which it is the sole provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable.

11. That the System's mission statement will be substantially similar to the existing mission statements of the Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital.

12. That the System will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Richland Memorial Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one Sponsoring Organization's facility, (as provided for in Condition Number 9 above) that medical, graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.

13. That should the System change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, that the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.

14. That as part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied will be used to calculate net of revenues over expenses in the annual report for determining the 10% public health commitment and that such financial statements will be certified by an independent auditor.

15. That neither the System, nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is not competitive. However, it must be the decision of the payer and not be required as a condition of a contract with the System or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

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16. That the System shall not enter into an exclusive arrangement which will preclude non-employee physicians, payers, or ancillary care providers from entering into contractual arrangements with other facilities and providers. Additionally, the System shall not enter into a new exclusive arrangement with a sole provider of any service in the core service area for the System without prior approval from the Department.

17. That neither the System, nor their affiliates, will enter into contracts with suppliers, vendors, or group purchasing organizations that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the Sponsoring Organizations.

18. That the Department will reevaluate the terms and conditions of this approval in regard to the 10% public health commitment and other community benefits in the aggregate should "[r]evenue and gains in excess of expenses and losses" as a percent of gross revenue escalate or decline (1) to a point where the System's commitment to public health and other community benefits becomes unbalanced as it relates to the System's profitability or (2) to a point where there is little or no commitment to public health or other community benefits.

19. That the Department, as necessary, will compare cost and other indices (such as cost per adjusted patient discharge) for the System to that of similar facilities to measure the efficiency and effectiveness of this alliance.

20. That the Department may amend these conditions to include, but not limited to, lowering prices (1) should the parties not achieve their efficiency goals; (2) should price, as measured in "revenue per stay" (or other measure that may be appropriate), in South Carolina be falling significantly, signaling that to hold prices to pre-Joint Operating Agreement level plus inflation has been too generous compared to what the competitive outcome would have been; or (3) should unexpected events lead to abnormally high margins, such as unexpectedly high disproportionate share payments being received.

21. That the System will provide to the Department copies of all managed care contracts in effect during the last year, within 45 days of the closing of the Joint Operating Agreement. In addition, as a part of the information required in Condition Number 1, the System will provide all existing managed care contracts to the Department. This information will be considered propriety and not subject to disclosure.

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22. That at the end of the first full year following the merger, the System will provide a comprehensive and specific plan, acceptable to the Department, for reaching merger specific efficiencies of at least four percent of cost, adjusted for volume.

23. That the System will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require the System to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will as a part of its ongoing monitoring process investigate consistent complaints from employers and managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

24. That the System will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.

25. That the System will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring this approval.

The proposed decision becomes the final agency decision fifteen (15) days after receipt of this notice by the applicant unless an administrative appeal is commenced pursuant to Section 311 of Regulation No. 61-31, Health Care Cooperative Agreements, and the Administrative Procedures Act. An appeal may be submitted by any affected person or the applicant, within this fifteen (15) day period, which gives notice in writing that the person is desirous of an administrative appeal. Should this be the case, the affected person/applicant should submit the original request to the following:

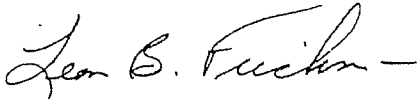
The Board of Health and Environmental Control
Attention: Clerk of the Board
Office of the Commissioner
2600 Bull Street
Columbia, South Carolina 29201

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 7

A copy of the correspondence must be forwarded to the Director of the Bureau of Health Facilities and Services Development. Should there be no request for appeal within the fifteen (15) day period, this decision will be final.

If you have any questions, please feel free to contact us at (803) 737-7200.

Sincerely,



Leon B. Frishman, Director
Bureau of Health Facilities and
Services Development

LBF:JCG:mwf

cc: The Honorable Charles M. Condon
Mr. Robert Armistead
Mr. Mark Ballew
Mr. Marty Bridges
Dr. Stuart A. Hamilton
Mr. Henry T. Hopkins
Mr. Julius Murray
Colonel Morris B. Rubenstein
Mr. Scott W. Trent, Jr.

EXHIBIT 3



2600 Bull Street
Columbia, SC 29201-1708

of
Joel
file

October 6, 1997

Mr. Charles D. Beaman, Jr., President
Baptist Healthcare System of South Carolina, Inc.
Taylor at Marion Street
Columbia, South Carolina 29220

Mr. Kester S. Freeman, Chief Executive Officer
Richland Memorial Hospital
Five Richland Medical Park
Columbia, South Carolina 29203

c/o Ms. M. Elizabeth Crum
McNair Law Firm, P.A.
P. O. Box 11390
Columbia, S. C. 29211

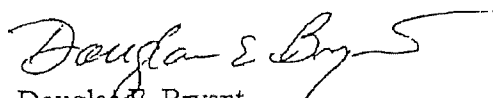
Re: COPA-97-01
Certificate of Public Advantage
BR Health System, Inc.
Columbia, South Carolina

Dear Messrs. Beaman and Freeman:

Enclosed is the Certificate of Public Advantage issued to BR Health System, Inc. pursuant to the Order of The Honorable John D. Geathers, Administrative Law Judge, dated August 28, 1997.

Should there be any questions regarding this action, please feel free to contact me.

Sincerely,

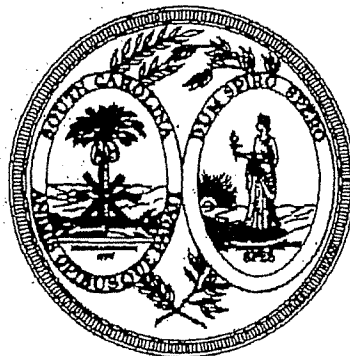

Douglas E. Bryant
Commissioner

DEB/vmm

Enclosure

cc: The Honorable Charles M. Condon

South Carolina Department of Health and Environmental Control

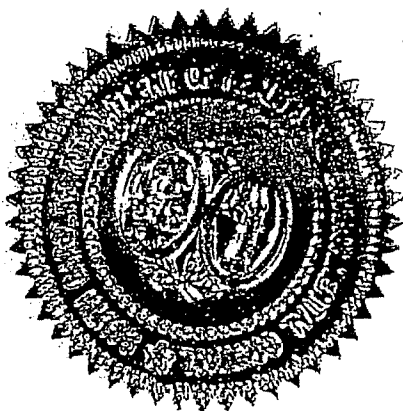


CERTIFICATE OF PUBLIC ADVANTAGE

This Certificate of Public Advantage, No. COPA-97-01, is issued to BR Health System, Inc., (the System) for the incorporation of a nonprofit entity to operate the hospitals of the Sponsoring Organizations as a single unit. The Sponsoring Organizations include (1) Baptist Healthcare System of South Carolina, Inc., Columbia and Easley, South Carolina and (2) Richland Memorial Hospital, Columbia, South Carolina.

In reaching this decision, the Department has determined that the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement. The Department has also determined that the reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.

This represents the Department's final decision regarding this agreement. This decision is subject to each condition described in the approval dated May 8, 1997.



In Witness Whereof I have hereunto set my hand and the seal
of the Department of Health and Environmental Control
this the 6th day of October, 1997.

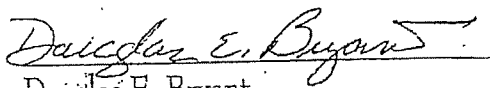

Douglas E. Bryant
Commissioner

EXHIBIT 4

BOARD:
Elizabeth M. Hagood
Chairman
Mark B. Kent
Vice Chairman
Howard L. Brilliant, MD
Secretary



C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

BOARD:
Carl L. Brizell
Louisiana W. Wright
L. Michael Blackmon
Coleman F. Buckhouse, MD

November 18, 2003

Mr. Kester S. Freeman, Jr., Chief Executive Officer
Palmetto Health Alliance
P. O. Box 2266
Columbia, South Carolina 29202-2266

Re: Update of the original conditions as set forth in Palmetto Health Alliance's Certificate of Public Advantage (COPA)

Dear Mr. Freeman:

Palmetto Health Alliance (The System) celebrated its fifth anniversary on February 8, 2003. Throughout this time, Palmetto Health Alliance has operated in accordance with the Certificate of Public Advantage (COPA) granted by the South Carolina Department of Health and Environmental Control (Department) on or around May 8, 1997. Many of the conditions set forth in the COPA were targeted for the first five (5) years of operations and have either been satisfied or are no longer applicable. Accordingly, we have reviewed the original twenty-five (25) conditions and have made modifications in which many conditions have been eliminated, while others were combined, amended, or restated.

The proposed modifications to the COPA are as follows:

1. That the Palmetto Health Alliance (the System) will provide a full report to the Department every other year beginning FY 2003, which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial statements; and information which will enable the Department to evaluate each of the conditions listed below. In years when a full report is not required, the System will provide the Department an abbreviated report which will include, at a minimum, an annual audited financial statement plus a description of the programs and services the System provides through its Community Outreach Programs as described in Condition 2. All reports, full and abbreviated, may require additional information the Department feels is necessary to adequately evaluate the compliance of the Certificate of Public Advantage. These annual reports are due to the Department no later than 120 days after the end of each fiscal year after the System's Joint Operating Agreement is consummated.

In addition, the System will provide a revised three (3) year forecasted financial statement, which may be based upon its most recently Board approved budget and Board accepted audited financial report. The System will also make available to the Department all of its managed care contracts for inspection, if necessary, which will be considered proprietary and not subject to disclosure.

Mr. Kester S. Freeman, Jr.
November 18, 2003
Page Three

5. That the System will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, the System will give them terms and conditions equal to the lowest of the amount which would be received from patients insured by either Premier PPO, Cigna or Aetna. That the System will continue this access for which it is the sole provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable. Additionally, the System must make available to the Department, upon request, names of any facilities, to include terms and conditions, to which services have been offered.
6. That the System will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Richland Memorial Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one Sponsoring Organization's facility, (as provided for in Condition Number 4 above) that medical, graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.
7. That should the System change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, that the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.
8. That as part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied, but excluding extraordinary revenue and expenses, losses on extinguishments of debt and the impact of any mark to market adjustments on derivative instruments; will be used to calculate net of revenues over expenses in the annual report for determining the 10% public health commitment and that such financial statements will be certified by an independent auditor. However, should any of these other items result in cash gains or losses, they may be included in net revenues over expenses.
9. That neither the System, nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is competitive.

2. That the System will provide 10% of its "excess revenues over expenses" to fund public health initiatives and community outreach programs, and the System will provide no less than seventeen million dollars to be allocated over the first seven years of the System's existence. As of September 30, 2002, the end of the fifth fiscal year of the COPA, the System provided \$12,143,200 to fund public health initiatives and community outreach programs. In year six the System will provide \$2,428,000 or ten percent of year six's excess revenues over expenses, whichever is greater to fund public health initiatives and community outreach programs. In year seven the System will provide \$2,429,000 of ten percent of year seven's excess of revenue over expenses, whichever is greater, to fund public health initiatives and community outreach programs. After year seven, the System will continue to provide ten percent of its excess revenue over expenses to fund such programming. Efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits/changes/accomplishments that occur because of the activities/services provided by the programs and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive these services without the Certificate of Public Advantage.

In addition the Department will re-evaluate the terms and conditions of the 10% public health commitment and other community benefits in the aggregate should "revenue and gains in excess of expenses and losses" as a percent of gross revenue escalate or decline (1) to a point where the System's commitment to public health and other community benefits becomes unbalanced as it relates to the System's profitability or (2) to a point where there is little or no commitment to public health or other community benefits.

3. That as a part of the information required in Condition Number 1, the System will report on the nature, source and amount of capital expenditures avoided during the preceding fiscal year. In addition, the System will report major operational savings that can be documented. Costs used to document the above savings must be merger specific, that is, savings that occurred because of the merger and not savings that would have been realized even if the merger had not occurred.
4. The System will report its prospective plans for changes of clinical services between the Sponsoring Organizations' facilities prior to making such changes. That the System, prior to changing, will receive approval from the Department of the change. The changes required to be reported are any consolidations, mergers, deletions, or other change or alteration of clinical services that may significantly affect patients' access to care; or medical, graduate medical, and allied health education program's access to the clinical service.

Mr. Kester S. Freeman, Jr.
November 18, 2003
Page Four

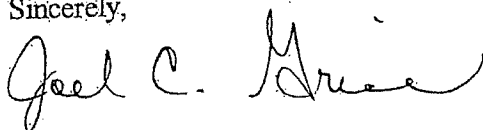
However, it must be the decision of the payer and not be required as a condition of a contract with the System or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

In addition, the System will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require the System to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will as a part of its ongoing monitoring process investigate consistent complaints from employers and managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

10. Except to the extent required by vendors, suppliers or GPOs, that neither the System, nor their affiliates, shall condition any contracts with suppliers, vendors, or group purchasing organizations that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the Sponsoring Organizations.
11. That the Department may amend these conditions to include, but not limited to, lowering prices should unexpected events lead to abnormally high margins from operations.
12. That the System will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specially described in these conditions.
13. That the System will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring this approval.

We appreciate the continued cooperation from the Alliance. If you have any questions regarding this letter, do not hesitate to contact me.

Sincerely,



Joel C. Grice, Director
Bureau of Health Facilities and Services Development

cc: Mr. Charles D. Beaman, Jr.
Mr. Howard West

EXHIBIT 5

Friday, December 13, 2019

Margaret P. Murdock, Esquire
Director, Division of Certificate of Need
301 Gervais Street
Columbia, SC 29201

Re: PRISMA HEALTH-MIDLANDS ACQUISITION OF LIFEPOINT ASSETS AND THEIR INCLUSION UNDER THE CONDITIONS OF THE 1997 CERTIFICATE OF PUBLIC ADVANTAGE.

Dear Ms. Murdock:

We are submitting this request to you in your capacity as Director of the Certificate of Need Program, which includes overseeing the State Certificate of Need and Health Facilities Licensure Act, S.C. Code Ann. §§ 44-7-110 (2010) and the Health Care Cooperative Act, S.C. Code Ann. §§ 44-7-500 (2010) .

HISTORICAL BACKGROUND.

Palmetto Health (PH) is the company that was formed by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital and is the legal entity to whom the Department of Health and Environmental Control (DHEC or Department) issued the Certificate of Public Advantage (COPA). On May 8, 1997, DHEC issued the decision letter, with twenty-five (25) conditions approving the COPA (COPA Conditions). Exhibit 1, Certificate of Public Advantage BR Health System, Inc., Columbia, South Carolina. Disaffected parties sought an administrative review by the S. C. Administrative Law Court (ALC). The ALC dismissed the case and the actual COPA was issued October 6, 1997. *Id.*

PH has complied with all of the COPA Conditions, including its title.¹ Over the years, DHEC has monitored PH's actions under the COPA Conditions. In 2003, DHEC and PH agreed to modify and update the COPA Conditions. Exhibit 2, Modified COPA Conditions dated November 8, 2003.

In late 2017, PH and Upstate Affiliate Organization d/b/a Greenville Health System (GHS) entered into an affiliation agreement to form Prisma Health (Prisma Health). Prior to closing the transaction, PH and GHS sought a determination from DHEC as to whether the affiliation between the two health systems implicated the COPA Conditions. This transaction is further described in Exhibit 3, attached hereto. DHEC determined that the affiliation between PH and GHS to form Prisma Health did not implicate the COPA Conditions, which remained in place with PH. *Id.* After Prisma Health was formed, PH changed its name to Prisma Health-Midlands. Exhibit 4, page from the S. C. Secretary of State website.

THE REQUEST AND SUPPORTING RATIONALE

Prisma Health entered into a Letter of Intent on September 13, 2019 to acquire three South Carolina hospitals, and other related assets and operations, (the "LPNT Assets") from LifePoint Health ("LPNT"), an investor-owned hospital management company based in Brentwood, Tennessee (the "Transaction"). Prisma Health-Midlands intends to purchase Providence Downtown ("PD") and Providence Northeast

¹ <https://www.palmettohealth.org/classes-events/community-outreach/community-health-initiatives/annual-reports>

("PNE"), both located in Richland County, and Kershaw Health ("KH"), located in Kershaw County. Prisma Health will acquire these LPNT Assets through the execution of an Asset Purchase Agreement ("APA"). Prior to the execution of the APA, we are notifying DHEC that it is our belief that the LPNT Assets being acquired by Prisma Health-Midlands are subject to the COPA Conditions and are asking DHEC after evaluating the benefits and competitive consequences of the asset acquisition: 1) to acknowledge that the LPNT Assets are subject to and will be monitored under the COPA Conditions, and 2) to make such updates and modifications to the COPA Conditions as the Department deems necessary. We believe that acquiring and integrating these health care facilities into Prisma Health, specifically Prisma Health-Midlands, will benefit healthcare consumers in the Midlands region, and advance our ability to create a better state of health for South Carolina.

We intend to integrate these facilities into Prisma Health-Midlands, a 501(c)3 entity that provides health care to the communities within the Midlands region of South Carolina. To facilitate this integration, we are requesting that the Department approve Prisma Health-Midlands' proposed modifications to the conditions of the COPA Conditions between Prisma Health-Midlands and the Department, to make the LPNT Assets a part of and subject to the COPA Conditions. It is our position that our acquisition and integration of the LPNT Assets, specifically including the three hospitals, falls squarely within the purpose and scope of the South Carolina Health Care Cooperation Act and regulation² and requires only that the COPA Conditions be modified and updated to make the LPNT Assets subject to the COPA Conditions when the Transaction closes. For the reasons set forth below, Prisma Health-Midlands believes the LPNT Asset acquisition fits perfectly within the active COPA Conditions that has been in place between DHEC and Prisma Health-Midlands for over 22 years and has provided over \$60 million in direct support through the Tithe (Exhibit 5 attached hereto), in addition to providing a myriad of healthcare benefits to the community including health screenings and health educational programs.

As we will describe in further detail, the community benefits of the Transaction fall into three primary categories:

- Increased Quality
- Improved Access to Care
- Lower Costs

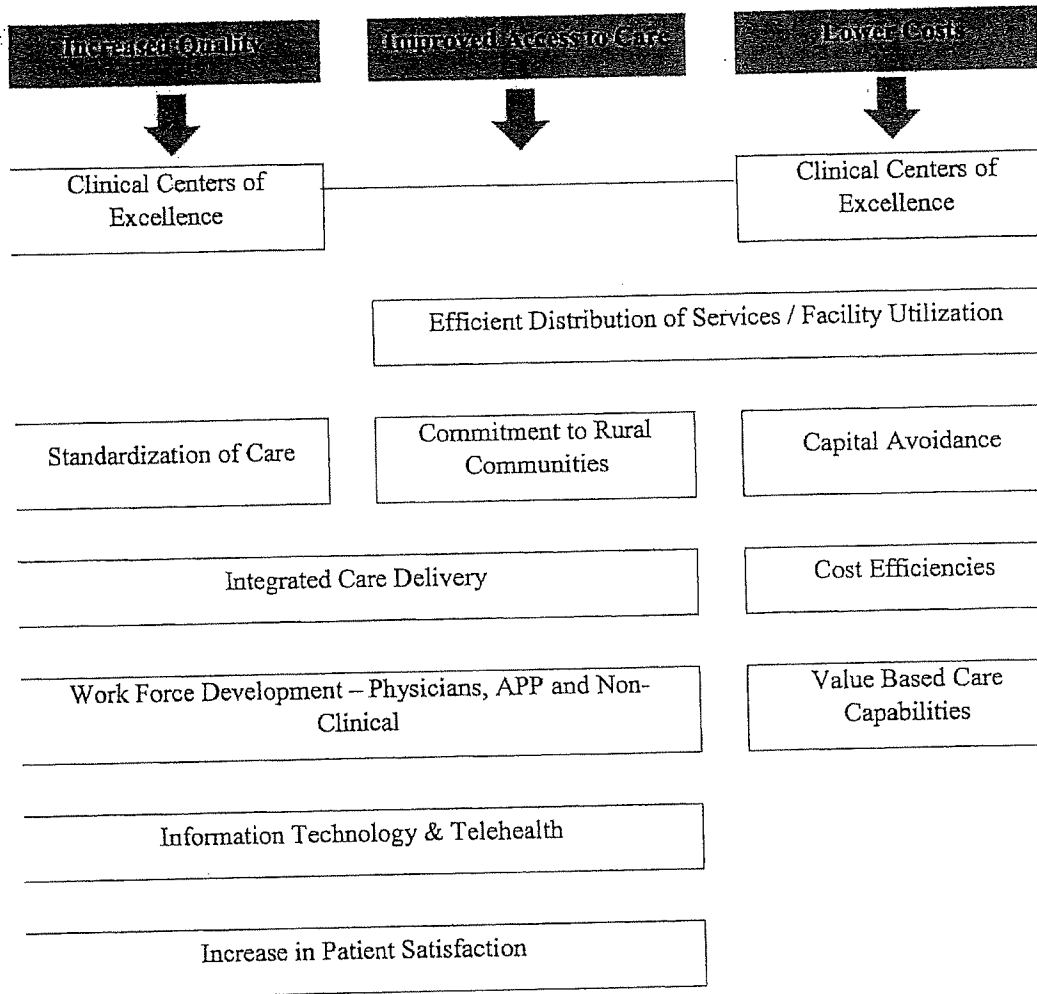
In addition to the community benefits, we believe the Transaction will have little to no effect on the competitive landscape in the COPA Service Area. If you believe that you need any further information in order to evaluate our proposed transaction, please let us know immediately and we will respond.

² SC Code Ann. Regs 61-31 (1995) Section 101 Purpose:

These Regulations implement the legislative intent that there be a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers, which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition.

This is encouraged because the cost of improved technology and scientific methods contribute significantly to the increasing cost of health care; and cooperative agreements among hospitals, health care purchasers, and other health care providers will foster improvements in the quality of health care for South Carolinians.

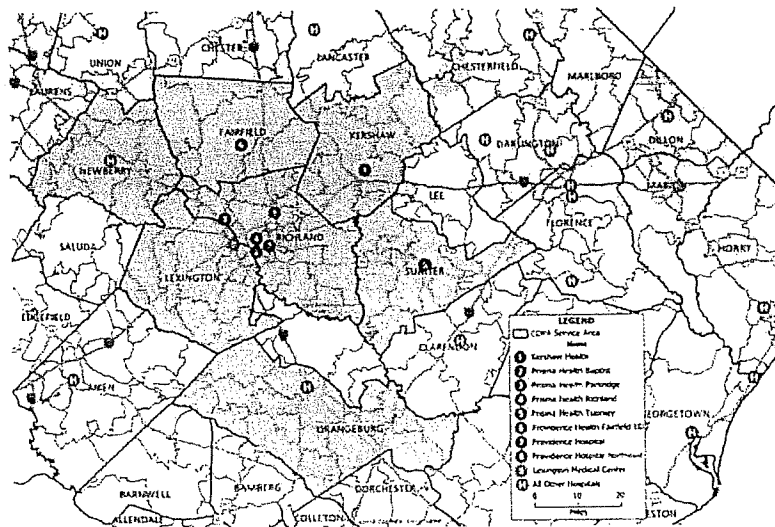
We believe that the Transaction has material and immediate benefits to the community and will improve the access to health care and the health of the citizens in the Midlands of South Carolina. The table below outlines how Prisma Health's core competencies will span multiple areas of community benefit:



1. The original COPA geographic region remains unchanged.

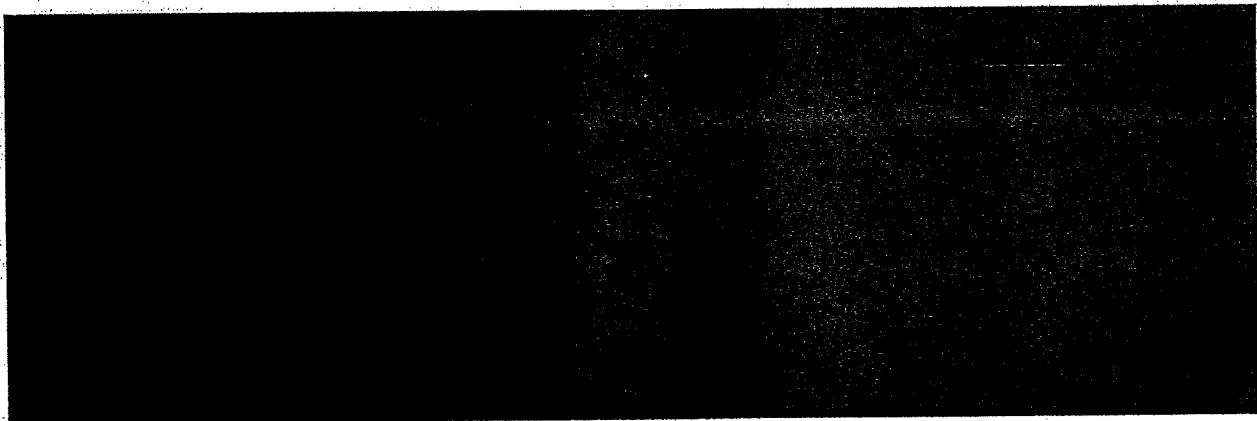
The geographic region ("Service Area") of the existing COPA is comprised of the following seven counties:

1. Richland
2. Lexington
3. Kershaw
4. Sumter
5. Orangeburg
6. Newberry
7. Fairfield



The three LPNT hospitals are physically located within Richland and Kershaw counties – and 88% of their discharges are from the existing Service Area. This distribution of patient discharges is not materially different from the current distribution of discharges for patients of Prisma Health–Midlands.³

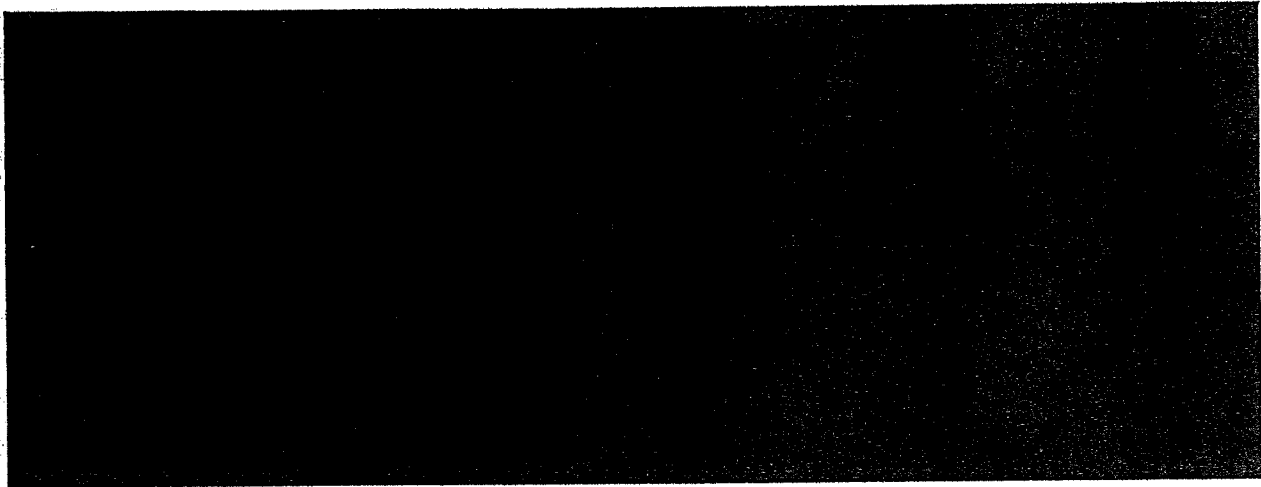
2018 Discharges by County of Patient Origin



The current distribution of discharges by hospital in the Service Area is depicted below:

³ The appendices that support the data compilations herein are being submitted under separate sealed cover

FY18 IP Discharges from COPA Service Area



Based upon the physical location of the hospitals and the patient origin for these facilities, the COPA Service Area is unchanged.

2. **An Integrated System of Care Enhances Quality, Access and Cost Containment** – Health systems and hospitals are under tremendous pressures to improve clinical outcomes, reduce costs to align with decreasing reimbursement and national emphasis on decreasing the costs of health care, invest in new technologies, provide care for uninsured and underinsured patients, and assume the risk for achieving predetermined clinical and financial outcomes for populations. We believe that an integrated delivery system encompassing the entire care continuum that is local and accountable to the community it serves is the right clinical and business model to create value in this increasingly complex and rapidly changing healthcare environment. There is no other healthcare organization within or outside of South Carolina that can integrate the LPNT facilities into a Midlands based system of care without first establishing a robust clinical, business, and community presence. Given its existing network of hospitals, physicians and ambulatory sites, Prisma Health–Midlands is uniquely positioned to deliver maximum efficiencies of scale in clinical and business operations while leveraging the scarce resources of our highly skilled and capable workforce and achieving the benefits of academic integration across the LPNT Assets. As discussed below, a third party entrant would put a significant strain on our region’s already over-taxed health care staffing resources.

Examples of the benefits that will be realized by consumers through Prisma Health–Midlands acquiring the LPNT Assets include:

- A. **Creating Centers of Excellence.** A prime example of an opportunity for eliminating unnecessary duplication of services, enhancing quality and cost containment involves our proposed center of excellence approach for cardiovascular services in Richland County. According to the draft 2020 South Carolina Health Plan (and numerous previous state health plans, including the 2018-2019 South Carolina Health Plan) the preponderance of literature on open heart surgery indicates that a minimum number of procedures is recommended per open heart suite (“OHS”) per year in order to develop and maintain

physician and staff competency in performing these procedures. Currently most of the Midlands hospital providers are utilizing less than the functional capability (defined as 70% of capacity) of their existing OHS. In fact, the number of open heart surgeries performed at PD has steadily declined in recent years. In FY14, 500 procedures were performed in the four (4) OHS, or 125 per OHS. In FY18, that number dropped to 304 surgeries, or 77 per OHS at PD. Both of these indicators fall far below the State-recommended minimum of 200 procedures per OHS. Conversely, Prisma Health Richland Hospital has grown steadily in its number of open heart surgeries, rising from 344 surgeries in FY14 to 484 in FY18, or 161 per OHS.

By virtue of this Transaction, the seven (7) OHS in Richland County can be reduced to four (4) by relocating one (1) OHS to Prisma Health Richland Hospital for a total of four (4) OHS and closing the three remaining OHS at PD. This would equate to a current distribution of 197 procedures per OHS and allow for organic growth in this center of excellence. This proposed consolidation meets all of the purposes of the CON Act, which are 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 State⁴.” This open heart surgery proposal is squarely within the public’s best interest as it ensures that, by meeting minimum volume criteria, the clinical staff and physicians are maintaining their skills and proficiencies, which will in turn translate to sustained excellent patient outcomes.

In addition, using the same reasoning as above, Prisma Health–Midlands proposes to consolidate cardiac catheterization (cath) labs between the between the Prisma Health–Midlands providers. Currently, PD has seven (7) cardiac cath labs and in FY18 5,007 equivalent caths were performed, or 715 per cath lab. This represents a 16% decrease from their FY17 volumes and falls short of the South Carolina Health Plan definition of capacity, which is set at 1,200 caths per lab per year. The Prisma Health–Midlands hospitals in Richland County have five (5) labs, where specialists performed a total of 6,464 cases (or 1,293 per cath lab) in FY18. By consolidating all heart and vascular services to Prisma Health Richland, patients will benefit from receiving all of their cardiovascular care in a center of excellence where clinicians can achieve the highest quality benchmarks through specialization and repetition. Through this consolidation, Prisma Health–Midlands will be able to reduce the number of licensed catheterization labs from 12 to 10, resulting in approximately 1,147 cases per cath lab annually. This consolidation will result in a total reduction in capital spending on costly equipment and infrastructure and will leave 10 other cath labs remaining in the Region II service area providing patients with ample non-Prisma Health choices. In addition, this consolidation will promote efficiencies with respect to highly skilled and scarce employee resources. In the Prisma Health Heart Hospital alone, \$1.6 million was spent on temporary staffing in FY2019.

These are just two examples of the center of excellence concept that will guide the integration of these assets once operated by Prisma Health. We will evaluate other

⁴ SC Code Ann. Regs 61-15 (2012 rev)

clinical services for consolidation and realignment in pursuit of similar benefits. Prior to taking action on relocation, consolidation and center of excellence opportunities, Prisma Health–Midlands will notify the Department and take such regulatory actions as may be necessary for each project in keeping with CON requirements.

- B. One Rising Standard of Clinical Excellence. We believe that the best healthcare is provided through evidence-based clinical protocols that remove unwarranted variations in care delivery. Studies show that up to 30% of all Medicare clinical care spending in the US is unnecessary and could be avoided without worsening health outcomes.⁵ Since we formed two years ago, we have established clinical councils across Prisma Health to develop and deploy clinical standards in several areas, including: cardiovascular, pediatrics, neurosciences, behavioral health, and primary care. Other clinical areas will follow, and the former LPNT facilities, clinical staff, and programs will be included in the work of these clinical councils. It has been our experience that the involvement of providers in the development and deployment of clinical standards leads to greater buy-in than simply being handed an order set or clinical protocol to follow. We will integrate the approximately 95 LPNT employed physicians into our Midlands medical group where they will engage with their physician colleagues in identifying areas for clinical improvement, as well as participating in clinical program development and expansion activities.
- C. Integrated Information Technology Platforms. Prisma Health is standardizing all IT platforms across the enterprise so that the right clinical, financial, operational, and demographic information is available to providers at the point of healthcare decision-making. This IT integration includes the use of the Epic Medical Records software system wide. Prisma Health is the first health system in South Carolina to achieve a level of IT integration matched by only six percent (6%) of U.S. hospitals, and this integration plays a role in ensuring electronic medical records (EMR) are readily available to clinicians which contributes to improved clinical care and patient safety. These integrated IT platforms are the foundational building blocks of achieving a single rising standard of care, and they also provide a means to assimilate each individual patient's health information from all of the various components of the Prisma Health care continuum in a format that is easy to access and understand. The LPNT assets will receive these IT platforms, which includes the Epic EMR. Currently, 80% of SC patients have medical information in an Epic electronic health record, with more than 230 million patients in Epic nationwide. Because LPNT currently utilizes several different EMR platforms, the LPNT Assets' use of Epic will result in a greater proportion of SC patients benefitting from the increased coordination of care. Equally important from the patient standpoint is that Epic will allow Prisma Health patients to access their medical records from all other providers who use Epic, regardless of the health care system or location in which they received care.
- D. Efficient distribution and utilization of physical assets. Health care organizations must maximize utilization of high cost fixed assets such as hospital facilities in order to achieve meaningful cost containment in an environment of shrinking inpatient

⁵ *Reducing Waste in Health Care*, Health Policy Brief, Health Affairs, December 2012 (www.healthaffairs.org)

reimbursement. A prime example of how acquisition of these LPNT Assets will also facilitate efficiency in the delivery of inpatient services is in the northeast Richland County market where PNE is located. The patient population in this region is a rapidly growing part of Prisma Health–Midlands’ core market and is projected to grow by eight percent (8%) in the next five (5) years. Incorporation of these LPNT Assets will provide residents in this area with improved access to Prisma Health programs and facilities. Our near term plan is to use the PNE facility, which is licensed for 74 beds, with an FY18 average daily census of 17 (or 23% occupancy), to address the current facility constraints at Prisma Health Baptist Parkridge, Prisma Health Baptist, and Prisma Health Richland facilities. This plan has several benefits for consumers.

- i. Improves patient access to Prisma Health–Midlands services in this northeast market area. Currently, people who live in this area and choose to use Prisma Health–Midlands physicians and services must travel to our downtown or northwest facilities. In FY2018, Prisma Health–Midlands had a fifty-five (55%) percent market share in the northeast region. In other words, over 7,000 patients per year from the northeast area receive inpatient care from a Prisma Health–Midlands facility despite having to travel to do so. By offering Prisma Health services at the PNE facility as well as at the KH facility (the northeast Richland County market area includes zip codes that carry over into Kershaw County), Prisma Health–Midlands services will be closer to where patients live and therefore more accessible to those who have already chosen Prisma Health as their healthcare system.
- ii. Reduces the type and amount of capital investments we would otherwise make at Prisma Health Baptist Parkridge to address demand for services provided in a community hospital setting with specialization in areas such as orthopedics and outpatient surgery. Facility and operating plans are under review for a surgical suite expansion project at the Parkridge campus entailing 43,000 square feet with 8-10 additional operating rooms. This \$32 million project addresses the need to offload selected surgical cases at Prisma Health Richland Hospital to Prisma Health Parkridge Hospital and to accommodate planned growth on that campus. The integration of PNE within Prisma Health brings on line 10 additional ORs which are currently operating at approximately 30% of capacity, providing us with the ability to utilize existing assets in the market and significantly reducing need for additional surgical suites at Parkridge at this time.
- iii. Makes our investment in the northeast region more efficient. The acquisition of PNE will allow Prisma Health–Midlands to invest in clinical programs and physician practices rather than pursuing an inpatient or major ambulatory facility plan that would add more high fixed cost structures to the northeast region. Our facility master plan contemplates the construction of a 65,000 square foot ambulatory facility in the northeast market place at an estimated construction cost of \$41.4 million, exclusive of the cost of the 12 acre site we already own in this region. The acquisition of the LPNT Assets will address our facility needs in this region, and we can shift our spending to expand existing or acquired clinical programs and clinical staffing which will cost much less and deliver immediate benefits in areas of access, clinical outcomes and staffing efficiencies.

Other optimization opportunities exist through Prisma Health–Midlands’ operation of the LPNT Assets. For instance, our intent is to repurpose or reimagine the PD facility within our system of care in the Service Area. We will likely not continue this asset as a full service acute care hospital, which will guide our investments in this facility so that it contributes maximum value to the community and does not unnecessarily duplicate existing health care services. Another purchaser, lacking our local resources and integrated system of care, would almost certainly have to make a significant capital investment in the aging PD infrastructure to reestablish it as a full service acute care hospital, all the while having to recruit and hire clinical staff in a market that has a shortage of these specialized healthcare workers. The federal and state governments, and Midlands businesses would inevitably bear the increased health care costs necessarily associated with such significant expenditures. Only Prisma Health has the ability to rationalize investment in and deployment of the PD facility efficiently to provide services within an integrated system of care.

- E. The Prisma Health Medical Groups. One of the core strengths of Prisma Health is its integrated medical groups. Altogether, we employ 1,801 physicians and 1,118 advanced practice providers across Prisma Health of which 578 physicians and 404 advanced practice providers are located in the Midlands. These clinicians are engaged in developing and advancing our clinical, academic and community health initiatives, and are responsible for creating the clinical and operational integration needed so all aspects of the healthcare continuum operate efficiently for the benefit of the patients and consumers. These physicians can be deployed to better utilize the LPNT facilities for the benefit of the entire community.

The approximately 95 physicians employed by LPNT will join the other Prisma Health physicians to become part of this integrated system of care. They will be responsible for establishing a single rising standard of quality, furthering the development and operation of centers of excellence, and utilizing the IT platforms, including Epic, to deliver safe and effective patient care. The integration of the employed physicians will allow for the configuration and operation of an efficient care continuum comprised of physical and clinical assets that work together to achieve targeted clinical outcomes within cost containment parameters. The use of Epic by all Prisma Health physicians will, as discussed above, also provide our patients a full view of their health information across every Prisma Health care delivery platform.

- F. Extending our commitment to care in rural communities. Prisma Health’s system of care begins in the community. We have been successful in fostering collaborative relationships with community-based organizations to meet the needs of our State’s most vulnerable patients outside of the traditional four walls of the acute care hospital environment. Prisma Health has demonstrated excellence through various and diverse partnerships that utilize community health workers to visit patients in their homes and connect them with health and social resources focused on improving their condition. This system of care will be extended to include the LPNT Assets and personnel which will provide a significant benefit to these patients.

Another benefit of the Prisma Health system of care is the investment in telehealth that will be made available to patients in more rural areas. Currently, several of the counties in the Service Area are either rural or have rural areas with health care access issues. For example, Fairfield County is one of eight (8) counties in the state with no inpatient hospital services. Fairfield and Kershaw counties will now be a part of an integrated delivery system with seamless connections to specialized clinical services that includes a comprehensive network of primary care and specialty care physicians. Our ability to recruit physicians and advanced practice providers, who are supported by digital health platforms, will facilitate community-based care in counties like Fairfield and the more rural parts of Richland and Sumter. Our telemedicine technology provides access to health services to people in the rural portions of these counties. Applications such as SmartExam, Post-Acute Remote Patient Monitoring, and pediatric video consults are examples of how Prisma Health is already reaching some of the Midlands' most vulnerable patients.

We will also integrate LPNT Assets with Prisma Health resources and clinical partnerships to expand offerings in post-acute areas such as hospital at home, skilled nursing, rehab, home health and hospice.

3. **The health care workforce, our team members, are our most important patient care asset.**

In October of this year, Prisma Health announced a \$125 million wage package that will bring all of our clinical, service, and support jobs up to market rates. This significant investment in our team members was undertaken to address staffing issues involving vacancy rates, turnover, use of temporary staffing agencies, and other factors affecting operations. We are also focused on making sure our clinical personnel are working at the top of their training and license so we can leverage their skill and experience to provide greatest benefit to our patients. The integration of the LPNT personnel provides additional opportunities to gain staffing economies through the reduction in use of travelers, and the ability to better schedule clinical staffing consistently and efficiently within their areas of clinical expertise.⁶ The integration of services and the consolidation of services into centers of excellence should help reduce Prisma Health–Midlands clinical workforce shortages. Examples of these opportunities include:

- A. Combine low volume programs and services to improve clinical and operating outcomes so that we maximize access to highly trained and scarce clinical personnel in areas of ICU, cardiac, and surgical services.
- B. Reduce utilization of agency personnel by combining programs and services using existing Prisma Health–Midlands and LPNT facility clinical staffing who can provide services in fewer locations.
- C. Increase options for employees to work at different Prisma Health locations, which will lead to increased satisfaction and lower turnover.
- D. Expand the clinical learning environment supporting the training and retention of the next generation of South Carolina caregivers. One of the most significant benefits of this acquisition will be the extension of the Prisma Health academic medical platform to the

⁶ As of December 9, 2019, Prisma Health–Midlands facilities have a combined total of 274 open requisitions for registered nurses.

LPNT Assets.

Prisma Health is a major producer of the clinical workforce in South Carolina. We and our academic partners, which include the University of South Carolina, Clemson University and Furman University, offer training programs in a variety of areas including: undergraduate medical education, graduate medical education, undergraduate nursing education, graduate nursing education, pharmacy and other clinical disciplines. In the Service Area alone, Prisma Health has 259 medical residents in 14 residency programs, 41 fellows in its 17 specialty fellowships, and teaches approximately 170 nurses in residency and training programs. By incorporating the LPNT Assets into the clinical learning environment of our workforce training programs, we are able to expand these programs and expose these learners to additional sites of care in the Service Area, particularly into the rural areas of Richland, Kershaw and Fairfield Counties.

According to the 2019 AAMC Annual State Physician Workforce Data Report, 76% of students who attended medical school and completed their residency in South Carolina remained in South Carolina to practice medicine. Integrating these sites into our workforce development activities will benefit the public for years to come as we take proactive measures to address the current and looming physician, nursing, and allied health professional shortages.

4. **Competition remains strong in the COPA Service Area.** According to South Carolina hospital discharge data for FY2018, the LPNT hospitals account for only 13% of total discharges in the Service Area, with an average daily census of 166⁷, or 36.6% occupancy (453 licensed beds). Other inpatient providers in the Service Area better utilize their 894 licensed beds, with an average daily census of 565, or 63.2% occupancy.

<u>Facility</u>	<u>General</u>		<u>%</u>
	<u>Beds</u>	<u>ADC</u>	<u>Occupancy</u>
Lexington Medical Center	557	427	76.7%
Newberry County Memorial Hospital	90	19	21.1%
Regional Medical Center Orangeburg	247	119	48.2%
Total	894	565	63.2%

(Source: Draft 2020 South Carolina Health Plan
11/1/19)

Lexington Medical Center (LMC) is the most aggressive provider in our Service Area, and has made significant investments over the past several years in both inpatient and outpatient services. LMC recently opened its \$400 million patient bed tower expansion which they describe as “the largest hospital expansion in the state’s history.”⁸ Their aggressive ambulatory expansion is especially true in physician practice acquisition and development in the more affluent areas of Richland County that have a higher percentage of patients with commercial coverage. In fact, LMC owns and operates 67 practices at 81 locations and has an additional 13 affiliated practices

⁷ Internal LPNT data (PD 99 ADC, PNE 17 ADC, KH 50)

⁸ Lexington Medical Center website. <https://www.lexmed.com/about/media-news/detail/388/lexington-medical-centers-new-patient-care-tower-opens>

at 21 locations in the Service Area.⁹

Considering where LMC is placing its facility and physician practice acquisition assets, it is fair to conclude that LMC's focus is on the commercially insured. Within the past 90 days, LMC hired South Carolina OBGYN (SCOB), a 10-physician practice that was based exclusively at Prisma Health Baptist in Columbia. These physicians, whose practice was comprised of approximately 75% commercially insured patients, represented roughly 500 deliveries per year for Prisma Health–Midlands. Within the past year, LMC also hired one neurologist and a group of four urologists from Prisma Health–Midlands.

LMC also submitted a CON application, which is currently under review by DHEC, for a 220,000 square foot advanced ambulatory facility for northeast Richland County, not four miles from PNE. Current plans for this facility include ambulatory surgery, imaging, physician practices and other outpatient services. The size of this planned center approaches that of inpatient facilities.¹⁰

Competition is also impacted by a number of providers in the non-general acute care setting, which is increasingly important since there is such a rapid movement to the ambulatory setting through payment policy, technological innovation, shifting of payment risk to consumer, etc. Since 2003, there has been a 55% increase in the number of outpatient procedures performed in an ambulatory surgical facility setting in the Service Area.¹¹ In fact, the ambulatory surgery and endoscopy marketplace has a significant number of strong competitors. Prisma Health currently captures only 33% of the ambulatory surgery market share in the Service Area and only captures 11% of the outpatient endoscopy share. In addition to outpatient departments of competitor hospitals, there are 50 surgical suites in 17 ambulatory surgical facilities in the Service Area.

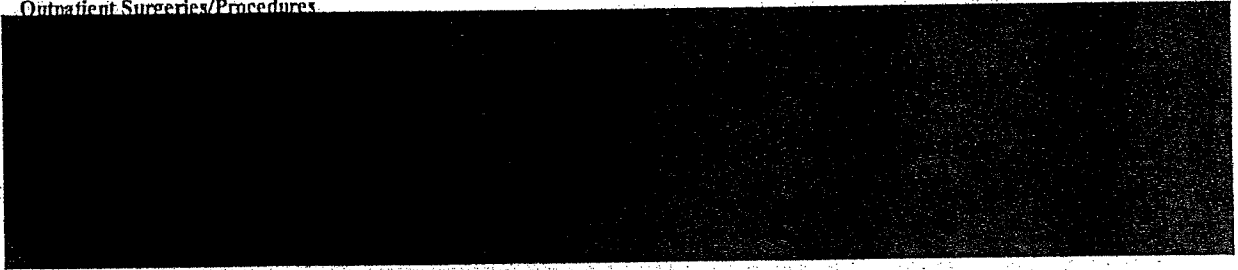
⁹ The acquisition and development of physician practices is particularly important from a competition standpoint, since it is a given that a patient's primary manner of access to an inpatient facility is through a physician with staff privileges.

¹⁰ The PNE hospital facility and an attached four story MOB is 239,113 square feet total (144,849 for the 74 bed hospital; 94,264 for the attached MOB)

¹¹ In 2003, 35,771 procedures were performed in ASFs in the Service Area. In 2018, that number grew to 55,543.

**FY18 Outpatient Market Share Report
COPA Service Area**

Outpatient Surgeries/Procedures

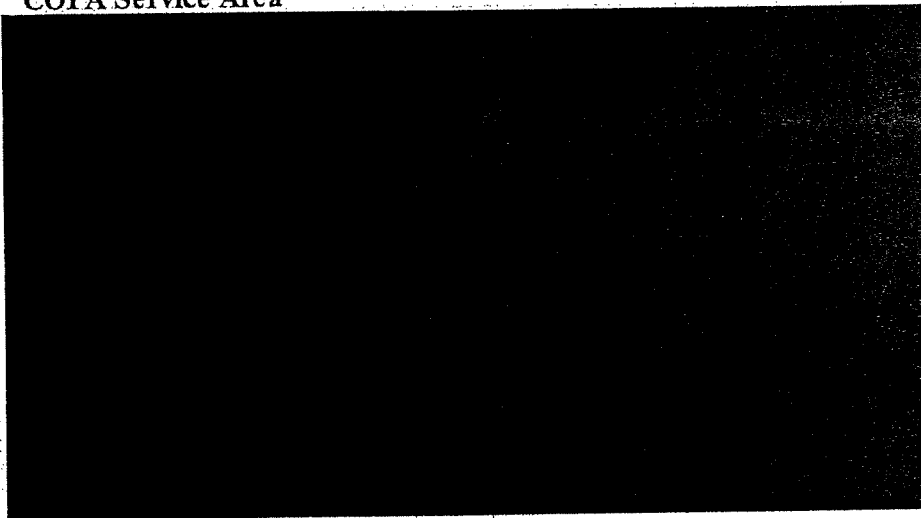


Outpatient Endoscopies



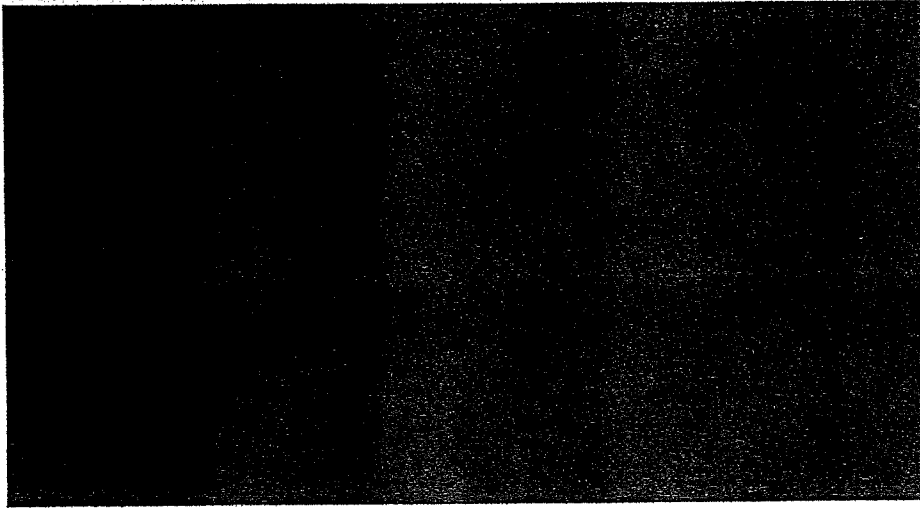
The Prisma Health–Midlands facilities currently capture 33% of the ambulatory surgery share, and post-transaction that capture only reaches 40%. The majority of the market share will still be provided by competitors in the Service Area.

**FY18 OP Surgery/Procedure Market Share
COPA Service Area**



And the endoscopy share moves from 11% pre-Transaction to 17% post-Transaction.

**FY18 OP Endoscopy Market Share
COPA Service Area**



Other non-general acute competitors within the Service Area to consider:

- Blue Cross Blue Shield of South Carolina operates 16 urgent care centers in the area under the name Doctors Care
- UHS/ Three Rivers Health operates a 112 bed inpatient psychiatric facility in Lexington County
- Palmetto Primary and Specialty Care¹² physician practice operates eight (8) locations in the Midlands
- McLeod Health, a regional health care system, operating, among other facilities, a tertiary acute care hospital in Florence, South Carolina, employs 10% of primary care physicians in Sumter County, a community in which they do not operate a hospital.

5. **Reimbursement and payment will align to support value-based care.** With the implementation of the Affordable Care Act (ACA) in March 2010, health care reimbursement policy and practice shifted from a fee-for-service orientation to one commonly referred to as “value-based”. Even if the ACA is substantially repealed or replaced, the US health care system will not return to the previous system of payment where hospitals and other health care providers just raised rates every year to generate their margins. This construct is simply not affordable to those who pay the bills, namely federal and state governments, South Carolina businesses, and patients.

The Centers for Medicare and Medicaid Services (CMS) has built value-based health care concepts into its foundational payment structures and systems, and private employers and households, who represent 87% of total health care spending outside of federal and state governments,¹³ will not and cannot afford to return to the days of unchecked cost shifting.

¹² Palmetto Primary and Specialty Care is a 100+ physician practice with multiple locations in the Midlands and Lowcountry

¹³ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> accessed 12/1/19

Prisma Health¹⁴ has taken deliberate action over the past 10 years to become a value-based health leader – to transform our organization so it can deliver services to patients, populations and communities that improve clinical outcomes, which are affordable and accessible. Please consider these four proof points on our approach to reimbursement and payment, which are germane to our plans to integrate the LPNT Assets into Prisma Health–Midlands.

- A. Prisma Health’s clinically integrated networks deliver high quality. We operate two clinically integrated networks in South Carolina: the Prisma Health–Upstate Network and the Prisma Health–Midlands Network. These two networks are the vehicles to engage 3,887 providers¹⁵ in value-based health care arrangements with federal, state and private payors. The Prisma Health–Midlands Network, comprised of 1,888 providers, was recently recognized for outstanding quality performance in its 2018 Medicare Shared Savings Program (MSSP) metrics. It scored a 98.4% which placed it as one of the top scoring networks nationally and it also scored a 100 out of a possible 100 points on the CMS Merit-based Incentive Payment System (MIPS). The LPNT physicians and advanced practice providers will join the Prisma Health–Midlands network and will become active participants in the care model and quality management programs that enabled our organization to achieve this level of high performance.
- B. Prisma Health is pursuing value-based payment models. As of December 2, 2019, we have 271,942 covered lives in performance based arrangements that have substantial upside and downside risk for achieving predetermined quality and cost containment goal for the covered populations. These covered lives account for between 20% and 25% of our entire patient base, which is a book of business sufficient to support the investment in analytics, clinical programs, and care management services required to perform under the value-based arrangements.

Importantly, the LPNT Assets will be included in these risk arrangements once they become part of Prisma Health. This will provide an expanded and more diverse platform from which to advance this new payment and care delivery model already accessed by such payors as Medicare, Medicaid and Blue Cross/Blue Shield of SC. This model will reward quality and cost containment, and is not built upon increasing rates to payors. Moving additional physicians and facilities into the value-based methodologies available through the clinically integrated network further realizes DHEC’s goals for the COPA Conditions.

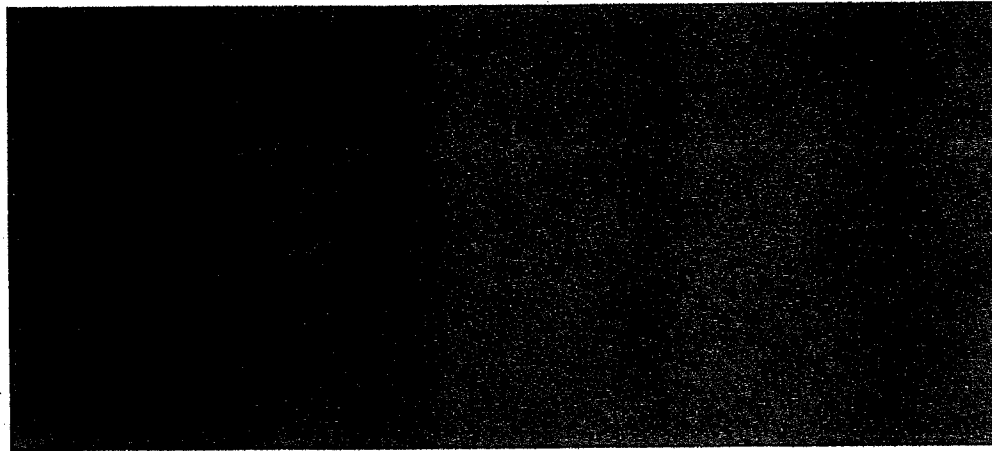
- C. Under the COPA Conditions, DHEC will monitor and oversee, *inter alia*, the rates charged at the former LPNT facilities as part of Prisma Health–Midlands. Please note however that any pricing concern at these facilities is materially mitigated insofar as the vast majority of LPNT’s revenue (rates) are established by the federal and state government payors.

LPNT’s commercially insured business accounts for only 23% percent of its total gross

¹⁴ Both GHS and PH began this process before the affiliation in 2017

¹⁵ There are 4,709 providers in the two networks, of which 1,801 are physicians and 1,118 are advanced practice providers in the Prisma Health Medical Group

revenue,¹⁶ the rates and terms of which are negotiated directly between providers and payors. The rates and terms for the majority of the remaining 77% percent of LPNT's gross revenue are directly set or heavily influenced by state and federal government payors. Areas where rates are set include:



- D. Over the more than 22 years the COPA Conditions have been in effect, inpatient price increases at Prisma Health–Midlands are “statistically indistinguishable from control hospitals.”¹⁷ This was in the findings presented at the Federal Trade Commission’s (FTC) June 18, 2019 meeting – “A Health Check on COPAs. Assessing the Certificate of Public Advantage in Healthcare Markets.” The study was conducted by a graduate fellow in the FTC’s Bureau of Economics, who examined Prisma Health–Midlands’ inpatient price increases between 1999-2008. The control hospitals consisted of those in the same Combined Statistical Area and cities with similar landscapes in South Carolina with the following characteristics similar to Richland Hospital and Baptist Hospital: staffed beds, net revenue, case mix index, and share of Medicare and Medicaid.

The results of this study suggest that Prisma Health–Midlands is not using the consolidations arising from the COPA Conditions to raise inpatient prices beyond market levels, and that the COPA Conditions are performing to expectations.

6. **Direct community benefits will be enhanced.** Since the COPA Conditions took effect in 1997, Prisma Health has funded more than \$60 million in direct community services (benefits) in the Service Area as part of the COPA Conditions. This is commonly referred to as the Tithe condition, or Condition #2 of the May 8, 1997 COPA Conditions,¹⁸ which specifies that Prisma Health–Midlands provide “10% of its ‘excess revenues over expenses’ to fund public health

¹⁶ Source – LPNT internal financial statements for FY2018

¹⁷ <https://www.ftc.gov/news-events/events-calendar/health-check-copas-assessing-impact-certificates-public-advantage>

¹⁸ The Tithe is continued as Condition # 2 as part of the 2003 amendments to the COPA Agreement.

initiatives and community outreach programs.”¹⁹

The addition of the LPNT assets will increase the revenue base of Prisma Health–Midlands by \$345 million day one, or by 19%.²⁰ This provides a greater revenue base to support the Tithe provision. However, even in years that there was a negative net operating margin at Prisma Health–Midlands, we still made investments. For example, in FY2018 and FY2019 Prisma Health–Midlands posted negative operating margins of <\$36.4 million> and <\$96.6 million> respectively. Based upon Condition #2, there was no requirement to provide direct community benefit. However, Prisma Health–Midlands funded over \$6.1 million in “public health initiatives and community outreach programs,”²¹ because these services are important to the community and our purpose.

However, that might not be sustainable in the future if we are not able to pursue a significant change in our delivery system configuration and the payment formats under which services are provided in the Midlands. Rationalization of the usage of the LPNT Assets and incorporation of these Assets into the Prisma Health value-based payment and care models will be an important step in maintaining the financial health of our system dedication to community benefit.

Summary

Going forward, the LPNT Assets are extremely important to the viability and success of Prisma Health–Midlands in attaining the efficiencies, integration and community benefit goals for which the original COPA was sought. The same factors that were in place when the COPA Conditions were issued in 1997 still exist today – pressures on reimbursement, increases in unfunded and underfunded patients, competition from other health care providers for medical/clinical staffing resources and dollars, the need to improve access especially for those most vulnerable, and the need for affordable health care. By bringing the LPNT Assets under the existing COPA Conditions, we can continue to provide the services and programs that the market wants and the community needs with little or no diminution in competition.

The framers of the original COPA Conditions anticipated just this opportunity and its rationale remains as true today as it did in 1997 and 2003. The Service Area is the same, the market place remains very competitive, and community benefits are clearly being achieved. The Department will maintain its involvement in overseeing the COPA Conditions but now, with more assets to regulate. Prisma Health will be in a position to advance quality, medical education, and the efficient use of resources further to benefit the residents of the Service Area. Through the Department’s acknowledgement that the LPNT Assets are subject to the COPA Conditions and making such modifications, if any, to the Conditions as it deems necessary, , Prisma Health–Midlands will be able to continue to advance the well-being of patients in the Service Area, while still being subject to DHEC monitoring and regulation under the COPA Conditions. As the FTC found in its 2018 study, for more than 22 years, Prisma Health–Midlands has not and will not use the consolidations arising from the COPA to raise inpatient prices beyond market levels. Put

¹⁹ From November 18, 2003 official communication from SCDHEC - “Update of the original conditions as set forth in Palmetto Health Alliance’s Certificate of Public Advantage (COPA)”

²⁰ For purposes of this analysis, Prisma Health–Midlands revenue is approximately \$1.8 billion

²¹ FY2018 spend was \$3.14 million, FY2019 spend was \$2.9 million

PROPRIETARY AND CONFIDENTIAL

another way, the public benefits of the COPA Conditions clearly have and will outweigh any impact on competition.

We look forward to working with the Department to modify the COPA Conditions to make the LPNT Assets subject to the conditions and are prepared to respond to any questions that you might have.

With best wishes,

A handwritten signature in black ink, reading "Mark S. O'Halla". The signature is fluid and cursive, with the first name "Mark" and last name "O'Halla" clearly legible.

Mark S. O'Halla
President and CEO
Prisma Health

cc: Rick Toomey
Louis Eubank
Ashley Biggers, Esquire
Howard P. West, Esquire
Malcolm Isley
Elizabeth Crum, Esquire

EXHIBIT 6



February 20, 2020

Via Electronic Mail Only

Robert D. Cook, Esq.
Solicitor General
SC Attorney General's Office
P.O. Box 11549
Columbia, South Carolina 29211

Dear Solicitor General Cook:

I am writing to request an opinion from the Attorney General regarding the scope of authority of the South Carolina Department of Health and Environmental Control (Department or DHEC) to conduct certain reviews under regulations promulgated pursuant to the Health Care Cooperation Act, S.C. Code Ann. Sections 44-7-500 through 44-7-590 (the Act).

Specifically, DHEC seeks an opinion on the following question:

What review must be conducted prior to departmental approval of proposed modifications to a cooperative agreement after issuance of a Certificate of Public Advantage if DHEC determines the proposed modifications are substantial under Section 508 of S.C. Code Regulation 61-31, *Health Care Cooperative Agreements*?

DHEC's interpretation is that "another review" under Section 508 does not necessarily require the same type of review as occurs when an applicant applies for a Certificate of Public Advantage. DHEC believes it is within its discretion to conduct the review it deems appropriate based on the facts and circumstances involved including, but not limited to, the significance of the proposed change, any relevant time constraints related to the proposed change, and any exigent circumstances as found by DHEC or as represented to DHEC by the parties to the cooperative agreement.

I. The Health Care Cooperation Act and Regulation 61-31

The Act is predicated upon Legislative findings set forth at Section 44-7-505(1)-(4). The findings recognize "that cooperative agreements among hospitals, health care purchasers, and other health care providers would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open," and "that competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition." Section 44-7-505(2), (4).

DHEC is the state agency authorized to enforce and implement the Act and is authorized to promulgate regulations pursuant to the Act. Sections 44-7-510(4) and - 570(D). The purpose of the regulation is to "implement the legislative intent that there be a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition." R.61-31, Section 101.

II. Role of DHEC After Issuance of Certificate of Public Advantage

The Act relies upon DHEC's continuing involvement following the approval of an application for a Certificate of Public Advantage. For example, DHEC monitors and regulates agreements approved under the Act and may request information whenever necessary to ensure that the agreements remain in compliance with any conditions of approval. Section 44-7-570(A). While the Act provides a detailed process for review of initial applications and changes to applications prior to issuance of a Certificate of Public Advantage, the Act is silent regarding any process for reviewing proposed changes to a cooperative agreement after issuance of a certificate. However, Section 508 of the regulation addresses this scenario.

SECTION 508. Changes After Receipt of a Certificate of Public Advantage:
If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires *another review*. A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the

community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.

R.61-31, Section 508 (Emphasis added). Therefore, if the Department finds proposed changes to a cooperative agreement after issuance of a certificate are substantial, another review must be performed. Neither the Act nor the regulations provide definitions for "review" or "another review." Because it is not clear from the text of Section 508 what the clear meaning of "another review" is, interpretation of the term is warranted. *See Kiawah Dev. Partners, II v. S.C. Dep't of Health & Env'tl. Control*, 411 S.C. 16, 333, 766 S.E.2d 707, 717(2014).¹

DHEC interprets "another review" in Section 508 to allow it the discretion to conduct the review that may be required, in the event it deems the change to be "substantial." This review will depend on the facts and circumstances involved, such as the significance of the proposed change, any relevant time constraints related to the proposed change, and any exigent circumstances as found by DHEC or as represented to DHEC by the parties to the cooperative agreement. This interpretation is reasonable and consistent with DHEC's statutory authority.

Evidence of the reasonableness of DHEC's interpretation is found in the contrary treatment in Section 308. That section addresses changes made by an applicant prior to the issuance of a certificate. Section 308 necessitates recommencement of the public notice and other steps if DHEC determines that the changes constitute a new application. In such cases, "the requirements of Section 301, 302, and 303" must be complied with. Those sections require submission of an application to DHEC, payment of filing fees, evaluation by DHEC for completeness, and notice of opportunity for public hearings. Section 308 also expressly requires that the time periods, deadlines and waiting periods, be complied with for revisions at the pre-issuance stage.

There is no parallel requirement in Section 508 (post-issuance of a Certificate) to recommence the extensive review process required in Section 308 (pre-issuance of a Certificate). Instead, Section 508 refers simply to "another review." The absence of

¹ Courts have found an agency's interpretation of its own regulation is entitled to deference. *See Kiawah Dev. Partners v. S.C. Dep't of Health & Env'tl. Control*, 411 S.C. 16, 34-35, 766 S.E.2d 707, 718 (2014) (deferring to an agency interpretation where it is neither arbitrary, capricious, nor manifestly contrary to the statute); *see also Murphy v. South Carolina Department of Health and Environmental Control*, 396 S.C. 633, 640-41, 723 S.E.2d 191, 195 (2012); *Brown v. South Carolina Dep't of Health & Env'tl. Control*, 348 S.C. 507, 560 S.E.2d 410 (2002)

express requirements like those in Section 308 is a strong indicator that DHEC can conduct the review it deems appropriate at the post-issuance stage.

Separately, further evidence of the Legislature's design to entrust DHEC with broad discretion and authority to conduct appropriate post-issuance reviews is found in the Act. The Legislature recognized the inability to exhaustively articulate criteria that may be material for the analysis to be undertaken by DHEC. Following the list of criteria for advantages and disadvantages in its evaluation of an application (Section 44-7-560(A)), the Act entrusts DHEC to use its discretion to execute the purpose of the effort:

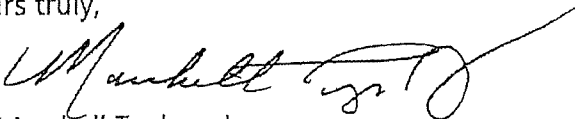
The department also may establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with this article and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure that the activity is appropriately supervised by the State.

Section 44-7-560(B).

Additionally, the regulations provide that the Certificate of Public Advantage may be revoked by DHEC if, in its discretionary assessment, the parties are not complying, or the benefits of the certified cooperative agreement no longer outweigh the disadvantages, or that the certificate was issued in reliance upon a misrepresentation or other improper basis. Section 503(A)-(C). The Certificate may also be revoked by a single, non-discretionary basis, failure to pay the annual monitoring fee. Section 503(D). The discretionary bases for revocation demonstrate that DHEC is uniquely relied upon in the Health Care Cooperation Act to be the State agent to conduct this activity. This reliance by the Legislature in statute and by approval of DHEC's regulations confirms the reasonableness of DHEC's interpretation regarding the inherent flexibility to determine the appropriate review of modifications pursuant to Section 508.

DHEC requests confirmation of its interpretation of S.C. Code Regulations 61-31, Section 508, to allow the review DHEC deems appropriate to give effect to the Health Care Cooperation Act. Thank you for your consideration of our question.

Yours truly,

A handwritten signature in black ink, appearing to read "W. Marshall Taylor, Jr.", with a stylized flourish at the end.

W. Marshall Taylor, Jr.
General Counsel

EXHIBIT 7



ALAN WILSON
ATTORNEY GENERAL

February 25, 2020

W. Marshall Taylor, Jr., General Counsel
S.C. Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

Dear Mr. Taylor:

You have requested our opinion "regarding the scope of authority of the South Carolina Department of Health and Environment Control (Department or DHEC) to conduct certain reviews under regulations promulgated pursuant to the Health Care Cooperation Act, S.C. Code Ann. Sections 44-7-500 through 44-7-590 (the 'Act.')" Specifically, DHEC seeks our opinion with regard to the following question: "[w]hat review must be conducted prior to departmental approval of proposed modifications to a cooperative agreement after issuance of a Certificate of Public Advantage if DHEC determines the proposed modifications are substantial under Section 508 of S.C. Code Regulation 61-31, Health Care Cooperative Agreements?" You further advise that "DHEC's interpretation is that 'another review' under Section 508 does not necessarily require the same type of review as occurs when an applicant applies for a Certificate of Public Advantage." You note that "DHEC believes it is within its discretion to conduct the review it deems appropriate based on the facts and circumstances involved including, but not limited to, the significance of the proposed change, any relevant time constraints related to the proposed change, and any exigent circumstances as found by DHEC or as represented to DHEC by the parties to the cooperative agreement."

As will be explained more fully below, we believe a court is likely to agree with DHEC's analysis as reasonable. As the agency charged with approval, monitoring and enforcement of Certificates of Public Advantage, a court will likely conclude DHEC possesses broad discretion to interpret its Regulation. As you note, the language of the Regulation, using the phrase "another review," does not necessarily require that DHEC conduct the same type of review as occurs when an applicant applies for a Certificate of Public Advantage. Thus, in our opinion, a court is likely to conclude that DHEC possesses the discretion to allow the agency to conduct "another review" pursuant to the Regulation, as it deems appropriate, based upon factors such as are specified in your letter.

By way of background, your letter further states:

I. The Health Care Cooperation Act and Regulation 61-31

The Act is predicated upon Legislative findings set forth at Section 44-7-505(1)-(4). The findings recognize "that cooperative agreements among hospitals, health care purchasers, and other health care providers would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open," and "that competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition." Section 44-7-505(2), (4).

DHEC is the state agency authorized to enforce and implement the Act and is authorized to promulgate regulations pursuant to the Act Sections 44-7-510(4) and -570(D). The purpose of the regulation is to "implement the legislative intent that there be a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition." R.61-31, Section 101.

II. Role of DHEC After Issuance of Certificate of Public Advantage

The Act relies upon DHEC's continuing involvement following the approval of an application for a Certificate of Public Advantage. For example, DHEC monitors and regulates agreements approved under the Act and may request information whenever necessary to ensure that the agreements remain in compliance with any conditions of approval. Section 44-7-570(A). While the Act provides a detailed process for review of initial applications and changes to applications prior to issuance of a Certificate of Public Advantage, the Act is silent regarding any process for reviewing proposed changes to a cooperative agreement after issuance of a certificate. However, Section 508 of the regulation addresses this scenario.

SECTION 508. Changes After Receipt of a Certificate of Public Advantage:
If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires another review. A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.

R.61-31, Section 508 (Emphasis added). Therefore, if the Department finds proposed changes to a cooperative agreement after issuance of a certificate are substantial, another review must be performed. Neither the Act nor the regulations provide definitions for "review" or "another review." Because it is not clear from the text of Section 508 what the clear meaning of "another review" is, interpretation of the term is warranted. See Kiawah Dev. Partners, II v. S.C. Dep't of Health & Envtl. Control, 411 S.C. 16, 333, 766 S.E.2d 707, 717(2014).[]

DHEC interprets "another review" in Section 508 to allow it the discretion to conduct the review that may be required, in the event it deems the change to be "substantial." This review will depend on the facts and circumstances involved, such as the significance of the proposed change, any relevant time constraints related to the proposed change, and any exigent circumstances as found by DHEC or as represented to DHEC by the parties to the cooperative agreement. This interpretation is reasonable and consistent with DHEC's statutory authority.

Evidence of the reasonableness of DHEC's interpretation is found in the contrary treatment in Section 308. That section addresses changes made by an applicant prior to the issuance of a certificate. Section 308 necessitates recommencement of the public notice and other steps if DHEC determines that the changes constitute a new application. In such cases, "the requirements of Section 301, 302, and 303" must be complied with. Those sections require submission of an application to DHEC, payment of filing fees, evaluation by DHEC for completeness, and notice of opportunity for public hearings. Section 308 also expressly requires that the time periods, deadlines and waiting periods, be complied with for revisions at the pre-issuance stage.

There is no parallel requirement in Section 508 (post-issuance of a Certificate) to recommence the extensive review process required in Section 308 (pre-issuance of a Certificate). Instead, Section 508 refers simply to "another review." The absence of express requirements like those in Section 308 is a strong indicator that DHEC can conduct the review it deems appropriate at the post-issuance stage.

Separately, further evidence of the Legislature's design to entrust DHEC with broad discretion and authority to conduct appropriate post-issuance reviews is found in the Act. The Legislature recognized the inability to exhaustively articulate criteria that may be material for the analysis to be undertaken by DHEC. Following the list of criteria for advantages and disadvantages in its evaluation of an application (Section 44-7-560(A)), the Act entrusts DHEC to use its discretion to execute the purpose of the effort:

The department also may establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with this article and its purpose to promote cooperation and limit health care costs, protect against abuse of

private economic power, and to ensure that the activity is appropriately supervised by the State.

Section 44-7-560(B).

Additionally, the regulations provide that the Certificate of Public Advantage may be revoked by DHEC if, in its discretionary assessment, the parties are not complying, or the benefits of the certified cooperative agreement no longer outweigh the disadvantages, or that the certificate was issued in reliance upon a misrepresentation or other improper basis. Section 503(A)-(C). The Certificate may also be revoked by a single, non-discretionary basis, failure to pay the annual monitoring fee. Section 503(D). The discretionary bases for revocation demonstrate that DHEC is uniquely relied upon in the Health Care Cooperation Act to be the State agent to conduct this activity. This reliance by the Legislature in statute and by approval of DHEC's regulations confirms the reasonableness of DHEC's interpretation regarding the inherent flexibility to determine the appropriate review of modifications pursuant to Section 508.

DHEC requests confirmation of its interpretation of S.C. Code Regulations 61-31, Section 508, to allow the review DHEC deems appropriate to give effect to the Health Care Cooperation Act.

LAW/ANALYSIS

In interpreting statutes or regulations, the cardinal rule of construction is to rely upon legislative intent. As was stated by our Supreme Court in Protection and Advocacy for People with Disabilities, Inc. v. Buscemi, 417 S.C. 267, 273-274, 789 S.E.2d 756, 760 (2016),

“[t]he cardinal rule of statutory construction is to ascertain and effectuate the legislative intent whenever possible.” Perry v. Bullock, 409 S.C. 137, 140, 761 S.E.2d 251, 253 (2014) (quoting State v. Bauer, 340 S.C. 339, 342, 531 S.E.2d 922, 923 (2000)). “All rules of statutory construction are subservient to the one that legislative intent must be construed in light of the intended purpose of the statute.” S.C. Prop. & Cas. Ins. Co. Guar. Assn. v. Brock, 410 S.C. 361, 367, 764 S.E.2d 920, 922 (2014) (quoting McClanahan v. Richland Cty. Council, 350 S.C. 433, 438, 567 S.E.2d 240, 242 (2002)). “The plain language of a statute is considered the best evidence of the legislature’s intent.” Perry, 409 S.C. at 140, 761 S.E.2d at 253. “When interpreting an undefined statutory term, the Court must look to its usual and customary meaning.” Id. at 140-41, 761 S.E.2d at 253.

In Kiawah Development Partners, II v. South Carolina Dept. of Health and Environmental Control, 411 S.C. 16, 32-33, 766 S.E.2d 7070, 717-718 (2014), the South Carolina Supreme Court set forth the rule for an agency’s interpretation of the statute’s regulations which it is charged to enforce. According to the Court,

[i]n reaching this conclusion, the ALC erred by failing to give deference to DHEC's interpretation of its regulation. Interpreting and applying statutes and regulations administered by an agency is a two-step process. First, a court must determine whether the language of the statute or regulations speaks to the issue. If so, the court must utilize the clear meaning of the statute or regulation. . . . [cases cited]. If the statute or regulation "is silent or ambiguous with respect to the specific issue," the court then must give deference to the agency's interpretation of the statute or regulation, assuming the interpretation is worthy of deference. . . .

Advancing to the second step, we must first consider the scope of South Carolina's deference doctrine.

. . . . [cases cited] . . .

As repeatedly stated in our decisions, our deference doctrine provides that courts defer to an administrative agency's interpretations with respect to the statutes entrusted to its administration or its own regulations "unless there is a compelling reason to differ." . . . Accordingly, the deference doctrine properly stated provides that where an agency charged with administering a statute or regulation has interpreted the statute or regulation, courts including the ALC, will defer to the agency's interpretation absent compelling reasons. We defer to the agency's interpretation unless it is arbitrary, capricious, or manifestly contrary to the statute." . . . (quoting Chevron U.S.A. v. Nat. Res. Def. Council, Inc. 437 U.S. 837, at 844 (1984)).

Our opinions are in accord. See e.g. Op. S.C. Att'y Gen., 2019 WL 4729535 (September 13, 2019) ["it is this Office's long standing policy, like that of our state courts, to defer to an administrative agency's reasonable interpretation of the statutes and regulations that it administers."] (citing numerous opinions).

Moreover, our Supreme Court stated in City of Cola. v. Bd. of Health and Environmental Control, 262 S.C. 199, 2020, 355 S.E.2d 536, 538 (1987),

[While] as creatures of statute, regulatory bodies are possessed only of those powers which are specifically delineated [,] . . . [t]he delegation of authority to an administrative agency is construed liberally when the agency [here DHEC] is concerned with the protection of the health and welfare of the public.

In other words, "regulations governing public health should be liberally construed." Putnam Lake Comm. Council Bathing Beaches v. Dept'y Comm'r of State of N.Y., 456 N.Y.S.2d 100 (1982).

It should be noted that R. 61-31, § 308 provides for the process that DHEC must utilize when the applicant makes an amendment during the initial application process. Section 308 specifically requires DHEC to review the amendments and notify the applicant if the amendment constitutes a new application. The Regulation requires that in such instance, the review process

provided for in §§ 301-303 must be followed and the review is considered “as though the amendment were a new application.” By comparison, § 508 is deemed “Changes After Receipt of a Certificate of Public Advantage.” Such Section regulates amendment post-issuance of a COPA. In other words, § 508 applies to an amendment to the operational COPA. If DHEC deems these amendments substantial, the agency is required to conduct “another review.”

Such a comparison is striking. As your letter notes, “[t]here is no parallel requirement in Section 508 (post-issuance of a Certificate) to recommence the extensive review process required in Section 308 (pre-issuance of a Certificate).” Instead, Section 508 refers simply to “another review.”

You also note that § 44-7-560(B) affords broad discretion to DHEC to “establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with this article and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure that the activity is appropriately supervised by the State.” With this legislative intent in mind, we now turn to the phraseology “another review.”

In this instance, as your letter indicates, the words “another review” are not defined in Section 508 of R. 61-31. Nor is there any suggestion, at least in the Regulation itself, either that “another review” must be a repeat of the original COPA process, or that something less may be undertaken. The Regulation simply states that if there is an amendment, alteration or change to the agreement by the applicant, the Department must determine if the amendment is “substantial” and, if so, “requires another review.” (emphasis added). Your question specifies that DHEC deems the amendment to be “substantial.”

As we stated in Op. S.C. Att’y Gen., 1996 WL 82894 (January 17, 1996), “[t]he term ‘review’ ordinarily means to ‘look over, study, or examine again.’” Use of such a term “envisions discretion.” And, as defined in Black’s Law Dictionary (7th ed.), the term “review” means a “consideration inspection or reexamination of a subject or thing.” As one court has explained, the term “‘review’ commonly denotes a ‘looking over or examination with a view to amendment or improvement.’” Kholi v. Wall, 582 F.3d 147, 153 (1st Cir. 2009).

Ordinarily, when the term “judicial review” is used, the reviewing court, of course, does not “start over” from what has already been determined, but examines the lower court’s performance for errors. As Chief Justice Hughes famously summarized in St. Joseph Stockyards Co. v. U.S., 298 U.S. 38, 53 (1936), the “judicial duty is performed in the light of the proceedings already had and may be greatly facilitated by the assembling and analysis of the facts in the course of the . . . [prior] determination.” In short, common sense and the economy of public resources typically does not require that “another review” entail the painstaking gathering of facts and analysis undertaken originally.

In Farm Management Co., LLC v. Rural Community Ins. Agency, 2015 WL 1809789 (E.D. Wash. 2015), the Court reached this very conclusion. There, the question was whether “the court may conduct a de novo review of the indemnity claims because the arbitrator’s decision is not binding. . . .” The Court concluded “on closer examination” that de novo review of the arbitrator’s decision was not intended. The provision in question specified that the arbitrator’s decision was binding unless “judicial review is sought.” Id. at * 4. According to the Court,

[t]he term “review” means to “view, look at, or look over again” or “to look back upon; view retrospectively.” . . . (citation). Accordingly, the Court is to “review” the arbitrator’s decision – not begin anew with the analysis of the issues presented to the arbitrator.

Id. In short, use of the word “review” [“another review”] was deemed to be an analysis which did not “begin anew,” but one which “look[s] over again” what was originally done.

In addition, the point you make in your letter regarding the contrast in procedures specified in Section 308 with that of Section 508 is well taken, and we believe a court would give it considerable weight. As your letter notes, “Section 308 necessitates recommencement of the public notice and other steps if DHEC determines that the changes constitute a new application. In such cases, ‘the requirements of Section 301, 302 and 303’ must be complied with.” By comparison, § 508 simply requires “another review.” In Op. S.C. Att’y Gen., 2014 WL 2619140 (May 30, 2014), we advised that such a comparison may be used in the interpretation of an agency’s Regulation, as follows:

[t]hus, because the canons of statutory construction explain that where, as here, a regulation provides multiple factors to evaluate within its text, the omission of others is considered intentional. See Hodges v. Rainey, 341 S.C. 79, 86, 533 S.E.2d 578, 582 (2000) (“The canon of construction ‘expressio unius est exclusio alterius’ or ‘inclusio unius est exclusio alterius’ holds that ‘to express or include one thing implies the exclusion of another, or of the alternative.’”).

In summary, DHEC’s interpretation of § 508 may be based upon comparison with other relevant provisions, as well as § 44-7-560(B), and particularly the flexibility and discretion implied by the use of the term “review” in § 508. The foregoing authorities all support DHEC’s interpretation.

CONCLUSION

The term “another review,” as employed in Section 508 of R. 61-31 is not defined and is open to interpretation. However, based upon the foregoing authorities, DHEC’s construction of “another review” – i.e. that the same degree of review and analysis for application of a COPA is not necessarily required for amendment of an existing COPA – would likely withstand scrutiny by a court. DHEC’s interpretation that it possesses the discretion to conduct the review it deems appropriate, based upon the relevant facts – such as the significance of the proposed change or

W. Marshall Taylor, Jr., General Counsel

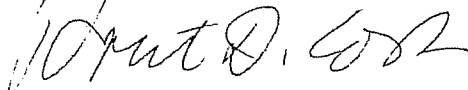
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exigent circumstances – would likely be given considerable deference by the courts as a reasonable interpretation. Moreover, comparison of the language of § 508 of the Regulation with § 308 thereof is striking, indicating that there is considerable difference in the review required pre-COPA approval and that required for a post-COPA amendment. Accordingly, we believe a court would likely conclude that DHEC's interpretation is consistent with the language of § 508, and is consistent with the public health. As the agency charged by the General Assembly with approving, monitoring and enforcing a COPA, as well as protecting the public health, in our judgment, a court would likely afford wide berth to DHEC's interpretation of its own Regulation regarding the meaning of "another review."

As we have consistently advised, "courts give great deference to an agency's interpretation of its own regulations even in circumstances where there may be more than one interpretation and even if such interpretation is not the one the court would adopt in the first instance." Op. S.C. Att'y Gen., 2010 WL 5578961 (December 6, 2010) (quoting other previous opinions). Moreover, as we have noted previously, the term "review" certainly "envisions exercise of discretion." Op. S.C. Att'y Gen., 1996 WL 82894 (January 17, 1996). Here, there are substantial reasons, discussed above, as to why a court would likely give great respect to DHEC's interpretation. Thus we advise that DHEC's interpretation of § 508 would likely be upheld by a court.

Sincerely,

A handwritten signature in dark ink, appearing to read "Robert D. Cook", written in a cursive style.

Robert D. Cook
Solicitor General

EXHIBIT 8

CHAPTER 7
Hospitals, Tuberculosis Camps, and Health Services Districts

ARTICLE 4
Health Care Cooperation Act

SECTION 44-7-500. Short title.

This article may be known and cited as the "Health Care Cooperation Act".

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-505. Findings.

The General Assembly makes the following findings:

(1) that the cost of improved health technology and scientific methods contributes significantly to the increasing cost of health care;

(2) that cooperative agreements among hospitals, health care purchasers, and other health care providers would foster improvements in the quality of health care for South Carolinians, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open;

(3) that federal and state antitrust laws may prohibit or discourage cooperative agreements that are beneficial to South Carolinians and that such agreements should be encouraged; and

(4) that competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-510. Definitions.

As used in this article:

(1) "Affected persons" means a health care provider or purchaser:

(a) who provides or purchases the same or similar health care services in the geographic area served or to be served by the applicants for a certificate of public advantage; or

(b) who has notified the department of his interest in applications for certificates of public advantage and has a direct economic interest in the decision. Other than health insurers licensed in South Carolina, persons from other states who would otherwise be considered "affected persons" are not included unless that state provides for similar involvement of persons from South Carolina in a similar process in that state.

(2) "Certificate of public advantage" means the formal approval, including any conditions or modifications, by the department of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health provider networks, or health care purchasers that might be construed to be violations of state or federal antitrust laws.

(3) "Cooperative agreement" means an agreement between two health providers, health provider networks, or purchasers or among more than two health care providers, health provider networks, or purchasers for the sharing, allocation, or referral of patients or the sharing or allocation of personnel, instructional programs, support services and facilities, medical, diagnostic or laboratory facilities, procedures, equipment, or other health care services traditionally offered by health care facilities or other health care providers or the acquisition or merger of assets among or by two or more health providers, health provider networks, or health care purchasers, provided the agreement does not involve price-fixing or predatory pricing or illegal tying arrangements.

(4) "Department" means the Department of Health and Environmental Control.

(5) "Health care provider" means a health care professional licensed, certified, or registered under the laws of this State, an organization licensed pursuant to Section 44-69-30 or Section 44-71-30, or a facility licensed pursuant to Section 44-7-260 or Section 44-89-40 to provide health care services or any other person as defined in Section 44-7-130(15) who provides health services in a freestanding or mobile facility.

(6) "Health care purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage of services is paid for by the purchaser or by the person receiving coverage or services including, but not limited to:

- (a) health insurers as defined by Section 38-71-920;
- (b) employee health plans offered by self-insured employers;
- (c) group health coverage offered by fraternal organizations, professional associations, or other organizations;
- (d) state and federal health care programs; and
- (e) state and local public employee health plans.

(7) "Health provider networks" means an organization of health care providers which offers health services to residents of this State. An organization may be a partnership, corporation including an association, a joint stock company, or any other legal entity recognized by the State.

(8) "Federal or state antitrust laws" means a federal or state law prohibiting monopolies or agreements in restraint of trade, including the Federal Sherman Act and Clayton Act, the Federal Trade Commission Act, and Chapters 3 and 5 of Title 39 of the 1976 Code.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-520. Intent.

~~(A) It is the intent of this article to require the State to provide direction, supervision, regulation, and control over approved cooperative agreements through the department and the Attorney General. This state direction, supervision, regulation, and control of cooperative agreements will provide immunity for health care providers, health provider networks, or purchasers who participate in discussions or negotiations authorized by this article from civil liability and criminal prosecution under federal or state antitrust laws.~~

(B) A health care provider, health provider network, or health care purchaser may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any state antitrust law. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith is immune from challenge or scrutiny under state antitrust laws, regardless of whether a certificate is issued. It is the intention of the General Assembly that this article immunizes covered activities from challenge or scrutiny under federal antitrust laws. Nothing in this subsection creates immunity for a person for conduct in negotiating or entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-530. Cooperative agreements.

A health care provider, health care purchaser, or health provider network may negotiate and enter into cooperative agreements with other health care providers or health provider networks or health care purchasers if the likely benefits resulting from the agreements outweigh any likely disadvantages resulting from the agreements. Parties to a cooperative agreement may apply to the department for a certificate of public advantage. The application must include an executed written copy of the cooperative agreement and describe the nature and scope of the cooperation in the agreement and any monetary or other consideration passing to a party under the agreement including change of ownership, merger, or other change in control of the assets of either party. Information obtained by the department under this section must be available to the public unless the department certifies the information as being proprietary. The department may make this certification where a person shows to the satisfaction of the department that the information should be

proprietary. The department may require an application fee from the submitting parties sufficient to cover the cost of processing the application.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-540. Publish; notice of receipt of application.

Upon receipt of an application, the department shall publish in the State Register notice of receipt of the application. The department shall review the application in accordance with the standards set forth in Section 44-7-560 and if requested by an affected person within thirty days of the department's receipt of a completed application, may hold a public hearing in accordance with regulations promulgated by the department. Within thirty days of receipt of the application, the department may request additional information as may be necessary to complete the application. The applicant has thirty days from the date of the request to submit the additional information. If the applicant fails to submit the requested information within the thirty-day period, the application is considered withdrawn. However, the department may grant one fifteen-day extension for the applicant to submit this information. The department shall grant or deny the application within sixty days after receipt of a completed application or from the date of the public hearing, if one is requested, and that decision must be in writing and must set forth the basis for the decision. The department shall furnish a copy of the decision to the applicants and any affected persons who have asked to be notified. The department shall publish its decisions in the State Register.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-550. Review of application; advisement by the Attorney General to the department to approve or deny application.

(A) Upon receipt of a completed application the department shall forward a copy of the application to the Attorney General. The Attorney General shall review the request not later than thirty days after receiving the completed application. The Attorney General may advise the department, in writing, to approve or deny the application. Failure by the Attorney General to notify the department within thirty days of receiving a completed application constitutes a recommendation for approval of the request. Advisement by the Attorney General to the department to deny a request shall set forth the reasons for the denial.

(B) Upon receipt of the advice of the Attorney General or at the end of the review period outlined in Section 44-7-540, the department shall issue an order approving or denying the application for a certificate of public advantage. Upon request from the applicant or an affected person, the department's order to approve or deny the application for the certificate is entitled to judicial review in accordance with the Administrative Procedures Act.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-560. Issuance of a certificate of public advantage for a cooperative agreement.

(A) The department shall issue a certificate of public advantage for a cooperative agreement if it determines that:

(1) the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement;

(a) in evaluating the benefits likely to result from the cooperative agreement, the department shall consider, but is not limited to:

(i) enhancement of the quality of health and health related care provided to South Carolina citizens;

(ii) preservation of health care providers close to communities traditionally served by those providers;

(iii) gains in the cost-efficiency of the services offered by the health care providers or purchasers involved;

(iv) improvements in the use of health care provider resources and equipment;
(v) avoidance or elimination or reduction of duplication of health care resources;
(vi) improvement in access to health care for citizens in the community;
(vii) support of the agreement by purchasers and payers in the health service area;
(viii) the extent of financial risk-sharing by the parties as a result of the agreement;
(ix) the provision or enhancement of health care services to Medicaid, indigent, or charity care patients by the parties to the agreement.

(b) In evaluating the disadvantages likely to result from the agreement, the department shall consider, but is not limited to:

(i) the likely adverse impact, if any, on the ability of the health care purchasers to negotiate optimal payment and service arrangements with the health care providers or health provider networks;

(ii) the extent of any reduction in competition among health care providers, purchasers, or other persons furnishing goods or services to or in competition with health care providers or purchasers that is likely to result directly or indirectly from the health care cooperative agreement;

(iii) the likely adverse impact, if any, on patients in the quality, availability, and price of health care services;

(iv) the extent to which the agreement may increase the costs or prices of health care at a hospital or other health care provider which is a party to the agreement;

(v) the extent to which services to Medicaid, indigent, or charity care patients are adversely impacted by the agreement; and

(2) reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result. In evaluating whether the reduction in competition is necessary to obtain the likely benefits, the department shall consider, but is not limited to:

(a) the availability of arrangements that:

(i) are less restrictive to competition and achieve the same benefits;

(ii) offer a more favorable balance of benefits over disadvantages attributable to a reduction in competition likely to result from the agreement.

(b) the ease with which health care providers or health care purchasers may obtain contracts with other health plans;

(c) the difficulty in establishing new competing health plans in the relevant geographic market, including the ability to offer services requiring a certificate of need or purchasing these services from another health care provider or health provider network; and

(d) the sufficiency of the number or type of providers under contract with the health plan available to meet the needs of plan enrollees.

(B) The department also may establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with this article and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure that the activity is appropriately supervised and regulated by the State.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-570. Monitoring and regulating agreements by the department.

(A) ~~The department shall actively monitor and regulate agreements approved under this article and may request information whenever necessary to ensure that the agreements remain in compliance with the conditions of approval.~~ The department shall charge an annual fee to cover the cost of monitoring and regulating these agreements, including certificates of public advantage. ~~During the time the certificate is in effect, a report on the activities pursuant to the cooperative agreement must be filed with the department every two years so that the department shall determine that the cooperative agreement continues to comply with the terms of the certificate of public advantage. The department may revoke a certificate upon a finding that:~~

~~(1) the agreement is not in substantial compliance with the terms of the application or the conditions of approval; or~~

~~(2) the likely benefits resulting from the certified agreement no longer outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement; or~~

(3) the department's certification was obtained as a result of intentional material misrepresentation to the department or as the result of coercion, threats, or intimidation toward any party to the cooperative agreement.

(B) A decision by the department to revoke a certificate of public advantage is entitled to judicial review in accordance with the Administrative Procedures Act.

(C) Nothing in this article limits the authority of the Attorney General to initiate civil enforcement action or criminal prosecution upon the determination that health care providers, health provider networks, or health care purchasers have exceeded the scope of the certificate of public advantage approved by the department. A review by the Attorney General must be conducted according to the standards set forth in this article.

(D) The department shall promulgate regulations to implement the provisions of this article including any fees and application costs associated with the monitoring and oversight of cooperative agreements approved under this article.

HISTORY: 1994 Act No. 437, Section 1; 2008 Act No. 353, Section 2, Pt 5.B, eff July 1, 2009.

SECTION 44-7-580. Maintaining on file all cooperative agreements which certificates of public advantage remain in effect.

The department shall maintain on file all cooperative agreements for which certificates of public advantage remain in effect. A dispute among the parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract or other applicable law. A party to a cooperative agreement who terminates the agreement shall notify the department within fifteen days of the termination. If all parties terminate their participation in the cooperative agreement, the department shall revoke the certificate of public advantage for the agreement.

HISTORY: 1994 Act No. 437, Section 1.

SECTION 44-7-590. Exemptions.

~~Nothing in this article exempts health care providers or purchasers from compliance with the provisions of Article 3 of this chapter concerning certificates of need.~~

HISTORY: 1994 Act No. 437, Section 1.

Source: South Carolina Legislature website, <https://www.scstatehouse.gov/code/t44c007.php> (Last visited April 13, 2020)

EXHIBIT 9

Regulation 61-31

Health Care Cooperative Agreements

Disclaimer

DHEC provides this copy of the regulation for the convenience of the public and makes every effort to ensure its accuracy. However, this is an unofficial version of the regulation. The regulation's most recent final publication in the *South Carolina State Register* presents the official, legal version of the regulation.



2600 Bull Street | Columbia, SC 29201

Statutory Authority:

S.C. Code Sections 44-7-500 through 44-7-590

Regulation History as Published in State Register

Date	Document Number	Volume	Issue
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CHAPTER 1 PURPOSE, DEFINITIONS, APPLICABILITY

SECTION 101. Purpose:

~~These Regulations implement the legislative intent that there be a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition.~~

~~This is encouraged because the cost of improved technology and scientific methods contribute significantly to the increasing cost of health care; and cooperative agreements among hospitals, health care purchaser, and other health care providers will foster improvements in the quality of health care for South Carolinians.~~

SECTION 102. Definitions:

As used in this regulation:

- 1) "Affected persons" means a health care provider or purchaser:
 - a) who provides or purchases the same or similar health care services in the geographic area served or to be served by the applicants for a Certificate of Public Advantage; or
 - b) who has notified the Department of his interest in applications for Certificates of Public Advantage and has a direct economic interest in the decision. Other than health insurers licensed in South Carolina, persons from other states who would otherwise be considered 'affected persons' are not included unless that state provides for similar involvement of persons from South Carolina in a similar process in that state.
- 2) ~~"Certificate of Public Advantage" mean the formal approval, including any conditions or modifications, by the Department of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health provider networks, or health care purchasers that might be construed to be violations of state or federal laws.~~
- 3) ~~"Cooperative agreement" means an agreement between two health care providers, health provider networks, or health care purchasers or among more than two health care providers, health provider networks, or health care purchasers for the sharing, allocation, or referral of patients or the sharing or allocation of personnel, instructional programs, support services and facilities, medical, diagnostic or laboratory facilities, procedures, equipment, or other health care services traditionally offered by health care facilities or other health care providers or the acquisition or merger of assets among or by two or more health providers, health provider networks or health care purchasers, provided the agreement does not involve price-fixing or predatory pricing or illegal tying arrangements.~~
- 4) "Department" means the Department of Health and Environmental Control.
- 5) "Health care provider" means a health care professional licensed, certified, or registered under the laws of this State, an organization licensed pursuant to Section 44-69-30 or Section 44-71-30, or a facility licensed pursuant to Section 44-7-260 or Section 44-89-40 to provide health care services or any other person as defined in Section 44-7-130(15) who provides health services in a freestanding or mobile facility.

6) "Health care purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage of services is paid for by the purchaser or by the person receiving coverage or services, including but not limited to:

- a) health insurers as defined by Section 38-71-92;
- b) employee health plans offered by self-insured employers;
- c) group health coverage offered by fraternal organizations, professional associations, or other organizations;
- d) state and federal health care programs; and
- e) state and local public employees health plans.

7) "Health provider networks" means an organization of health care providers which offers health services to a resident of this State. An organization may be a partnership, corporation including an association, a joint stock company, or any other legal entity recognized by the State.

8) "Health service area" means the proposed primary service area of all facilities or entities involved in the cooperative agreement.

9) "Federal or state antitrust laws" means a federal or state law prohibiting monopolies or agreements in restraint of trade, including the Federal Sherman Act and Clayton Act, the Federal Trade Commission Act, and Chapters 3 and 5 of Title 39 of the 1976 Code.

10) "Party" or "Party to a cooperative agreement" means a person who negotiates or enters into a cooperative agreement.

11) "Person" means an individual, a trust or estate, a partnership, a corporation, an association, a joint stock company, an insurance company, a health maintenance organization, a state, a political subdivision of a state, an instrumentality including a municipal corporation of a state, or any legal entity recognized by the State.

12) "A complete application" means a Questionnaire [page 15 of these Regulations] with all applicable questions answered, and a narrative addressing each point set out in Section 202, and any additional information requested by the Department pursuant to Section 302.

13) "Receipt" means actual receipt of a written document.

SECTION 103. Applicability:

This regulation applies to health care providers, health care networks, and health care purchasers who apply for a Certificate of Public Advantage and to those who receive a Certificate of Public Advantage.

The issuance of a Certificate of Public Advantage is not required in order for health care providers, purchasers or networks, to negotiate and enter into cooperative agreements with other health care providers. Parties to a cooperative agreement may apply to the Department for a Certificate of Public Advantage, should they desire.

CHAPTER 2 APPLICATION

SECTION 201. Application Submission:

Two copies of the application shall be forwarded to the Department in the format described in Section 202. The application shall be on 8 1/2 × 11 paper, one side only, and three hole punched on the left side.

SECTION 202. Application:

In answering the following questions, the applicants may refer to specific sections of the executed cooperative agreement in lieu of repeating the required information.

For each response for which confidentiality has been sought pursuant to Section 310, include the following statement: "Submitted separately under claim of confidentiality."

An application shall consist of:

(a) PART A. Questionnaire.

QUESTIONNAIRE			
PART A.			
Parties To The Cooperative Agreement			
	Name	Title	Address
1.			
2.			
3.			
4.			
5.			
Brief Description of Proposal			
Describe Proposed Market Area			
Person Responsible For This Application			Title
Address			Telephone Number
All parties hereby certify that the information contained in this Application, including all assurances and attachments, are accurate and correct to the best of our knowledge and belief.			
Signature			Date

(b) PART B. Narrative

1. (A) Describe the agreement in detail, including all the parties and each party's responsibilities, obligations and commitments.

(B) State whether the project will change the existing services of a health care provider.

(C) Describe any shared services.

(D) Describe any obligation for future commitments or negotiations.

(E) Describe the nature and scope of the cooperation that is required by each party to the agreement.

(F) Describe in detail any monetary or other consideration passing to a party under the cooperative agreement.

(G) Describe in detail any merger, lease, change of ownership or other change in control of the assets of any party to the cooperative agreement.

2. Provide the total cost of the project and the costs to be incurred by category. Examples include but are not limited to consultants, capital costs, and management costs. Describe what part of the cost is borne by each party.

3. Provide the following ownership disclosure for each party in the agreement.

(A) The name of the party;

(B) Address of each party;

(C) The complete title of the governing body (if any);

(D) The name, title and address of the presiding officer of the governing body;

(E) The name and mailing address of all persons and/or entities having 5% or more ownership interest or owner's equity of any of the parties to include a schedule of percent and type ownership of each;

(F) A list of all officers of each party;

(G) A copy of any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information provided in subparagraphs (A) through (F) above. If such an agreement exists, provide similar information for the party after the terms of the arrangement are carried out; and

(H) If any of the licensees of the cooperative agreement are a subsidiary corporation, provide a diagram of the licensee's relationship to the parent corporation and list the name and address of the parent corporation.

4. Demonstrate and document that the likely benefits accruing from the cooperative agreement outweigh the likely disadvantages. At a minimum, include the economic, administrative, and patient impact of the agreement. Describe how the cooperative agreement will foster cost containment, eliminate duplicate

services or otherwise positively impact the health care system. Describe how the cooperative agreement will reduce competition, reduce patient choice, or otherwise negatively impact the health care system.

5. Discuss alternatives that have been considered and the advantage and disadvantages of each alternative.

6. Discuss any improvements in access and any problems patients may experience, such as costs, availability, or accessibility, upon initiation of the proposed cooperative agreement.

7. Identify any costs associated with implementation of the cooperative agreement and provide documentation of the availability of the necessary funds.

8. Describe the current service area of each party to the cooperative agreement and describe the proposed service area upon initiation of the cooperative agreement.

9. Describe the current market share of each party to the cooperative agreement and describe the proposed market share upon initiation of the cooperative agreement.

10. Provide a current annual budget for each party involved in the cooperative agreement and a three year projected budget for all entities after the initiation of the cooperative agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of this cooperative agreement on each party. The budgets must be prepared by a Certified Public Accountant (CPA) and all assumptions used must be shown.

11. Document that the proposed agreement is economically feasible both immediately and long term. Describe the impact that the cooperative agreement will have on costs per unit of service.

12. Describe how the agreement enhances or restricts health care services to Medicaid, indigent or charity patients.

13. Provide the name, address and telephone number of the individual who should be contacted for monitoring the implementation of this agreement.

14. Provide a timetable for implementing all components of the cooperative agreement.

15. Provide any additional information that would assist the Department in evaluating this cooperative agreement.

(c) Part C. Programmatic Documents

1. An executed copy of the negotiated cooperative agreement between all parties; or

2. A written copy of the negotiated cooperative agreement and documentation that the proposed subject has been approved by the governing body of each party.

(d) Part D. Assurances

The parties must furnish written assurance of each of the following:

1. that the parties will submit to the Department for approval any changes that occur to the approved cooperative agreement;

2. that the parties will carry out the agreement in accordance with the approved application;
3. that the parties understand that the Department may revoke a Certificate of Public Advantage at any time for reasons outlined in Section 503 of these regulations;
4. that the Department or its authorized representatives at any time during normal hours of operation shall be allowed to make an on-site inspection to determine compliance in accordance with the application for which the Certificate of Public Advantage was issued;
5. that the parties will cooperate with the Department or any investigation regarding compliance with the application for which the Certificate of Public Advantage was issued by providing relevant information in a timely manner, assisting in the collection of data, or satisfying other relevant requests from the Department;
6. that the parties will submit at least every two years, the information required by Section 502 of these regulations;
7. that this cooperative agreement does not involve price fixing, predatory pricing or illegal tying arrangements;
8. that the parties understand that the issuance of a Certificate of Public Advantage does not exempt any of the parties from compliance with the provisions of Regulation 61-15, Certification of Need for Health Facilities and Services.

CHAPTER 3

DISPOSITION OF APPLICATION

SECTION 301. Submission of Application:

Two copies of the application, and the filing fee set forth in Section 509 shall be submitted to the Bureau of Health Facilities and Services Development, S.C. Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201.

SECTION 302. Additional Information:

(A) After receipt of an application and the appropriate filing fee, the Department will review the application. The Department may request additional information within thirty days of receipt of the application. The applicant will have thirty days from the date of the request to submit the additional information.

(B) If the additional information submitted in response to the Department's request is incomplete, the Department will have fifteen (15) days in which to request further information. If information necessary to deem the application complete is not submitted within thirty (30) days of the second request, the application will be considered withdrawn. An application that is withdrawn does not preclude the applicant from resubmitting a new application.

(C) An application is complete when the Department notifies the applicant that all necessary information has been received or when no request for additional information has been made within thirty days of receipt of the original application.

SECTION 303. Notice and Opportunity for Public Hearing:

(A) Upon receipt of an application and the appropriate filing fee the Department shall publish in the State Register a notice of the receipt of the application.

(B) An affected person as defined in these regulations who requests a public hearing must do so in writing within thirty days of notice pursuant to Section 304 that a completed application has been received by the Department.

(C) The Department will determine whether a public hearing will be held; grounds for denying a public hearing include, but are not limited to, a finding that the requestor is not an affected person. When such a public hearing is held, thirty days prior notice of the hearing will be provided to affected persons. The written notification of the hearing shall include the proposed schedule for review, time, date and place of the public hearing. The public hearing shall provide an opportunity for any person to present information relevant to the application.

SECTION 304. Notification of Affected Persons:

Upon the Department's determination that an application is complete, the Department shall publish in a newspaper having general circulation in the area a public notice that the cooperative agreement application is complete, and when affected persons may request a public hearing. The public notice shall run three consecutive days. Any affected person who has requested in writing to be notified of the determination of the completeness of an application shall be notified in writing by the Department.

SECTION 305. Review by the S.C. Attorney General:

Upon receipt of a completed application, the Department shall forward a copy of the application to the S. C. Attorney General. After review in accordance with SC Code Section 44-7-550, the Attorney General may advise the Department in writing to approve or deny the application. If no report is received from the Attorney General within thirty days, the Department will consider that as a recommendation to approve the request. If the Attorney General recommends denial of the Certificate of Public Advantage, the Department will consider the reasons therefor. The Attorney General's opinion is advisory and DHEC is responsible for rendering the final decision.

SECTION 306. Review Time Frames:

The Department must make a decision on the complete application within 60 days of the receipt of a complete application or notification to the applicant that an application is complete, if additional information has been requested, or within sixty days of any public hearing, whichever is later.

SECTION 307. Department Decision:

On the basis of staff review of the record established by the Department, including but not limited to comments from the Attorney General's office, the application, written and verbal comments by affected persons and other persons concerning the application, data studies, literature and other information available to the Department, the staff of the Department shall make a proposed decision to grant or deny the Certificate of Public Advantage. The proposed decision of the Department shall be in writing and shall set forth the basis for the decision. The Department shall furnish a copy of the decision to applicants and any affected persons who have asked to be notified. The proposed decision becomes the final agency decision within fifteen (15) days after the receipt of a notice of the proposed decision by the applicant or an affected person who has requested to be notified of the decision, unless a contested case hearing is requested

pursuant to Chapter 5-Appeals of this regulation. The Department's proposed decision is not final until the completion of the contested case proceedings. The Department shall publish its final decisions in the State Register.

SECTION 308. Project Changes During Review Period:

The Department will review any amendments submitted during the review process and may notify the applicant that the amendments constitute a new application, and that the requirements of Section 301, 302, and 303 of this regulation must be complied with. All applicable times shall be counted as though the amendment were a new application.

SECTION 309. Validity of Certificate of Public Advantage:

The Certificate of Public Advantage, if issued, is only valid for the project described in the application including parties involved, services to be offered, mergers or consolidations approved, or other factors as set forth in the application, except as it may be modified in accordance with these regulations. Implementation of a project or undertaking a project that is not in accordance with the Certificate of Public Advantage application or conditions subsequently agreed to by the applicant and the Department may be grounds for revocation of the Certificate of Public Advantage.

SECTION 310. Proprietary Information:

Information obtained by the Department from the parties requesting a Certificate of Public Advantage shall be available to the public in accordance with the Freedom of Information Act unless the Department determines that the information is protected from disclosure. The Department will make this determination if an applicant submits the information sought to be protected separately, clearly marked as "Confidential", and submits justification that the information is entitled to protection from disclosure under one or more of the grounds therefore in the Freedom of Information Act. Such grounds include but are not limited to:

- 1) Trade secrets including feasibility planning, marketing studies, and evaluations and other materials which contain references to potential customers, competitive information, or evaluations;
- 2) Information of a personal nature where the public disclosure thereof would constitute unreasonable invasion of personal privacy;
- 3) Documents of and documents incidental to proposed contractual arrangements and documents of and documents incidental to proposed sales or purchases of property; or
- 4) Correspondence or work products or any other material that would violate attorney-client relationships.

SECTION 311. Administrative and Judicial Review:

Upon receipt of the advice of the Attorney General or at the end of the review period outlined in Section 306 of these regulations, the Department shall issue a staff decision approving or denying the application for a Certificate of Public Advantage. The Department's staff decision is final fifteen days after receipt by the applicant unless an administrative appeal is commenced in accordance with applicable regulations. The applicant or affected party is entitled to administrative and judicial review in accordance with the State's Administrative Procedures Act.

SECTION 312. Conditional Approval

~~The Department may establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with these regulations and its purpose to promote cooperation and limit health care costs; protect against abuse of private economic power; improve access to care; improve efficiencies in the delivery of care, including improving economics of scale in the delivery of services; reduce or eliminate unnecessary duplication of services or technology; and to ensure that the activity is appropriately supervised and regulated. Such conditions shall be stated in the Certificate of Public Advantage and shall be fully enforceable.~~

CHAPTER 4 CRITERIA FOR REVIEW

SECTION 401. Issuance of a Certificate of Public Advantage:

~~The Department shall issue a Certificate of Public Advantage for a cooperative agreement if it determines that the applicant has demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement, and the reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.~~

SECTION 402. Evaluation of Benefits and Disadvantages:

1. In evaluating the benefits likely to result from the cooperative agreement the Department shall consider, but is not limited to:

- a) enhancement of the quality of health and health related care provided to South Carolina citizens;
- b) preservation of health care providers close to communities traditionally served by those providers;
- c) gains in the cost-efficiency of the services offered by health care providers or purchasers involved;
- d) improvements in the use of health care provider resources and equipment;
- e) avoidance or elimination or reduction of duplication of health care resources;
- f) improvements in access to health care for citizens in the community;
- g) support of the agreement by purchasers and payers in the health service area;
- h) the extent of financial risk-sharing by the parties as a result of the agreement;

i) the provision or enhancement of health care services to Medicaid, indigent, or charity care patients by the parties to the agreement.

2. In evaluating the disadvantages likely to result from the agreement, the Department shall consider but is not limited to:

- a) the likely adverse impact, if any, on the ability of the health care purchasers to negotiate optimal payment and service arrangements with the health care providers or health provider networks;

b) the extent of any reduction in competition among health care providers, purchasers, or other persons furnishing goods or services to or in competition with health care providers or purchasers that is likely to result directly or indirectly from the health care cooperative agreement;

c) the likely adverse impact, if any, on patients in the quality, availability, and price of health care services;

d) the extent to which the agreement may increase the costs of prices of health care at a hospital or other health care provider which is a party to the agreement;

e) the extent to which services to Medicaid, indigent, or charity care patients are adversely impacted by the agreement.

SECTION 403. Evaluation of Impact of Reduction of Competition:

In evaluating whether the reduction in competition is necessary to obtain the likely benefits, the Department shall consider, but is not limited to:

1) The availability of arrangements that:

a) are less restrictive to competition and achieve the same benefits;

b) offer a more favorable balance of benefits over disadvantages attributable to a reduction in competition likely to result from the agreement;

2) The ease with which health care providers or health care purchasers may obtain contracts with other health plans;

3) The difficulty in establishing new competing health plans in the relevant geographic market, including the ability to offer services requiring a certificate of need or purchasing these services from another health care provider or health provider network; and

4) The sufficiency of the number or type of providers under contract with the health plan available to meet the needs of plan enrollees.

SECTION 404. Additional Considerations:

The Department may consider other information or factors relevant to the purposes of the Health Care Cooperation Act and this regulation. The information or factors so considered shall be specifically stated in the staff decision. Should the Department consider other information or factors that are not published in these regulations, the Department will notify the applicant as soon as is reasonable practical and will provide them an opportunity to respond.

CHAPTER 5 **MONITORING**

SECTION 501. Monitoring:

~~The Department shall actively monitor and regulate agreements approved under this regulation.~~ The Department may request information, conduct inspections, or conduct audits whenever necessary to ensure that the agreements remain in compliance with the conditions of approval and the approved application.

The same rules apply to information acquired by the Department through information received, inspections conducted or audits conducted as in Section 310 of these regulations. The Department shall provide the applicant at least ten day notice of a compliance audit. The Department shall afford the applicant at least ten days to respond to any complaint, question or problem identified by the Department.

SECTION 502. Activities Report:

~~(A) During the time the Certificate of Public Advantage is in effect, a report on the activities pursuant to the cooperative agreement must be filed by the parties to the cooperative agreement with the Department at least every two years. Based on this report the Department shall determine whether the cooperative agreement continues to comply with the terms of the Certificate of Public Advantage.~~

~~(B) The report shall contain, but not be limited to the following:~~

1. a detailed description of the implementation of the approved application, contract or other agreement between parties;

~~2. a detailed description of any changes, modifications, deviations, amendments, or other differences from the approved application;~~

3. an assessment of the success or failure of the agreement to accomplish the goals, benefits, or other results expected from the approved application. Provide any supporting documentation on which these conclusions are based; and

4. any additional information the parties feel will assist the Department in order to make the assessment required in this Section.

SECTION 503. Revocation of Certificate of Public Advantage:

~~The Department may revoke a certificate upon a finding that:~~

~~(A) the parties to the agreement are not complying with its terms or the conditions of approval as stated in the Certificate of Public Advantage, or the agreement is not in substantial compliance with the terms of the application or conditions of approval; or~~

~~(B) the likely benefits resulting from the certified agreement no longer outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement; or~~

(C) the Department's certification was obtained as a result of intentional material misrepresentation to the Department or as the result of coercion, threats, or intimidation toward any party to the cooperative agreement; or

(D) failure to pay the annual monitoring fee.

SECTION 504. Administrative and Judicial Review:

A decision by the department to revoke a Certificate of Public Advantage is subject to administrative and judicial review in accordance with the State's Administrative Procedures Act.

SECTION 505. Civil or Criminal Enforcement:

Nothing in this regulation limits the authority of the Attorney General to initiate civil enforcement action or criminal prosecution upon the determination that health care providers, health providers networks, or health care purchasers have exceeded the scope of the Certificate of Public Advantage approved by the Department.

SECTION 506. Termination of Agreements:

A party to a cooperative agreement who terminates the agreement shall notify the Department within fifteen days of the termination. If all parties terminate their participation in the cooperative agreement, the Department shall revoke the Certificate of Public Advantage for the agreement.

SECTION 507. Certificate of Need Requirement:

~~Nothing in this Regulation exempts health care providers or purchasers from compliance with the provisions of the S. C. Certification of Need Program.~~

SECTION 508. Changes After Receipt of a Certificate of Public Advantage:

~~If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires another review. A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.~~

SECTION 509. Fees:

(A) Filing Fee: A non-refundable filing fee shall accompany each application for a Certificate of Public Advantage. The filing fee shall be \$3,000 per party to the cooperative agreement up to a maximum of \$15,000 per application. The filing fee must be received with the application in order for the Department to accept the application and begin processing the application.

(B) Monitoring Fee: An annual monitoring fee shall be assessed to each approved application for which a Certificate of Public Advantage is in effect. The annual monitoring fee shall be \$5,000 for each Certificate which has five or fewer parties and \$7,000 for each Certificate that involves more than five parties. Failure to pay this fee will result in revocation of the Certificate of Public Advantage.

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services)
District, d/b/a Lexington Medical Center)
)
)
Petitioner)
)
v.)
)
South Carolina Department of Health)
Environmental Control and Prisma Health-)
Midlands)
)
Respondents.)

Docket No.: 20-ALJ-07-____-CC

CERTIFICATE OF SERVICE

I certify that I have this date served a true and accurate copy of Request for Administrative Review and Contested Case Hearing with corresponding exhibits upon the following counsel of record in the above-captioned matter by mailing a copy of same to them, postage prepaid, in the United States mail, addressed as shown below.

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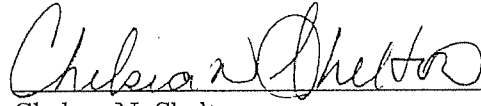
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FILED

MAY 14 2020

SC ADMIN LAW COURT

JOLLEY LAW GROUP, LLC


Chelsea N. Shelton

May 14, 2020
Hilton Head Island, South Carolina

FILED

MAY 14 2020

SC ADMIN LAW COURT

FILED

MAY 14 2020

SC ADMIN LAW COURT

EXHIBIT B

To LMC's Return

RECEIVED

Jan 08 2021

SC Court of Appeals

ALC Order Denying Motion to Expedite

Lexington County Health Services)
District, d/b/a Lexington Medical Center,)
)
Petitioner,)
)
vs.)
)
South Carolina Department of Health and)
Environmental Control and Prisma Health-)
Midlands,)
)
Respondents.)
)

ORDER DENYING MOTION TO EXPEDITE

BACKGROUND

¹ A certificate of public advantage is “the formal approval, including any conditions or modifications, by the Department [of Health and Environmental Control] of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health providers networks, or health care purchasers that might be construed to be violations of state of [sic] federal laws.” S.C. Code Ann. Regs. 61-31 § 102(2) (2012).

FILED

SC ADMIN. LAW COURT

In late 2017, Palmetto Health and Upstate Affiliate Organization d/b/a Greenville Health System (GHS) entered into an affiliation agreement to form Prisma Health (Prisma), a non-profit South Carolina Corporation. Prior to closing the transaction, Palmetto Health and GHS contacted the Department to determine whether the affiliation between the two health systems implicated COPA-97-01. DHEC determined the COPA was not implicated, and it remained in place with Palmetto Health. After Prisma was formed, Palmetto Health changed its name to Prisma Health—Midlands (PHM).

In 2019, Prisma was invited by LifePoint Health to purchase three of its South Carolina hospitals and a freestanding emergency department (FSED): Providence Downtown, Providence Northeast, Kershaw Health, and Fairfield County FSED (collectively, Assets). LifePoint Health and Prisma entered into the Asset Purchase Agreement (Agreement) for Prisma to purchase the Assets.

On December 13, 2019, PHM notified the Department that it intended to acquire the Assets and wanted them to be subject to the COPA. On February 28, 2020, the Department issued a decision in which it determined the COPA should be amended to include the Assets.³ On March 2, 2020, the Agreement was executed, and by that point, PHM had paid a non-refundable \$10 million towards the transaction. LMC requested a final review conference before the Department's Board (Board). On April 21, 2020, the Board refused to hold a final review conference and staff decision became the final agency decision. On May 14, 2020, LMC filed a request for contested case with this Court.

DISCUSSION

PHM filed this Motion pursuant to Rule 19(A) of the Rules of Procedure for the Administrative Law Court (SCALC Rules), the South Carolina Rules of Civil Procedure (SCRCPP), and applicable law. SCALC Rule 19(A) generally provides for the filing of pre-hearing motions, whereas SCALC Rule 19(E) specifically governs motions for expedited hearings. Nevertheless, even though PHM did not cite the specific rule governing motions to expedite, PHM's reference

³ Unlike most Department decisions that come before this Court, it does not appear that any public announcement and review of the request to amend the COPA was made such that potentially affected parties could participate in the administrative review process. The extent to which PHM and the Department did or did not adhere to the appropriate administrative process is one of the primary issues in this case.

to the general provision provides sufficient notice to this Court as to the remedy it seeks. Accordingly, PHM's error is harmless.

SCALC Rule 19(A) requires that the movant "state the grounds for relief and the relief sought." Interestingly, Prisma contends that in evaluating this issue the Court should not use the "good cause" standard because rule 19(A) does not express a standard of review. Prisma however failed to provide an alternative standard. The Court finds that "good cause" is the appropriate standard for review. Good cause means a "legally sufficient reason." *Good Cause*, BLACK'S LAW DICTIONARY (11th ed. 2019). Indeed, if the Court does not make its decision based upon a legally sufficient reason, what standard is it to utilize? Moreover, in defining good cause, Black's Law Dictionary implicitly recognizes the definitions of "just cause," "lawful cause," and "sufficient cause" are all intertwined. *See Cause*, BLACK'S LAW DICTIONARY (11th ed. 2019).

PHM contends that if this case is not expedited the transaction could fall apart and it could lose \$10 million. Although the asserted facts are somewhat confusing in the Motion, it appears that the Agreement was executed on March 2, 2020, but the transaction has not yet closed and PHM is apprehensive about this case not being concluded by the closing date of the transaction. In its Motion, PHM does not mention the closing date of the transaction, whether the closing date is fluid, or otherwise present a timeline for the Court to consider. However, in its Reply, PHM clarifies that if the transaction does not close by March 2, 2021, then LifePoint Health can terminate the transaction and retain the \$10 million. Also in its Reply, PHM gives a date by which it requests litigation be concluded: February 28, 2021. In contrast, LMC argues there is no need to expedite this case because it is statutorily required to be decided within twelve months from May 14, 2020, unless the parties agree otherwise.⁴ S.C. Code Ann. § 1-23-600(H)(4)(b) (Supp. 2019). In its Reply, PHM argues this statutory deadline does not apply to the case at bar.

Regardless of whether the statutory time period in section 1-23-600(H)(4)(b) applies, it is now clear that PHM is requesting this case be concluded before a year passes; therefore, the issue is whether PHM has demonstrated good cause for that request. At the outset, PHM failed to demonstrate that the contractual deadline it willingly agreed to merits a determination of good

⁴ It is notable that in replying to PHM's Motion, LMC did not have the benefit of knowing the date that PMC wished to have these proceedings concluded. Rather, it was addressing an undefined timeframe under which the hearing should be expedited.

cause to expedite this case. In other words, PHM argues good cause exists to expedite this case based upon its own actions that created the need to expedite this case. Although even under these circumstances there could conceivably be a need to expedite this case, PHM does not explain why it was necessary to enter into a contract with this specific closing date or why the contract and/or closing date cannot be amended to accommodate this litigation. In fact, as PHM itself admits, a COPA is not necessary for it to purchase the Assets. If a COPA is not necessary, then PHM has no need to expedite this case to complete the sale. Rather, it is PHM's decision to voluntarily pursue a COPA that put itself in this position.⁵

PHM further argues this case should be expedited because several permits and/or licenses from various federal agencies, state agencies, and local governments will need to be issued or approved "effective at the closing date, and prior to the execution of the [Agreement]." Oddly, PHM stated in its Motion that the Agreement was already executed on March 2, 2020, which would suggest that the deadline for these licenses and permits has already passed. PHM also asserts it is time consuming for PHM, LifePoint Health, and these various agencies and government to develop, review, and process these licenses and permits. However, PHM never states why this lengthy review process matters in the context of this case. Moreover, PHM does not explain how these approvals are related to the approval of the COPA. Therefore, PHM has failed to show good cause in this regard.

Next, PHM argues "the uncertainty regarding the ability to close the transaction, now coupled with the COVID-19 pandemic, has and is having adverse [sic] on PHM and the [LifePoint Health] Assets." PHM contends that the hearing should be expedited to allow PHM to better utilize its assets to provide treatment, care, and access to healthcare services in the Midlands.

⁵ LMC also noted in its opposition that the transaction can close without the issuance of the COPA and points to Regulation 61-31, section 103, to support this argument. Indeed, Regulation 61-31 § 103 provides:

This regulation applies to health care providers, health care networks, and health care purchasers who apply for a Certificate of Public Advantage and to those who receive a Certificate of Public Advantage.

The issuance of a Certificate of Public Advantage is not required in order for health care providers, purchasers or networks, to negotiate and enter into cooperative agreements with other health care providers. Parties to a cooperative agreement may apply to the Department for a Certificate of Public Advantage, should they desire. S.C. Code Ann. Regs. 61-31 § 103 (2012).

This regulation suggests that the transaction can proceed without the COPA. The Court can infer that PHM and LifePoint Health do not wish to complete the transaction without approval of the COPA to avoid any appearance of anti-trust; however, it is PHM's burden to express its concerns and not this Court's.

Specifically, PHM argues an expedited decision is necessary to: (1) reduce patient fear so they begin accessing routine health care and non-COVID-related illnesses;⁶ (2) promote efficiency in the healthcare system and alleviate the health care professional shortage in the Midlands; (3) resolve the uncertainty health care professionals have surrounding the transaction; and (4) help alleviate the financial strain the pandemic has caused for PHM and LifePoint Health assets.⁷

The Court does not find PHM's reasons related to COVID-19 establishes a sufficient reason to conclude this case by the suggested date. Good cause is something more than "any cause" and requires the court to evaluate the facts presented in light of the legal issues to determine if the movant's request is warranted. *See, e.g., Faile v. S.C. Employment Sec. Comm'n*, 267 S.C. 536, 541-42, 230 S.E.2d 219, 222-23 (1976) (evaluating good cause and unemployment compensation determination based upon the factual and legal context); 17 Am. Jur. 2d *Continuance* § 51 (explaining consideration of good cause to grant a continuance). Moreover, a legally sufficient reason must be something more than circumstances or facts that are common to the population in general. In this instance, COVID-19 is affecting all hospitals across the State, as PHM admits in its Motion. Its issues and those of patients are not unique to it and are common to all hospitals at this troubled time. Moreover, as suggested by LMC, a viable reason PHM and the Assets are having staffing issues is because the transaction could potentially result in the closure of Providence Hospital and the natural reaction of its employees to seek employment elsewhere before such an event can occur. In fact, PHM asserts, itself, that since the transaction was announced, Providence has lost thirty nurses. Whether or not a hospital is closed, mergers and acquisitions often cause these kinds of losses and these staffing issues are not good reason to expedite this case as suggested by PHM.

LMC argues the novelty of the issues presented and public policy weigh against expedited treatment. Specifically, LMC suggests the novel issue of whether the Department could issue an

⁶ PHM explains that it provides charity care to persons up to 400% of the poverty level while LifePoint and LMC only provide charity care up to 180% and 200% respectively. If the Assets become subject to the COPA, they will be required to adhere to the 400% threshold and, therefore, according to PHM, serve more patients who need healthcare during this pandemic but cannot afford it. The Court finds there is no reason to believe that this line of reasoning is any more true during the current pandemic than normal times of operation – regardless, a higher charity threshold would encourage more low-income patients to visit a hospital without fear of financial consequences. Therefore, I do not find this argument to be a uniquely compelling reason to expedite this hearing.

⁷ PHM attached an unsigned affidavit to its Motion, which the Court cannot consider.

amended COPA without following the public review procedures outlined in the COPA statutes and regulations should be carefully considered. *See* S.C. Code Ann. § 44-7-510 *et seq.*; S.C. Ann. Regs. 61-31. PHM claims novel issues should not prevent this type of case from being expedited. PHM further argues LMC overlooks the fact that the Department's decision in this case was merely an "update" to the existing COPA and COPAs are voluntary.

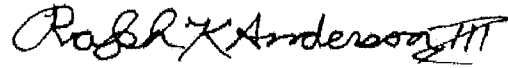
The Court agrees that novelty is not a reason, in and of itself, to expedite a case. Moreover, public policy generally favors the speedy resolution of decisions, but not without the requisite contemplation demanded by a factual presentation of each case to resolve it in a thorough and just manner. Thus, public policy is similarly not a reason, on its own, to expedite or not expedite a case. Here, I find the issues in this case warrant a thorough review that is most likely not possible within PHM's suggested timeframe. Furthermore, PHM's argument that the COPA is voluntary and merely an "update" suggests that the Department's decision is not worthy of or subject to review. Even if COPAs are voluntary, once PHM chose to utilize the COPA protections, it bound itself to the attending law and due process that is afforded others who disagree with a COPA decision. To what procedural requirements PHM bound itself and the Department once it engaged in the COPA process appears to be one of the ultimate issues in this case.

Finally, LMC complains that PHM did not consult it before filing the Motion to determine if the parties could reasonably agree on an expedited schedule. PHM contends it had no duty to consult under SCALC Rule 19(E), unlike, for example, SCALC Rule 19(C). Whether or not the SCALC Rules specifically require consultation under a particular subsection, consulting another party **before** filing a motion is a courtesy generally encouraged in the practice of law in this State. *See* Rule 11(a), SCRCPP ("All motions filed shall contain an affirmation that the movant's counsel prior to filing the motion has communicated, orally or in writing, with opposing counsel and has attempted in good faith to resolve the matter contained in the motion, unless the movant's counsel certifies that consultation would serve no useful purpose, or could not be timely held."). However, in this instance, it is not a reason to deny PHM's request.

Overall, the Court finds PHM failed to show good cause why this case should be expedited as it has requested. Nonetheless, through this Order the Court wishes to emphasize to the parties that any effort to delay the decision in this case will be reviewed circumspectly.

ORDER

IT IS THEREFORE ORDERED that a PHM's Motion to Expedite is **DENIED**.
AND IT IS SO ORDERED.



Ralph King Anderson, III
Chief Administrative Law Judge

July 14, 2020
Columbia, South Carolina

RECEIVED

Jan 08 2021

SC Court of Appeals

CERTIFICATE OF SERVICE

I, Stephanie Michelle Perez, 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).



Stephanie Michelle Perez
Judicial Law Clerk

July 14, 2020
Columbia, South Carolina

RECEIVED

Jan 08 2021

SC Court of Appeals

EXHIBIT C

To LMC's Return

ALC Order on Intervention

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services	)	Docket No. 20-ALJ-07-0108-CC
District, d/b/a Lexington Medical Center,	)	
	)	
Petitioner,	)	
	)	
vs.	)	ORDER GRANTING
	)	MOTION TO INTERVENE
	)	
South Carolina Department of Health and	)	
Environmental Control and Prisma Health-	)	
Midlands,	)	
	)	
Respondents.	)	
	)	

This matter is before the South Carolina Administrative Law Court (ALC or Court) pursuant to a Motion to Intervene (Motion) filed by Providence Hospital, LLC d/b/a Providence Health, Providence Health Northeast, and Providence Health Fairfield, and Kershaw Hospital, LLC d/b/a KershawHealth Medical Center (Providence and Kershaw or, collectively, “Movants”). Lexington County Health Services District, d/b/a Lexington Medical Center (LMC) filed a Response in Opposition to the Motion. Based upon a thorough review of the Motion and the parties’ filings, I conclude the Motion must be granted subject to limitations.

BACKGROUND

On or about October 23, 1996, Baptist Healthcare System of South Carolina, Inc., (Baptist Hospital) and Richland Memorial Hospital applied for a Certificate of Public Advantage (COPA)¹ to serve the Midlands service area² of South Carolina. On October 6, 1997, DHEC issued Certificate of Public Advantage (COPA-97-01) to BR Health System, Inc. (BR Health), the non-profit entity incorporated to operate the hospitals as a single entity. BR Health later changed its name to Palmetto Health.

¹ A certificate of public advantage is “the formal approval, including any conditions or modifications, by the Department [of Health and Environmental Control] of a contract, business or financial arrangement, or other activities or practices between two or more health providers, health providers networks, or health care purchasers that might be construed to be violations of state or federal laws.” S.C. Code Ann. Regs. 61-31 § 102(2) (2012).

² The Midlands service area includes the following counties: Fairfield, Kershaw, Lexington, Newberry, Orangeburg, Richland, and Sumter.

In late 2017, Palmetto Health and Upstate Affiliate Organization d/b/a Greenville Health System (GHS) entered into an affiliation agreement to form Prisma Health (Prisma), a non-profit South Carolina Corporation. Prior to closing the transaction, Palmetto Health and GHS contacted the Department to determine whether the affiliation between the two health systems implicated COPA-97-01. DHEC determined the COPA was not implicated, and it remained in place with Palmetto Health. After Prisma was formed, Palmetto Health changed its name to Prisma Health–Midlands (PHM).

In 2019, Prisma was invited by LifePoint Health to purchase three of its South Carolina hospitals and a freestanding emergency department (FSED): Providence Downtown, Providence Northeast, Kershaw Health, and Fairfield County FSED (collectively “the Assets”). LifePoint Health and Prisma entered into the Asset Purchase Agreement (Agreement) for Prisma to purchase the Assets.

On December 13, 2019, PHM notified the Department that it intended to acquire the Assets and wanted them to be subject to the COPA. On February 28, 2020, the Department issued a decision in which it determined the COPA should be amended to include the Assets.³ On March 2, 2020, the Agreement was executed, and by that point PHM had paid \$10 million towards the transaction, which is non-refundable. LMC requested a final review conference before the Department’s Board (Board). On April 21, 2020, the Board refused to hold a final review conference and staff decision became the final agency decision. On May 14, 2020, LMC filed a request for contested case with this Court. On July 14, 2020, Providence and Kershaw filed a Motion to Intervene. On July 24, 2020, LMC filed a Response in opposition to the Motion. On July 31, 2020, Providence and Kershaw filed a Reply.

DISCUSSION

Rule 20 of the Rules of Procedure for the South Carolina Administrative Law Court (SCALC Rules) governs interventions. Rule 20 provides that any person may intervene in a pending contested case upon showing that:

- (1) the movant will be aggrieved or adversely affected by the final order;

³ Unlike most Department decisions that come before this Court, it does not appear that any public announcement and review of the request to amend the COPA was made such that potentially affected parties could participate in the administrative review process. The extent to which PHM and the Department did or did not adhere to the appropriate administrative process is one of the primary issues in this case.

(2) the interests of the movant are not being adequately represented by existing parties, or that it is otherwise entitled to intervene; and

(3) that intervention will not unduly prolong the proceedings or otherwise prejudice the rights of existing parties.

SCALC Rule 20(B). SCALC Rule 20(B) includes some similar requirements to Rule 24 of the South Carolina Rules of Civil Procedure (SCRCP), which also discusses intervention in an action. Specifically, Rule 24(a), SCRCP, “Intervention of Right,” requires an intervenor to show their interest in the action is not adequately represented by existing parties, which is similar to SCALC Rule 20(B)(2). Additionally, Rule 24(b), SCRCP, “Permissive Intervention,” requires the court to consider “whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties,” which is similar to SCALC Rule 20(B)(3). Overall, the ALC’s Rule is one of permissive intervention.

“Generally, the rules of intervention should be liberally construed where judicial economy will be promoted by declaring the rights of all affected parties.” *Kiawah Resort Assocs., L.P. v. Kiawah Island Cmty. Ass’n, Inc.*, 421 S.C. 538, 552, 808 S.E.2d 521, 528 (Ct. App. 2017). In determining whether to allow a party intervene, the court should consider the practical implications of denying or allowing intervention. *Gov’t Employee’s Ins. Co., Ex parte*, 373 S.C. 132, 138, 644 S.E.2d 699, 702 (2007).

Standing

A party must have standing to intervene in an action. *Kiawah Resort Assocs., L.P.*, 421 S.C. at 552, 808 S.E.2d at 528. “Generally, a party must be a real party in interest to the litigation to have standing.” *Hill v. S.C. Dep’t of Health & Envtl. Control*, 389 S.C. 1, 22, 698 S.E.2d 612, 623 (2010). “A real party in interest is a party with a real, material, or substantial interest in the outcome of the litigation.” *Id.* at 22, 698 S.E.2d at 623; *see Sea Pines Ass’n for Prot. of Wildlife, Inc. v. S.C. Dep’t of Nat. Res.*, 345 S.C. 594, 600, 550 S.E.2d 287, 291 (2001) (“A real party in interest is one who has a real, material, or substantial interest in the subject matter of the action, as opposed to one who has only a nominal or technical interest in the action.”).

LMC argues Movants do not have standing. Citing *Government Employee’s Insurance Company, Ex parte*, LMC argues Movants’ financial interest in the proposed purchase of themselves by PHM “is peripheral to the subject matter before the court” and is not sufficient to establish standing. 373 S.C. at 139, 644 S.E.2d at 702. LMC also argues Movants are not parties

to the sale, but rather LifePoint Health, as Movants' owner, is the party involved in the sale. LMC asserts that because Movants cannot establish standing, they cannot be permitted to intervene.

Movants argue that "as parties to the [Agreement] with [PHM], as the current owners of the assets being added to the COPA, and as providers of hospital services in the area covered by [PHM's] COPA, Providence and Kershaw meet all of the requirements for intervention in this matter." Movants nevertheless acknowledge "[t]he assets being transferred are ultimately owned and controlled by LifePoint Health and are being operated by the local subsidiaries as part of the LifePoint Health portfolio," but contend this "in no way, contradicts the fact that Providence and Kershaw are proper parties for intervention." Movants argue that not only do they, like LMC, provide hospital services in the geographic area served by PHM, but they are also the operators of the assets to be covered by the amended COPA. For these reasons, Movants argue they have standing.

The purpose of a COPA is to encourage two entities to come together to improve the quality of health care for South Carolinians and moderate costs, etc., by giving assurance against suit for anti-trust. S.C. Code Ann. § 44-7-505. Therefore, the combining of the entities is at the heart of the issue in a COPA. PHM and LifePoint Health seek a COPA to combine their entities and, therefore, an adverse decision denying the COPA will thwart that desire. Thus, an adverse decision will adversely affect PHM and LifePoint Health because they will not receive the anti-trust protection they seek. While it is strange that LifePoint Health did not file this Motion, simply because Movants are owned by LifePoint Health and do not currently hold the COPA, does not mean that they should have **no** voice when they are one the entities that will be covered under the COPA. While Movants fail to explicitly argue that they will suffer a loss of anti-trust protection, the value of this protection to Movants is obvious because the sale is conditioned on receipt of the COPA. Movants will also continue to suffer financial losses if the completion of the sale is further drawn out and jeopardized by this litigation. I find Movants are real parties in interest and have standing. *See Hill*, 389 S.C. at 22, 698 S.E.2d at 623; *see also* S.C. Code Ann. § 44-7-510(1) (defining "affected person" under the COPA statute).

Adversely Affected

Movants argue they will be "directly and substantially adversely impacted from the loss of the sale, but also from the financial and fiduciary obligations they have to continue operating the facilities that comprise the Providence/Kershaw Assets until these facilities are sold or closed or

unless they otherwise receive a substantial infusion of capital.” Movants argue they are also being adversely affected because their value diminishes each day that the sale is delayed. Furthermore, Movants argue that as long as the sale remains uncompleted, Providence, in particular, will continue to struggle to recruit and maintain qualified staff.

LMC argues Movants have not demonstrated they will be “aggrieved or adversely affected” by any final decision rendered in this contested case. LMC notes that PHM has already conceded that a “COPA is not a prerequisite for PHM to purchase the [LifePoint Health] assets” and, therefore, Movants cannot argue that this litigation will “thwart” or prevent a timely sale. LMC maintains “it is incomprehensible how LMC’s request that [the Department] follow the legal process set by the General Assembly for review and issuance of Certificates of Public Advantage has any bearing on [Movants’] obligation to operate its health care facilities or prevents [Movants] from pursuing a sale of its assets or obtaining an infusion of capital.”

Movants have demonstrated that the COPA directly impacts whether the sale goes forward, and Movants have a financial interest in the sale being completed. Therefore, an adverse decision in this case will adversely affect Movants. However, the question remains whether Movants’ interests are being adequately represented by existing parties.

Adequate Representation by Existing Parties

“The burden to show that the representation may be inadequate is on the [intervenor].” *S.C. Tax Comm’n v. Union Cty. Treasurer*, 295 S.C. 257, 260, 368 S.E.2d 72, 74 (Ct.App. 1988). “This burden is minimal and the [intervenor] need only show that the representation of his interests ‘may be’ inadequate.” *Berkeley Elec. Co-op., Inc.*, 302 S.C. at 191, 394 S.E.2d at 715. For guidance on this particular requirement, it is helpful to look at jurisprudence discussing Rule 24(a), SCRCP. Under Rule 24(a), if the intervenor and an existing party have “the same interests or ultimate objective in the litigation a presumption arises that its interests are adequately represented and the application should be denied unless a showing of inadequate representation is made by demonstration of adversity of interest, collusion, or nonfeasance.” *Union Cty. Treasurer*, 295 S.C. at 260, 368 S.E.2d at 74. Further, to determine whether the movant’s rights are adequately represented, our Supreme Court has referred to three factors to consider. *Berkeley Elec. Co-op., Inc. v. Town of Mt. Pleasant*, 302 S.C. 186, 191, 394 S.E.2d 712, 715 (1990) (referencing the three factors examined by the U.S. Ninth Circuit Court of Appeals in *Sagebrush Rebellion, Inc. v. Watt*, 713 F.2d 525 (9th Cir.1983)). The three factors include:

(1) whether the existing parties will undoubtedly make all of the intervenor's arguments; (2) whether the existing parties are capable and willing to make such arguments; and (3) whether the intervenor offers different knowledge, experience, or perspective on the proceedings that would otherwise be absent.

Id.

Movants argue their interests will not be adequately represented by the existing parties because “while Prisma Midlands and Providence and Kershaw are [both] in favor of upholding the Department’s decision and amending the conditions of the COPA, their specific interests are not so aligned that Providence and Kershaw’s interests can be adequately represented by Prisma Midlands.” Regarding PHM, Movants raise two distinctions. Movants generally contend “[t]he purchaser’s and seller’s interests in a transaction are by nature at odds.” Movants also distinguish their position from PHM by noting that their long-term viability is at stake whereas the same is not necessarily true for PHM. Movants similarly contend “the Department cannot be relied upon to represent Providence and Kershaw’s interests, as the Department’s interest is primarily a public interest” and although Providence agrees with the Department’s decision, [Movants] have additional interests that are personal and economic.”

LMC asserts PHM adequately represents Movants’ interests. LMC argues that “while PHM may desire to pay the lowest market value and [Movants] would strive for the highest market value, this (unknown) difference in financial objectives is irrelevant to their clearly unified objective: a successful purchase transaction.” LMC observes that PHM has already asserted nearly identical arguments as Movants in its Motion for Expedited Hearing, in which PHM argued an expedited hearing was necessary because of the financial losses Movants were suffering and the potential loss of Providence as a viable entity if the sale continued to remain uncertain due to this litigation.

As evidenced by the arguments PHM made in its Motion to Expedite in this case, PHM appears to be ready, willing, and able to make many of the arguments Providence raises here – in particular, PHM has already argued this litigation and any delays in it will hamper Providence financially and exacerbate Providence’s staffing issues. *See Berkeley Elec. Co-op., Inc.*, 302 S.C. at 191, 394 S.E.2d at 715. Thus, I find Movants have failed to show the first two factors considered under *Berkeley Electric*. *See id.* As to the third factor—whether Movants have different knowledge, experience, or perspective on the proceedings—I find a purchaser’s and seller’s interest are not inherently at odds. Although purchaser and seller often have distinct interests, this

case is not about whether the sale should take place. Indeed, in this case, the purchaser and seller have reached a meeting of minds to consummate the sale of Providence and Kershaw. This case is about whether the COPA should be approved. In that regard, if both seek the approval of the COPA, then their interests are aligned. See *S.C. Tax Comm'n v. Union Cty. Treasurer*, 295 S.C. 257, 260, 368 S.E.2d 72, 74 (Ct. App. 1988) (“When an applicant for intervention and an existing party have the same interests or ultimate objective in the litigation a presumption arises that its interests are adequately represented and the application should be denied unless a showing of inadequate representation is made by demonstration of adversity of interest, collusion, or nonfeasance.”). Accordingly, the issue for the Court to determine is whether Movants’ interests are different from PHM’s regarding the issuance of the COPA. In making that determination, the Court is mindful that “the rules of intervention should be liberally construed where judicial economy will be promoted by declaring the rights of all affected parties.” *Kiawah Resort Assocs., L.P.*, 421 S.C. at 552, 808 S.E.2d at 528. Although the potential that Providence and Kershaw will have claims that will not be adequately represented by PHM appears to be unlikely, the Court cannot, at this point, clearly discern whether that situation would never occur. Therefore, the Court will allow Movants to intervene and present arguments **but only** to the extent their arguments are different from PHM’s and uniquely reflect their interests. Any effort to extend their representation to issues that overlap with PHM would be a violation of the Movant’s conditional intervention.

Prejudice

Movants argue there “there will be no undue delay or prejudice to the existing parties because they “will comply with all Court scheduling orders and deadlines.” Movants also note that “discovery has not yet concluded and [Movants] will work with the other parties with regard to scheduling and condensing the amount of discovery needed to the extent possible.”

LMC submits Movants’ request will (1) increase the time necessary to engage in discovery and prepare for a contested case hearing, (2) extend the length of the hearing itself, and (3) will result in significantly higher fees and expenses than would otherwise be incurred if LMC is forced to litigate not only with the Department and PHM, but also with Movants. LMC argues this delay and extra expense would be prejudicial.

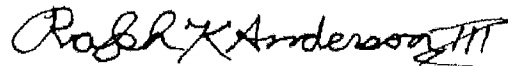
If Movants seek to engage in discovery regarding the same issues raised by PHM, their intervention will unduly prolong the proceedings. Accordingly, Movants participation in the discovery process should be limited only to exploring issues that are different from those raised

by PHM and which uniquely reflect their interests. Any effort to extend discovery to the issues that overlap with the discovery sought by PHM would be a violation of this condition. Furthermore, if Movants comply with this condition, I do not find allowing intervention to be prejudicial.

ORDER

IT IS THEREFORE ORDERED that a Providence and Kershaw's Motion to Intervene is **GRANTED** but their intervention is limited to the presentation of arguments that are different and unique compared to PHM's arguments in this case.

AND IT IS SO ORDERED.

A handwritten signature in black ink, reading "Ralph King Anderson, III". The signature is written in a cursive, flowing style.

Ralph King Anderson, III
Chief Administrative Law Judge

September 4, 2020
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Stephanie Perez, 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).



Stephanie Perez
Judicial Law Clerk

September 4, 2020
Columbia, South Carolina

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Jan 08 2021

SC Court of Appeals

EXHIBIT D

To LMC's Return

LMC's Prehearing Statement

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Jan 08 2021

SC Court of Appeals

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

Docket No. 20-ALJ-07-0108-CC

**PETITIONER'S PREHEARING
STATEMENT**

Petitioner Lexington County Health Services District, d/b/a Lexington Medical Center (LMC), submits the following Prehearing Statement pursuant to the June 22, 2020 Order of the Court.

1. **The nature of this proceeding.**

This contested case proceeding arises from the Respondent South Carolina Department of Health and Environmental Control's (DHEC or the Department) decision dated February 28, 2020, directed to Respondent Prisma Health – Midlands (PHM) and purporting to amend the ongoing conditions of an existing Certificate of Public Advantage (COPA) originally issued to Baptist Healthcare System of South Carolina, Inc. (BHS), and Richland Memorial Hospital (RMH), on October 6, 1997 ("COPA-97-01"), in order to include PHM's proposed acquisition of acute care facilities owned and operated by LifePoint Health (LPNT), a separate healthcare provider operating in the same service area as LMC and PHM. According to DHEC's decision, the assets PHM seeks to acquire from LPNT include Providence Health (HTL-0928), Providence Health – Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department (FED) in Fairfield County operating under HTL-0929. On May 20, 2020, contested case

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challenges to DHEC's decision were also filed by Fairfield County and Fairfield County Memorial Hospital (Fairfield County), assigned Docket No. 20-ALJ-07-0120-CC, Kershaw County (Kershaw County), assigned Docket No. 20-ALJ-07-0120-CC, and the City of Columbia, assigned Docket No. 20-ALJ-07-0122-CC. On June 4, 2020, PHM moved with the consent of all parties to consolidate this proceeding with the contested cases filed by Fairfield County, Kershaw County and the City of Columbia. Shortly thereafter, PHM withdrew its motion to consolidate as the contested cases filed by Fairfield County, Kershaw County and the City of Columbia were each separately dismissed. On June 19, 2020, PHM filed a Motion to Expedite, which is now pending before the Court.

2. **The statutory provision (s) conferring subject matter jurisdiction to the agency and other applicable statutes and regulations.**

The Administrative Law Court has jurisdiction over this contested case pursuant to S.C. Const. Art. I, § 22; the South Carolina Administrative Procedures Act, S.C. Code Ann. §§ 1-23-310, *et seq.* and 1-23-505, *et seq.*; the Health Care Cooperation Act (HCCA or the Act), S.C. Code Ann. §§ 44-7-500, *et seq.*; S.C. Code Ann. Regs. 61-31 § 311; and Rule 11 of the Rules of Procedure for the Administrative Law Court, as well as other applicable laws, such as S.C. Code Ann. §§ 44-1-60 and 1-23-600.

3. **The issues to be presented for determination set forth with particularity, including any claims or defenses expected to be raised.**

Reserving the right to supplement or amend this Prehearing Statement as the facts are developed through discovery, LMC anticipates the following issues will be presented for determination by the Court, described herein with particularity:

LMC submits that DHEC does not have the authority to "update" or "amend" the ongoing conditions of COPA-97-01, originally issued to BSH and RMH on October 6, 1997, in order to

include PHM's proposed acquisition¹ of LPNT's assets. By the plain language of the HCCA, PHM and LPNT are each "health care providers" under Section 44-7-510(5) and the proposed transaction identified in DHEC's decision represents a "cooperative agreement" under Section 44-7-510(3), such that if PHM (and/or Prisma Health) desires the benefits of a COPA to apply to the "acquisition . . . of assets," DHEC is required to review the proposed transaction in accordance with the requirements of the HCCA prior to any COPA benefits being afforded, to include the submission of an application by the applicants in accordance with Section 44-7-530 and participation in the review process set forth in Sections 44-7-540, -550 and -560, as well as Chapters 2, 3 and 4 of Regulation 61-31. DHEC also has an obligation to affirmatively "determine[] that the applicant has demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement; and the reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result." S.C. Code Ann. Regs. 61-15 § 401. As there is no evidence of an application received by DHEC, a review conducted by DHEC, or a determination that the likely benefits outweigh the likely disadvantages in accordance with these legal requirements, DHEC lacked the authority to approve the proposed transaction by way of additional conditions to COPA-97-01.

Furthermore, even if DHEC has the authority to update or amend the ongoing conditions as represented in DHEC's decision letter without the necessary finding as to benefits and disadvantages, DHEC's interpretation of Regulation 61-31 § 508 that "another review" of the COPA does not require the review process set forth in the HCCA or Regulation 61-31 is contrary to the plain language of the regulation and manifestly at odds with the legislative intent. DHEC's interpretation of Section 508 in

¹ By attachment to its Reply to LMC's Opposition to PHM's Motion to Expedite, for the first time on July 6, 2020, PHM provided a copy of the letter of intent ("LOI") underlying the proposed acquisition. According to the LOI dated September 13, 2019 and the amendments through Amendment No. 4 dated January 31, 2020, the "Buyer" of the LPNT facilities is "Prisma Health," principally located in Greenville, SC, not PHM. To the extent that PHM is not the entity acquiring the assets within the meaning of the HCCA, but instead the transaction is explicitly or for all practical purposes between Prisma Health and LPNT, DHEC cannot address the proposed transaction through amendment or update to COPA-97-01 issued to BSH and RMH in 1997.

this matter of first impression in fact necessitates a finding that the regulation fails for vagueness and must be struck down as exceeding DHEC's powers under the HCCA. *See S.C. Coastal Conservation League v. S.C. Dept. of Health and Env'tl. Control*, 363 S.C. 67, 75, 610 S.E.2d 482, 486 (2005). While DHEC is empowered to promulgate regulations "to implement the provisions" of the HCCA, nothing within the HCCA contemplates DHEC's authority to review or approve cooperative agreements in a manner contrary to the law (such as without a public review, input from affected persons, or consultation with the Attorney General, and without submission of an application with an executed written copy of the cooperative agreement). *See* S.C. Code Ann. §§ 44-7-530 to -570. For these reasons, as will be further developed during discovery, DHEC's decision must be reversed or, in the alternative, the matter remanded to DHEC for "another review" in accordance with the HCCA and Regulation 61-31.

4. **The action requested of the Court and a detailed statement of the law which supports the requested action, including statutory and/or case citations.**

LMC respectfully requests that this Court reverse the decision of DHEC and deny PHM's request, or remand this matter back to DHEC with instructions to engage in the review process established by the HCCA. "As a creature of statute, [DHEC] has only those powers expressly conferred or necessarily implied for it to effectively fulfill the duties with which it is charged." *S.C. Coastal Conservation League v. S.C. Dept. of Health and Env'tl. Control*, 363 S.C. at 74, 610 S.E.2d at 485 (internal quotations omitted). DHEC's authority to issue a COPA is limited to those cooperative agreements for which DHEC has reviewed an application with the substantive supporting documentation necessary to demonstrate that the potential benefits of the proposed cooperative agreement outweigh any potential disadvantages caused by the reduction in competition. *See* S.C. Code Ann. §§ 44-7-510, -530, -540, -550; -560; *see also*, S.C. Code Ann. Regs. 61-31 §§ 201, 202, 301, 302, 305, 306, 307, 401, 402, 403, 404. DHEC may only issue a

COPA after it determines, with notice to affected persons and in consultation with the Attorney General, that the applicants have demonstrated the likely benefits such as enhanced quality, improved access, preservation of providers, utilization, or cost-efficiency of health care from the cooperative agreement outweighs any likely disadvantages associated with the agreement such as reduced competition and impact on quality and availability of services. *See* S.C. Code Ann. § 44-7-560; *see also* S.C. Code Ann. Regs. 61-31 § 401. The Act expressly requires that DHEC “shall consider . . . support of the agreement by purchasers and payers in the health service area.” *See* S.C. Code Ann. § 44-7-560(A)(1)(vii); *see also* S.C. Code Ann. Regs. 61-31 § 402.1(g).

Conversely, DHEC does not have the authority to issue a COPA for a proposed transaction where the applicant has not “demonstrated that the likely benefits resulting from the [transaction] outweigh the likely disadvantages from the [transaction]; and the reduction in competition likely to result from the [transaction] is reasonably necessary to obtain the benefits likely to result.” S.C. Code Ann. Regs. 61-31 § 401. While there are no administrative or judicial opinions addressing the merits of a Department decision to approve or deny a COPA application, there have been issued a plethora of analogous decisions evaluating DHEC’s approval or denial of applications for certificates of need, which demonstrate the obvious conclusion that a Department decision approving a non-compliant application must be reversed. *See e.g., Roper Hosp. Inc. et al. v. S.C. Dept. of Health and Envtl. Control*, Docket No. 01-ALJ-07-0378-CC, 2002 WL 31423787 (S.C. Admin. Law J. Div. Sept. 5, 2002).

When interpreting regulations, the South Carolina Supreme Court has observed that regulations are construed using the same canons of construction as statutes. *S.C. Dept. of Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 261, 725 S.E.2d 480, 483 (2012); *see also Murphy v. S.C. Dept. of Health and Envtl. Control*, 396 S.C. 633, 639, 723 S.E.2d 191, 195 (2012). As

such, “[t]he words of a regulation must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand the regulation operation.” *Blue Moon of Newberry, supra*. “Furthermore, the regulation must be construed as a whole rather than read in its component parts in isolation.” *Id.* A court “will not construe a [regulation] in a way which leads to an absurd result or renders it meaningless.” *Florence Cty. Democratic Party v. Florence Cty. Republican Party*, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012). While courts generally defer to an agency’s interpretation of a statute or regulation with which the agency is charged with administering, where the agency’s interpretation is “manifestly at odds with legislative intent,” the court should conclude that “the deference [it may] normally accord an agency’s policy determinations is not warranted.” *MRI at Belfair, LLC v. S.C. Dept. of Health and Env’tl. Control*, 392 S.C. 314, 322, 709 S.E.2d 626, 620 (2011). Similarly, an interpretation that is contrary to the plain language should be rejected. *See Brown v. Bi-Lo, Inc.*, 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003).

Again in the analogous context of certificates of need, the South Carolina Supreme Court has observed that DHEC has formulated “exacting procedural requirements” governing the submission, review, and appeal procedures for CON applications. *See Amisub of South Carolina, Inc. v. S.C. Dept. of Health and Env’tl. Control*, 403 S.C. 576, 590, 743 S.E.2d 786, 794 (2013); *see also* S.C. Code Ann. § 44-7-120(2) and S.C. Code Ann. Regs. 61-15 § 307(1). Exacting procedural requirements in the law are not to be ignored, even if the end objectives of the regulation are believed to be satisfied. *See Sierra Club v. S.C. Dept. of Health and Env’tl. Control*, 426 S.C. 236, 256, 826 S.E.2d 595, 606 (2019). The “exacting procedural requirements” governing the submission, review, and appeal procedures for CON applications are quite similar to those set forth for COPA applications. For example, both regulations promulgated by DHEC include explicit

format requirements for the written application submission for a CON and a COPA, with four separate sections for the Part A, Part B, Part C and Part D information. *See* S.C. Code Ann. Regs. 61-15 § 202 and 61-31 §§ 201-202. Also similar are the “Disposition of Application” provisions in both the CON Regulation 61-15 and the COPA Regulation 61-31, both of which include procedural requirements for additional information, public notice and opportunity for public hearing, and the following nearly identical obligation as to the “Department Decision”:

In CON Regulation 61-15 § 308:

On the basis of staff review of the record established by the Department, including but not limited to, the application, comments from affected persons and other persons concerning the application, data, studies, literature and other information available to the Department, the staff of the Department shall make a proposed decision to grant or deny the Certificate of Need.

In COPA Regulation 61-31 § 307:

On the basis of staff review of the record established by the Department, including but not limited to comments from the Attorney General’s office, the application, written and verbal comments by affected persons and other persons concerning the application, data studies, literature and other information available to the Department, the staff of the Department shall make a proposed decision to grant or deny the Certificate of Public Advantage. . . .

Despite similar (in fact, more extensive) “exacting procedural requirements” that must be followed in order to receive the benefits of a COPA, in this instance, DHEC did not require PHM to comply with the “exacting procedural requirements” of Regulation 61-31. Instead, DHEC was “persuaded” to evaluate the proposed transaction as if a change to the originally issued COPA-97-01, and interpreted “another review” under Regulation 61-31 § 508 to mean something entirely contrary to the legal requirements addressed above.

The Department’s apparent approval of the proposed transaction without receipt and review of the required documentation or participation in the applicable public review process, coupled with its finding “that the proposed changes resulting [from PHM’s acquisition of three

hospitals and a FED] might materially impact the benefits or disadvantages to the community to be served” but without determining the likely benefits outweigh the likely disadvantages, constituted a reckless disregard of the duties placed on the Department by the General Assembly. As in performance of its duties in implementing the CON program, DHEC should “use common practice and common sense” in applying the COPA Regulations in review of proposed transactions. *See e.g. MRI at Belfair, LLC v. S.C. Dept. of Health and Envtl. Control*, 292 S.C. 314, 319, 709 S.E.2d 626, 629 (2011) (quotations omitted). In *MRI at Belfair*, the Supreme Court held “DHEC must not allow a potential CON applicant to avoid the CON process based on an arbitrary factor.” *Id.* In that proceeding, the Department’s method for allocating project costs for an imaging center for purposes of a non-applicability determination “was affected by an arbitrary factor that strayed substantially from legislative intent and worked substantial prejudice to [the applicant’s] competitors.” *Id.* at 321, 709 S.E.2d at 630. LMC submits that similarly here, DHEC has allowed PHM to avoid the COPA process based on an arbitrary factor – the one-sided, self-interested allegations of the applicant – which resulted in a process and outcome that “strayed substantially from legislative intent and worked substantial prejudice to [affected persons].” *See id.* Because there is no evidence PHM followed the “exacting procedural requirements” of Regulation 61-31, to include submission of the necessary application with responses to the questionnaire, submission of programmatic documents, or even written assurance as required by Section 202(d) of Regulation 61-31, DHEC could not have (and LMC and this Court cannot now) evaluate any potential benefits to the proposed transaction as necessary to outweigh the apparent disadvantages and the Department’s decision must be reversed.²

² In significant contrast, just the narrative portion of the application submitted by RMH and BHS in 1996 in accordance with Regulation 61-31, which culminated in the issuance of COPA-97-01, spanned 79 pages. Attached as **Exhibit A** is the cover page, table of contents and application summary for COPA-97-01.

Alternatively, should the Court believe the existing COPA issued to RMH and BHS can be amended to address the LPNT transaction, the matter must at a minimum be remanded to DHEC with the instruction that DHEC engage in the review process necessary to evaluate the “amendment” sought by PHM of the existing COPA, which review cannot solely consist of the self-interested opinions of the applicant that stands to benefit from the approval. Once issued, a COPA “is only valid for the project described in the application including parties involved, services to be offered, mergers or consolidations approved, or other factors as set forth in the application, except as may be modified in accordance with these regulations.” S.C. Code Ann. Regs. 61-31 § 309. As further proscribed by regulation, “[i]f an applicant amends, alters, or otherwise changes the agreement after receipt of a [COPA], the Department will decide whether or not the amendment is substantial and thereby requires another review.” *Id.* at § 508. It is undisputed that DHEC determined the transaction proposed by PHM, to the extent disclosed to DHEC by PHM,³ was a “substantial” change to the COPA issued to RMH and BHS. *See* DHEC decision, p. 1 (“[T]he Department determined that the proposed changes resulting from the transaction might materially impact the benefit or disadvantages to the community to be served. The Department therefore undertook another review of the COPA.”) DHEC’s interpretation of Regulation 61-15 § 508 to allow for the inadequate and incomplete review that occurred here is manifestly erroneous and contrary to the plain meaning of Section 508. Where parties desire the benefit of a COPA, such request to DHEC must be in an application, and the General Assembly has instructed that DHEC “**shall review** the application in accordance with the standards set forth

³ It does not appear from the documents produced to LMC in response to a FOIA request that DHEC was provided all of the documentation necessary under the HCCA for review and approval of a cooperative agreement. At a minimum, and by statute, PHM is required to provide “an executed written copy of the cooperative agreement and describe the nature and scope of the cooperation in the agreement and any monetary or other consideration passing to a party under the agreement” S.C. Code Ann. § 44-7-530. The significance of this required disclosure is evidenced by the Department’s separate statutory obligation to “maintain on file all cooperative agreements for which certificates of public advantage remain in effect.” S.C. Code Ann. § 44-7-580.

in Section 44-7-560 and if requested by an affected person within thirty days of the department's receipt of a completed application, may hold a public hearing in accordance with regulations promulgated by the department." S.C. Code Ann. § 44-7-540 (emphasis added). By interpreting Section 508 to allow for something other than the review process set forth in the HCCA and Regulation 61-31, DHEC "denied contemporaneous notice and participation opportunities that DHEC's own regulations required be provided to both the public and [affected persons]." *Pickens Cty. v. S.C. Dept. of Health and Envtl. Control*, 429 S.C. 92, 105, 837 S.E.2d 743, 750 (Ct. App. Jan. 8, 2020), *reh'g denied*. Based on the foregoing, LMC submits that reversal of the DHEC decision is appropriate, or that the matter must be remanded to DHEC for an appropriate review in accordance with the law.

5. **A brief summary of the facts to be presented at the hearing.**

LMC will present fact and expert testimony and documentary evidence demonstrating that the Department's decision violates the HCCA and Regulation 61-31 in the particulars described in Sections (3) and (4) above. In acquiescing to PHM's demands for a limited and one-sided review without the submission of an application and the substantive documentation required by Regulation 61-31, DHEC did not develop the record necessary to reasonably evaluate the benefits and disadvantages that will result from combining the only providers of acute and emergency care services in Richland, Kershaw, Fairfield and Sumter Counties.⁴ See S.C. Code Ann. Regs. 61-31 §§ 307, 401, 402, 403. In fact, Regulation 61-31 specifically requires DHEC to consider "written and verbal comments by affected persons and other persons concerning the application." S.C. Code Ann. Regs. 61-31 § 307. Rather than a robust, detailed, and transparent review process, the

⁴ Notably, the COPA application and subsequent submissions in support of BHS and RMH's request for a COPA in 1996 were *replete* with references to both LMC and "Columbia/HCA hospitals" as existing competitors in the core service area that militated against any disadvantage from the combination of BHS and RMH. See *e.g.* Ex. A at 0008; see also Exhibit B, Section II (Evaluation of Disadvantages) portion of the application for COPA-97-01.

Department inexplicably “conducted a review without public notice or hearing” based only on the “persuasive” writings of PHM and its representations as to the benefits of the transactions and dire consequences should the Department’s conduct not comport with the demands made by PHM. *See* Staff Response to RFR at p. 5 (“PHM represented to the Department that the seller of the assets would not proceed with the proposed transaction if the review included public notice and review and provided information to the Department regarding the potential consequences if the transaction were not consummated.”) By acquiescing to PHM’s demands, DHEC has impermissibly made “the [COPA] process vulnerable to manipulation.” *See MRI at Belfair, LLC*, 392 S.C. at 322, 709 S.E.2d at 630 (reversing DHEC decision based on a cost allocation methodology with “no basis in the facts of the proposal and arbitrarily allows a potential applicant to avoid the CON review process, is contrary to the purposes of the CON Act and therefore an error of law.”)

6. **A summary of any motions expected to be raised at the hearing and the appropriate authority underlying the motion.**

LMC believes the parties should confer on a Consent Scheduling Order and enter an appropriate Confidentiality Order for the protection of sensitive information without need for motion practice. LMC reserves the right to file a dispositive motion in the event it is determined to be appropriate under the facts and law applicable to the case.

7. **A list of proposed witnesses and exhibits.**

As to proposed witnesses, and in addition to those witnesses identified by any other party to this proceeding, LMC intends to present factual and/or expert testimony from the following individuals:

- Tod Augsburger
President and Chief Executive Officer
Lexington Medical Center

- Armand Balsano
Balsano Consulting, LLC
- Louis Eubank
Chief, Bureau of Healthcare Planning & Construction
SC DHEC
- Margaret Murdock, Esq.
Director, Division of CON
SC DHEC
- Mark O'Halla
President and Chief Executive Officer
Prisma Health
- Malcolm Isley
Vice President of Strategic Services
Prisma Health

LMC specifically and expressly reserves the right to identify additional witnesses, fact and/or expert, as discovery in this proceeding progresses and in response to disclosures made by other parties.

As to proposed exhibits, and in addition to the right to refer to and introduce as evidence any documents identified by any party to this proceeding, and to introduce documents gathered during the discovery period, LMC identifies the following documents as potential exhibits at the final hearing:

- The Department's Record underlying the February 28, 2020 decision;
- The Department's Record for COPA-97-01;
- The DHEC Staff Response to Request for Review; and
- Any other evidence produced and/or obtained during discovery that may be relevant to the subject matter of this proceeding.

8. **A statement regarding the necessity for discovery, if any.**

LMC believes discovery as allowed by SCALC Rule 21(A) is necessary and, given the novelty and significance of the issues before this Court, good cause exists for the expansion of discovery as provided by the Rules of the Court.

9. **The estimated length of the hearing.**

LMC estimates the hearing will require 4-5 days.

10. **Any dates in the next one hundred twenty (120) days when you will not be available for a hearing.**

LMC will confer with counsel of record in an effort to reach an agreeable Scheduling Order to allow for an orderly progression of this case. In the next 120 days, counsel for LMC is unavailable for a hearing on July 23, 24 and August 10, and is currently under a Scheduling Order for a contested case hearing set for October 12-21, 2020.

11. **An e-mail address where you can be reached:**

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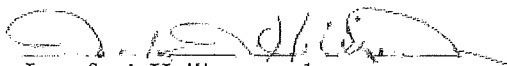
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Respectfully submitted,



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July 13, 2020
Columbia, SC

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

Docket No. 20-ALJ-07-0108-CC

CERTIFICATE OF SERVICE

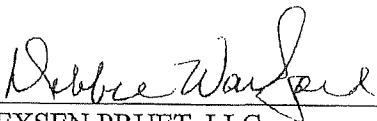
This is to certify that the foregoing **Petitioner's Prehearing Statement** has been served upon all counsel of record by electronic mail and U.S. Mail, addressed as shown below, this 13 day of July, 2020:

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EXHIBIT A

To Petitioner's Prehearing Statement

***APPLICATION
FOR
CERTIFICATE OF
PUBLIC ADVANTAGE***

by

*Baptist Healthcare System
of South Carolina, Inc.,*

and

Richland Memorial Hospital

October 23, 1996

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11.	<i>Document that the proposed agreement is economically feasible both immediately and long term. Describe the impact that the cooperative agreement will have on costs per unit of service.</i>	75
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*CERTIFICATE OF PUBLIC ADVANTAGE
APPLICATION SUMMARY*

The attached proposal is submitted by the Boards of Richland Memorial Hospital and Baptist Healthcare System in the sincere belief that the system proposed will allow the hospitals to continue their charitable missions during an era of fiscal restraints and to produce significant benefits for the community that could not be achieved by the hospitals if they were to remain separate.

The challenge: The Boards of Richland Memorial Hospital and Baptist Healthcare System are faced with the prospect that with declines in hospital utilization and government and other reimbursements, as well as the continued shift of indigent care from for-profit hospitals, the hospitals must achieve significant new efficiencies.

The choices: The Boards felt that they were facing several unacceptable choices and only one choice that ensured maximum benefit to the community. The unacceptable choices were:

- * Allow Richland and Baptist to deteriorate.
- * Increase the "cost shift" to employers, commercial payors and self-pay customers.
- * Raise rates.
- * Reduce the quality, accessibility, and/or range of services offered.
- * Reduce the amount of care provided to medically indigent patients.

The only acceptable choice was the development of a locally controlled nonprofit health care system with continuing supervisory responsibility over the jointly operated hospitals by the Sponsoring Boards.

The benefits: By virtue of the joint operating agreement, the hospitals will be able to achieve:

- * Approximately \$71 million in efficiencies, cost reductions and capital expenditure savings over the first five years the hospitals are jointly operated.
- * Savings will be passed on to the community in the form of community outreach programs and two major new preventive public health efforts -- a strong initiative to improve maternal and child care and a program to expand cancer education, screening and early detection and treatment.
- * These and other initiatives will be funded in the aggregate with 10% of the System's excess revenues over expenses.
- * Savings will also be passed on to the community in the form of rate increase avoidance and quality and access enhancements.
- * Additional savings will be identified as the hospitals consolidate some of their clinical services and programs.
- * Unrestricted commitment to care for the indigent members of the community regardless of their ability to pay at no cost to Richland County thereby reducing the tax burden.
- * Protection of local control of hospital services.

The assurances: The well being of the community is assured because of a number of factors, including the conditions the Boards of the two hospitals have imposed on themselves. They include:

- * The System will remain non-profit.
- * Its control will remain with local Boards.
- * Emphasis and focus will remain on improving the health of the community.
- * Competition from Lexington and Columbia/HCA hospitals, as well as from other hospitals in the System's core service area, will help to ensure that the hospitals continue to be efficient, low-cost, high quality hospitals.
- * Employees will be protected from layoffs as a result of the alliance.
- * No rate increases for the first five years of operation.

The bottom line: In an era of widespread fiscal constraints, it is imperative that the deliverers of health care remain a bastion of generosity and access to those we serve. This alliance will allow the hospitals to continue charitable missions, to maintain and even expand the range of service to patients, and foremost to assure the community that we are united for the good of people with a goal in common--the best and highest quality health care.

The Boards of Richland Memorial Hospital and Baptist Healthcare System sincerely believe that together we can achieve that which, separate, would be impossible.

SUMMARY OF SYSTEM COMMITMENTS AND PROPOSED DHEC MONITORING

It is the intent of South Carolina's Health Care Cooperation Act to provide direction, supervision, regulation and control over cooperative agreements that have received a Certificate of Public Advantage ("COPA") pursuant to the Act in order to provide the parties to that agreement immunity from challenge or scrutiny under the federal antitrust laws. In order to provide such immunity, the Act directs the South Carolina Department of Health and Environmental Control ("DHEC") to actively monitor and regulate the cooperative agreement. Consistent with DHEC's duty to monitor and regulate the cooperative agreement, the System (See Response to Question 1.(A) for a definition of "System") propose that the System report on and be monitored in several specific areas. The following commitments are contained in the application but are summarized here for convenience.

1. The System will report to DHEC annually to facilitate the formal review by DHEC of the System's continued compliance with the terms and conditions of the COPA. In addition to the information identified with regard to specific commitments described below and elsewhere within the COPA application, the System will provide DHEC annually with the previous year's audited financial statements.
2. The System commits, for as long as the COPA is in effect, to allocating 10% of its excess revenues over expenses to fund public health initiatives (specifically, the cancer and maternal and child health initiatives described in the response to Question 4, and summarized below) and a community outreach program. Additionally, the System guarantees, as a condition of the COPA, that the total amount it will commit to fund the public health initiatives and community outreach program during the first five years of operation will be no less than \$15 million. The System will report annually regarding its efforts and activities related to the public health initiatives. In addition to the commitments and active involvement of DHEC personnel in the implementation and operation of the public health initiatives described below, the System will submit and obtain DHEC approval of a yearly budget for the public health initiatives. The System will continue to fund and operate the cancer and maternal/child health initiatives until such time as the System and DHEC agree that the System's resources committed to public health initiatives should be employed to develop and implement different public health initiatives.
3. During its first five years, the System will increase educational programs relating to cancer and cancer screening opportunities for the Target Groups. Individuals identified during screening will receive treatment regardless of ability to pay. During the first five years the System commits to:

Year 1

Coordinate efforts with established health providers (e.g., parish nurses) for the identification of effective methods of communication and screening locations; conduct focus groups with Target Group(s) to determine most effective way to offer educational programs and screenings; plan and, with DHEC approval, implement pilot program in Postal ZIP Code 29203 (Eau Claire/Greenview); and evaluate process effectiveness.

Year 2

Continue screening, education and support programs in Postal ZIP Code 29203; report to DHEC the results of consultations with other health care providers and with focus groups, an evaluation of the implementation of the previous year's action plan and its effectiveness, measured in part, against baseline data; collaborate with the Richland Community Health Association and other providers in Postal ZIP Code 29044 (Eastover) to assess most effective means of reaching the population; conduct focus groups with Target Group(s) to determine most effective way to offer educational programs and screenings; plan, and with DHEC approval, expand screening, education and support in Postal ZIP Code 29044 (Eastover); and evaluate process effectiveness.

Year 3

Continue screening, education and support programs in Postal ZIP Codes 29203 and 29044; report to DHEC the results of consultations with other health care providers and with focus groups, an evaluation of the implementation of the previous year's action plan and its effectiveness, measured in part, against baseline data; conduct focus groups with Target Group(s) to determine most effective way to offer educational programs and screenings; plan, and with DHEC approval, expand screening, education and support pilot program to Postal ZIP Code 29204 (Oak/Waverly/Two Notch); and evaluate process effectiveness.

Year 4

Maintain, and with DHEC approval, refine the screening, education and support programs in all three geographic areas; report to DHEC on the implementation of the previous year's action plan and its effectiveness, measured in part, against baseline data; and evaluate process effectiveness.

Year 5

Maintain, and with DHEC approval, refine the screening, education and support programs in all three geographic areas; evaluate process effectiveness; measure and validate process results with the assistance of the South Carolina Cancer Center (SCCC) and DHEC; and plan, in consultation with DHEC, expansion of services to the Midlands region.

In addition to the information to be reported to DHEC identified above, the System will also provide annually comparisons to baseline data for screenings performed for breast, prostate, colorectal and cervical cancers (baseline data for lung cancer screening are not available because there is no recognized screening method for lung cancer; however, all screenings will be performed by trained medical personnel who will monitor those screened for signs of lung cancer); listings of screening opportunities by site and type; results of focus group meetings; expenditures incurred; analysis of detection rates; delineation of educational efforts; support group participation; and patient follow-up.

4. During its first five years, the System will implement a program to provide maternal and child health related educational, treatment, and counseling opportunities for women in Richland and Lexington County, but particularly to those women who have traditionally not obtained those services as soon or as often as they should. During the first five years the System commits to:

a. Install and Develop a Database. The System will install and develop a database that will be used to track Target Groups within the System, including those in the Richland OB Clinic as well as Richland and Lexington county callers to the *1-800-CareLine*. Through the database management program, mothers-to-be will be (1) referred to the appropriate participating physician for prenatal care and (2) reminded regularly of scheduled appointments. The database management program will serve as an evaluation tool for determining reasons for potential non-compliance. Individualized efforts with these patients will enable System personnel to determine barriers to compliance such as transportation, childcare, work or other issues. System personnel will work with patients to help overcome those issues where practicable, and/or provide referral for other private and public programs. All births at the two hospitals will be registered in the System's database and an immediate effort will be made to assure that each pediatric patient has a physician or clinic for future needs. Using the database management program, System personnel will work with pediatricians or family practitioners to case manage each pediatric patient to assure compliance with the needed well-baby check-ups or other appropriate follow-up. The System will develop with DHEC a plan for data collection and reporting with review and adjustments made annually.

b. Enhance the Awareness of 1-800-CareLine. Through the combined resources of the two hospitals, the System will provide additional public promotion of *1-800-CareLine*. This promotional message will encourage pregnant women to call the CareLine for referral and will provide valuable educational information about the importance of prenatal care. All promotional plans will be developed in consultation with DHEC and will be subject to DHEC approval before implementation. The System will encourage the CareLine to refer all Richland and Lexington County callers seeking prenatal care to the System's call center 24 hours a day where calls will be triaged and the maternal child process may begin.

c. Expand the Richland OB Clinic. The present Richland OB Clinic is at maximum capacity and is inadequate to provide for additional patients.

d. Increase Education Programs and Activities. The combined educational resources of the two hospitals in maternal and child health will use media, meetings, publications and programs, to assure that coordinated and effective education is provided to reach patients' needs. The System's efforts directed to the **preconception** stage will include teen pregnancy prevention, genetic testing and counseling for at-risk patients and sickle cell patients, and the relationship between healthy lifestyles and healthy babies.

The System will provide education about **pregnancy**, including promotion of *1-800-CareLine* to encourage callers to seek prenatal care and to emphasize the importance of prenatal care, vitamins, and abstinence from drugs, alcohol and other chemical substances. Special efforts will be directed to teens. Both hospitals currently have child birth education programs which will be evaluated to assure that classes meet all cultural diversity needs.

The System's efforts relating to the **post-partum** stage will include providing parents with an appropriate complement of educational material, which may include a manual, audiotape and/or videotape, about caring for babies. These resources are available through DHEC, DSS and the hospitals. A nurse will visit the home after discharge for more personal contact, and a telephone call line, the CHATLine, will be available for parents to call for child health consultation. Parenting skills training will be provided as needed.

e. Focus Additional Resources on Teens. In addition to all the features of the maternal and child health initiative, additional emphasis will be placed on the special needs of teens. Teenagers will be referred to family planning for counseling after the first pregnancy. The System will encourage teens to be followed during pregnancy in a special teen setting as opposed to the traditional adult obstetric setting. The System will explore barriers preventing teens from using the present teen clinic and seek another appropriate setting to reach this

population if necessary. This may include expansion of the teen clinic into the community. The program will establish support groups for teen parents and counseling to prevent repeat pregnancies. Educational efforts will be taken to schools whenever practical. Teens will be enrolled in the System database and will be followed throughout the course of their pregnancy and at least one year after delivery. They will receive the full complement of the System's maternal and child health resources for compliance with prenatal care to enhance the opportunities for a healthy baby and to avoid repeat pregnancies. The System will work with DHEC and other agencies and resources to assure that this group is attended to appropriately.

f. Encourage Compliance with EPSDT Program Guidelines. The System will enroll eligible children in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), a program for Medicaid children under 21 years. The database management protocols will enable System personnel to remind parents of appointments and determine barriers to compliance with the EPSDT schedule. Appropriate community physicians will be encouraged to participate in the Pediatric Partnership Program, a program between pediatricians and DHEC, to increase the EPSDT compliance rate. The System will develop a plan in consultation with and approval of DHEC for enhanced participation in EPSDT and the Pediatric Partnership Program.

g. Enhance awareness of genetic testing/counseling for at-risk women and families. The System will enhance awareness of the availability of genetic counseling for at-risk women and families with sickle cell trait or disease. Referrals will be encouraged and genetic counseling provided for those without resources who need it.

h. Increase collaboration with public and private practitioner and other entities. The System will facilitate collaboration among health care organizations to enhance service linkage and provide a medical home for mother and child. The System will seek to make information available through the program and the database with existing agencies, programs and physicians interested in working with the System. The System will work with DHEC to develop a plan for the appropriate use of information gained through the System's public health initiatives.

The System will report to DHEC annually on progress made toward implementing the above initiatives. During the initial year of the project, the System will seek to establish appropriate baseline data and set specific goals to be achieved. The annual report will include at a minimum: the number of mothers seen in the program and registered in the database; the percentage of mothers measuring "adequate" on the Kesner Index; the number of appointments made and the percentage of appointments kept with participating physicians and in the

Richland OB Clinic; the number of eligible newborns enrolled in the EPSDT program; the percentage of compliance with the EPSDT schedule; the number of pregnant teens receiving parental care in the teen clinic as opposed to the Richland OB Clinic; and the number of referrals to high risk services, based on numbers of high risk mothers-to-be.

5. The System will achieve \$71 million in operational savings and avoided capital expenditures over the first five years the System is in operation. The System's commitment to achieve \$71 million in operational savings and capital avoidance is based on estimates by the Parties' management, the advice of outside consultants, and the current financial performance of the hospitals that will be part of the System. In conjunction with a formal annual review by DHEC of the System's compliance with the COPA, the System will report on the nature, source, and amount of operational savings achieved, and capital expenditures avoided during the preceding year as well as other financial performance information. The report will include an audited financial statement for the preceding year, a revised five-year budget projection (adding an additional year -- a new fifth year projection), and will compare actual savings and capital costs avoided with the estimates of yearly savings and capital cost avoidance contained in the financial projections submitted with the original COPA application. If the System has not substantially complied with its commitment to achieve \$71 million in operational savings and capital cost avoidance after five years of being in operation, the System will be committed, as a condition of the COPA, to transfer to the public health initiatives budget an amount equal to the difference between the actual amount of operational savings and capital costs avoided during the first five years, and the \$71 million estimate included in the COPA application, less the sum of (a) the aggregate total already expended or committed to the public health initiatives and community outreach, plus (b) the amount by which aggregate indigent/charity care over such five year period exceeds five times the amount of indigent/charity care the Parties provided in fiscal year 1995.
6. The System commits, as a condition of the COPA, to continue to serve the citizens of its services areas regardless of ability to pay; no medically necessary services will ever be refused or deferred because of inability to pay. In addition, the bills of those patients with no third party coverage whose income for their size family falls at or below the federal poverty guideline and whose net property value is not over \$35,000 will be written off as indigent/charity care. The System's annual report to DHEC will identify the amount of charity care provided by the System during the previous year.
7. The System commits, as a condition of the COPA, that, during each of the first five years of the operation of the System, the System will adjust its charges to nongovernmental payers so that, after adjustments for changes to the medical consumer price index (southeast region), new services, and governmentally

imposed requirements, the System will not realize higher case mix adjusted net inpatient revenue from nongovernmental payers per admission than that realized by Baptist Healthcare System and Richland Memorial Hospital in combination in 1995. The System will retain an independent auditor to insure compliance with this commitment not to increase adjusted net inpatient revenue. The System's annual report to DHEC will include a copy of the auditor's report.

8. The System commits, as a condition of the COPA, that, during each of the first five years of the operation of the System, the System will reduce its gross charges to all payers. The System will report annually with verification of this commitment.

**QUESTIONNAIRE
PART A.**

Parties To The Cooperative Agreement

Name	Title	Address
Baptist Healthcare System of South Carolina, Inc.	Charles D. Beaman, Jr. Chief Executive Officer	Taylor at Marion Street Columbia, SC 29220
Richland Memorial Hospital	Kester S. Freeman, Jr. Chief Executive Officer	Five Richland Medical Park Columbia, SC 29203

Brief Description of Proposal

The Parties request their Preincorporation and Joint Operating Agreement ("JOA") dated July 10, 1996 be certified as being to the public's advantage. The JOA provides for the incorporation of a nonprofit entity to operate the hospitals of the Parties as a single unit. This company will be structurally and financially able to achieve operating efficiencies and avoid duplicate capital expenditures and health care services, so as to permit the Parties, despite expected changes in government and commercial reimbursement and increased demand for services by those without the ability to pay, to maintain the scope and quality of their services to Midlands residents. The JOA will also allow the Parties to develop, implement and fund new initiatives to improve public health and a community outreach program, and to expand the counseling centers of the Pastoral Institute.

Describe Proposed Market Area

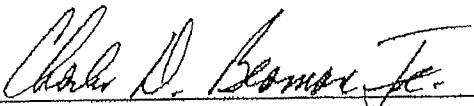
The new company will have two core service areas -- the first being the seven county area around the Baptist and Richland campuses (Richland, Lexington, Fairfield, Kershaw, Newberry, Orangeburg and Sumter ("Core Service Area")) and the second being the counties serviced by the Easley campus (Pickens and Greenville).

Persons Responsible For This Application		Title
1.	J. Marty Bridges	Executive Vice President and Chief Financial Officer
2.	Robert A. Armistead	Executive Vice President and Chief Financial Officer

Address		Telephone Number
1.	Baptist Healthcare System of South Carolina, Inc. Taylor at Marion Street Columbia, SC 29220	(803)771-5172
2.	Richland Memorial Hospital Five Richland Medical Park Columbia, SC 29203	(803)434-6133

All parties hereby certify that the information contained in this Application, including all assurances and attachments, are accurate and correct to the best of our knowledge and belief.

BAPTIST HEALTHCARE SYSTEM OF SOUTH CAROLINA, INC.

Signature  Date Oct. 24, 1996
Charles D. Beaman, Jr., President

RICHLAND MEMORIAL HOSPITAL

Signature  Date Oct. 24, 1996
Kester S. Freeman, Jr., Chief Executive Officer

EXHIBIT B

To Petitioner's Prehearing Statement

II. EVALUATION OF DISADVANTAGES

A. *Likely adverse impact, if any, on ability of health care purchasers to negotiate optimal payment arrangements with health care providers or health provider networks*

The System is unlikely to have an adverse impact on the ability of purchasers to negotiate favorable rates.⁶ Several factors will ensure that purchasers will be able to negotiate favorable rates after the System is in operation:

- competition from Lexington and Columbia/HCA;
- increasing aggressive competitiveness of Columbia/HCA;
- the loyalty of many Lexington County residents to Lexington, and its importance to managed care plans;
- competition from other hospitals located in the System's Core Service Area;
- the increasing use of non-hospitals for outpatient surgery and ancillary services;
- the growth in size and influence of large physician groups;
- responsiveness of the System to community needs resulting from its total local control;
- absence of pressure to pay dividends to investors or to generate funds to operate systems outside the System's service areas; and
- the effect of the System's non-profit status and local control on cost savings and rates.

1. Competition from Lexington and Columbia/HCA Hospitals

Lexington and Columbia/HCA will provide more than enough competition to prevent the JOA from having an adverse effect on the ability of purchasers to negotiate favorable rates.

⁶ The service area of BMCE does not currently overlap with Richland's service area and, consequently, no adverse impact on competition will result from the inclusion of BMC in the System. Therefore, there is little discussion of BMCE in this section.

Between them, Columbia/HCA and Lexington offer practically all the services offered by the System hospitals. Both Lexington and Columbia/HCA have very positive reputations in the community and are important to many patients, employers, and health plans. A health plan that included Lexington and Columbia/HCA on its panel, but did not include Baptist or Richland, would be a viable and marketable alternative to, and could be more attractive to certain employers than, a health plan that offered Baptist and Richland only. Moreover, some employers have expressed a willingness to enter contracts with hospitals for specific services if necessary. Service-specific contracts would increase competition among all the hospitals by minimizing the impact of differences in service offerings.

2. Increased aggressive competitiveness of Columbia/HCA Hospital

The sale of a controlling interest of Providence Hospital to Columbia/HCA has made for a much more competitive market. Columbia/HCA is an international health care conglomerate which owns about 343 hospitals, 137 outpatient surgery centers, 200 home health agencies, and dozens of other health care services and facilities nationwide. Columbia/HCA earned \$4.6 billion in net revenues in 1995. Columbia/HCA has access to large capital reserves⁷ and purchasing power. Columbia/HCA is well-known for its competitiveness. Columbia/HCA's presence in Columbia is uniformly viewed as a significant constraint on, and competitive threat to, the System. In fact, one employer went so far as to say that separately, Baptist and Richland would not be able to compete against Columbia/HCA, and that if the System were not created, Columbia/HCA would buy one of the hospitals and completely dominate the market.

Columbia/HCA has every incentive to improve its competitive position even further by attempting to offer primary and secondary care services in this area. Moreover, Columbia/HCA has announced that in addition to its continued commitment to its heart program, Columbia/HCA is also committed to providing services for the entire family. Columbia/HCA has made public statements and taken definitive actions to accomplish what Columbia/HCA presumably believes would increase its already significant competitive presence in the Core Service Area. (See, Response to Question 8 for the definition of "Core Service Area").

3. Competitive significance of Lexington Medical Center

The competitive significance of Lexington must be considered. Lexington is a well-respected community hospital offering a broad array of services. Lexington offers many of the

⁷ Columbia/HCA's access to capital can confer on it a significant competitive advantage. For example, in a recent CON application, Columbia/HCA proposed a \$26 million expansion project that would be paid for entirely with cash. The ability to fund major expansions or renovations with cash (as opposed to financed projects) lowers the costs associated with such projects and thereby enables the hospital to be more price-competitive.

same services available at the System hospitals. For example, Lexington's oncology program generally offers the same services and sophistication as the oncology programs at Baptist and Richland. Moreover, payors and purchasers recognize the strong loyalty Lexington County residents have toward Lexington. Given the fact that Lexington is the only hospital located in Lexington, which is the fastest-growing county in the state, it is very important to employers and managed care plans to have Lexington in their network. Consequently, as the population in Lexington grows, the competitive significance of Lexington will increase further as will the competitive disadvantage at which any network that did not include Lexington would find itself.

4. Competition from other hospitals located in the System's Core Service Area

Richland and BMCC attract patients from a wide geographic area, as do the other two facilities located in the Columbia metropolitan area (Columbia/HCA and Lexington). All four Columbia area hospitals currently compete with many other hospitals for at least 30% of their patients. More specifically, BMCC and Richland compete with seven hospitals -- five of which (including Lexington and Columbia/HCA) are large hospitals with over 200 beds -- in their Core Service Area.

Patient origin data show that Richland, BMCC, Columbia/HCA, and Lexington ("Columbia Area Hospitals") compete against each other and against five other hospitals in five surrounding counties for a significant portion of their patients. Those seven counties (Richland, Lexington, Kershaw, Fairfield, Orangeburg, Sumter and Newberry) account for at least 85% of the patients admitted to the Columbia Area Hospitals. While most residents of Richland and Lexington Counties use one of the Columbia Area Hospitals, 15% of the hospitals' patients come from the five other counties in the Core Service Area. Another 15% come from generally more distant counties and occasionally from out of state.

5. Trend toward providing more care in non-inpatient hospital settings

There is a clear and growing trend in health care toward moving services out of the inpatient acute care hospital setting to outpatient and other non-inpatient settings. For example, one health plan representative estimated that 30% of the health plan's premium dollars went to hospitals, but no more than 50% of that amount (i.e., 15% of total) was for inpatient hospital services. The health plan representative also opined that the proportion of premium dollars spent on inpatient hospital services is consistently decreasing.

The System's five-year projections (See, Response to Question 10) indicate that inpatient days will decline over 6% over the period. The System and other hospitals will therefore put increasing emphasis on outpatient and many other ancillary services to compensate for the loss of inpatient revenue. Outpatient revenue will account for roughly 28% of the System's 1996 revenue and is projected to grow in importance in the future.

This trend brings hospitals into direct competition with physicians and non-hospital providers of outpatient and ancillary services. Hospitals typically face much greater competition for outpatient and ancillary services from hospital and non-hospital competitors than they do for inpatient hospital services. Moreover, the threat of new providers entering the market is more significant, and the costs of entering the market is substantially less, with respect to outpatient and ancillary services than it is for inpatient hospital services.

The increasing percentage of hospital revenue that comes from outpatient surgery and ancillary services will require the System to compete successfully in those other markets. Payors and purchasers recognize that the threat of moving patients requiring outpatient and ancillary services to non-hospital based providers of those services gives them the ability to prevent the System from trying to take advantage of any leverage it might be alleged to enjoy in one or more inpatient hospital service lines.

6. The growth in number and influence of large physician groups

There is a strong trend toward physicians merging their practices or selling and accepting employment with large institutions or groups. Other recent trends in health care include expansion by physicians (especially large groups) beyond traditional office practice to build and operate outpatient surgery facilities and to provide other outpatient and ancillary services; and physicians' entry into new and innovative arrangements with health plans in which physicians accept risk and assist in cost containment efforts. These trends have contributed to a general increase in the power and influence held by large physician groups, usually at the expense of hospitals. The growth of managed care has further solidified the physician's role, and particularly the primary care physician's role, as the entry point to the entire health care system for an increasingly large percentage of patients.

Physicians have a great deal of influence over which health care services and providers their patients use. As increasing numbers of physicians join large groups, their ability to control significant numbers of potential hospital admissions makes hospitals much more vulnerable to patient steering mechanisms. The existence of large physician groups also significantly enhances the potential for health plans and employers to discipline hospitals that are unwilling to deal on terms payors and purchasers believe are fair. Steering patients is a much more feasible and effective threat when it only requires the health plan or employer to get the coordination and cooperation of a few large physician groups, than when it requires the cooperation of many solo practitioners and small groups. In some markets, certain hospitals are included only nominally (e.g., for marketing purposes or special services) in a network but payor arrangements with physician groups result in substantial steerage away from those particular institutions.

In addition to their ability to affect the care decisions of significant numbers of patients, large physician groups have become an increasingly important source of direct competition for hospitals. Large physician groups often operate outpatient surgery centers and provide other ancillary services in competition with those same services usually offered by hospitals. These groups are typically more likely to have the financial strength and patient base needed to establish

successfully and operate outpatient and ancillary service providers than are solo practitioners or small groups. The existence of non-hospital based outpatient surgery and ancillary service providers diminishes the amount of influence hospitals have over physicians, because physicians became less dependent on hospitals to provide facilities and services not available in most physicians' offices.

Many large physician groups gain additional leverage over, or independence from, hospitals by virtue of reimbursement arrangements with health plans. In the purest form the physician group might enter into a global capitation or percentage of premium arrangement under which the physician group receives a fixed amount based on the number of the health plan's subscribers who use physicians in the group, and the group is then responsible for paying for all health care service costs incurred by covered persons. The physician group then is motivated to negotiate the reimbursement the hospital receives for its services. Payors are typically more willing to enter capitation arrangements with large physician groups than with hospitals, and capitation-like arrangements are likely to develop more rapidly in communities that have large physicians groups.

Global capitation and other forms of risk transferring contracts between physician groups and health plans can have a dramatic impact on a hospital's actions for three reasons. First, they align more closely the physician group's interests with the health plan's interests, which makes it more likely that the health plan will be able to obtain the group's cooperation if necessary to steer patients away from particular hospitals. Risk based contracts create an economic interest on the physician's part to admit patients to hospitals that not only provide good medical care but that are cost-efficient as well. Second, they create an incentive for physicians to admit their patients to hospitals only when absolutely necessary, thereby potentially reducing overall hospital utilization. Finally, where the physician group has undertaken most of the hospital services risk, the hospital is in the position of having to negotiate fees with the physicians with whom they need to maintain a positive, cooperative relationship. A hospital cannot afford to negotiate as aggressively with physicians as it might with health plans.

Carolina Primary Care, LLC is one such large and well-regarded physician group in the Columbia area. Moreover, it appears to be affiliated with Phycor (a national physician practice management company), from which it can draw capital for continued growth and for experience in negotiating and managing capitation agreements, offering outpatient surgery and other ancillary services, and assuming a larger role in the health care community. Judging by developments in other markets where physicians have tended to align rapidly, the number of physician groups and the percentage of physicians so organized in the Columbia area will likely increase sharply in the near future.

As some of the physicians in the Core Service Area organize large physician practice groups, hospitals are forced to share their traditional influence in the health care community with a greater number of entities, often face direct competition from physicians in providing outpatient surgery as well as other outpatient and ancillary services, and the hospitals' ability to determine the reimbursement levels for the services the hospitals offer is eroded even further.

7. The effect of the System's non-profit status and local control on cost savings and rates

The rate commitments made by the System, DHEC's ongoing monitoring of the System's activities, and the fact that the System will be a locally-owned and operated not-for-profit entity will also guarantee that savings achieved through the creation of efficiencies and cost reductions will be passed on to the community and consumers. The System's pricing commitments guarantee that cost savings will be passed on to the community because, without the cost savings, the System would have additional revenue needs. Moreover, DHEC's supervision under the COPA will also ensure that savings result in community benefit. Finally, locally-controlled not-for-profit hospitals do not pay dividends to investors and are governed by the same people who use the hospitals' services. That perspective ensures that rates will not be raised arbitrarily and that savings will be used to lower the costs of health care to the Core Service Area, and/or improve the health status of the Core Service Area, because those who make the pricing decisions also feel the impact of those decisions.

The courts have recognized the fact that non-profit, community-run hospitals have different incentives from hospitals operated by for-profit companies. For example, the District Court in one merger case held that the business leaders on the boards of the merging hospitals would ensure that efficiencies were passed on to consumers and held that this factor weighed in favor of the merger. Another District Court, with respect to the likelihood that a local community-based hospital board would raise rates, recognized the following about locally-controlled, nonprofit hospitals:

Arguably, a private nonprofit hospital that is sponsored and directed by the local community is similar to a consumer cooperative. It is highly unlikely that a cooperative will arbitrarily raise prices merely to earn higher profits because the owners of such an organization are also its consumers. . . . Similarly, if a nonprofit organization is controlled by the very people who depend on it for service, there is no rational economic incentive for such an organization to raise its prices to the monopoly level even if it has the power to do so. Federal Trade Commission v. Freeman Hospital & Tri-State Osteopathic Hospital Association, 1995-1 Trade Cases ¶71,037 (W.D.Mo. 1995).

Most recently, the District Court that heard the FTC's motion for an preliminary injunction to prevent the merger of two hospitals in Grand Rapids, Michigan noted that the involvement of prominent community and business leaders on the boards can be expected to bring real accountability to price structuring. Thus, the Court considered it unlikely that hospitals controlled by boards comprised of local community and business leaders would raise rates arbitrarily. Here, the System's board will include not only local community and business leaders, but also members accountable to a public board -- The Board of Trustees of Richland Memorial Hospital. (See, Part C. Programmatic Documents). Thus, there will be several layers of community involvement

and direction to ensure that savings from cost reductions and efficiencies are passed on to consumers.

In summary, there are many forces at work that significantly diminish the likelihood that the System would have an adverse impact on the ability of purchasers to negotiate favorable rates. Both employers and health plans have a number of means at their disposal to ensure that the System will remain eager to negotiate competitive rates. Moreover, the System faces significant competition from Lexington, Columbia/HCA, hospitals in neighboring counties, and non-hospitals with respect to the increasingly important non-inpatient and other ancillary services.

B. The extent of any reduction in competition among health care providers

Richland and Baptist attract patients from a wide geographic area, as do the other two facilities located in the Columbia metropolitan area (Columbia/HCA and Lexington). Obviously, the creation and operation of the System will eliminate competition between Richland and Baptist so as to realize the opportunity to avoid unnecessary duplication and to generate other efficiencies. However, both hospitals currently compete and will continue to compete against Lexington and Columbia/HCA, as well as against several other large hospitals in the Core Service Area. The Parties also experience competition from several regional hospitals for patients requiring tertiary and quaternary services. Current and, if rates were to rise, new competition from all these sources ensures that the creation of the System will not substantially reduce competition in the area the hospitals serve.

Patient origin data confirm that the Columbia Area Hospitals compete against each other and against other hospitals in surrounding counties. While most residents of Richland and Lexington Counties use one of the Columbia Area Hospitals, 30% of the hospitals' patients come from counties other than Richland or Lexington. These patients represent a significant percentage of the hospitals' patients, which the hospitals cannot afford to lose to other hospitals. Since those patients already live outside the Columbia area, they are particularly likely to seek care at other hospitals if the rates at Richland and Baptist were to increase above the competition's or the System's quality or accessibility was to decrease.

Approximately one-half of the admissions that come to the Columbia Area Hospitals from outside of Lexington and Richland Counties are from Fairfield, Kershaw, Newberry, Orangeburg, and Sumter Counties, three of which have large hospitals with over 200 beds each. Columbia Area Hospitals treated between 14 and 57% of all patients residing in those five counties that were admitted to a hospital during 1995. The facts that a significant percentage of the residents of those counties use the Columbia Area Hospitals, and that those admissions represent a significant percentage of all admissions at Columbia Area Hospitals, suggest that there is a significant amount of competition between the Columbia Area Hospitals and those hospitals located in the other five counties. While these facilities are not often used by residents of Richland and Lexington Counties, they are frequently relied on by persons who reside outside of the Columbia area. Patient migration data indicate that residents of these counties have, and make use of, a variety of hospital choices. If the System were to raise rates or reduce the quality

of or access to its services, it would risk losing those patients to other hospitals. More particularly, managed care payors and fully or partially at risk physician groups are in a position to punish any rate increase by the System (or decrease in quality or access) by diverting inpatient admissions to other hospitals. As discussed above, diversion of patients to outpatient and other settings is also a powerful competitive response.

Richland and Baptist compete against the other two Columbia Area Hospitals and many other hospitals for patients requiring tertiary services. One might expect that the four Columbia Area Hospitals would have higher market shares in the more complex services than the hospitals in the surrounding counties since the Columbia Area Hospitals are larger than some of those other facilities. However, patient migration data for the counties in the Core Service Area show that such is not the case.

Admissions were divided into five broad categories (obstetrics, surgery, medical, pediatric, and psychiatric), and the surgical and medical admissions were divided into major diagnostic categories to compare market shares in different service lines. The current data show that, for almost all service lines, the Columbia Area Hospitals collectively provide less than one-half of all care in that ten-county area. Out of 36 service lines or categories, in only five categories do the four Columbia Area Hospitals together provide over 50% of the care. The greatest percentage of care provided by the four Columbia Area Hospitals in any one category is 54%. On average, the four Columbia Area Hospitals only provide 42.5% of the care across all categories.

In addition to the hospitals located in the Core Service Area that generally provide a full range of services, tertiary facilities comparable to Baptist and Richland also exist in Spartanburg, Greenville, Charleston, Florence, Rock Hill, Augusta (GA), and Charlotte (NC). The Columbia Area Hospitals compete with many hospitals for at least 15% - 30% of their patients. Since those patients already travel to Columbia for hospital care, and since they have many hospital choices located at least as close to their homes as the Columbia Area Hospitals, they could easily use other hospitals if the System was to increase rates or decrease quality or access.

Lexington and Columbia/HCA hospitals have provided, and will continue to provide, significant competition to Baptist and Richland. The Columbia Area Hospitals currently compete with many hospitals for almost 30% of their patients. More specifically, Baptist and Richland compete with seven hospitals -- five of which (including Lexington and Columbia/HCA) are large hospitals with over 200 beds -- in their Core Service Area. If the System were to raise rates above those of its competition (assuming the pricing constraints discussed in the Response to Question 4.II.B.2. did not apply), it would risk losing at least 15% of its patients to Lexington and Columbia/HCA, and another 30% to many other hospitals outside of Columbia. In other words, patient flow data shows that the System would risk losing at least 40 - 45% of its patients if it were to raise rates or reduce quality or availability of service. Moreover, the System will continue to face the many other competitive pressures identified in the preceding paragraphs.

1. The likely adverse impact, if any, on patients in quality, availability, and rates of health care services

The creation and operation of the System will not have an adverse impact on the quality, availability, or prices of health care services, and of hospital services in particular. One of the primary motivations for creating the System is to increase and enhance the quality of care rendered at the hospitals. Making health care financially and physically more accessible to residents of Richland and Lexington Counties is also a tenet of the System. The System's sponsors have formally committed to making services available to those who are underinsured or indigent. (See, Response to Question 12.) The System commits itself in this application for a COPA to take measures and implement programs that can reasonably be expected to enhance the quality and accessibility of health care to the community in general, and particularly to those underserved residents of the community. Finally, the System has committed itself to limitations on rates and revenue (discussed below) that, together with competition and other factors, will prevent the System hospitals from raising prices above competitive levels.

2. The extent to which agreement may increase the costs of [sic] prices of health care at a hospital

The creation of the System will not increase the costs or rates of health care at the System hospitals. With respect to payment source, there are essentially four types of patients: government (e.g., Medicare, Medicaid, state employees and CHAMPUS), commercial insurance (indemnity and managed care), self-pay (those who pay their own hospital costs), and indigent. Each of the four groups is protected by one or more factors including statutorily or regulatorily-imposed reimbursement levels, competition, and System commitments relating to rates and revenue.

Patients covered by Medicare, Medicaid, state government employee health plans and CHAMPUS (which collectively account for approximately 60-65% of the System's patients) are not vulnerable to a rate increase by the System hospitals because the government dictates the rates that are paid for services rendered to them. While these programs do not limit what a hospital can charge, that figure is irrelevant because these programs pay only an amount that is capped no matter what rates hospitals charge. Consequently, competitive pressures aside, the System does not have pricing discretion relative to this very large component of consumers.

Patients covered by commercial insurance and future managed care contractors are not at risk from rate increases for two primary reasons. First, competition will prevent the System from raising rates above those of the competition. The Columbia hospital market will, for all the reasons discussed above, remain competitive after the System is created. Health plans and employers believe that competition from Lexington and Columbia/HCA precludes any ability by the System to increase rates. If the System were to attempt to increase prices, it would lose enough patients to Lexington, Columbia/HCA, and other hospitals to make the rate increase imposed on the remaining patients unprofitable. Moreover, health plans and at-risk physician groups could steer patients needing outpatient surgery or other ancillary services to other providers

in retaliation for any proposed or threatened inpatient price increases. The likelihood of net revenue losses mitigates against a System attempt to increase inpatient prices.

Second, the System commits, as a condition of the COPA, that during each of the first five years of the operation of the System, the System will adjust its charges to nongovernmental payers so that, after adjustments for changes to the medical consumer price index (southeast region), new services, and governmentally imposed requirements, the System will not realize higher case mix adjusted net inpatient revenue from nongovernmental payers per admission than that realized by Baptist Healthcare System and Richland Memorial Hospital in combination in 1995. The System will retain an independent auditor to insure compliance with this commitment not to increase adjusted net inpatient revenue. The System's annual report to DHEC will include a copy of the auditor's report. Although the System has already committed itself publicly to this provision and is thus morally bound to uphold it, including it in the COPA will make the System legally bound to comply with such a pricing policy. The System's competitors will have this five-year period to organize their various efforts, if any organization is needed, to compete with the System.

The System also will not increase rates to the third group of patients -- those persons who pay for their own hospital care. The Sponsoring Organizations have publicly committed and the System commits, as a condition of the COPA, that during each of the first five (5) years of the operation of the System, the System will reduce its gross charges to all payors. The System's annual report to DHEC will include information necessary for DHEC to ensure that the System has complied with this commitment. This commitment, like the commitment regarding net inpatient revenues, is limited to five years because the rapid changes taking place in the health care industry would render the assumptions and predictions required to extend such commitments further into the future mere conjecture.

The final category is comprised of indigent patients who cannot afford to pay for their own health care. Since these patients do not pay for their own care, they are not at risk to a rate increase. It is worth reemphasizing that, in making their commitment to indigent care, the Sponsoring Organizations have insured that the JOA will inure to the benefit of all South Carolina patients, regardless of their ability to pay.

Although there are many factors that would prevent the System from raising rates above competitive levels, the System retained the services of a nationally recognized economics research firm Charles River Associates ("**Charles River**") to study what effect the JOA might have on rates if those factors did not exist, and how that effect might compare against the JOA-related benefits to the community. The Charles River economists employed an economic model commonly used to predict the potential effect a merger might have on rates. (See Exhibit 6). The model has several limitations, including the inability to take into account the effect of competition and other real-world factors (such as pricing and regulatory constraints), and the fact that the model only produces ranges of price or rate effects. What all this means is that the model essentially produces a worst-case scenario -- the most rates could increase if a merger were to occur where none of the System's mitigating commitments existed, and everything else

remained exactly the same. The model also allows economists to determine the level of savings that the merged entity would have to achieve to offset the predicted worst-case effect on rates. The economic model predicted that, at most, the JOA could affect rates somewhere in the range of 1 - 5%, and that savings and efficiencies of 1 - 5% would offset any theoretical rate increase. Thus, even the theoretical potential for a rate increase is small, and the savings and efficiencies that will result from the JOA will outweigh that risk and ensure that the community is not harmed by creation of the System.

3. **The extent to which services to Medicaid, indigent, or charity care patients are adversely impacted by the agreement**

Again, one of the primary motivating factors in the Sponsoring Organizations' development of a JOA was to achieve the cost savings and efficiencies necessary to continue their commitment to serving Medicaid and indigent patients without a diminution in the quality of care. Far from having an adverse impact on services available to Medicaid and indigent patients, the JOA will have a very positive impact on the quality of care and extent of services available to those patients. The System also expects that its community health initiative will improve both the access to care for Medicaid, indigent, and charity care patients and the health status of those patients.

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EXHIBIT E

To LMC's Return

*LMC's Response in Opposition to Summary Judgment and
Cross-Motion for Summary Judgment*

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

Docket No. 20-ALJ-07-0108-CC

**PETITIONER'S RESPONSE IN
OPPOSITION TO MOTION FOR
SUMMARY JUDGMENT AND NOTICE
OF MOTION AND CROSS-MOTION
FOR SUMMARY JUDGMENT**

**TO: ATTORNEYS FOR RESPONDENTS, SOUTH CAROLINA DEPARTMENT OF
HEALTH AND ENVIRONMENTAL CONTROL AND PRISMA HEALTH-MIDLANDS:**

Pursuant to Rules 19 and 68 of the Rules of Procedure for the Administrative Law Court and Rule 56 of the South Carolina Rules of Civil Procedure, Petitioner, Lexington County Health Services District, Inc., d/b/a Lexington Medical Center (LMC), hereby submits this Response in Opposition to the Motion for Summary Judgment filed by Respondent Prisma Health-Midlands (PHM), and further moves this Court to grant summary judgment in favor of Petitioner on the issues raised herein because no genuine issue exists as to any material fact, and Petitioner is entitled to judgment as a matter of law on those issues. In opposition to PHM's Motion and in support of this Motion for Summary Judgment, Petitioner submits the following:

BACKGROUND

On or about October 23, 1996, Baptist Healthcare System of South Carolina, Inc. (BHS) and Richland Memorial Hospital (RMH) submitted an application for a Certificate of Public Advantage (COPA) to Respondent South Carolina Department of Health and Environmental Control (DHEC or Department) for approval of a cooperative agreement whereby BHS and RMH would be jointly operated as a single unit by a newly formed nonprofit entity: BR Health System,

SC ADMIN. LAW COURT

Inc. (BR Health). (DHEC FOIA 0016)¹. According to the COPA application, the competitive landscape within which BHS and RMH proposed to merge included “LMC and Columbia/HCA hospitals, as well as other hospitals, in the [] core service area.” (DHEC FOIA 0008, 0062-65). Following a public review process that included participation by affected persons and the Attorney General, as well as a public hearing, DHEC issued a decision on May 8, 1997 to approve the application for the COPA (DHEC FOIA 1253-1259), and COPA-97-01 was ultimately issued to BR Health on October 6, 1997 (DHEC FOIA 1408). As provided in the May 8, 1997 decision, COPA-97-01 is subject to 25 enumerated conditions, which are preceded by two explicit findings of the Department, *to wit*:

The decision to approve the Certificate of Public Advantage is based on the following reasons:

- (1) The Department has determined that the applicant has demonstrated that the likely benefits resulting from the cooperative agreement outweigh the likely disadvantages from the cooperative agreement; and
- (2) The Department has determined the reduction in competition likely to result from the cooperative agreement is reasonably necessary to obtain the benefits likely to result.

(DHEC FOIA 1253-59).

This contested case proceeding arises from DHEC’s decision dated February 28, 2020, purporting to amend COPA-97-01 with additional conditions in order to include PHM’s proposed acquisition of acute care facilities owned by LifePoint Health (LPNT), a separate healthcare provider operating in the same service area as LMC and PHM (the “DHEC Decision”). According to the DHEC Decision, which is attached as *Exhibit A* to LMC’s Request for Contested Case Hearing, the assets PHM seeks to acquire from LPNT include Providence Health (HTL-0928),

¹ The documents produced by DHEC pursuant to LMC’s FOIA request prior to commencement of this contested case proceeding are identified by the Bates label “DHEC FOIA _____” and referenced excerpts are provided in numerical order at **Exhibit A**.

Providence Health – Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department (FED) in Fairfield County operating under HTL-0929. As will be further discussed herein, and unlike DHEC’s review of the BSH and RMH COPA application, there was no public notice of the Department’s receipt and review of the proposed “amendment” and no opportunity for affected person participation or public hearing prior to the DHEC Decision.

By decision dated April 21, 2020, the DHEC Board declined Requests for Final Review Conference filed by LMC, the City of Columbia, Fairfield County and Fairfield Memorial Hospital, and Kershaw County. LMC thereafter commenced this proceeding by Request for Contested Case Hearing filed May 14, 2020.² On June 14, 2020, PHM filed a Motion to Expedite, which was denied by Order dated July 14, 2020. Also on July 14, 2020, Providence Hospital, LLC d/b/a Providence Health, Providence Health Northeast, and Providence Health Fairfield (Providence Hospitals) and Kershaw Hospital, LLC d/b/a KershawHealth Medical Center (Kershaw Hospital) submitted a Motion for Leave to Intervene as Respondents, which the Court granted subject to certain limitations on September 4, 2020.

The parties are engaged in written discovery and LMC is currently awaiting DHEC’s written responses and production of documents pursuant to LMC’s First Requests to Produce Documents served on June 25, 2020, as well as documents that are still outstanding and due from PHM in response to discovery served that same date. PHM served written discovery to LMC on August 14 and 18, 2020, and LMC is timely in its responses. The contested case is currently set to be heard January 11-14, 2021.

On August 28, 2020, PHM served a Notice of Motion and Motion for Summary Judgment asserting that there are “three issues that are strictly matters of statutory interpretation, no

² The three remaining entities that were denied final review by the DHEC Board also filed requests for contested case hearings in this Court, but those matters were subsequently withdrawn with consent of DHEC and PHM.

additional discovery is necessary to address them, and there are no disputed issues of material fact relevant to them.” PHM Mot. Summ. J., p. 1. For the reasons described in detail below, PHM’s Motion must be denied, and LMC is entitled to judgment in its favor as a matter of law on those issues identified herein.

STANDARD OF REVIEW

“The purpose of summary judgment is to expedite the disposition of cases not requiring the services of a fact finder.” *Matsell v. Crowfield Plantation Cmty. Servs. Ass’n, Inc.*, 393 S.C. 65, 70, 710 S.E.2d 90, 93 (Ct. App. 2011). “[A]n adverse party may not rest upon the mere allegations or denials of his pleading, but his response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him.” Rule 56(e), SCRCF. “[W]hen the evidence is susceptible of only one reasonable interpretation, summary judgment may be granted.” *Bell v. Progressive Direct, Co.*, 407 S.C. 565, 576, 757 S.E.2d 399, 404 (2014) (quoting *Brooks v. Northwood Little League, Inc.*, 327 S.C. 400, 403, 489 S.E.2d 647, 648 (Ct. App. 1997).

“Summary judgment is not appropriate where further inquiry into the facts of the case is desirable to clarify the application of the law.” *Lanham v. Blue Cross Blue Shield of S.C., Inc.*, 349 S.C. 356, 363, 563 S.E.2d 331, 334 (2002) (reversing summary judgment that operated to deprive plaintiff of full and fair discovery and trial of disputed factual issues). Instead, “[s]ummary judgment is appropriate only if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law.” *Cunningham ex rel. Grice v. Helping Hands, Inc.*, 352 S.C. 485, 491, 575 S.E.2d 549, 552 (2003). As to the issues on which LMC seeks summary judgment, there are no genuine issues of material fact in dispute to the knowledge of LMC from

the documents made available to date. *See Matsell*, 393 S.C. at 70, 710 S.E. 2d at 93; *see also Town of Hollywood v. Floyd*, 403 S.C. 466, 478, 744 S.E.2d 161, 167 (2013) (upholding summary judgment where zoning administrator had no lawful authority to approve subdivision plats); *Palmetto Princess, LLC v. Georgetown County*, 369 S.C. 34, 38, 631 S.E.2d 68, 70 (2006) (upholding summary judgment where county lacked legal authority to enact ordinances prohibiting gambling cruises).

ARGUMENTS

I. DISPUTED AND INCOMPLETE FACTUAL BACKGROUND

A. History of COPA-97-01

Before addressing the legal grounds as identified by PHM's Motion, there are several representations in the Motion's Background that are disputed as facts or lack support in the record. With regard to the public review process required by the Health Care Cooperation Act, S.C. Code Ann. §§ 44-7-500, *et seq.* (the COPA Act), LMC participated as an "affected person" during DHEC's review of the COPA application, as did dozens of citizens, businesses and other providers interested in and affected by the proposed combination of BHS and RMH. (DHEC FOIA 1012-1014, 1016-1027, 1038, 1136, 1140, 1150). This participation was made possible by DHEC's notification to the public in the November 22, 1996 State Register of its receipt of a COPA application.³ (DHEC FOIA 0963-965). As explained at that time by DHEC to an interested person inquiring about the public hearing, "[t]he overriding issue is whether the benefits of the proposed merger outweigh the disadvantages caused by their potential adverse effects on competition." (DHEC FOIA 1061). LMC also attended the public hearing held on March 10, 1997 (DHEC FOIA

³ The public was also notified that the COPA application was deemed complete for review by notices published December 25, 26, and 27, 1996, in The State Newspaper, and notified in advance of the public hearing. (DHEC FOIA 1010, 1068).

1204-1215), and submitted the letter provided as *Ex. 2* to PHM's Motion outlining concerns with the proposed combination. Contrary to PHM's allegation, DHEC did not "impose[] each condition requested by LMC as part of the conditions of the COPA-97-01" (PHM Mot. Summ. J., p. 3), although the issues raised by LMC bear similarity to the conditions numbered 10, 15, 16 and 17. (DHEC FOIA 1247-1249). As demonstrated by the documents in DHEC's file, there was significant public participation and input, and the conditions ultimately imposed by DHEC were understandably meant to touch on a myriad of concerns received from a variety of affected persons.

In addition to the breadth of public participation, PHM's Background fails to address the participation of the South Carolina Attorney General (AG) during DHEC's review of the COPA application. On receipt of the COPA application, DHEC notified the AG of the submission in accordance with Section 44-7-550(A) of the COPA Act and "request[ed] that [he] conduct a thorough review of the application so that any issues [he] may have can be addressed by the department." (DHEC FOIA 0961). DHEC followed up by letter of November 12, 1996, reminding the AG of the timing by which DHEC must notify the applicants of additional information requested pursuant to the COPA Act and Regulation 61-31. (DHEC FOIA 0962). Additional communications between DHEC and the AG's Office are included at DHEC FOIA 0967-969, 977, 986. The AG provided a substantive response to DHEC by letter dated January 22, 1997, including an Executive Summary that "itemizes the areas of concern that have been brought to [AG Condon's] attention" and that he "would advise DHEC to resolve the issues raised in the [Executive Summary] prior to making a final approval in reference to this merger." (DHEC FOIA 1028-1031). On March 12, 1997, DHEC provided the AG with additional information regarding the COPA application and sought his "advice as to whether or not all of this additional information that has been submitted satisfies your concerns that you pointed out in your recommendation to

this Department.” (DHEC FOIA 1218). The record demonstrates DHEC provided for the participation and input⁴ of the AG from the date the COPA application was submitted through the date of DHEC’s decision to approve the application.⁵

Finally, PHM’s Motion briefly mentions the affiliation between Upstate Affiliate Organization d/b/a Greenville Health System (GHS) and Palmetto Health Alliance, resulting in the formation of Prisma Health and renaming of Palmetto Health Alliance to PHM. *See* PHM Mot. Summ. J., p. 4. PHM’s claim that “the Department confirmed that the affiliation did not implicate COPA-97-01 and that the COPA would remain in effect and binding” is more accurately described as DHEC’s “agreement” with an analysis submitted by PHM regarding the proposed affiliation. *Id.* This is because the only document evidencing any analysis or discussion of the proposed affiliation and the existing COPA is PHM’s, which concluded, “[t]he transaction contemplated by the Agreement does not change Palmetto Health’s provision of services or the service area described by the COPA that Palmetto Health and the Department entered into pursuant to S.C. Code Ann. § 44-7-330. S.C. Code Ann. § 44-7-510, et seq. is not implicated by the transaction.” (DHEC FOIA 2032-2035). Other than an e-mail from DHEC to PHM stating its agreement with the letter (in response to multiple prompts from PHM), there is no evidence of an independent determination by DHEC of the impact, if any, of the Prisma affiliation on COPA-97-01. (DHEC FOIA 2032-2039). Thus, LMC disputes any suggestion as fact that DHEC made an independent

⁴ Interestingly, DHEC also requested the AG’s approval to hire an out-of-state attorney to assist with review of the COPA application, because the “review will require expertise in legal, financial, health care, and antitrust matters which is not currently possessed by Department staff” and that while DHEC “would greater prefer to use in-state legal counsel to assist [them] in the early stages and in developing this expertise, [DHEC is] not aware of any in-state attorney who has the require expertise and is not barred by a conflict due to representing one of the parties which will be filing an application.” (DHEC FOIA 0958-960).

⁵ Indeed, a File Memorandum dated May 9, 1997, memorializes a meeting between DHEC and representatives of the AG during which the COPA conditions were individually reviewed to ensure the AG’s concerns were addressed, and in conclusion then-Director of DHEC’s Health Facilities and Services wrote, “in future COPA reviews, the Attorney General or his representative was welcome to participate in developing the conditions, sit at the table during meetings with the applicant, and otherwise be a partner with the Department in developing our decision.” (DHEC FOIA 1311).

determination of the impact of the Prisma affiliation on COPA-97-01.

B. Pending Transaction

PHM's discussion of the pending transaction is replete with unverified facts, intermittently sourced to affidavit testimony obtained to support unrelated motions and self-selected, highly redacted excerpts from transaction documents exchanged between Prisma Health and LifePoint Health. Despite that many of the representations are unverifiable at this preliminary stage of the contested case, particularly given the relevant, responsive documents that have not yet been produced by DHEC or PHM in discovery⁶, what is significant is PHM's description in the Motion of its request to DHEC "[b]efore executing the APA" that led to the DHEC Decision, which were:

- (1) To approve PHM's acquisition of the LifePoint Health Assets;
- (2) To amend COPA-97-01 to include the LifePoint Health Assets; and
- (3) To acknowledge DHEC would "monitor the LPNT Assets under COPA-97-01 and that it would make such updates and modification to COPA-97-01 as the Department deemed necessary in light of the amendment to include the LPNT Assets."

See PHM Mot. Summ. J., p. 5. PHM represents that "the Department later sought and obtained additional information from PHM," but LMC is not aware of nor received through FOIA or in discovery any documents evidencing a request for additional information from DHEC. *See id.*

Unlike the AG's participation during DHEC's review of BHS and RMH's COPA application in late 1996 and early 1997, it does not appear from the record that the AG's input was solicited to review the proposed change to COPA-97-01 prior to DHEC's Decision, but instead the AG's Office was engaged a few days prior to the Decision date to provide an advisory opinion on the deference a reviewing body may give to DHEC's interpretation of Regulation 61-31. In addition to Mr. Taylor's February 20, 2020 letter requesting the advisory opinion (*Ex. 11* to PHM's

⁶ *See* Affidavit of Armand Balsano, ¶ 7 (attached as **Exhibit B**) (herein "Balsano Aff.").

Motion), Solicitor General Robert Cook received a detailed analysis from PHM detailing a legal framework for answering DHEC's question, and at least one private conversation took place between Mr. Cook, DHEC, PHM and its counsel prior to the opinion's issuance. (DHEC FOIA 2350-2355; *see also* PHM_00329-332 at **Exhibit C**).

It is unclear whether Mr. Cook was also given the Memorandum detailing "Prisma-Health Midlands[]" interpretation of sec. 508" that was provided to DHEC on February 6, 2020, which described a legal framework for evaluating whether the proposed transaction was a "substantial" change under Regulation 61-31. (DHEC FOIA 2341-2349). This Memorandum is significant in several respects, including the express incorporation of the Certification of Need and Health Facilities Licensure Act (the CON Act) as being the other (along with the COPA Act) of "two of the major programs that DHEC administers in promoting and protecting the public health." *Id.* at 2344. According to PHM, "[s]ince this Transaction involves the purchase of health care facilities, DHEC must also consider the purposes of the CON Act." *Id.* The Memorandum is also notable in that, at least as of February 6, 2020, PHM's analysis was that "Section 508 [of Regulation 61-31] clearly authorized DHEC to approve changes to the COPA Agreement conditions *without another review unless DHEC considers the change to be substantial.*" (DHEC FOIA 2345 (emphasis added)).

It is undisputed that DHEC found the transaction proposed by PHM "might materially impact the benefits or disadvantages to the community to be served," *i.e.*, the change proposed by PHM to COPA-97-01 was substantial. DHEC Decision, p. 1; *see also* DHEC's Answers to LMC's Req. for Admis. No. 1 (attached as **Exhibit D**); Balsano Aff. ¶ 9. According to the DHEC Staff Response to the Requests for Final Review, "[i]nformation contained in a February 2020 submission, while proprietary, was persuasive to the Department in conducting its review pursuant

to Section 508 without a public notice or comment period.” DHEC Staff Resp. to RFR at p. 5, *Ex. C* to LMC’s Req. for Contested Case. What is evidenced by the Department’s record received through FOIA, and PHM’s partial discovery production, is that the review that took place was dominated and directed by PHM in all facets – before, during, and after the reviewing bodies had the issues before them.⁷ Thus, LMC disputes any representation of fact suggesting DHEC’s review was independent under the facts and circumstances revealed to date. *See Lanham*, 349 S.C. at 362-63, 563 S.E.2d at 334 (finding error in grant of summary judgment to insurer without first ruling on discovery motions challenging insurer’s refusal to produce documents asserting trade secret protections).

II. RESPONSE IN OPPOSITION TO PHM’S MOTION

A. Historical Context to Antitrust Immunity and Purpose of the COPA Act

As a threshold matter, PHM’s discussion of antitrust immunity and the state action doctrine is notably incomplete. *See* PHM Mot. Summ. J., pp. 7-8. While neither the parties nor the Court need venture into a subject matter as complex as federal oversight of anticompetitive activities in order to resolve the issues presented by these Motions, the implication that immunity from federal antitrust laws for transactions involving competing health care providers is a foregone conclusion following the General Assembly’s adoption of the COPA Act is misguided. In fact, in *Federal Trade Commission v. Ticor Title Insurance Co.*, 504 U.S. 621 (1992), the United States Supreme Court expressly rejected a holding “that the existence of a state regulatory program, if staffed, funded, and empowered by law, satisfied the requirement of active supervision.” *Id.* at 631-32. The significance of the Supreme Court’s discussion is highly relevant here:

⁷ Additional documents demonstrating contacts by PHM with the AG, DHEC staff, and the DHEC Board are included at **Exhibit C** (PHM_0000521-522; 812, 1728, 1731, 1734-1735, 1745). Most concerning is the control exercised by PHM over the “additional conditions” identified in the DHEC Decision, with PHM in multiple respects rejecting conditions DHEC sought to impose to address the proposed transaction. (DHEC FOIA 2411-2436).

Our decisions make clear that the purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices. Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties.

Ticor Title Ins., 504 U.S. at 634-35; *see also N.C. State Bd. of Dental Exam'rs v. F.T.C.*, 574 U.S. 494, 505 (2015) (explaining “active market participants cannot be allowed to regulate their own markets free from antitrust accountability”). Thus, the analysis adopted by the United States Supreme Court requires the active participation by state actors and their exercise of independent judgment and analysis⁸ before an implication of immunity under federal antitrust law could even arise, not just the specter of oversight which is the most DHEC can demonstrate here.

B. Issues Presented by the Contested Case for Summary Judgment

PHM's Motion seemingly misapprehends the nature of the issues raised by LMC in this contested case. *See* PHM Mot. Summ. J., pp. 1, 10-11. For the sake of clarity, those issues presented for determination that are ripe for consideration on summary judgment are as follows:

- (1) Whether DHEC has the authority to approve a proposed transaction involving two health care providers in which the assets of one health care provider are acquired by a competing health care provider in the same market without requiring the health care providers to first submit an application for a COPA and engage in the public review process set forth in the COPA Act and Regulation 61-31.
- (2) Whether DHEC has the authority to amend an existing COPA previously issued to a health care provider by adding conditions purportedly to approve a new agreement to acquire the assets of a competing health care provider in the same market without engaging in the review process set forth in the COPA Act and Regulation 61-31.
- (3) Whether Regulation 61-31 § 508 is unconstitutionally vague as applied to the facts underlying this contested case.

⁸ In *North Carolina State Board of Dental Examiners*, the Supreme Court stated, “the question is whether the State’s review mechanisms provide ‘realistic assurance’ that a nonsovereign actor’s anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’” *Id.* at 515 (quoting *Patrick v. Burget*, 486 U.S. 94, 100-01 (1988)).

See LMC Prehr’g Stmt., pp. 2-4.

In PHM’s Motion, Issue No. 1 incorrectly represents that LMC only challenges whether DHEC “has the authority to amend an existing COPA.” PHM Mot. Summ. J., p. 10. The nature of LMC’s challenge, correctly stated, is whether DHEC can approve a proposed transaction between Prisma Health/PHM and LifePoint Health by way of “amendment” to the COPA issued 23 years ago, rather than requiring Prisma Health/PHM and LifePoint Health to engage in the process set forth in the COPA Act and Regulation 61-31 to receive a COPA, starting with the submission of an application. *See* S.C. Code Ann. § 44-7-530 (providing that health care providers may apply to DHEC for a COPA); *see also* Balsano Aff. ¶ 9. Whether DHEC has the authority to approve an amendment to an existing COPA as a rhetorical question is irrelevant to whether Prisma Health/PHM and LifePoint Health are required to submit an application in order to be eligible for any protections associated with a COPA. Similarly, whether DHEC has the authority to approve *an* amendment to COPA-97-01 is irrelevant to the questions presented to the Court. To the extent PHM’s Motion is construed to seek judgment as a matter of law that “[t]he Department has the authority to approve, monitor and regulate an amendment to COPA-97-01” (PHM Mot. Summ. J., p. 10), the Motion should be denied. “The function of [the Court] is not to give opinions on merely abstract or theoretical matters, but only to decide actual controversies injuriously affecting the rights of some party to the litigation.” *Wallace v. City of York*, 276 S.C. 693, 694, 281 S.E.2d 487, 488 (1981).

Regarding the second and third issues noted, PHM’s summary rejection of the validity challenge to Regulation 61-31 § 508 is puzzling in light of the discussion among counsel and the Court on August 26, 2020, and specifically the Court’s authority to hear as-applied challenges. Nonetheless, this Court is not foreclosed from considering the due process concerns attendant to

DHEC's application of Section 508, whereby DHEC undertook the equivalent of a private, internal "desk review" of a change proposed by PHM to COPA-97-01 that all parties agree was substantial. See Balsano Aff. ¶ 8; see also LMC Prehr's Stmt., pp. 3-4; **Ex. D**, DHEC's Answers to LMC's Req. for Admis. at No. 1. The Supreme Court addressed this precise issue in *Travelscape, LLC v. South Carolina Department of Revenue*, 391 S.C. 89, 705 S.E.2d 28 (2011), nearly a decade ago:

Initially, we take this opportunity to clarify our law regarding the power of an ALC to determine the constitutionality of a statute. It is well settled in this State that ALCs, as part of the executive branch, are without power to pass on the constitutional validity of a statute or regulation. In *Video Gaming Consultants*, we said those challenges present an exception to our preservation rules and should be raised for the first time on appeal to the circuit court. However, the legislature has since amended the process for appeals from the ALC, providing for a direct appeal to the court of appeals instead of the circuit court. This procedural change results in a conundrum for litigants bringing "as-applied" constitutional challenges to a statute or regulation: they must first bring an inherently factual issue before a tribunal generally not suited to make factual determinations. While we have not addressed this issue, the court of appeals, in a case arising before the change in the governing statutes, said, "While it is true that AL[C]s cannot rule on a facial challenge to the constitutionality of a regulation or a statute, AL[C]s can rule on whether a law as applied violates constitutional rights."

We find the principle enunciated in *Dorman* and *Ward* to be sound and hold that ALCs are empowered to hear as applied challenges to statutes and regulations. ALCs are better suited for making the factual determinations necessary for an as applied challenge, and finding a statute or regulation unconstitutional as applied to a specific party does not affect the facial validity of that provision. We wish to reiterate that our decision today does not affect the ALC's inability to decide facial challenges to a statute or regulation; those are legal questions that are properly raised for the first time on appeal or in a declaratory judgment action before the circuit court. Thus, the ALC in the case before us had jurisdiction to determine whether section 12-36-920 violates the Dormant Commerce Clause as applied to Travelscape. Accordingly, all of our preservation and exhaustion of remedies rules apply before the ALC and other administrative tribunals with respect to an as applied challenge.

Id. at 108-109, 705 S.E.2d at 38-39 (internal citations omitted) (quoting *Dorman v. Dept. of Health and Env'tl. Control*, 350 S.C. 159, 171, 565 S.E.2d 119, 126 (Ct. App. 2002) and *Ward v. State*, 343 S.C. 14, 18, 538 S.E.2d 245, 247 (2000)). Thus, to the extent PHM's Motion seeks judgment as a matter of law that the Court "does not have the authority to rule on the vagueness challenge

to section 508,” the Motion must be denied as contrary to established law. Similarly, to the extent PHM’s Motion seeks judgment as a matter of law that Regulation 61-31 § 508 authorizes DHEC “to determine what type of review it should conduct, based on the circumstance of [the] matter before it,” PHM’s Motion must again be denied as contrary to the law. *See S.C. Coastal Conservation League v. S.C. Dept. of Health and Envtl. Control*, 363 S.C. 67, 74-75, 610, S.E.2d 482, 486 (2005) (“Allowing OCRM to exercise unrestrained discretion is inconsistent with the statute requiring the agency to evaluate permit applications pursuant to regulation.”) These three issues are further discussed below as part of LMC’s request for relief.

III. SUMMARY JUDGMENT IN FAVOR OF PETITIONER

A. The Proposed Transaction Requires a New Application.

LMC submits that as a matter of law, Prisma Health/PHM and LifePoint Health must submit a COPA application as provided by Section 44-7-530 in order to allow for review of the proposed transaction as set forth in Sections 540 to 560 of the COPA Act and Chapters 2, 3 and 4 of Regulation 61-31, and that DHEC lacks the authority to circumvent that process by way of additional conditions to COPA-97-01. As conceded by PHM, the COPA Act is a “comprehensive legislative scheme” that “establishes a process whereby the parties to a cooperative agreement may submit an application for a COPA to the Department.” PHM Mot. Summ. J., pp. 12-13. PHM is also correct that, “[u]pon receipt of an application, the Department must conduct a review that includes public notice and the opportunity for a public hearing and the requirement that certain findings be made by the Department prior to the issuance of the initial COPA.” *Id.* at p. 13. As has been noted in various filings with this Court, a COPA is not required for health care providers to negotiate and enter into mergers and acquisitions of assets; to the contrary, providers are free to conform their conduct to the applicable state and federal requirements, including antitrust laws.

See S.C. Code Ann. Regs. 61-31 § 103.

Despite the voluntary nature of a COPA, it appears the Court has reviewed information from PHM that suggests “the sale is conditioned on receipt of the COPA.” Order Granting Mot. Intervene, p. 4. To date as of this filing, LMC has not been provided with the documents submitted in response to the Court’s inquiry on August 6, 2020, despite the entry of a Consent Protective Order as demanded by PHM. *See* Balsano Aff. ¶ 7. LMC also does not know whether DHEC received the documents provided to the Court during this contested case, or for that matter what transaction documents were reviewed prior to the DHEC Decision, if any.

For purposes of a certificate of public advantage and the “comprehensive legislative scheme” of the COPA Act and Regulation 61-31, a “cooperative agreement” is defined as:

an agreement between two health care providers, health provider networks, or health care purchasers **or among more than two health care providers**, health provider networks, or health care purchasers **for** the sharing, allocation, or referral of patients or the sharing or allocation of personnel, instructional programs, support services and facilities, medical, diagnostic or laboratory facilities, procedures, equipment, or other health care services traditionally offered by health care facilities or other health care providers or **the acquisition** or merger **of assets among** or by **two or more health providers**, health provider networks or health care purchasers, provided the agreement does not involve price-fixing or predatory pricing or illegal tying arrangements.

S.C. Code Ann. Regs. 61-31 § 102(3) (emphasis added); *see also* S.C. Code Ann. § 44-7-510(3). Prisma, PHM and LifePoint Health are each a “health care provider” as defined by the COPA Act and Regulation 61-31. *See* PHM Prehr’g Stmt, pp. 5-6; S.C. Code Ann. § 44-7-519(6); S.C. Code Ann. Regs. 61-31 § 102(5). It is undisputed that Prisma Health proposes ***the acquisition of assets*** owned by LifePoint Health pursuant to an agreement⁹ – a transaction that clearly falls within the

⁹ The Letter of Intent (LOI) dated September 13, 2019, offered as *Attachment A* to the Affidavit of Malcolm Isley and the only iteration bearing all signatures, clearly identifies the “Proposed Acquisition of Certain Facilities” to be “a sale of the Acquired Assets by Seller to Buyer” and is signed by Prisma Health, LifePoint Holdings 2, LLC, Providence Holding Company, LLC, and Kershaw Health Holdings, LLC. PHM’s Mot. Summ. J., Ex. 9 at Attach. A, pp. 1, 8. Thus, a disputed factual issue with regard to PHM’s Motion is whether Prisma Health is the real party in interest to

definition of “cooperative agreement” set forth above – and the statute is clear that in order to obtain the benefits of a COPA, an application must first be filed in order to be reviewed and approved by DHEC. *See id.*; *see also* S.C. Code Ann. § 44-7-530. The authority vested in the Department by the General Assembly is also clear: “The department shall issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement; . . . [and] reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.” S.C. Code Ann. § 44-7-560(A)(1)-(2). DHEC’s own regulation succinctly provides,

The Department shall issue a Certificate of Public Advantage for a cooperative agreement *if it determines* that the applicant has demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement; and the reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.

S.C. Code Ann. Regs. 61-31 § 401 (emphasis added). In this case, it is undisputed that DHEC did not determine the benefits of the proposed transaction outweighed the disadvantages. *See* DHEC’s Answers to LMC’s Req. for Admis. No. 2, at **Ex. D**; *see also* DHEC Decision, p. 1.

There is no provision in the law authorizing DHEC to informally support a new cooperative agreement by adding conditions to an existing COPA that approved a different cooperative agreement between different parties¹⁰. *See* S.C. Code Ann. Regs. 61-31 § 102(10) (defining “Party to a cooperative agreement” as “a person who negotiates or enters into a cooperative agreement”). To the contrary, the formal nature of the COPA is encompassed in the statutory definition, which

the proposed transaction such that Prisma Health lacks standing or authority to seek any changes to COPA-97-01 in the first instance. *See Lanham*, 349 S.C. at 362-63, 563 S.E.2d at 334.

¹⁰ Though issued to BR Health, the parties to the cooperative agreement that was formally approved by COPA-97-01 were BHS and RMH. From the limited information made available to LMC, the parties to a cooperative agreement for the proposed transaction would include Prisma Health and PHM, as well as LifePoint Health and the Providence and Kershaw entities. *See* PHM’s Mot. Summ. J., Ex. 9 at Attach. B.

is that a certificate of public advantage “means the formal approval, including any conditions or modifications, by the department of a contract, business or financial arrangement, or other activities or practices between two or more health providers, . . . that might be construed to be violations of state or federal antitrust laws.” S.C. Code Ann. § 44-7-510(2).

The General Assembly clearly states the legislative intent for the COPA statutory scheme:

(A) It is the intent of this article to require the State to provide direction, supervision, regulation, and control over approved cooperative agreements through the department and the Attorney General. This state direction, supervision, regulation, and control of cooperative agreements will provide immunity for health care providers, . . . who participate in discussions or negotiations authorized by this article from civil liability and criminal prosecution under federal or state antitrust laws.

(B) A health care provider, . . . may negotiate, enter into, and conduct business pursuant to a cooperative agreement without being subject to damages, liability, or scrutiny under any state antitrust law. In addition, conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is filed in good faith is immune from challenge or scrutiny under state antitrust laws, regardless of whether a certificate is issued. It is the intention of the General Assembly that this article immunizes covered activities from challenge or scrutiny under federal antitrust laws. Nothing in this subsection creates immunity for a person for conduct in negotiating or entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.

S.C. Code Ann. § 44-7-520. PHM’s Motion and the voluminous filings to date offer no explanation for Prisma or PHM’s refusal to apply for a COPA in order to obtain approval of this new transaction. In fact, and in light of the extensive negotiations evidenced by the multiple iterations of the LOI that predated the March 2, 2020 agreement (*see Ex. 9* to PHM’s Mot. Summ. J.), the absence of an application is even more bewildering because there is no antitrust immunity “for a person for conduct in negotiating or entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.” S.C. Code Ann. § 44-7-520(B).

The scope of the Department’s authority is determined by the COPA Act, and includes the receipt and review of COPA applications using a review process clearly described in the statute

(S.C. Code Ann. §§ 44-7-530, -540), with a mandate to forward any applications to the AG for his or her review, who may then advise DHEC as to whether an application should be approved or denied (S.C. Code Ann. § 44-7-550(A)), and monitor and regulate “agreements approved under [the COPA Act].” S.C. Code Ann. § 44-7-570(A). The General Assembly sets forth in great detail a comprehensive (yet not all-inclusive) list of issues DHEC “shall consider” in “evaluating the benefits likely to result from the cooperative agreement” and “the disadvantages likely to result” from the agreement. *See id.* at § 44-7-560(A)(1)(a)-(b) (emphasis added). Similarly mandated are issues DHEC “shall consider” in evaluating the risks attendant to the reduction in competition. *See id.* at § 44-7-560(A)(2) (emphasis added). Fundamental to the entirety of the “complex legislative scheme” is that the General Assembly intends only for those agreements between health care providers that DHEC has determined “the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement” are eligible for any protection under the COPA Act. *See* S.C. Code Ann. §§ 44-7-505(4), -560(A), -570(A)(2); *see also* S.C. Code Ann. Regs. 61-31 § 401.

By the plain terms of the COPA Act, the only method by which parties to a cooperative agreement can obtain State approval of a proposed transaction that may otherwise be contrary to federal and state antitrust laws is to apply for and receive a COPA. S.C. Code Ann. §§ 44-7-530, -550(B); *see also S.C. Farm Bureau Mut. Ins. Co. v. Mumford*, 299 S.C. 14, 17-18, 382 S.E.2d 11, 13 (Ct. App. 2011) (finding policy exclusion contrary to plain terms of the compulsory coverage statute and therefore invalid). This makes sense, because in order to even attempt to satisfy the requirements of state action immunity described in the COPA Act, the regulatory review must, among other things, be a deliberate and considered act of the State. *See* S.C. Code Ann. § 44-7-520(A); *see also Ticor Title Ins.*, 504 U.S. at 639 (declining to allow for a finding of active state

supervision where in fact there was none). Contrary to the outcome PHM seeks here, there is nothing in the COPA Act that suggests parties to a cooperative agreement can circumvent or avoid the requirements of the review process by “amending” an existing COPA to add additional conditions. There is also no support in the law that an asset purchase among competing health care providers can be informally approved without public notice, participation from the public and AG, and a determination by DHEC that the benefits outweigh the disadvantages in order to receive any protection under the COPA Act. *See Ex. D* at Req. for Admis. No. 2.

LMC submits that Prisma Health’s agreement to acquire the assets of LifePoint Health, even if through its affiliate PHM, is a new cooperative agreement for which a COPA application must be submitted and reviewed in accordance with the COPA Act in order to receive the formal approval contemplated by the General Assembly. As such, the DHEC Decision must be reversed as a matter of law and the request to “amend” COPA-97-01 to include the competing facilities be denied.

B. DHEC’s Interpretation of “Another Review” for a Substantial Change under Regulation 61-31 § 508 is Arbitrary, Capricious, and Manifestly Contrary to the Law.

The DHEC Decision references only Regulation 61-31 § 508 as authority for the “amendment” of COPA-97-01. The COPA Act provides, “[t]he department shall promulgate regulations to implement the provisions of this article including any fees and application costs associated with the monitoring and oversight of cooperative agreements approved under this article.” S.C. Code Ann. § 44-7-570(D). The statute provides DHEC the authority to set conditions for a COPA and recognizes a power to “modify” those conditions in the definition of COPA at Section 44-7-510(2). DHEC’s authority to impose conditions is more clearly described in Section 44-7-560(B) of the COPA Act:

The department may also establish conditions for approval that are reasonably

necessary to ensure that the agreement and the activities engaged in under it are consistent with [the COPA Act] and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic power, and to ensure that the activity is appropriately supervised and regulated by the State.

S.C. Code Ann. § 44-7-560(B); *see also* S.C. Code Ann. Regs. 61-31 § 312 (explicitly requiring that “[s]uch conditions shall be stated in the Certificate of Public Advantage and shall be fully enforceable.”) PHM claims that DHEC has the authority to interpret Regulation 61-31 § 508 “to allow the Department to fashion the nature of the review on a case-by-case basis” based on the circumstances of each COPA. PHM Mot. Summ. J., p. 19. According to PHM,

the phrase ‘another review’ for amendments to an existing COPA does not require the Department to utilize the review process outlined in Regulation [61-31] §§ 303, 304 and 305, which by their terms apply to new COPA applications. The phrase simply authorizes the Department to determine what type of review it should conduct, based on the circumstances of matter (*sic*) before it.

PHM Mot. Summ. J., p. 16. To the contrary, the Supreme Court was exceedingly clear in *South Carolina Coastal Conservation League*, that a regulation affording DHEC “unrestrained discretion” in deciding what constitutes a “small island” under the Small Island Regulation was impermissible and therefore invalid. *See id.*, 363 S.C. at 74-75, 610 S.E.2d at 486 (“The problem is there is nothing to interpret or apply. Allowing [DHEC] to exercise unrestrained discretion is inconsistent with the statute requiring the agency to evaluate permit applications pursuant to regulation.”) The construction suggested in PHM’s Motion similarly suggests DHEC has “unrestrained discretion” in deciding what type of review it will conduct of changes after issuance of a COPA based on unstated and therefore unknown parameters. The construction is unreasonable and manifestly improper.

(1) *The regulation is plain and unambiguous.*

“Regulations are interpreted using the same rules of construction as statutes.” *Bruning v. S.C. Dept. of Health and Envtl. Control*, 418 S.C. 537, 545, 795 S.E.2d 290, 294 (2016). “All rules

of statutory construction are subservient to the one that legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in the light of the intended purposes of the statute.” *McLanahan v. Richland Cty. Council*, 350 S.C. 433, 567 S.E.2d 240 (2002). “The words in a statute must be given their plain and ordinary meaning without resorting to subtle or forced construction which limits or expands the statute’s operation.” *Charleston Co. Parents for Public Schools v. Moseley*, 343 S.C. 509, 519, 541 S.E.2d 533, 538 (2001). The plain meaning rule is based on the principle that “it is not the court’s place to change the meaning of a clear and unambiguous statute.” *Hodges v. Rainey*, 341 S.C. 79, 86, 533 S.E.2d 578, 581 (2000). Only where a regulation is silent or ambiguous will the court consider deference to an agency interpretation, assuming the interpretation is worthy of deference. *See Bruning*, 418 at 545, 795 S.E.2d at 294.

The COPA Act provides the process for review of agreements between health care providers seeking the protections of a COPA. *See* S.C. Code Ann. §§ 44-7-540, -550, -560. Indeed, the COPA Act mandates this same review process for the AG’s pursuit of enforcement or criminal prosecution proceedings for actions exceeding the scope of an approved COPA. S.C. Code Ann. § 44-7-570(C) (“A review by the Attorney General must be conducted according to the standards set forth in this article.”) LMC submits that Regulation 61-31 § 508 is plain and unambiguous, if an applicant amends an agreement after receipt of a COPA, “the Department will decide whether or not the amendment is substantial and thereby requires another review.” S.C. Code Ann. Regs. 61-31 § 508. The only review is that set forth in the statute, and DHEC’s failure to adhere to the statute was error. *See S.C. Dept. of Revenue v. Blue Moon of Newberry*, 397 S.C. 256, 262-63, 725 S.E.2d 480, 484-85 (2012) (rejecting agency’s interpretation using notion of what terms should mean where language of regulation plainly met and imposed no other requirements).

- (2) *A substantial change under the CON Act's similar provision results in a new project.*

DHEC promulgated Regulation 61-31 to “implement the legislative intent that there be a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition.” S.C. Code Ann. Regs. 61-31 § 101. The COPA Regulations are strikingly similar to the regulations DHEC has promulgated pursuant to the CON Act in several relevant respects. The interplay of these two major public health enactments was acknowledged by PHM.¹¹

Regulation 61-31 § 309 provides that the COPA “if issued, is only valid for the project described in the application including parties involved, services to be offered, mergers or consolidations approved, or other factors as set forth in the application, except as it may be modified in accordance with these regulations.” S.C. Code Ann. Regs. 61-31 § 309. The nearly identical limitation is found in Regulation 61-15, which provides that a CON “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 set forth in the application, except as may be modified in accordance with these regulations.” S.C. Code Ann. Regs. 61-15 § 310.

In overseeing both the CON Program and the COPA Program, DHEC’s regulations address changes that may be proposed by an applicant during the review and after issuance of a COPA or CON. In Chapter 3 (Disposition of Application) of the COPA Act, Section 308 addresses “Project Changes During Review Period” as follows:

The Department will review any amendments submitted during the review process

¹¹ As explained in PHM’s Memorandum to DHEC interpreting Section 508, “[u]nder the statutory construction rubric of reading statutes *in pari materi*, in interpreting § 508, DHEC should look to the legislative findings of the COPA Act and the purposes of the CON Act together, since they are both statutes that deal with the same subject matter, i.e[.], promotion and protection of health care in this state.” (DHEC FOIA 2344-2345).

and may notify the applicant that the amendments constitute a new application, and that the requirements of Section 301, 302, and 303 of this regulation must be complied with. All applicable times shall be counted as though the amendment were a new application.

S.C. Code Ann. Regs. 61-31 § 308. The parallel provision for changes to a CON application during review is found at Regulation 61-15 § 310 (providing that DHEC will review amendments to CON applications during review to determine whether an amendment is substantial and constitutes a new application). In Chapter 5 (Monitoring) of the COPA Act, Section 508 addresses “Changes After Receipt of a Certificate of Public Advantage” and provides,

If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, ***the Department will decide whether or not the amendment is substantial and thereby requires another review.*** A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.

S.C. Code Ann. Regs. 61-31 § 508. (emphasis added). This language for post-issuance changes and the significance of substantial amendments is also paralleled in the CON Regulations, which provide at Regulation 61-15 § 605 (Project Changes After Receipt of Certificate of Need): “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 (emphasis added).

While there is no jurisprudence addressing the COPA regulations, the Court of Appeals has addressed Regulation 61-15 § 605 in a contested case challenging changes after approval of a CON application. *See MRI at Belfair, LLC, v. S.C. Dept. of Health and Envtl. Control*, 394 S.C. 567, 575-76, 716 S.E.2d 111, 115 (Ct. App. 2011). In that case, the Court of Appeals affirmed the analysis under Section 605 for changes to a CON, finding “any change that would impact the

applicant's ability to comply with the same criteria as relevant evidence on whether the change is substantial enough to create a new project." *Id.* at 574-75, 716 S.E.2d at 114-15. The jurisprudence of the ALC is consistent, recognizing that substantial changes to a CON after approval would "constitute[] a new Project requiring further CON approval." *Providence Hosp. v. S.C. Dept. of Health and Env'tl. Control*, Docket No. 02-ALJ-07-0155-CC, 2002 WL 3143801 *12 (S.C. Admin. Law J. Div. Sept. 11, 2002). More recently, in *Carolina Regional Cancer Center v. South Carolina Department of Health and Environmental Control*, Docket No. 11-ALJ-07-0629-CC, 2015 WL 2159497 (S.C. Admin. Law J. Div. Apr. 30, 2015), this Court explained: "A finding that a project has substantially changed requires the CON applicant to start the CON process over again with the filing of a new CON application." *Id.* at *18. LMC submits this evidence of parallel provisions within the CON regulatory scheme and the interpreting jurisprudence demonstrates DHEC's method of review for a substantial change to COPA-97-01 was erroneous.

(3) *There are compelling reasons to reject DHEC's interpretation.*

A "regulation must be construed as a whole rather than read in its component parts in isolation." *Blue Moon of Newberry*, 397 S.C. at 261, 725 S.E.2d at 483. According to DHEC's request to Mr. Cook, "DHEC interprets 'another review' in Section 508 to allow it the discretion to conduct the review that may be required, in the event it deems the change to be 'substantial.' This review will depend on the facts and circumstances involved" Ex. 11 to PHM's Mot. Summ. J., p. 3. Apparently, DHEC enjoys "the inherent flexibility to determine the appropriate review of modifications pursuant to Section 508." *Id.* at p. 4. While DHEC makes mention of the legislature's "approval of DHEC's regulations" (*see id.*), it is undisputed this contested case involves an issue that was novel to DHEC. *See Gilstrap v. S.C. Budget and Control Bd.*, 310 S.C. 210, 215, 423 S.E.2d 101, 104 (1992) (refusing to defer to recently adopted agency interpretation

that conflicted with legislative and administrative history of authorizing statutes).

In *South Carolina Coastal Conservation League v. South Carolina Department of Health and Environmental Control*, 390 S.C. 418, 702 S.E.2d 246 (2010), the Supreme Court addressed DHEC's responsibility for managing the welfare of our public health systems. "In discharging these duties, DHEC has implemented practices and procedures which foster transparency and full disclosure in all matters regarding its regulatory authority." *Id.* at 430, 702 S.E.2d at 252-53. In this instance, DHEC has interpreted Regulation 61-31 § 508 in a manner that violates these important policies of the agency, abandoning transparency in a matter of widespread public concern. Where the Department's interpretation of "another review" is arbitrary, capricious or manifestly contrary to the COPA Act, the Court should refuse any deference. *See Kiawah Devel. Part., II v. S.C. Dept. of Health and Envtl. Control*, 411 S.C. 16, 34-35, 766 S.E.2d 707, 718 (2014) (holding that compelling reasons to differ from an agency interpretation include when the interpretation is arbitrary, capricious or manifestly contrary to the statute); *Brown v. S.C. Dept. of Health and Envtl. Control*, 348 S.C. 507, 515, 560 S.E.2d 410, 414 (2002) (rejecting DHEC Board's interpretation that read a restriction into the regulation that was contrary to the clear meaning and plain language of the regulation); *Brown v. Bi-Lo, Inc.*, 354 S.C. 436, 440, 581 S.E.2d 836, 838 (2003) (holding that there is no deference due to an agency construction that is contrary to the plain language).

LMC submits this Court can find as a matter of law, having determined the proposed transaction represents a substantial change to COPA-97-01, DHEC is required to "review the agreement again" as provided in the COPA Act and Regulation 61-31, which review process is detailed in Sections 44-7-530 to 560 of the Act and Parts 2, 3 and 4 of Regulation 61-31. *See Balsano Aff.* ¶¶ 8-9. In the alternative, the matter should be remanded to DHEC with instruction

to engage in the review process required by the COPA Act. This is so because “[t]he traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress.” *Fox v. Moultrie*, 379 S.C. 609, 614, 666 S.E.2d 915, 917 (2008) (quoting *Bd. of Governors, FRS v. Dimension Fin. Corp.*, 474 U.S. 361, 368 (1986)).

C. Regulation 61-31 § 508 Fails for Vagueness As-Applied.

In authorizing DHEC to promulgate regulations, the General Assembly directed the Department to address provisions for public hearings (Section 44-7-540) and “to implement the provisions of this article including any fees and application costs associated with the monitoring and oversight of cooperative agreements approved under this article.” *Id.* § 44-7-570(D). PHM’s suggestion that this grant of authority allows DHEC to “fill up the details” in a way that eviscerates the public’s right to notice and participation in evaluating the benefits and disadvantages of major transactions of the kind at issue here would in actuality rewrite the law. “The Department, pursuant to § [44-7-570(D)], has the authority to promulgate necessary rules and regulations to carry out the provisions of the [article], but not to alter the material intent of the provisions.” *Richard Street Partners, LLC, et al. v. S.C. Dept. of Health and Env’tl. Control*, Docket No. 04-ALJ-07-0304-CC, 2007 WL 1577990 *6 (S.C. Admin. Law J. Div. April 30, 2007). “Such rules are valid for the enforcement of the law, not for a non-enforcement or suspension of the law.” *Heyward v. S.C. Tax Comm’n*, 240 S.C. 347, 355, 126 S.E.2d 15 (1962) (holding agency lacked authority to adopt by regulation a method of reporting income for tax purposes not provided for by statute).

In *Young v. South Carolina Department of Highways and Public Transportation*, 287 S.C. 1008, 336 S.E.2d 879 (1985), the Supreme Court explained, “[t]he key issue in this case is whether the regulation is a proper exercise of authority granted to the Department.” *Id.* at 112, 336 S.E.2d at 881. ““An administrative regulation is valid so long as it is reasonably related to the purpose of

the enabling legislation.” *Id.* (quoting *Hunter & Walden Co. v. S.C. State Licensing Bd. for Contractors*, 272 S.C. 211, 213, 251 S.E.2d 186 (1978)). “Although a regulation has the force of law, it must fall when it alters or adds to a statute.” *Soc’y of Prof. Journalists v. Sexton*, 283 S.C. 563, 567, 324 S.E.2d 313, 315 (1984) (holding DHEC regulation limiting public access to death certificates “invalid and repugnant to FOIA”). Agency rules or regulations that materially alter or add to the law are void. *See Milliken and Co. v. S.C. Dept. of Labor*, 275 S.C. 264, 267, 269 S.E.2d 763, 764 (1980).

“A facial challenge is a claim that a statute is unconstitutional on its face — that is, that it always operates unconstitutionally.” *S.C. Dept. of Health and Envtl. Control v. Mastercare, Inc., a/k/a Mastercare Contracting, Inc.*, Docket No. 10-ALJ-07-0546-CC, 2011 WL 7119230 (S.C. Admin. Law J. Div. Mar. 15, 2011). “An as-applied challenge is an argument that the statute or regulation is unconstitutional as it has been applied to a specific party or class of individuals.” *Id.* LMC’s challenge is as-applied, and the ALC has jurisdiction to address the validity of Regulation 61-31 § 508 as applied by DHEC in this contested case. *See Travelscape, LLC*, 391 S.C. at 109, 705 S.E.2d at 39. In determining whether a statute or regulation is unconstitutionally vague, the Supreme Court has held, “[t]he concept of vagueness or indefiniteness rests on the constitutional principle that procedural due process requires fair notice and proper standards for adjudication.” *City of Beaufort v. Baker*, 315 S.C. 146, 152, 432 S.E.2d 470, 473 (1993) (quoting *State v. Albert*, 257 S.C. 131, 134, 184 S.E.2d 605, 606 (1971)); *see also Huber v. S.C. State Bd. Of Phys. Therapy Exam’rs*, 316 S.C. 24, 26, 446 S.E.2d 433, 435 (1994) (“The constitutional standard for vagueness is the practical criterion of fair notice to those to whom the law applies.”)

A statute fails for vagueness unless it satisfies two criteria: “First, the statute must provide sufficient notice of the conduct prohibited. Second, the statute must also not be written in such a

manner as to permit or encourage arbitrary and discriminatory enforcement. If a challenger sufficiently proves the statute fails either prong, then the statute is impermissibly vague.” *Town of Mount Pleasant v. Chimento*, 401 S.C. 522, 541, 737 S.E.2d 830, 842 (2012) (Hearn, J., dissenting) (citations omitted). Applicable here is the second prong, and as illustrated in the context of criminal statutes, “[a] vague statute would [] allow police to be guided not by clear language, but by whim.” *Id.* at 542, 737 S.E.2d at 843 (quotation omitted).

“As a creature of statute, [DHEC] has only those powers expressly conferred or necessarily implied for it to effectively fulfill the duties with which it is charged.” *S.C. Coastal Conservation League*, 363 S.C. at 74, 610 S.E.2d at 485 (quotations omitted). “Where a statute provides controlling principles, an administrative agency may exercise a large measure of discretion within those principles.” *S.C. Dept. of Revenue v. Clyde J. Burris, Sr., d/b/a C. Joseph Burris Liquors*, Docket No. 96-ALJ-17-0201-CC, 1996 WL 909574 *3 (S.C. Admin. Law J. Div. July 24, 1996) (citing 1 Am. Jur. 2d *Administrative Law* § 118 (1962)). The Department is required to “issue a certificate of public advantage for a cooperative agreement if it determines that” the likely benefits outweigh the likely disadvantages after review of an application and receipt of input from affected persons and the Attorney General. *See* S.C. Code Ann. §§ 44-7-530 to -560. “If the statute is to have meaning, it does not follow that the award of a permit can be presumed without some evaluation of the need for that permit.” *Waste Mgmt. of Carolinas, Inc. v. S.C. Dept. of Health and Envtl. Control*, Docket No. 07-ALJ-07-0429-CC, 2008 WL 4659522 *7 (S.C. Admin. Law J. Div. Sept. 24, 2008) (denying permit for restricted activity until agency properly develops test to determine need on remand).

In *MRI at Belfair, LLC v. South Carolina Department of Health and Environmental Control*, 392 S.C. 314, 709 S.E.2d 626 (2011), the Supreme Court rejected DHEC’s treatment of

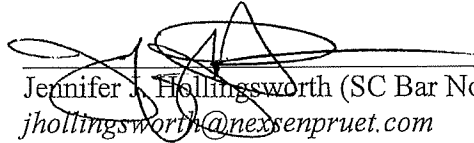
costs for determining whether projects required CON review: “Where, as here, DHEC's chosen method has no basis in the facts of the proposal and arbitrarily allows a potential applicant to avoid the CON review process, it is contrary to the purposes of the CON Act and therefore an error of law.” *Id.* at 321-22, 709 S.E.2d at 630. DHEC’s application of Section 508 to the substantial change proposed by PHM has done exactly what the Supreme Court cautioned against, by “creating incentives for potential applicants to manipulate” the COPA process “and avoid [COPA] review.” *Id.* at 322, 709 S.E.2d at 630. Indeed, the suggestion that the type of review under Section 508 can be ever-changing “based on the circumstances of matter (*sic*) before” the Department would mean DHEC staff are “to be guided not by clear language, but by whim.” *See* PHM Mot. Summ. J., p. 16; *Town of Mount Pleasant* at 542, 737 S.E.2d at 843. Because the question of whether or what type of review DHEC may require for substantial changes to existing COPAs lacks any practical criterion of fair notice, the Regulation is invalid as applied and the DHEC Decision must be reversed.

CONCLUSION

For the reasons stated herein, LMC respectfully requests the Court deny the Motion of PHM for Summary Judgment and grant judgment as a matter of law in favor of Petitioner on the issues raised herein, thereby reversing the DHEC Decision.

[Signature page follows]

Respectfully submitted,



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Counsel for Petitioner

Dated: September 14, 2020

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

Docket No. 20-ALJ-07-0108-CC

This is to certify the foregoing *Petitioner's Opposition to Motion for Summary Judgment and Notice of Motion and Cross-Motion for Summary Judgment* has been served upon counsel of record addressed as shown below, this 14 day of September, 2020.

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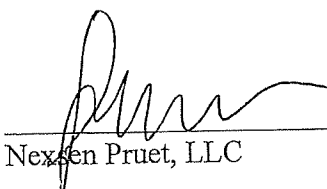

Nexsen Pruet, LLC

EXHIBIT A

To Response and Cross-Motion

**CERTIFICATE OF PUBLIC ADVANTAGE
APPLICATION SUMMARY**

The attached proposal is submitted by the Boards of Richland Memorial Hospital and Baptist Healthcare System in the sincere belief that the system proposed will allow the hospitals to continue their charitable missions during an era of fiscal restraints and to produce significant benefits for the community that could not be achieved by the hospitals if they were to remain separate.

The challenge: The Boards of Richland Memorial Hospital and Baptist Healthcare System are faced with the prospect that with declines in hospital utilization and government and other reimbursements, as well as the continued shift of indigent care from for-profit hospitals, the hospitals must achieve significant new efficiencies.

The choices: The Boards felt that they were facing several unacceptable choices and only one choice that ensured maximum benefit to the community. The unacceptable choices were:

- * Allow Richland and Baptist to deteriorate.
- * Increase the "cost shift" to employers, commercial payors and self-pay customers.
- * Raise rates.
- * Reduce the quality, accessibility, and/or range of services offered.
- * Reduce the amount of care provided to medically indigent patients.

The only acceptable choice was the development of a locally controlled nonprofit health care system with continuing supervisory responsibility over the jointly operated hospitals by the Sponsoring Boards.

The benefits: By virtue of the joint operating agreement, the hospitals will be able to achieve:

- * Approximately \$71 million in efficiencies, cost reductions and capital expenditure savings over the first five years the hospitals are jointly operated.
- * Savings will be passed on to the community in the form of community outreach programs and two major new preventive public health efforts -- a strong initiative to improve maternal and child care and a program to expand cancer education, screening and early detection and treatment.
- * These and other initiatives will be funded in the aggregate with 10% of the System's excess revenues over expenses.
- * Savings will also be passed on to the community in the form of rate increase avoidance and quality and access enhancements.
- * Additional savings will be identified as the hospitals consolidate some of their clinical services and programs.
- * Unrestricted commitment to care for the indigent members of the community regardless of their ability to pay at no cost to Richland County thereby reducing the tax burden.
- * Protection of local control of hospital services.

The assurances: The well being of the community is assured because of a number of factors, including the conditions the Boards of the two hospitals have imposed on themselves. They include:

- * The System will remain non-profit.
- * Its control will remain with local Boards.
- * Emphasis and focus will remain on improving the health of the community.
- * Competition from Lexington and Columbia/HCA hospitals, as well as from other hospitals in the System's core service area, will help to ensure that the hospitals continue to be efficient, low-cost, high quality hospitals.
- * Employees will be protected from layoffs as a result of the alliance.
- * No rate increases for the first five years of operation.

The bottom line: In an era of widespread fiscal constraints, it is imperative that the deliverers of health care remain a bastion of generosity and access to those we serve. This alliance will allow the hospitals to continue charitable missions, to maintain and even expand the range of service to patients, and foremost to assure the community that we are united for the good of people with a goal in common--the best and highest quality health care.

The Boards of Richland Memorial Hospital and Baptist Healthcare System sincerely believe that together we can achieve that which, separate, would be impossible.

**QUESTIONNAIRE
PART A.**

Parties To The Cooperative Agreement

Name	Title	Address
Baptist Healthcare System of South Carolina, Inc.	Charles D. Beaman, Jr. Chief Executive Officer	Taylor at Marion Street Columbia, SC 29220
Richland Memorial Hospital	Kester S. Freeman, Jr. Chief Executive Officer	Five Richland Medical Park Columbia, SC 29203

Brief Description of Proposal

The Parties request their Preincorporation and Joint Operating Agreement ("JOA") dated July 10, 1996 be certified as being to the public's advantage. The JOA provides for the incorporation of a nonprofit entity to operate the hospitals of the Parties as a single unit. This company will be structurally and financially able to achieve operating efficiencies and avoid duplicate capital expenditures and health care services, so as to permit the Parties, despite expected changes in government and commercial reimbursement and increased demand for services by those without the ability to pay, to maintain the scope and quality of their services to Midlands residents. The JOA will also allow the Parties to develop, implement and fund new initiatives to improve public health and a community outreach program, and to expand the counseling centers of the Pastoral Institute.

Describe Proposed Market Area

The new company will have two core service areas -- the first being the seven county area around the Baptist and Richland campuses (Richland, Lexington, Fairfield, Kershaw, Newberry, Orangeburg and Sumter ("Core Service Area")) and the second being the counties serviced by the Easley campus (Pickens and Greenville).

II. EVALUATION OF DISADVANTAGES

A. *Likely adverse impact, if any, on ability of health care purchasers to negotiate optimal payment arrangements with health care providers or health provider networks*

The System is unlikely to have an adverse impact on the ability of purchasers to negotiate favorable rates.⁶ Several factors will ensure that purchasers will be able to negotiate favorable rates after the System is in operation:

- competition from Lexington and Columbia/HCA;
- increasing aggressive competitiveness of Columbia/HCA;
- the loyalty of many Lexington County residents to Lexington, and its importance to managed care plans;
- competition from other hospitals located in the System's Core Service Area;
- the increasing use of non-hospitals for outpatient surgery and ancillary services;
- the growth in size and influence of large physician groups;
- responsiveness of the System to community needs resulting from its total local control;
- absence of pressure to pay dividends to investors or to generate funds to operate systems outside the System's service areas; and
- the effect of the System's non-profit status and local control on cost savings and rates.

1. Competition from Lexington and Columbia/HCA Hospitals

Lexington and Columbia/HCA will provide more than enough competition to prevent the JOA from having an adverse effect on the ability of purchasers to negotiate favorable rates.

⁶ The service area of BMCE does not currently overlap with Richland's service area and, consequently, no adverse impact on competition will result from the inclusion of BMC in the System. Therefore, there is little discussion of BMCE in this section.

Between them, Columbia/HCA and Lexington offer practically all the services offered by the System hospitals. Both Lexington and Columbia/HCA have very positive reputations in the community and are important to many patients, employers, and health plans. A health plan that included Lexington and Columbia/HCA on its panel, but did not include Baptist or Richland, would be a viable and marketable alternative to, and could be more attractive to certain employers than, a health plan that offered Baptist and Richland only. Moreover, some employers have expressed a willingness to enter contracts with hospitals for specific services if necessary. Service-specific contracts would increase competition among all the hospitals by minimizing the impact of differences in service offerings.

2. Increased aggressive competitiveness of Columbia/HCA Hospital

The sale of a controlling interest of Providence Hospital to Columbia/HCA has made for a much more competitive market. Columbia/HCA is an international health care conglomerate which owns about 343 hospitals, 137 outpatient surgery centers, 200 home health agencies, and dozens of other health care services and facilities nationwide. Columbia/HCA earned \$4.6 billion in net revenues in 1995. Columbia/HCA has access to large capital reserves⁷ and purchasing power. Columbia/HCA is well-known for its competitiveness. Columbia/HCA's presence in Columbia is uniformly viewed as a significant constraint on, and competitive threat to, the System. In fact, one employer went so far as to say that separately, Baptist and Richland would not be able to compete against Columbia/HCA, and that if the System were not created, Columbia/HCA would buy one of the hospitals and completely dominate the market.

Columbia/HCA has every incentive to improve its competitive position even further by attempting to offer primary and secondary care services in this area. Moreover, Columbia/HCA has announced that in addition to its continued commitment to its heart program, Columbia/HCA is also committed to providing services for the entire family. Columbia/HCA has made public statements and taken definitive actions to accomplish what Columbia/HCA presumably believes would increase its already significant competitive presence in the Core Service Area. (See, Response to Question 8 for the definition of "Core Service Area").

3. Competitive significance of Lexington Medical Center

The competitive significance of Lexington must be considered. Lexington is a well-respected community hospital offering a broad array of services. Lexington offers many of the

⁷ Columbia/HCA's access to capital can confer on it a significant competitive advantage. For example, in a recent CON application, Columbia/HCA proposed a \$26 million expansion project that would be paid for entirely with cash. The ability to fund major expansions or renovations with cash (as opposed to financed projects) lowers the costs associated with such projects and thereby enables the hospital to be more price-competitive.

same services available at the System hospitals. For example, Lexington's oncology program generally offers the same services and sophistication as the oncology programs at Baptist and Richland. Moreover, payors and purchasers recognize the strong loyalty Lexington County residents have toward Lexington. Given the fact that Lexington is the only hospital located in Lexington, which is the fastest-growing county in the state, it is very important to employers and managed care plans to have Lexington in their network. Consequently, as the population in Lexington grows, the competitive significance of Lexington will increase further as will the competitive disadvantage at which any network that did not include Lexington would find itself.

4. Competition from other hospitals located in the System's Core Service Area

Richland and BMCC attract patients from a wide geographic area, as do the other two facilities located in the Columbia metropolitan area (Columbia/HCA and Lexington). All four Columbia area hospitals currently compete with many other hospitals for at least 30% of their patients. More specifically, BMCC and Richland compete with seven hospitals -- five of which (including Lexington and Columbia/HCA) are large hospitals with over 200 beds -- in their Core Service Area.

Patient origin data show that Richland, BMCC, Columbia/HCA, and Lexington ("Columbia Area Hospitals") compete against each other and against five other hospitals in five surrounding counties for a significant portion of their patients. Those seven counties (Richland, Lexington, Kershaw, Fairfield, Orangeburg, Sumter and Newberry) account for at least 85% of the patients admitted to the Columbia Area Hospitals. While most residents of Richland and Lexington Counties use one of the Columbia Area Hospitals, 15% of the hospitals' patients come from the five other counties in the Core Service Area. Another 15% come from generally more distant counties and occasionally from out of state.

5. Trend toward providing more care in non-inpatient hospital settings

There is a clear and growing trend in health care toward moving services out of the inpatient acute care hospital setting to outpatient and other non-inpatient settings. For example, one health plan representative estimated that 30% of the health plan's premium dollars went to hospitals, but no more than 50% of that amount (*i.e.*, 15% of total) was for inpatient hospital services. The health plan representative also opined that the proportion of premium dollars spent on inpatient hospital services is consistently decreasing.

The System's five-year projections (See, Response to Question 10) indicate that inpatient days will decline over 6% over the period. The System and other hospitals will therefore put increasing emphasis on outpatient and many other ancillary services to compensate for the loss of inpatient revenue. Outpatient revenue will account for roughly 28% of the System's 1996 revenue and is projected to grow in importance in the future.

This trend brings hospitals into direct competition with physicians and non-hospital providers of outpatient and ancillary services. Hospitals typically face much greater competition for outpatient and ancillary services from hospital and non-hospital competitors than they do for inpatient hospital services. Moreover, the threat of new providers entering the market is more significant, and the costs of entering the market is substantially less, with respect to outpatient and ancillary services than it is for inpatient hospital services.

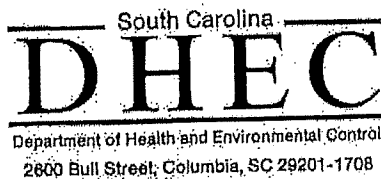
The increasing percentage of hospital revenue that comes from outpatient surgery and ancillary services will require the System to compete successfully in those other markets. Payors and purchasers recognize that the threat of moving patients requiring outpatient and ancillary services to non-hospital based providers of those services gives them the ability to prevent the System from trying to take advantage of any leverage it might be alleged to enjoy in one or more inpatient hospital service lines.

6. The growth in number and influence of large physician groups

There is a strong trend toward physicians merging their practices or selling and accepting employment with large institutions or groups. Other recent trends in health care include expansion by physicians (especially large groups) beyond traditional office practice to build and operate outpatient surgery facilities and to provide other outpatient and ancillary services; and physicians' entry into new and innovative arrangements with health plans in which physicians accept risk and assist in cost containment efforts. These trends have contributed to a general increase in the power and influence held by large physician groups, usually at the expense of hospitals. The growth of managed care has further solidified the physician's role, and particularly the primary care physician's role, as the entry point to the entire health care system for an increasingly large percentage of patients.

Physicians have a great deal of influence over which health care services and providers their patients use. As increasing numbers of physicians join large groups, their ability to control significant numbers of potential hospital admissions makes hospitals much more vulnerable to patient steering mechanisms. The existence of large physician groups also significantly enhances the potential for health plans and employers to discipline hospitals that are unwilling to deal on terms payors and purchasers believe are fair. Steering patients is a much more feasible and effective threat when it only requires the health plan or employer to get the coordination and cooperation of a few large physician groups, than when it requires the cooperation of many solo practitioners and small groups. In some markets, certain hospitals are included only nominally (e.g., for marketing purposes or special services) in a network but payor arrangements with physician groups result in substantial steerage away from those particular institutions.

In addition to their ability to affect the care decisions of significant numbers of patients, large physician groups have become an increasingly important source of direct competition for hospitals. Large physician groups often operate outpatient surgery centers and provide other ancillary services in competition with those same services usually offered by hospitals. These groups are typically more likely to have the financial strength and patient base needed to establish



Commissioner: Douglas E. Bryant

Board: John H. Burdiss, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leaks, Jr., Secretary

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October 24, 1996

J. Robert Bolchoz, Jr.
Chief of Staff
Office of Attorney General
P.O. Box 11549
Columbia, SC 29211

VIA FAX AND MAIL

Re: Form 1 for Erin Farwell, Esquire

Dear Robert:

I am writing in connection with a Form 1 for Erin Farwell, which has been submitted to Zeb Williams for approval. A copy of the Form 1 is attached. I have discussed this issue with Zeb and I am writing you to explain the special circumstances surrounding the Department's request to obtain the services of an out-of-state attorney.

When Commissioner Doug Bryant and I visited you a few months ago, we discussed the new Certificate of Public Advantage (COPA) Law. This is a new area of law in South Carolina and we have received the first application under this law today, from the Baptist-Richland Alliance. We have thirty days to review the application and ask the applicant for any required additional information. This review will require expertise in legal, financial, health care, and antitrust matters which is not currently possessed by Department staff.

It is DHEC's desire to develop this expertise among our own legal and technical staff so that we will not have to pay for outside assistance indefinitely. While we would greatly prefer to use in-state legal counsel to assist us in the early stages and in developing this expertise, we are not aware of any in-state attorney who has the required expertise and is not barred by a conflict due to representing one of the parties which will be filing an application. Because of these unusual circumstances, we believe we need to hire an attorney such as Erin Farwell of Atlanta, who has the experience and the resources we need to assist us within the next thirty days and thereafter in reviewing this application and developing the ability to handle these applications in-house in the future. I do not believe that it would be useful to hire an in-state attorney who has no more expertise than we currently have on these matters.

J. Robert Bolchoz, Jr.

October 24, 1996

Page Two

I share your desire to keep the state's legal business in-state, and I believe this is an instance in which the use of an out-of-state attorney is justified and necessary. I therefore request approval of the Form 1 for Erin Farwell. Time is of the essence since we have only thirty days to review the application and determine if it is complete. We need the assistance of counsel experienced in this area to make that determination.

As always, thank you for your assistance.

Sincerely,



Carlisle Roberts, Jr.
General Counsel

cc: Zeb Williams, Deputy Attorney General
Doug Bryant, Commissioner
Leon Frishman, Director, Bureau of Health Facilities & Services Development
Cheryl Bullard, Chief Attorney for Health Services

SOUTH CAROLINA ATTORNEY GENERAL
REQUEST FOR AUTHORIZATION TO EMPLOY ASSOCIATE COUNSEL

FROM (AGENCY): The South Carolina Department of Health & Env. Control
INDIVIDUAL REQUESTING AUTHORIZATION (INCLUDE TITLE): _____
Jacquelyn S. Dickman, Assistant General Counsel

DATE: 10/3/96

CASE CAPTION (or subject): Certificate of Public Advantage

COUNTY (in which case/matter occurs): N/A

REQUESTED ATTORNEY/LAW FIRM INFORMATION

NAME: Erin Farwell, JD

ADDRESS: Ten Piedmont Center, Suite 412, Atlanta, GA 30305

BRIEF DESCRIPTION OF LEGAL SERVICES TO BE PERFORMED:

Provide legal advice and consultation to DHEC attorneys and health regulation staff in financial feasibility, joint venture plan, merger analysis, antitrust analysis, and public and community benefit requirements and analysis of proposals in Certificate of Public Advantage application

REASON WHY PRIVATE ATTORNEY IS NEEDED TO PERFORM THE SERVICES:

There is no DHEC attorney or staff member with the expertise necessary to conduct the complete analysis of the COPA application, which will involve complex legal and health planning principles involved in mergers of major healthcare entities.

REQUESTED DATES OF SERVICES (Maximum of one fiscal year):

10/10/96 - 6/30/97

REQUESTED HOURLY RATE OR OTHER COMPENSATION: \$ 120.00

JUSTIFICATION IF HOURLY RATE OR OTHER COMPENSATION EXCEEDS STANDARD RATE RANGE:

Hourly rate is standard for the expertise and complexity involved, and is decreased from the usual hourly rate of \$170.00 for this attorney.

REQUESTED MAXIMUM COMPENSATION (Fees and Costs): \$ 15,000.00

TO BE COMPLETED BY ATTORNEY GENERAL'S OFFICE:

APPROVED BY: _____

DATE: _____

FILE NUMBER: _____

SERVICE CODE: _____

ATTORNEY APPROVED: _____ 0944

FIRM CODE: _____

REV. 7/90

South Carolina
DHEC
Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201-1708

Commissioner: Douglas E. Bryant

Board: John H. Burriss, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leaks, Jr., Secretary

Promoting Health, Protecting the Environment

Richard E. Jabbour, DDS
Cyndi C. Mosteller
Brian K. Smith
Rodney L. Grandy

November 12, 1996

The Honorable Charles M. Condon
Attorney General of South Carolina
P. O. Box 11549
Columbia, SC 29211

Dear Mr. Condon:

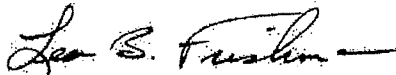
Reference my enclosed letter of October 24, 1996, to you which forwarded a copy of an application for a Certificate of Public Advantage (COPA) from Richland Memorial Hospital and Baptist Healthcare System of South Carolina, Inc.

We would appreciate your notifying us as soon as possible as to the name of the individual in your office who has been assigned the responsibility for the review of the Certification of Public Advantage Program. In addition, please provide the name of any other contact person in your office that we may communicate with regarding this program, if appropriate.

Several representatives of DHEC will meet to discuss the additional information which must be requested regarding the COPA application at 10:00 a.m. on Wednesday, November 20, 1996, in Suite 201 of the Heritage Building, 1777 St. Julian Place, Columbia, South Carolina. You or your representative are cordially invited to attend this meeting to have input and assist our staff in requesting appropriate additional information for the COPA application.

Thank you for your attention to this matter. Should there be any questions, please do not hesitate to contact Mr. Joel Grice or me at (803) 737-7200.

Sincerely,



Leon B. Frishman, Director
Bureau of Health Facilities and
Services Development

LBF:gd

Enclosure

S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

In accordance with Section 44-7-200(C), Code of Laws of South Carolina, the public is hereby notified that a Certificate of Need application has been accepted for filing and publication November 22, 1996, for the following project(s). After the application is deemed complete, affected persons will be notified that the review cycle has begun. For further information, please contact Mr. Albert N. Whiteside, Director, Division of Planning and Certification of Need, 2600 Bull St., Columbia, SC 29201 at (803) 737-7200.

Affecting Allendale, Berkeley, Charleston, Colleton, Dorchester and Georgetown Counties

Purchase of Abbey Home Health Agency, a Medicare certified and licensed Home Health Agency which serves Berkeley, Charleston, Dorchester, Georgetown, Colleton and Allendale Counties by Columbia Trident Medical Center.
Columbia Trident Medical Center
Charleston, South Carolina
Project Cost: \$ 300,000

Affecting Anderson County

Upfitting of a building presently under construction for the addition of a Telsa 1.5 MRI unit to provide services to patient at the AnMed Health Campus.
Anderson Area Medical Center
Anderson, South Carolina
Project Cost: \$ 2,941,950

Affecting Charleston County

Construction/renovation of ten (10) additional nursing home beds which will not participate in the Medicaid (Title XIX) Program for a total licensed capacity of fifty-four (54) nursing home beds.
Bishop Gadsden Episcopal Health Care Center
Charleston, South Carolina
Project Cost: \$ 735,074.50

Renovation of specific areas of the old St. Francis Xavier Hospital Building in order to provide appropriate hospital support and ancillary services for the relocation and consolidation of ambulatory care services.
MUSC Medical Center
Charleston, South Carolina
Project Cost: \$11,330,739

Affecting Darlington County

Renovation for the addition of eight (8) nursing home beds, which will not participate in the Medicaid Program, for a total of 140 nursing home beds.
Morrell Memorial Convalescent Center
Hartsville, South Carolina
Project Cost: \$ 28,210

Affecting Florence County

Establishment of a two (2) station chronic outpatient dialysis unit within the hospital.
McLeod Regional Medical Center
Florence, South Carolina
Project Cost: \$ 36,429

Affecting Georgetown County

Construction of a twelve (12) station outpatient hemodialysis facility.
Bio-Medical Applications of S.C. d/b/a Murrells Inlet Dialysis Center
Murrells Inlet, South Carolina
Project Cost: \$ 1,174,557.45

Affecting Lexington County

Upfitting of a leased building to house an Hitachi Open MRI unit to provide outpatient services to the residents of the Midlands Region.
Lexington Open MRI
West Columbia, South Carolina
Project Cost: \$1,338,500

In accordance with S.C. DHEC Regulation 61-15, the public and affected persons are hereby notified that the review cycle has begun for the following project(s) and a proposed decision will be made within 60 days beginning November 22, 1996. "Affected persons" have 30 days from the above date to submit comments or requests for a public hearing to Mr. Albert N. Whiteside, Director, Division of Planning and Certification of Need, 2600 Bull Street, Columbia, S.C. 29201. For further information call (803) 737-7200.

Affecting Anderson County

Upfitting of a building presently under construction for the addition of a Telsa 1.5 MRI unit to provide services to patients at the AnMed Health Campus.
Anderson Area Medical Center
Anderson, South Carolina
Project Cost: \$ 2,941,950

Affecting Clarendon County

Purchase of home health services for Clarendon County from Total Care, Inc., by Clarendon Memorial Hospital.
Clarendon Memorial Hospital
Manning, South Carolina
Project Cost: \$ 150,000

Affecting Darlington County

Renovation for the addition of eight (8) nursing home beds, which will not participate in the Medicaid Program for a total of 140 nursing home beds.

Morrell Memorial Convalescent Center

Hartsville, South Carolina

Project Cost: \$ 28,210

Affecting Greenwood County

Construction of 11,752 square feet of additional space to include twenty (20) replacement nursing home beds, therapy and ancillary space for a total licensed capacity to remain at 152 nursing home beds.

NHC HealthCare, Greenwood

Greenwood, South Carolina

Project Cost: \$ 1,378,900

Affecting Spartanburg County

Construction and renovation to expand for the addition of nine (9) outpatient hemodialysis stations, for a total of thirty-two (32) hemodialysis stations.

Dialysis Clinics, Inc.-East Spartanburg

Spartanburg, South Carolina

Project Cost: \$ 1,221,158

In accordance with Section 44-7-540, Code of Laws of South Carolina, the public is hereby notified that a Certificate of Public Advantage application has been accepted for filing and publication November 22, 1996, for the following project(s). After the application is deemed complete, affected persons will be notified of such action including when affected persons may request a public hearing with a notice which will be published in a newspaper having general circulation in the area. For further information, please contact Mr. Leon B. Frishman, Director, Bureau of Health Facilities and Services Development, 2600 Bull Street, Columbia, SC 29201 at (803) 737-7200.

Affecting Richland, Lexington, Fairfield, Kershaw, Newberry, Orangeburg, Sumter, Pickens and Greenville Counties

Certification as being to the public advantage for the incorporation of a nonprofit entity to operate the hospitals of the Parties as a single unit, where the Parties will develop, implement, and fund new initiatives to improve public health and a community outreach program, and to expand the counseling centers of the Pastoral Institute.

Parties: (1) Baptist Healthcare System of South Carolina, Inc.
Columbia and Easley, South Carolina

(2) Richland Memorial Hospital
Columbia, South Carolina



CHARLES MOLONY CONDON
ATTORNEY GENERAL

The State of South Carolina
OFFICE OF THE ATTORNEY GENERAL

Ramsey C. Deane Building
Post Office Box 11749
Columbia, S.C. 29211-1749
Telephone: 803-734-3970
Facsimile: 803-257-6283

TO Leon B. Fishman

Fax Number 737-7212

FROM Sonny Jones

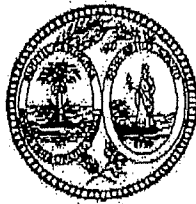
Office Number 734-3680

DATE 11/19/96

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET 2

CONFIDENTIALITY NOTE:

The information contained in this facsimile message is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify us by telephone and return the original message to us at the address above via the United States Postal Service. Thank you.



The State of South Carolina
OFFICE OF THE ATTORNEY GENERAL

CHARLES MOLONY CONDON
ATTORNEY GENERAL

November 19, 1996

VIA FACSIMILE

Mr. Leon B. Frishman, Director
Health Facilities and Services Development
SC Department of Health and
Environmental Control
2600 Bull Street
Columbia, SC 29201-1708

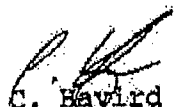
Re: Certificate of Public Advantage from Richland Memorial
Hospital and Baptist Health Care System

Dear Mr. Frishman:

Your letter to this Office dated October 24, 1996, and received October 29, 1996, concerning the above-referenced matter has been referred to me for review and response. Due to the complexity of the review, in that it involves legal and health planning principles unique to the mergers of major health care entities, please accept this as a request for additional time for you to receive the advice of the Attorney General as to whether or not the application should be approved or denied.

If you have any questions concerning this matter, please do not hesitate to contact me.

Very truly yours,


C. Baylrd Jones, Jr.
Senior Assistant Attorney General

CHJJr/rho

cc: J. Robert Bolchoz, Jr., Esquire

November 21, 1996

Mr. C. Havird Jones, Jr.
Senior Assistant Attorney General
P.O. Box 11549
Columbia, South Carolina 29211-1549

Dear Mr. Jones:

This is in response to your letter dated November 19, 1996, requesting additional time for you to provide the Department advice on the application of Richland Memorial Hospital and Baptist Medical Center for a Certificate of Public Advantage.

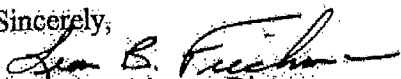
Section 44-7-550. (A) provides, "The Attorney General may advise the department, in writing, to approve or deny the application. Failure by the Attorney General to notify the department within thirty days of receiving a completed application constitutes a recommendation for approval of the request." (Emphasis added.) Regulation 61-31, Health Care Cooperative Agreements, Section 302. (C) provides that, "An application is complete when the Department notifies the applicant that all necessary information has been received..."

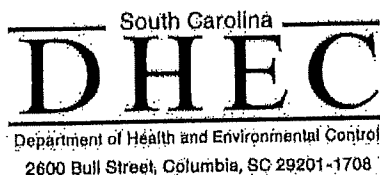
This office has not notified the applicant that the application is complete. We are requesting additional information as provided for in Section 302 of Regulation 61-31. We have requested your input into this process; however, law and regulation require the Department to request this information within thirty days of receipt of the application (November 23, 1996).

Once the application is determined to be complete, the Department will notify the applicants as is required in Section 302 of Regulation 61-31. In addition, we will notify you as required in Section 305 of the Regulation. From that date, the Attorney General will have thirty days to advise the Department in writing to approve or deny the application. By law, the Department does not have the authority to grant the Attorney General additional time to advise the Department regarding the approval or denial of an application.

We continue to welcome any assistance you may provide during this review process. Should you desire to discuss this application, or the review process, do not hesitate to contact me at (803) 737-7200.

Sincerely,


Leon B. Frishman, Director
Health Facilities and Services Development



Commissioner: Douglas E. Bryant

Board: John H. Burris, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leaks, Jr., Secretary

Promoting Health, Protecting the Environment

Richard E. Jabbour, DDS
Cyndi C. Mosteller
Brian K. Smith
Rodney L. Grandy

December 9, 1996

The Honorable Charles M. Condon
Attorney General of South Carolina
P. O. Box 11549
Columbia, SC 29211-1549

Dear Mr. Condon:

Enclosed for your review is a copy of the additional information received by this Department on December 6, 1996, regarding the application for Certificate of Public Advantage (COPA) submitted by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital.

Pursuant to Section 302(B) of Regulation No. 61-31, Health Care Cooperative Agreements, this Department has fifteen (15) days from its receipt of the enclosed information in which to request further information on the application or to deem the application complete.

We continue to welcome any assistance you may provide during the review process. Should you desire to discuss the application or the additional information, please do not hesitate to contact me at (803) 737-7200.

Sincerely,

Leon B. Frishman, Director
Bureau of Health Facilities and Services Development

LBF:gad

Enclosure

South Carolina
DHEC
Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201-1708

Commissioner: Douglas E. Bryant

Board: John H. Burriss, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leaks, Jr., Secretary

Promoting Health, Protecting the Environment

Richard E. Jabbour, DDS
Cyndi C. Mosteller
Brian K. Smith
Rodney L. Grandy

December 23, 1996

The Honorable Charles M. Condon
Attorney General of South Carolina
P. O. Box 11549
Columbia, SC 29211-1549

Dear Mr. Condon:

Enclosed for your review is a copy of the complete letter issued by the Department on December 23, 1996, regarding the application for Certificate of Public Advantage (COPA) submitted by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital. This office has already forwarded to you a copy of the COPA application on October 24, 1996, and the additional information submitted by the applicants on December 9, 1996.

Pursuant to Section 305 of Regulation No. 61-31, Health Care Cooperative Agreements, you may advise the Department in writing to approve or deny the application within thirty days of the complete letter, which is January 22, 1997, or 30 days from the date of a Public Hearing should one be requested. Section 305 of Regulation No. 61-31 also states "If no report is received from the Attorney General within thirty days, the Department will consider that as a recommendation to approve the request."

We continue to welcome any assistance you may provide during the review process. Should you desire to discuss the application, please do not hesitate to contact me at (803) 737-7200.

Sincerely,

Joel C. Grace for

Leon B. Frishman, Director
Bureau of Health Facilities and Services Development

LBF:JCG:gad

Enclosure

THE STATE-RECORD CO., INC.
Columbia, South Carolina
publisher of

The  State

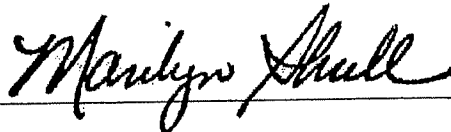
STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

Personally appeared before me Marilyn Shull, Classified Inside Sales Manager
of THE STATE, and makes oath that the advertisement,

Public Notification - application for COPA, Baptist Healthcare
System of SC and Richland Memorial Hospital

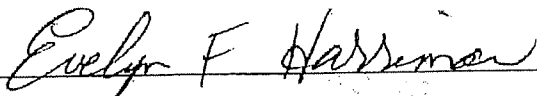
was inserted in THE STATE, a daily newspaper of general circulation published in the
City of Columbia, State and County aforesaid, in the issues of

December 25, 26, 27, 1996



Subscribed and sworn to before me

this 3rd day of January 19 97.



My Commission Expires May 5, 2003

Notary

PUBLIC NOTIFICATION
In accordance with Section 304 of S.C. OHEC Regulation No. 01-91, Health Care Cooperatives Agreements, the public and affected persons are hereby notified that the application for a Certificate of Public Advantage (COPA) submitted by the Parties, Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital, Columbia, South Carolina, has been determined to be complete for purposes of review by the S.C. Department of Health and Environmental Control. The application requests approval for the incorporation of a nonprofit entity to operate the hospitals of the Parties as a single unit, where the Parties will develop, implement, and fund new initiatives to improve public health and a community outreach program, and to expand the counseling center of the Pastoral Services. "Affected Persons" have thirty (30) days from the publishing of this notice to submit comments or requests for a public hearing to Mr. Earl A. Harrison, Director, Bureau of Health Facilities and Services Development, S.C. Department of Health and Environmental Control, 2600 Bull Street, Columbia, S.C. 29201. For further information, please call (803) 737-1200.

"Errors - the liability of the publisher on account of errors in or omissions from any advertisement will in no way exceed the amount of the charge for the space occupied by the item in error, and then only for the first incorrect insertion."

Eau Claire Cooperative Health Center

Post Office Box 3788
Columbia, SC 29230-3788
Telephone: 803-252-7001
Facsimile: 803-252-5219

January 14, 1997

Mr. Leon Frishman
COPA Document Director
SCDHEC
2600 Bull Street
Columbia, South Carolina 29201

Dear Mr. Frishman:

The Eau Claire Cooperative Health Center (ECCHC), an independent, community sponsored, nonprofit, neighborhood health center in Columbia, is an integral part of the city's medical safety net for vulnerable children and families. One third of Richland County's children covered by Medicaid insurance are patients of the ECCHC. The ECCHC's mission is to provide quality health care in traditionally underserved areas of Columbia. The ECCHC does not receive federal grants, but it does enjoy a large measure of community support. The ECCHC is quite concerned about some of the proposed activities of the Richland- Baptist merged hospital (entity). There are three concerns which are discussed in this letter.

First, in the COPA document, it is stated that during the first year of operation the entity will enter the Eau Claire/ Greenview area of Columbia and establish educational and service activities. It is also stated that the entity will collaborate with local health care providers such as the parish nurses. It should be pointed out that the area's one part-time parish nurse can only provide limited help. The Eau Claire Cooperative Health Center (ECCHC) has providers that have been serving in the Eau Claire/ Greenview area since 1981. The ECCHC has an excellent clinical reputation and solid community support. In 1996, the ECCHC had 30,000 patient encounters. The ECCHC is the logical choice for any collaborative primary care efforts that are established by the entity in the Eau Claire/ Greenview area. SCDHEC has recognized ECCHC's being a significant, established point of contact with the community by establishing a WIC (Women, Infant, Children Nutrition Support) office in its facility at 4801 Monticello Road. Further, with the opening of the Sterling Sharpe Pediatric Center there is a 10,000 square foot facility already existing to provide health care to children. The 4,700 square foot Eau Claire Family Practice Center at 4801 Monticello Road is home to a family practice, a WIC office, a part-time podiatrist, and a family counseling service. The ECCHC plans to begin offering comprehensive Ob/Gyn services by the summer of 1997.

In the third year of the merger the entity plans to enter the Oak-Waverly area of Columbia with unspecified educational and service activities. Again, the ECCHC is already present in the defined service area, and has been since 1993. A new facility was

0997

Locations: Sterling Sharpe Pediatric Center
4605 Monticello Road
Telephone: 803-252-7001
FAX: 803-252-5219

Eau Claire Family Practice Center
4801 Monticello Road
Telephone: 803-754-0151
FAX: 803-691-1778

Waverly Family Practice Center
2117 Gervais Street
Telephone: 803-748-1181
FAX: 803-748-1185

DEC 10 1997

dedicated by the ECCHC at 2117 Gervais Street in January 1996. In the COPA document there is no mention of any planned collaboration with the ECCHC.

It is apparent that the entity plans to enter areas of Columbia that have been traditionally underserved by the medical establishment. The ECCHC has responded to the glaring needs in those areas by using its modest resources and with some support from area hospitals. The political winds have been shifting in the medical community in Columbia, and now the ECCHC finds that its former hospital relationship characterized by modest support has been transformed into one that can only be described as competitive. The ECCHC cannot compete with the entity. By setting up a large, well financed parallel system of care in the ECCHC service areas, the ECCHC will find itself hard pressed to continue. It may succumb to the siege. Please explain the public advantage of such an action.

The burden of caring for poor patients has actually enriched the Richland Memorial Hospital over the years due to the special reimbursement methodology currently offered by the Medicaid and Medicare programs. The hospital has received tens of millions of dollars in disproportionate share funds and Medicaid matching funds over the last several years. A fair percentage of these funds, derived from the services to the poor, could have been reinvested in the health care institutions and initiatives in the communities where the poor live. Two percent of the disproportionate share/ matching funds could have built and funded an entire series of neighborhood health care centers over the last five to eight years.

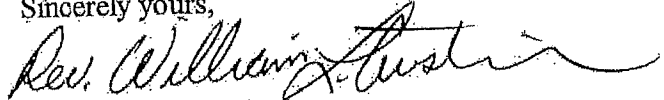
Second, the ECCHC's Waverly Family Practice Center, located in the Oak-Waverly MUA (Medically Underserved Area) was constructed with the help of the Duke Endowment, the Providence Hospital, and the Baptist Medical Center. The deed to the property is held by the Baptist Medical Center, as agreed by the three parties and the ECCHC. The merged hospital entity will change the way that real estate assets are held. Because the Baptist Medical Center has been a participant in the Waverly Family Practice Center project, the ECCHC does not wish to have the deed removed from the sole control of the Baptist Medical Center and transferred to the merged entity.

Third, the Richland Memorial Hospital has agreed to partially underwrite the financing of a new satellite of the Richland Community Care Association (the Eastover based federally supported community health center) in the Oak-Waverly MUA at a site that is only 250 yards from the ECCHC's Waverly Family Practice Center. The logic of establishing a parallel system rather than enhancing the community based system that already exists is unclear. The ECCHC is about to become the object of well planned and financed competitive activity supported by the entity. Richland Memorial Hospital already has out-patient clinics, both general and sub-specialty types. It will now create an additional feeder organization. Rather than assist the Richland Community Care Association in establishing locations in the underserved rural portions of Richland County, the entity will assist in the construction of a competitive facility in the Oak-Waverly area. The ECCHC fails to see the public advantage of such an activity.

This letter outlines only a few of the concerns of the ECCHC as it finds itself in the potentially untenable position of continuing to provide care to vulnerable families in Columbia while a parallel system of care is fostered or established in its service area by the merged hospital entity. Prudence would dictate that the entity work with the ECCHC to strengthen and expand the services already provided at ECCHC rather than duplicate services.

Your timely response to these matters is greatly appreciated. We are open to a discussion of these issues.

Sincerely yours,



Rev. William Austin
Chairman, Board of Directors

cc D. Bryant, Commissioner SCDHEC
ECCHC Board
Mr. C. Beaman
Mr. K. Freeman
Mayor Coble

Dr. Hamilton

Colonel Morris B. Rubenstein (USAF rtd.)

1/17/97

Leon B. Frishman
Director, Bureau of Health Facilities and Services Development
South Carolina Department of Health and Environmental Control
2600 Bull Street, Columbia, SC 29201-1708.

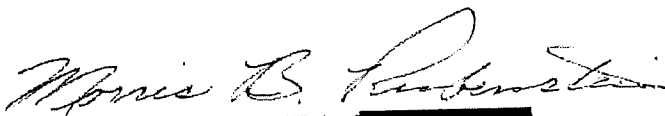
Re: Baptist Medical Center-Richland Memorial Hospital (BR) Alliance

Dear Mr. Frishman,

PETITION

- The potential opportunities for business and apparently local control of the proposed Baptist Medical Center-Richland Memorial Hospital (BR) Alliance are noteworthy. However, I and the other undersigned healthcare consumers and citizens of this county and state have certain concerns about the proposal as it stands currently. We are concerned about the degree of oversight for and accountability of this powerful new tax-exempt entity among other issues including profit management, cost, freedom to choose one's physician, medical education and quality of care.
- In addition to investigating and clarifying the issues, please organize a public hearing and invite independent experts and advocates for public interest not only from Columbia but also from other parts of the state or country for an in-depth discussion of the concerns outlined in the accompanying document (Appendix 1). The issues raised are real and deserve careful attention so that changes can be made before the issuance of a certificate of public advantage.

Sincerely,



Morris B. Rubenstein (Tel: [REDACTED])

c:

Honorable Charles M. Condon
Attorney General
State of South Carolina
Post Office Box 11549
Columbia, SC 29211

101-
out
Schedule
public
hearing
People's And
Newspaper
ad, etc.

JAN 21 1997

Name	Signature
WARREN S. COMPTON SR.	Warren S. Compton
HELG A. CROCKER	Helga A. Crocker
MARY T. RICE	Mary T. Rice
AARON A. RICE	A. A. Rice
MORRIS B. RUBENSTEIN	Morris B. Rubenstein
RAVENEL J. RUBENSTEIN	Ravenel J. Rubenstein

C:

Honorable Charles M. Condon
 Attorney General
 State of South Carolina
 Post Office Box 11549
 Columbia, SC 29211

APPENDIX 1

Community Concerns about the Certificate of Public Advantage
(COPA) application filed by the proposed Baptist Medical Center-
Richland Memorial Hospital Alliance

MISSION STATEMENT

1. It is of concern that DHEC is considering a COPA for an organization that has not revealed its mission statement. Why is the mission statement being held back until the process of administrative, political, and legal review is complete?

DHEC should insist on seeing the mission statement before further considering the application. The mission statement should incorporate the promised community benefits and be used as a grand strategic template against which to assess all other claims and commitments made by the Alliance.

GOVERNANCE

1. The Alliance Systems Board will have 15 members with equal representation from RMH and Baptist even though RMH is bringing the lion's share of investment to the table. By agreeing to this arrangement, the community is surrendering an undue degree of political leverage and oversight over the 'public' component of the Alliance. *[If the BR Alliance fails, tax payers will bear ultimate responsibility for disproportionate liability costs that may be passed back to the Richland County Council along with its 'real estate' and 'operational assets']*
2. The CEO and President are employees of the Alliance but will have designated permanent voting rights as Directors on the highest policy making Board and participate in appointing the three 'appointed' (at large) directors. They will together constitute a 'Management Executive Committee' which will be a fortress of simultaneous authority, responsibility and power under minimal effective oversight. Without a clear-cut advantage to the public, this is a radical departure from the current structure at RMH which enables (but does not guarantee) public accountability. The situation with the Alliance would be even less accountable. There is no statutory stockholders board above the 'Systems Board'. Other than the CEO and President, every other Director shall be essentially limited to two(2) consecutive three year terms although elected Directors have staggered lengths of service. 'Appointed' (at large) members of the Systems board do not have the same rights (removal

mechanism) as other directors. *System Board voting rights should be taken away from the CEO and President and their seats reallocated to the community. All other System Board Directors should have the same degree of seat security.*

3. The process of terminating the employment (appointment) of either the initial CEO (Kester Freeman) or President (Chuck Beamon) of the Alliance will require initiation by $\frac{3}{4}$ of the Systems Board and confirmation by a simple majority of both sponsoring boards. The initial terms of both individuals is for three years followed by automatic yearly renewals for an indefinite duration [JOA 10.18.1]. Removing them (without threatening the Alliance) will be practically impossible unless they quit voluntarily or get stampeded out on account of a cataclysmic felony. Even more bothersome, their personal names are used intermittently throughout the COPA application rather than their titles and offices. Their appointments (in name) will not only be reflected in their employment agreements but also in the System ByLaws! (Article 5, page 22) This circumvents the need to advertise both positions and conduct a national search for suitable candidates and amounts to coronation without review. Further, article 4 [section 4.2] also technically allows both men to hold other Corporation Offices (Chair, Vice Chair, Treasurer or Secretary) simultaneously. The entire arrangement almost guarantees both men [who will wield considerable clout and patronage] these jobs for life. *This job construct needs careful reevaluation. The CEO and President should have specified finite terms of office, to prevent the inordinate accumulation of power. If they are employed by the 'system', the process of terminating their appointments (if necessary) should be achievable by a simple majority of the Systems Board.*
4. *As currently provided, at least one elected Director each (from Baptist and Richland) on the Systems Board shall be a physician (or Dentist). However, the elected physician(s) (or dentist(s)) need not be the respective Chiefs of Staff at each hospital or even be on the active medical staff. Thus, the historical role of the Medical staff reporting independently to Boards of Trustees as a 'check and balance' parallel track to the administration will be seriously weakened. This will further undermine the role of patients and physicians in critical health care decision making. For example, *input* about consolidation of clinical services and programs is ostensibly being sought through a medical staff questionnaire survey (COPA Exhibit 1, page 21). There is no definition of an acceptable respondent rate and final decisions will be made by the Management Executive Committee after which the System Board ratifies. There is no combined Chief (and Vice-Chief) of Medical Staff in the Alliance with stable protected seats on the System Board through which the will and views of the medical staff (and their patients) can be projected independent of administrative chains of command. *The absence of a truly**

independent Medical Staff chain of command in the proposed governance structure is a potential violation of JCAHO requirements and needs to be reevaluated.

5. The Boards of Trustees respectively at each hospital will have very minimal roles once the Systems Board is consummated since the vast majority of 'issues confronting the system' will be resolved by the Systems board. *This needs to be clarified. The management executive committee can practically play musical chairs with the three different boards unless their roles are very clearly spelt out.*

EXECUTIVE COMPENSATION

1. By determining base salary in accordance with the average and competitive salary levels provided to the two top executives in similar healthcare systems nationally with 'comparable gross revenues', a significant instant increase in the personal salary of both executives can be anticipated. [JOA 10.18.3]. (Annual gross revenues of the BR Alliance may be well in excess of 700 million dollars). However, it is by no means certain that either executive can properly claim immediate credit for BR Alliance gross revenues or whether there is a 'similar healthcare system nationally' that uses gross revenues generated from a combination of public and private assets in determining its executive salaries. (If the incomes of either Governor Beasley or President Clinton were to be based on the gross revenues of South Carolina or the United States, they would be very rich men indeed.) Moreover, a salary package based on 'gross revenues' ensures a highly profitable income *even if the Alliance is losing money*, since 'gross revenues' in no way reflect the viability of the corporation! The community, corporate and national standard is for a regional and industry-adjusted base salary plus a performance based bonus based on net revenue and other factors. *For an organization under 'local control', the current base salaries (adjusted for inflation) of the CEO/President of Baptist Medical Center and Richland Memorial Hospital respectively, exceed the 99th percentile of personal incomes in the region, and should suffice for the top two executives of the BR Alliance.*
2. As previously noted, by etching the names of the initial CEO and President into its system by-laws, the BR Alliance is handcuffing both men to their jobs and may be setting itself up for a massive termination pay-off of either executive in the event of a future buy-out by a third party. *Perhaps the community can be reassured that these unusual arrangements are neither critical for the BR Alliance to exist nor essential to gain a public advantage.*

APPLICABILITY OF STATE ETHICS LAW

1. The Alliance of a public institution with a private one is a unique arrangement. Will the BR Alliance be a private non profit public benefit organization or a public non profit public benefit organization? Will the 'State Ethics Law' apply to all its business and administrative practices? For example, the Alliance intends to contract physician services in a 'non-discriminatory' manner. *This clause (among others) needs very specific language to ensure that the State Ethics Law is upheld and that bidding and other aspects of contracting are an open process.*

DISEASE PREVENTION & SCREENING EFFORTS

1. While laudable, the 'new' community preventive health efforts in maternal and child health and cancer education, screening and early detection do not address the number one killer in the Core Service area and South Carolina: *Heart Disease and Stroke.*
2. How was '10%' of the 'bottom line' arrived at? Why not more? What would the remaining 90% of the 'bottom line' be used for by this non-profit public benefit organization? *Clearly, an independent agency should administer this and other funds derived from the 'bottom line'.*
3. It is curious indeed that while funds for the prevention program are based on the 'profit margin' of the BR Alliance, its executive compensation levels will be based on 'gross revenues'.

EDUCATION AND RESEARCH

1. On the one hand, the Alliance intends to 'integrate research, training, information technology and academic medicine' but states in its lease agreements that it will only use its 'best efforts' to continue educational and research programs (so long as it promotes the *economic interest* of the Alliance). However, the tax exempt status of the organization is predicated on the assumption that the organization is organized and operated exclusively for charitable, educational and/or scientific purposes. In seeking to realign healthcare institutional arrangements to protect the quality and range of services currently offered, the proposed Alliance is curiously vague about its commitment to research and education. There is virtually no independent oversight for these activities (which HAVE heretofore been lucrative) and no percentage of the annual current or future bottom line is being committed to a reserve fund to protect research and education. It can be surmised that only those programs which promote the specific economic interests of the Alliance will be nurtured. It cannot, however, be assumed that the economic interests of the Alliance are synonymous with those of the community. In other words, as we enter an era of potential declining federal financing for education and

disproportionate agreements, the community loses the prerogative to influence the prioritization of a key element of the current mission statement of Richland Memorial Hospital - its only community teaching hospital.

2. Profits which have been realized from education in the past and present may not be available to protect it in the future. The hospital is the primary teaching hospital of the USC School of Medicine and is home to a number of graduate medical education and other allied health programs. Yet there is no role for the University of South Carolina on the System Board and the application for a Certificate of Public Advantage contains no clear commitments to DHEC and the Public on this issue. In reality, the Alliance can hold its affiliated institutions hostage.
3. *The COPA should contain a commitment to maintain current educational commitments for several years, while a set-aside fund (with DHEC, USC and Community oversight) should be created to protect education and research in the future. The pre-condition that commitments to education and research are contingent on economic interest should be deleted. Additionally, DHEC should consider sponsoring legislation that allows other area hospitals outside the Alliance the right to sponsor undergraduate and graduate medical education in order to allow competition - to the public advantage.*

RELATIONSHIP WITH EXISTING COMMUNITY SERVICES

1. The COPA should contain a commitment that the Alliance is not simply going to use its size, power and monopoly to compete with, eliminate and/or subsume existing community services. Proposed community health clinics and programs should be organized in collaboration with existing community facilities. *It is to the public's advantage to enhance current services without replacing them. Continuity of care and patient choice should be integral to all future proposed programs.*

QUALITY OF CARE

1. There is no clear commitment to define and follow set benchmarks for quality of care. Independent assessment of the evolution of the quality of community health over time is crucial. *Annual patient satisfaction surveys should be conducted by an independent organization and the results made available to DHEC for public dissemination. If the Alliance falls below a pre-agreed benchmark, its COPA should be withdrawn.*

PROJECTED COSTS OF INDIGENT CARE

1. The COPA application claims that costs of indigent care will be stable as a percentage of gross revenues from 1997-2001 even though the indigent population will increase. This claim on the part of the Alliance needs further clarification beyond what has been provided in the response to a November 21, 1996 DHEC query on the subject. *In particular, the Alliance should categorically declare whether indigent patients will be steered to obtain primary health care from non-physician providers thus creating a separate level of care within the system on the basis of economic status. If this is indeed the case, it would be a potential violation of JCAHO requirements and clearly would not be to the public's advantage.*

MARKET DOMINANCE

1. The issue of market monopoly remains a concern. The concern is not so much the current regional market share as is the potential gradient of market share expansion over time. The nature of the healthcare industry is fundamentally different from other sectors of the economy because supply has a way of driving demand rather than the reverse. The BR Alliance has a critical initial market mass. It will train many of its own physicians and combine hospitals, long-term care, home healthcare, community clinics and outpatient surgery facilities against a background of Alliance-owned physician practices, HMO and managed care patients. It will network with a chain of other hospitals, insurance companies and employers. *In summary, the BR Alliance will have a significant piece of most stages of the entire health system 'Food Chain'. Protected from Federal Antitrust laws, it will rapidly expand into a dominant force and within a few years, nearly everyone with a stake in the healthcare industry in the region will have to negotiate with the BR Alliance and its allies to stay in business, unless there is a forceful market response from a correspondingly (or even more) powerful organization or government intervention. It is not immediately apparent that this configuration is in the public interest.*

GOVERNMENTAL SUPERVISORY CAPABILITY

1. *DHEC should reassure the public that it has the political will, executive capacity and funds to independently oversee the activities of the Alliance and authenticate its reports in the future.*
2. *Should the Alliance grow beyond a critical threshold market size, (as determined by pre-agreed criteria), the government should automatically trigger a withdrawal of the COPA in order to allow federal antitrust statutes leeway to contain the organization.*

Julius Murray



January 20, 1997

Mr. Leon Frishman
Department of Health and
Environmental Control
2600 Bull Street
Columbia, S.C. 29203

RE: Baptist-Richland Alliance Certificate of
Public Advantage

Dear Mr. Frishman:

It is my understanding that in considering the Certificate of Public Advantage (COPA) for the Baptist-Richland Alliance, the Department of Health and Environmental Control allows for input from the public.

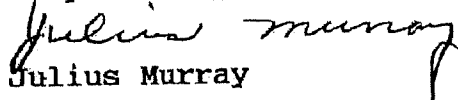
Thus, I request that a public hearing be held for input to facilitate this process. I have approximately ten concerned citizens who are interested in making statements germane to this matter who will take roughly five to ten minutes each. Obviously, any other individuals wishing to comment could follow.

In the interest of community involvement, I request that the hearing be held in one of the communities which can be affected by this endeavor and would suggest Eau Claire High School or if not possible, then the Bethlehem Community Center.

I would appreciate your answer and information concerning such a hearing as soon as feasible.

Thank you.

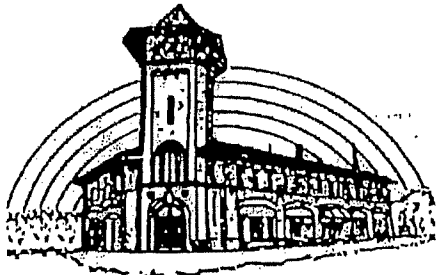
Respectfully,


Julius Murray

JAN 22 1997

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Eau Claire Community Council

INCORPORATED

P.O. Box 3431 - Eau Claire Station - Columbia, South Carolina 29230-3431

01-20-97

Council Officers

Mr. Scott Trent
President

Mr. Henry Bracey
President Elect

Ms. Lydia Griffith
1st Vice President

Mrs. Emily Cooper
2nd Vice President

Ms. Edith Fisher
Secretary

Mrs. Rosemary Bracey
Assistant Secretary

Mr. Tom Felder
Treasurer

Mr. Henry Hopkins
Executive Director

Newsletter

Ms. Becky Bailey
Editor-Publisher

Mr. Leon Frishman, COPA Document Director,
SCDHEC
2600 Bull St.
Columbia SC 29201

Dear Mr. Frishman,

As President of Eau Claire Community Council which is an organized, recognized 501C3 body, representing 22 organized neighborhoods in Eau Claire/North Columbia, I have just discovered a distressing fact about the proposed RMH/BMC merger.

While we as a Council have benefitted over the years from the support, services, and funds of both RMH & BMC the new proposed merger seems to create a problem in our neighborhood area. We as a Council do not wish to be seen as biting the hand that has helped us, but we feel we must address a concern that this new merger creates.

For in our community we have a very good medical entity in the form of the Eau Claire Cooperative Health Center. As a state employee when I need medical services I rely on ECCHC as other major medical services are just too expensive for me, or will not allow a payment plan that will help me as needed.

With the planned merger of RMH & BMC and the new entity's plans to compete directly with ECCHC not only in the Greenview/Fairwold area, but also in the Oak/Waverly area this is very distressing to us as a Council and we do not see this as being a public advantage.

As a Council we feel it would better serve the new RMH/BMC entity to concentrate its new medical delivery services in those areas of the metro county that are under served and not come into areas now being served by ECCHC as a direct competitor.

In fact the Council has hoped that as ECCHC became stronger as a medical service they would establish their own medical service center in the North Main St./Wilkes Rd. area so they could serve residents of not only Greenview/Fairwold, but Meadowlakes and Highlands.

We do not agree with the new entity's plans to build medical service facilities in the Greenview/Fairwold

JAN 22 1997

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and Oak/Waverly areas. As a Council we do not see the need to compete in those areas against ECCHC and cause it to cease to operate by removal of its client base. I also have some personal doubts as to the lowering of costs for those medical services for residents like myself and those residents in these areas.

I also know that the ECCHC had help with the construction of its Waverly Family Practice Center, and is now operating under guidelines and deed matters with BMC. I have some concern the new entity will threaten the continuation of services provided by ECCHC in that center, and if the new entity builds a second center in that area, will the new entity close the Waverly/Oak Center since it will have deed control of that center? I don't believe either action will be of public advantage!

This duplication of buildings and services by the new entity is a matter that needs to be explored further by you and all concerned bodies. Assistance and direct competition in what are developing target areas of service for ECCHC is what we need to work towards.

The Council and I also have some concerns about the fair sharing of the profit funds from the new entity. While I don't know about the percentages, I do believe that over the past years more help with those disproportionate share/medicaid funds would have provided better medical services to those under served areas.

Now that ECCHC is helping to do that(serve) in those areas, the new entity needs to look at supporting ECCHC and its client base, not destroying ECCHC as a medical service provider in those areas. The Council believes ECCHC is the logical choice for health care in those areas!

A final concern of ours is in the limited dental services in our Council area. One of the options we have looked at is the establishment of a dental cooperative like ECCHC. At the present time there are no community funds or groups to create such an organization with dental health care as its goal.

One of the outcomes we would like to see is the use of the merged entity's funds and commitment to help fund such a dental cooperative for under served populations.

Thus we as a Council would hope you and other concerned groups will take a serious look at all these issues. We are open to a discussion of these areas.

Sincerely,

Scott Trent Jr.

Scott Trent Jr, Pres-ECGC

Henry T. Hopkins

Henry T. Hopkins
Ex. Director-ECOC

cc:D. Bryant, SCDHEC

ECCHC

C. Beaman

K. Freeman

City Council

County Council

Richland County Legislative Delegation



STATE of SOUTH CAROLINA

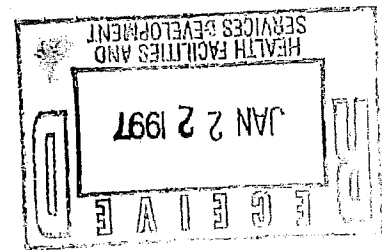
CHARLES MOLONY CONDON
ATTORNEY GENERAL

Office of the Attorney General
Columbia 29211

January 22, 1997

VIA FACSIMILE 737-7212 & HAND DELIVERED

Mr. Leon B. Frishman
Director, Health Facilities and Services Development
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, South Carolina 29201-1708



RE: Certificate of Public Advantage/Richland Memorial Hospital and Baptist Healthcare System of South Carolina, Inc.

Dear Mr. Frishman:

On December 23, 1996, you requested that my Office review, pursuant to your regulation number 6131, Health Care Cooperative Agreements, Section 305 and Section 44-7-50 of the South Carolina Code, the completed application for Certificate of Public Advantage submitted by Baptist Healthcare System of South Carolina, Inc. and Richard Memorial Hospital. During the weeks following our receipt of your letter we have had several meetings with the applicants and have been impressed with their efforts to establish long-term benefits for the community in several areas. Clearly, they have expended great efforts to bring about this merger, and in many regards it appears to serve the interests of the citizens of the midlands of South Carolina. Particularly in light of current developments in the area of healthcare, and the continuing trend in which local facilities are being bought out by large national healthcare organizations.

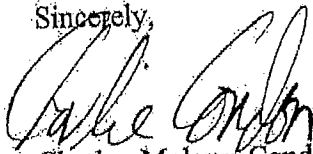
I realize that your department has done yeoman's work in examining the proposal offered by these parties. Additionally, my Office has engaged the assistance of consultants with expertise in this area to review the transaction. The attachment to this letter itemizes the areas of concern that have been brought to my attention. Therefore, in keeping with my obligation under the statutory and regulatory law regarding these types of transactions, I would advise DHEC to resolve the issues raised in the attachment prior to making a final approval in reference to this merger.

Mr. Leon B. Frishman
January 22, 1997
Page 2

As you can see, resolving these concerns would only serve to better promote the welfare and interests of the citizens of the midlands and I am sure that is a concern shared by all of the parties involved.

Again, I appreciate the massive amount of work performed by your department and agency in examining this merger. You have certainly been of great assistance to this Office and my staff, and I hope that if we can return the favor, you will not hesitate to call on me.

Sincerely,



Charles Molony Condon
Attorney General

CMC/mfw

EXECUTIVE SUMMARY

A summary of the issues follows:

1. The proposed consolidation of Baptist Healthcare System of South Carolina, Inc. (Baptist) and Richland Memorial Hospital (Richland) will significantly increase the market concentration for hospital inpatient services in the Columbia area.
 - a. The seven-county service area defined in the application appears overly broad in light of the market share and patient origin information received from the South Carolina Budget and Control Board. Even under this market definition, however, under the Federal Merger Antitrust guidelines, this market would be considered moderately concentrated and experience a significant increase in concentration as a result of this transaction.
 - b. Narrowing the market to those counties in which Columbia area hospitals receive the vast majority of their patients and in which they have a meaningful market share, would reduce the service area to five counties (Orangeburg and Sumter would be removed). The pre- and post-merger levels of market concentration.
2. The application discusses a number of "benefits" to the community as a result of the proposed joint operating agreement, but these benefits are not well-defined. Specifically, these relate to efficiencies (cost savings), price reductions, and outreach and public health programs. However, the commitments are vague and will be difficult for DHEC to monitor.
3. The application expresses a strong commitment to indigent care, but the financial projections in the application do not demonstrate that this commitment will at least maintain current levels of care. Economic access is particularly important in this transaction since Richland is a public hospital and the largest provider of indigent care services in the area.
4. The application does not clearly address the impact of the transaction on the teaching and research programs at Richland. Richland serves an important role as the primary clinical site for the University of South Carolina Medical School; however, no specific commitments regarding teaching and research were included in this application.

5. The uncertainty regarding all of these issues is underscored by the fact that the mission statement for the new organization has not been finalized or received by DHEC.
6. The application does not address the impact of the transaction on smaller rural hospitals, which are the principal source of inpatient care for service area residents outside of Richland and Lexington Counties.
7. Because the parties have indicated that the Alliance will make a Federal Hart-Scott-Rodino filing, the Attorney General is of the opinion that the present application will be intensely scrutinized.

FAX TRANSMITTAL SHEET

YOUNG, CLEMENT, RIVERS & TISDALE, LLP
28 Broad Street
Charleston, South Carolina 29401

Post Office Box 993
Charleston, South Carolina 29402

FAX NUMBER: (803) 724-6600

FOR IMMEDIATE DELIVERY TO:

NAME: Leon B. Frishman, Director
COMPANY: DHEC, Health Facilities & Service Dev.
CITY/STATE: Columbia, SC
FAX NUMBER: (803) 737-7212

FROM:

NAME: MICHAEL A. MOLONY (803) 724-6631

TOTAL NUMBER OF PAGES (INCLUDING THIS SHEET): 4

TODAY'S DATE: Jan 22, 1997 TIME TRANSMITTED: _____

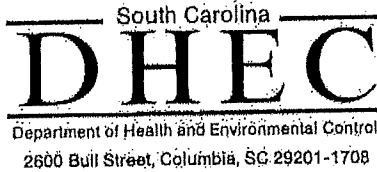
COMMENTS: Letter with attachment follows -

The information contained in this transmission is privileged and confidential. It is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.

IF THERE ARE ANY QUESTIONS OR PROBLEMS WITH THE TRANSMISSION OF THIS FACSIMILE, PLEASE CALL (803) 577-4000, EXTENSION 275.

INTER-OFFICE ONLY

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Board: John H. Burriess, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leake, Jr., Secretary

Promoting Health, Protecting the Environment

Richard E. Jabbour, DDS
Cyndi C. Mosteller
Brian K. Smith
Rodney L. Grandy

February 4, 1997

Ms. Debra Brown
U.S.C. School of Medicine
Department of Pathology
6439 Garners Ferry Road
Columbia, South Carolina 29202

Dear Ms. Brown:

This is in response to your telephone inquiry regarding a public hearing this office will be conducting on March 10, 1997. The hearing is scheduled to begin at 1:30 P.M. in the Peoples Auditorium, at the Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina. The purpose of the public hearing is to solicit public comment and input into the Department's decision as to whether or not a Certificate of Public Advantage ought to be issued for Richland Memorial Hospital and Baptist Medical Center to form a joint operating entity. The overriding issue is whether the benefits of the proposed merger outweigh the disadvantages caused by their potential adverse effects on competition.

I hope this information is useful to you. Anyone who has information they would like to share with the Department is welcome to present their information at the public hearing or they may submit written information to me. It would be helpful to the Department if written information could be provided by March 10, 1997. If you have any questions, do not hesitate to contact me at 737-7200.

Sincerely,

Leon B. Frishman, Director
Health Facilities and Services Development

THE STATE-RECORD CO., INC.

Columbia, South Carolina

publisher of

The State

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

Personally appeared before me ~~Marilyn Shull, Classified Inside Sales Manager~~

of THE STATE, and makes oath that the advertisement,

Public Notice - (COPA) Baptist Healthcare System of South Carolina Inc
and Richland Memorial Hospital.

was inserted in THE STATE, a daily newspaper of general circulation published in
City of Columbia, State and County aforesaid, in the issues of

February 3, 4, 5, 1997

Marilyn Shull

Subscribed and sworn to before me

this 10th day of February 19 97.

Evelyn F. Heffernan

Notary Public

My Commission Expires May 5, 2003

"Errors - the liability of the publisher on account of errors in or omissions from any advertisement will in no way exceed the amount of the charge for the space occupied by the item in error, and then only for the first incorrect insertion."

PUBLIC NOTICE

The Bureau of Health Facilities and Services Development, South Carolina Department of Health and Environmental Control, will conduct a Public Hearing regarding an application for a Certificate of Public Advantage (COPA) submitted by the Parties, Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital, Columbia, South Carolina. The application requests approval for the incorporation of a non-profit entity to operate the hospitals of the Parties as a single unit, where the Parties will develop, implement and fund new initiatives to improve public health and a community outreach program, and to expand the counseling centers of the Pastoral Institute. The Public Hearing will be held in Peoples Auditorium located on the Third Floor of the Sims Building, 2800 Bull Street, Columbia, South Carolina on Monday, March 10, 1997, at 1:30 PM. The public is cordially invited to attend, and an opportunity shall be provided for any person to present information. No decision shall be made at the hearing, but the Department shall make a decision within 60 days from the date of this Public Hearing, which will be by May 8, 1997. Comments on the COPA application are solicited and may be presented at the Public Hearing or in writing until 5:00 P.M. on March 10, 1997, to Mr. Leon B. Frishman, Director, Bureau of Health Facilities and Services Development, South Carolina Department of Health and Environmental Control, 2800 Bull Street, Columbia, SC 29201.

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SCANA Corporation
Columbia, SC 29218
(803) 748-3030

Cathy B. Novinger
Senior Vice President
Administration,
Governmental and
Public Affairs

March 3, 1997

Mr. Leon Frishman
COPA Document Direct
SCDHEC
2600 Bull St.
Columbia, SC 29201

Dear Mr. Frishman:

As chairperson of the Baptist Medical Center Foundation Board and as a senior officer of a major area corporation that employs some 4,500 health care users, I would like to take this opportunity to express my support of the proposed alliance (the Alliance) between Baptist Healthcare System (BHS) and Richland Memorial Hospital (RMH). In light of the fact that a public hearing pertaining to this issue is scheduled for March 10, I wanted to express my support in writing.

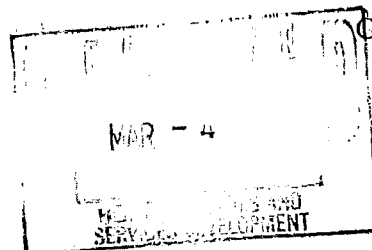
A consolidation of these two outstanding healthcare systems would be a cost effective "joint venture" that would, in the long term, pass savings on to the citizens of our community. This would be accomplished through such measures as cost reductions in capital expenditures, operating costs, etc. while enhancing the overall efficiency and effectiveness of the quality of care provided. The community would reap the positive impact of a price freeze over the next five years, new health care programs that would be funded, and indigent care funding.

In addition to the above mentioned benefits the Alliance would bring to our community, there is the issue of ACCOUNTABILITY. This Alliance would afford our area citizens the opportunity to hold the Alliance accountable to its promises and its performance, as well as the management of funds, i.e. any profits made by the Alliance would be allocated to assist and improve local health care needs.

I urge you to keep in mind the many benefits consolidating the services of the Baptist Hospital System and Richland Memorial Hospital would bring to the Columbia area, and ask you to commit your support to the proposed Alliance.

Sincerely,

Cathy B. Novinger



1121



National Youth Sports Program (NYSP)
Dr. A. A. Neal, Project Administrator

HEALTH PROMOTION AND EDUCATION
SCHOOL OF PUBLIC HEALTH

Mr. Leon Frishman
Dept. of Health & Environ. Control
2600 Bull Street
Columbia, SC 29201

Dear Mr. Frishman:

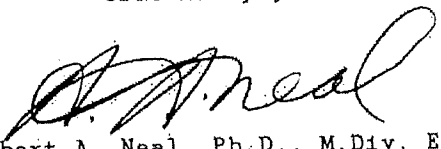
This is just a quick note to express my concerns regarding the pending merger of Baptist and Richland Memorial Hospitals, for the following reasons:

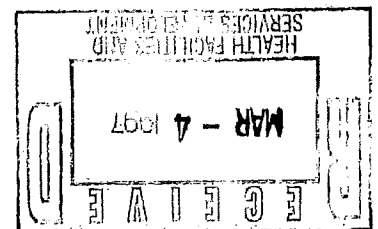
- o Indigent care - since the alliance of the two hospital have stated that they have to make a stated profit in the form of cost savings, ect.
- o The market place mentality indicate that \$5,000,000 dollars in profit is not enough.
- o The community need, in writing, in the operating document of the Alliance, that the profit motive, and the 'bottom line,' will not be the overriding consideration.
- o Physicians need to have an adequate voice in the governance of the system.
- o Executive system need to have an equal representation from the public, patients, and physicians.

These issues are being discussed in my circle of Columbia, by all affected parties and deserve your immediate attention.

With kindest personal regards and best wishes, I remain . . .

Gratefully yours,


Albert A. Neal, Ph.D., M.Div. Ed.D.
Clinical Assistant Professor
Project Administrator of NYSP



NationsBank
Personnel Division
P. O. Box 448
Columbia, SC 29202-0448

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al

NationsBank

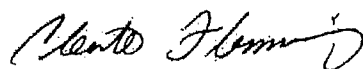
Mr. Leon B. Frishman, Director
Health Facilities and Services
South Carolina Department of
Health and Environmental Control
Heritage Building, 2nd Floor
1777 St. Julian Place
Columbia, SC 29204

Dear Mr. Frishman:

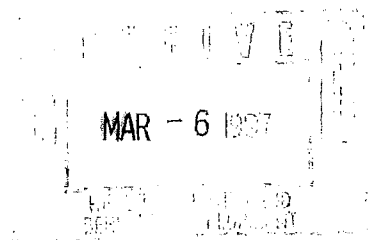
As the Carolinas Personnel Executive for a corporation that has self insured healthcare and approximately 1,000 employees in the Midlands area, we indeed support the Alliance between the Baptist Healthcare System and Richland Memorial Hospital. The Alliance will enable hospitals to avoid unnecessary duplication of facilities that drives up the cost of healthcare for all taxpayers. The Alliance has pledged 10% of the annual bottomline to fund healthcare initiatives, such as the Cancer Program, Maternal and Child Health Program and the Community Outreach Program. The entire community will benefit from this type of commitment. Furthermore, a commitment was made not to increase rates for five years. Above all, employees of both organizations will not lose their jobs as a result of the Alliance and many of the medical staffs will retain all rights and privileges they currently have. The Alliance will be maintained by local control and will also be a community based non-profit healthcare system with the possibility of saving \$71MM in the first five years, which will, once again, benefit our community outreach programs.

I will be out of town on March 10 and unable to attend the hearing in person. Therefore, I request that this letter be presented during the public hearing, if possible. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,



Clente Flemming
Senior Vice President



ROSTER OF ATTENDANCE FOR PUBLIC HEARING

MARCH 10, 1997

CERTIFICATE OF PUBLIC ADVANTAGE

RICHLAND MEMORIAL HOSPITAL

AND

BAPTIST HEALTHCARE SYSTEM OF S.C., INC.

1189

NAME	REPRESENTING
Frank Byrd	RMH
Ruby Ward	RMH
William Tucker	Standish Area - Gyermek Neighborhood Org.
Sandra H. Glover	USC - School of Public Health
Robert A. Powell	Cola
Bob Higgins	RMH
Samela Byrd-Reed	RMH
James Buskins	RMH
Gene Turner	RMH
James Raymond	RMH
Brian Jones	RMH
Dale Pfl	RMH
Mary Clarkson	BH &
Sindy Bear	RMH
Kendy Buchanan	RMH
Charles Welch	CPH
Michael A. Morales	Mt Elon Baptist Church
Shirley Davis	Family Connection
Sheila Marshall	USC College of S&H / Bethel A.M.E. Church
Tom Kleinhaus	RMH Admin.
Oliver Odell	RMH CH
BOB MORSE	RMH
Scott Duncan	RMH
Louise Benson	Cola.

NAME	REPRESENTING
Tom Brown	Richland Community Health Partners
Wayne Phillips	BMC
Oliver Stephens	Board member
Michael Matkiewicz	Center for Cancer Treatment & Research
Debra D. Seale	CCTR / RMH
Sharon Mann	HomeCare Resources / Baptist Med
Ron Carrou	Baptist Med Ctr
Jennifer Brown	RMH
Julie L. Lawrence	RMH
Ken Porter	RMH
Don Beardsley	RMH
Sandra Sawyer	
Carol Adams	RMH
Gay Helton	
David Hood	RMH
Dr. R. Hudson	RMH
Wesley Richardson	
Ernest Best	
Robert L. Waldron II	RMH Trustee
Stan McConkey	BMC
Christine A. Bittel	McNair Law Firm
Mary Charnan	RMH
Al Adams	RMH
Kevin Ballance	BMC

NAME	REPRESENTING
Felice Lempert Charles Cobb	Planned Parenthood CBNA
Lewis Burns	
~~DATA OFF~~ MARJORIE BARNARD	NBA
Julius Murray	Self
~~DATA OFF~~ Tom Duggan	The Women's Shelter Self
Joseph Kinney	NASU
The Women's Shelter	Kathy Kelly
Kay Harwood	RAH
Roe Harts	Colonial Life
Earl B. Kerlan	Retirees of First Colony
John Gross	Rockland Memorial Foundation
Maie Hinder	
Janet Rose	BMC
Barbara Singer	Kieper Group
Tom Bolt	BMC
Henry T. Hopkin	ECC
Steve Benjamin	
Sylvester Coleman	Coleman Group
Alma Williams	MMH Palmetto Senior Care
Harry Ward	MMH Children's Hospital
John Snyder	ECCHC
Clement Agbata	ECCHC
Kathy Howell	Baptist Medical Center

NAME	REPRESENTING
Herman Walker	Lil Bauman
James Taylor	Queen Kenty
~~Randy~~	
~~Robert~~	
Charles Walker	
Shirley Long	
Indie John	
Wanda Taylor	
Bill Cogdill	
LEWIS J. WALLACE	
JAMES C. REYNOLDS, M.D.	
Gwendolyn Gibson	
Jessie Wilson, R	
Joan Lawrence	
Wally	
Paul Davis	
Joseph R. C.	
Robert H. SPRETT	
Gary B. J.	
Gladys Fair	
Sylvia Swinton	
John Hays	
Wally	

NAME	REPRESENTING
Julie Marchant	
Esther Welch	
Bernice Felson	
DEBBY CHAMBLEE	CCTR Board member
Albert E. Cremer MD	Retired Surgeon Gen
Hubert H. Williams Jr.	
Tammy Wallace	
Jamie Lynn Suber	
Rita H. Kasper MD	
James H. Wright	
James B. Blyard	
Virginia Vincent	
Robert L. Smith MD	
Cleopatra White	
Daren Hamilton	RAH
Bryson Cooper	RMT
Ken Kirk	RMT
Mark Kuts	Epstein, Balin & Green, P.C.
V. P. Pinner	Community
B. S. W. H. S.	Doctors Care
Dynda Kessler	RMT
Thomas Smith	BMCC
TRIP GREGORY	BMC

NAME	REPRESENTING
Paul L. Ross	Community (self)
S. Catalano	Network (Medley)
Kay COVER	Midlands Community
Fotena Squirewell	Columbia Housing Authority
Carolee Sengler	BMC
Rachel Hill	BMC
Linda Silver	BMC
Bernice C. Bynum	BMC
Chuck Hunter	RmH
Lucile Adams	RmH
Nydia Harter	RmH
Reed Taylor	RmH
Harvey Alexander	
Sue Ann Warren	RmH
Don Fenech	RmH
Oliver Tinsley	DHEC
Leah Anderson	Minister Church
William J. Wilson	AME Church
Ronald W. Lindberg	BMC
Leola Lewis	RmH
Gene Smith	RmH
Oliver Langston	RmH
Leola B. Blakely	AME Church

NAME	REPRESENTING
Lynn Bailey	Lynn Bailey Assoc.
Alexander G. Donald	BOARD RMH
Chris Wanket	Self
James H. Gamm	Staff RMH
Liz Fawcett	Self
John G. Gamm	Self
Tom O'Leary	RMH
Wallace Brown Jr.	Richland Community Health Care Assoc
Debbie P. Smith	Midlands AHEC - RMH
Janet Henry	AHEC
George E. Spencer	Columbia Medical Society
Greg Galtman	RMH
Angie Fisher	RMH
Donna Spagnola	RMH
David Jones	POMCC
Quinn McChesley	RMH
Agnes Johnson	RMH
Karen Lemay	RMH
Jan S. S. S. S.	RMH
Anthony J. S.	Health South
Lesley S.	USC SOM
Shelly Magee	PHIS
Jim Sheffield	

NAME	REPRESENTING
Mike Fath	OP - DHEC
Joe Papp	Columbia Minniford's Alliance
Ray Allen	S.C. SENATE
R. L. WISD	MEDLANDS One Day
Ken Huger MD	B M C C
Reggie Turner	Palmetto Senior Care
Rena Vandalak	Palmetto Health Dist (prev)
Maria Cannon	Earl Clair Health Coop
Eme Boz	Palmetto Health District
Keller Kelly	Baptist Medical Center
Joe Galt	Baptist
Dottie Murray	American Home Patient
Benita Jeff	Earl Clair Cooperative Health
Scott Trent	Earl Clair Community Council
Henry Hopkins	Earl Clair " "
Delores C. Washington	The Makanyan Tree
Lathan Woodard	S.C. Primary Care
Marilyn Donat	School AS The Center of Community ^{S.C.C.P.}
DERRICK JACKSON	Community
C. S. M. James	North Coll. Devel. Club
W. K. Cullen MD	Board B-R Alliance
John M. Bown	Self
Walter James	Self
Cara Ferguson	Big Brothers/Big Sisters

NAME	REPRESENTING
Nicole Spain	Big Brothers / Big Sisters
Darren J. Damon	Big Brothers / Big Sisters
Shelley B. Rife	Dexington Medical Center
Charlene Catzcart	Richland Memorial Hospital
Sue Hagan Shumers	Richland Memorial Hospital
Kathy Cousins	Richland Memorial Hospital
James R. DAVIS	Personal Interest & Tax payers
Dr. Rose Sicking	" "
Alice Holison	Baptist Medical Center
Harriet Fehr-	Carolina Home Therapies
Peggy Schwartz	Carolina Home Therapies
Sue Berkowitz	S.C. Legal Services Association
Karen A. Bickley	Baptist Medical Center
~~James M. O'Leary~~	Self
Carole Keeney	Richland Memorial Center
Margaret W. Crawford	Alliance for SC's Children
Star Reedy	Baptist Medical Center
Vicki Corp	College Park United Methodist Ch.; Earle R. Hahn
Bob Dyer	1208 WINTERWOOD RD COVINGTON, SC
Nancy Smith	RMH
Stephen Floyd	BMCC
Orlando B. S. S. S.	ICUSC
Flora Hays	RMH Children's Hospital
Ardis Mims	RMH

Commissioner: Douglas E. Bryant

Board: John H. Burris, Chairman
William M. Hull, Jr., MD, Vice Chairman
Roger Leaks, Jr., Secretary

Promoting Health, Protecting the Environment

Richard E. Jabbour, DDS
Cyndi O. Mosteller
Brian K. Smith
Rodney L. Grandy

March 12, 1997

The Honorable Charles M. Condon
Attorney General of South Carolina
PO Box 11549
Columbia, South Carolina 29211

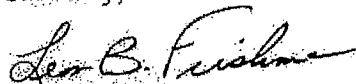
Dear Mr. Condon:

Enclosed for your information is additional information that has been provided to this office by The BR System, a proposed merger of Richland Memorial Hospital and Baptist Healthcare System of South Carolina. They are entitled as follows: 1. Response of Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital to Rubenstein Request for Public Hearing; and 2. Supplemental Documentation Submitted by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital in Support of the Application for Certificate of Public Advantage.

The second submission's third section is entitled "Response to Attorney General Issues". This is to request your advice as to whether or not all of this additional information that has been submitted satisfies your concerns that you pointed out in your recommendation to this Department. Because this agency must make a decision in the near future, please respond as soon as possible.

If you have any questions regarding this letter, do not hesitate to contact Mr. Joel Grice or myself at 737-7200.

Sincerely,



Leon B. Frishman, Director
Health Facilities and Services Development

LBF

Enclosures

1203



2720 Sunset Boulevard
West Columbia, SC 29169
803-791-2000

April 29, 1997

Mr. Leon B. Frishman, Director
Bureau of Health Facilities
and Service Development
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, SC 29201

RE: COPA/Baptist-Richland Merger

Dear Mr. Frishman:

As you and I discussed recently on the phone, Lexington Medical Center (LMC) desires to provide input into the Certificate of Public Advantage (COPA) requested by Baptist Medical Center (Baptist) and Richland Memorial Hospital (Richland). Our understanding is that the COPA would set forth conditions under which the hospital operations would be conducted by the new entity which would operate Baptist and Richland.

In order to preserve competition in the marketplace, it is crucial that the COPA sought by Baptist and Richland preserve the ability of LMC and other providers to remain competitors in the market. The comments set forth in this letter suggest some modest conditions we feel are necessary to help preserve the ability of LMC and other providers to compete with the consolidated operations of Baptist and Richland. LMC requests the inclusion of these conditions in the COPA in order to promote competition.

As you know Baptist and Richland together enjoy a dominant market share of hospital services in Richland/Lexington counties of approximately 65-70 percent. The consolidation of Baptist and Richland creates tremendous market concentration and clout. Thus, we feel that certain conditions are necessary and appropriate. In particular, LMC requests that the Richland-Baptist COPA include, among other conditions that might be imposed by the State, the following conditions:

Mr. Leon B. Frishman

April 29, 1997

Page 2

1. The COPA should provide that neither Baptist nor Richland, nor their affiliates, nor any health maintenance organization, integrated delivery system or physician practice that is "captive" of Richland-Baptist, may enter into exclusive agreements with third party payers. By "exclusive," we mean a contract which by its terms precludes other hospitals in the Columbia area from contracting with the third party payers. It is essential that LMC and other providers be able to compete for all third party payer contracts. It will be up to the third party payers to determine whether LMC or others are competitive. Baptist-Richland, however, should not be permitted to contract with any payer on the basis of being the only hospitals in the Columbia market that contract with the payer. If Baptist-Richland are the only hospitals selected, that decision should be the unilateral decision of the payers, and not be required under any contract with Baptist-Richland. This condition protects the ability of other providers to compete for third party payer business in the Columbia area.
2. The COPA should provide that neither Baptist nor Richland nor their affiliates may enter into exclusive contracts with suppliers, vendors or group purchasing organizations that preclude or limit such suppliers', vendors' or group purchasing organizations' abilities to contract with other entities. By "exclusive," we mean any contract which by its terms would preclude LMC and other providers in the Columbia area from contracting with the suppliers, vendors or group purchasing entities. It is essential that LMC and other providers have the same ability to contract with suppliers, vendors and group purchasing organizations as Baptist-Richland. Baptist-Richland should not ask for or be granted any special franchise or exclusive arrangement with such entities. LMC and other providers should be able to negotiate terms that are competitive with terms offered to Baptist-Richland in the acquisition of goods and services necessary to provide health care to the public.
3. In a managed care environment, it is essential that other hospitals in the area have access to the tertiary care and other essential facilities of Baptist-Richland on a basis which permits those hospitals to compete with Baptist-Richland. Thus, the COPA should require that Baptist-Richland and their affiliates make available to other hospitals in the Columbia area their tertiary care services and other essential facilities, at a cost equal to the average charges of Baptist-Richland to health maintenance organizations and other managed care entities. This condition is necessary to preserve other hospitals' abilities to compete by offering a full range of services to patients.

With the proliferation of mergers in the health care industry, regulators must carefully guard against changes that will be detrimental to the quality of services offered to patients. Competition among providers is a key factor in the preservation of quality services to patients. Further, of course, competition results in lower prices for those services. We ask that you subject the

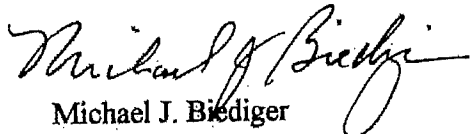
Mr. Leon B. Frishman
April 29, 1997
Page 3

Baptist-Richland COPA to the three conditions described above, to maintain competition in the Columbia area, and with it quality of services to patients and price sensitivity.

As you know, we have a great deal of respect for the honesty and integrity of the executive leadership at both Baptist and Richland. From all that we have heard, the intentions of the current leadership is not inconsistent with the three conditions suggested above. As you know, however, from time to time the leaders (whether Board or executive) of our organizations change. Therefore, we feel that the conditions presented above should be incorporated into the COPA so that the good intentions of the COPA be ensured.

If you would like to discuss any of these issues, please call me at 791-2109.

Sincerely,



Michael J. Biediger
President and CEO

CSS



2600 Bull Street
Columbia, SC 29201-1708

May 8, 1997

CERTIFIED MAIL

Mr. Charles D. Beaman, Jr., President
Baptist Healthcare System of South Carolina, Inc.
Taylor at Marion Street
Columbia, South Carolina 29220

Mr. Kester S. Freeman, Jr., Chief Executive Officer
Richland Memorial Hospital
Five Richland Medical Park
Columbia, South Carolina 29203

Re: Certificate of Public Advantage
BR Health System, Inc.
Columbia, South Carolina

Dear Messrs. Beaman and Freeman:

Pursuant to Section 307 of Regulation No. 61-31, Health Care Cooperative Agreements, this is to advise that it is the decision of this Department that a Certificate of Public Advantage be issued to BR Health System, Inc. (the System) for the incorporation of a nonprofit entity to operate the hospitals of the Sponsoring Organizations as a single unit, where the Sponsoring Organizations will develop, implement, and find new initiatives to improve public health and community outreach programs, and to expand the counseling centers of the Pastoral Institute. The Sponsoring Organizations include (1) Baptist Healthcare System of South Carolina, Inc., Columbia and Easley, South Carolina and (2) Richland Memorial Hospital, Columbia, South Carolina.

The decision to approve the Certificate of Public Advantage is based on the following reasons:

- (1) The Department has determined that the applicant has demonstrated that the likely benefits resulting from the cooperative agreement outweigh the likely disadvantages from the cooperative agreement; and

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Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 2

- (2) The Department has determined that the reduction in competition likely to result from the cooperative agreement is reasonably necessary to obtain the benefits likely to result.

The Department's decision to approve the Certificate of Public Advantage is made subject to the following conditions pursuant to Section 312 of Regulation 61-31, Health Care Cooperative Agreements:

1. That the System will provide an annual report to the Department, which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial statements; information which will enable the Department to evaluate each of the conditions listed below; and any additional information the Department feels is necessary to adequately evaluate the compliance of the Certificate of Public Advantage. This annual report is due to the Department no later than 120 days after the end of each fiscal year after the System's Joint Operating Agreement is consummated.
2. That the System will provide 10% of its "excess revenues over expenses" to fund public health initiatives and community outreach programs; and the System will provide no less than fifteen million dollars to be allocated over the first five years of the System's existence. This 10% or \$15 million, whichever is greater, will be over and above the current annual effort of \$3,370,700 for cancer and maternal and child health efforts and any current fiscal year expenditures for other community health benefits. However, in addition to maternal and child health and cancer programs, the fifteen million additional dollars may be used for other approved community benefits. Any efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits /changes/ accomplishments that occur because of the activities /services provided by the program and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive these services without the Certificate of Public Advantage.
3. That as a part of the information required in Condition Number 1, the System will report on the nature, source and amount of operational savings and depreciation and interest expense reductions from the capital expenditures avoided during the preceding fiscal year. Costs used to document the above savings must be merger specific, that is, savings that occurred because of the merger and not savings that would have been realized even if the merger had not occurred.
4. That the System, as a part of the information required in Condition Number 1, will provide a revised five year budget projection based on the independently audited financial report.

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 3

5. If seventy one million dollars in operational savings and capital cost avoidance is not achieved after five years, that the System will transfer to the public health initiatives budget an amount equal to the difference between the actual amount of operational savings and capital costs avoided during the first five years and 71 million dollars. Should indigent /charity care substantially exceed the average indigent/charity care provided by the parties in FY95 and FY96, the System may request the Department to review this condition to determine the necessity of an adjustment.

6. That the System will provide medically necessary services to individuals regardless of their ability to pay. Because of this commitment, the System will continue to provide one level of care to patients regardless of their ability to pay. This commitment is absolute, predicated on no assumptions, and unconditional. The System will identify the amount of indigent/charity care provided during the fiscal year as part of the information required by Condition Number 1.

7. That the System will adjust its charges to non-governmental payers for the first five years, so that after adjustments for changes to the medical consumer price index (Southeast region or the South Carolina medical consumer price index, whichever is lower), new services, and governmentally imposed requirements, the System will not realize a higher case mix adjusted net inpatient revenue from non-governmental payers per admission than that realized by Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital in combination in 1995.

8. That the System will reduce its gross charges to all payers during each of the first five years of the operation of the System. The System will report, as part of the information required in Condition Number 1, any rate changes (increase or decrease, inpatient or outpatient) to the Department in enough detail to assure the Department that any growth in gross revenue over the five year period is due strictly to changes in patient volume.

9. As part of the information provided in Condition Number 1, the System will report its prospective plans for changes of clinical services between the Sponsoring Organizations' facilities for the upcoming year. That the System, prior to changing, will receive approval from the Department of the change. The changes required to be reported are any consolidations, mergers, deletions, or other change or alteration of clinical services that may significantly affect patients' access to care; or medical, graduate medical, and allied health education program's access to the clinical service.

10. That the System will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 4

competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, the System will give them terms and conditions no less favorable than that covering state employees who have selected the standard non-HMO coverage that is in effect at the time the competing licensed facility requests access to a service. That the System will continue this access for which it is the sole provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable.

11. That the System's mission statement will be substantially similar to the existing mission statements of the Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital.

12. That the System will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Richland Memorial Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one Sponsoring Organization's facility, (as provided for in Condition Number 9 above) that medical, graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.

13. That should the System change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, that the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.

14. That as part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied will be used to calculate net of revenues over expenses in the annual report for determining the 10% public health commitment and that such financial statements will be certified by an independent auditor.

15. That neither the System, nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is not competitive. However, it must be the decision of the payer and not be required as a condition of a contract with the System or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 5

16. That the System shall not enter into an exclusive arrangement which will preclude non-employee physicians, payers, or ancillary care providers from entering into contractual arrangements with other facilities and providers. Additionally, the System shall not enter into a new exclusive arrangement with a sole provider of any service in the core service area for the System without prior approval from the Department.

17. That neither the System, nor their affiliates, will enter into contracts with suppliers, vendors, or group purchasing organizations that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the Sponsoring Organizations.

18. That the Department will reevaluate the terms and conditions of this approval in regard to the 10% public health commitment and other community benefits in the aggregate should "[r]evenue and gains in excess of expenses and losses" as a percent of gross revenue escalate or decline (1) to a point where the System's commitment to public health and other community benefits becomes unbalanced as it relates to the System's profitability or (2) to a point where there is little or no commitment to public health or other community benefits.

19. That the Department, as necessary, will compare cost and other indices (such as cost per adjusted patient discharge) for the System to that of similar facilities to measure the efficiency and effectiveness of this alliance.

20. That the Department may amend these conditions to include, but not limited to, lowering prices (1) should the parties not achieve their efficiency goals; (2) should price, as measured in "revenue per stay" (or other measure that may be appropriate), in South Carolina be falling significantly, signaling that to hold prices to pre-Joint Operating Agreement level plus inflation has been too generous compared to what the competitive outcome would have been; or (3) should unexpected events lead to abnormally high margins, such as unexpectedly high disproportionate share payments being received.

21. That the System will provide to the Department copies of all managed care contracts in effect during the last year, within 45 days of the closing of the Joint Operating Agreement. In addition, as a part of the information required in Condition Number 1, the System will provide all existing managed care contracts to the Department. This information will be considered propriety and not subject to disclosure.

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 6

22. That at the end of the first full year following the merger, the System will provide a comprehensive and specific plan, acceptable to the Department, for reaching merger specific efficiencies of at least four percent of cost, adjusted for volume.

23. That the System will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require the System to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will as a part of its ongoing monitoring process investigate consistent complaints from employers and managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

24. That the System will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.

25. That the System will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring this approval.

The proposed decision becomes the final agency decision fifteen (15) days after receipt of this notice by the applicant unless an administrative appeal is commenced pursuant to Section 311 of Regulation No. 61-31, Health Care Cooperative Agreements, and the Administrative Procedures Act. An appeal may be submitted by any affected person or the applicant, within this fifteen (15) day period, which gives notice in writing that the person is desirous of an administrative appeal. Should this be the case, the affected person/applicant should submit the original request to the following:

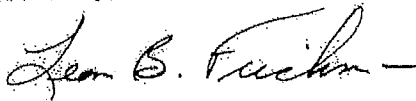
The Board of Health and Environmental Control
Attention: Clerk of the Board
Office of the Commissioner
2600 Bull Street
Columbia, South Carolina 29201

Mr. Charles D. Beaman, Jr.
Mr. Kester S. Freeman, Jr.
May 8, 1997
Page 7

A copy of the correspondence must be forwarded to the Director of the Bureau of Health Facilities and Services Development. Should there be no request for appeal within the fifteen (15) day period, this decision will be final.

If you have any questions, please feel free to contact us at (803) 737-7200.

Sincerely,



Leon B. Frishman, Director
Bureau of Health Facilities and
Services Development

LBF:JCG:mwf

cc: The Honorable Charles M. Condon
Mr. Robert Armistead
Mr. Mark Ballew
Mr. Marty Bridges
Dr. Stuart A. Hamilton
Mr. Henry T. Hopkins
Mr. Julius Murray
Colonel Morris B. Rubenstein
Mr. Scott W. Trent, Jr.

May 9, 1997

MEMORANDUM

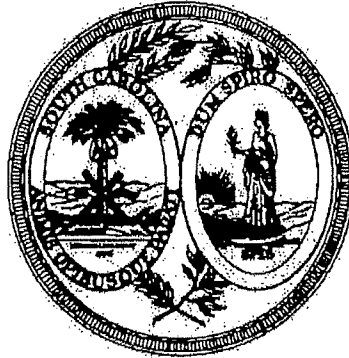
TO: File

FROM: Leon B. Frishman, Director
Health facilities and Services Development

Re: Attorney General's response to my letter to him dated March 12, 1997

I met with Mr. Mike Molony and Ms. Cheryl Bullard on May 8, 1997 in the DHEC Board Room at 2:00 P.M. I gave Mr. Molony a copy of our letter approving the Certificate of Public Advantage for the BR System. We went through each condition and Mr. Molony asked numerous questions about the conditions. He explained that he needed to be able to assure the Attorney General that the Department had satisfied the Attorney General's concerns, particularly by placing conditions on the approval that would address his concerns. After approximately forty five minutes of answering Mr. Molony's questions he asked if he could fax the letter to his consultant and the Attorney General. Ms. Bullard stated that we could not release the letter until the applicants were notified. Mr. Molony then called his consultant and talked to him for approximately ten minutes. Mr. Molony then told me that he was satisfied with the decision and that he would fax a draft letter to the Attorney General's office for his approval that would support the Department's decision. Mr. Molony then stated that he would have the signed letter back to us by Friday, May 9, 1997. We explained that it was our intention to release the letter to the applicants and the press this afternoon. Mr. Molony then called the Attorney General's office. Upon hanging up the phone, Mr. Molony told me to go ahead and release the letter; that the Attorney General would not be sending us a letter, but that he supported our decision. I told Mr. Molony that in future COPA reviews, the Attorney General or his representative was welcome to participate in developing the conditions, sit at the table during meetings with the applicant, and otherwise be a partner with the Department in developing our decision.

South Carolina Department of Health and Environmental Control



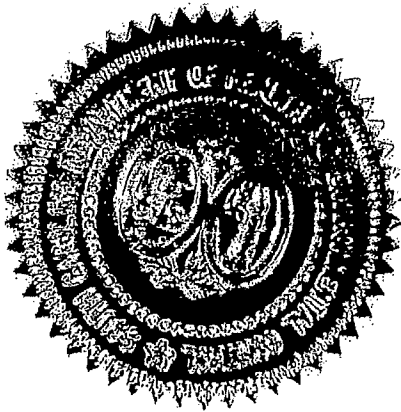
CERTIFICATE OF PUBLIC ADVANTAGE

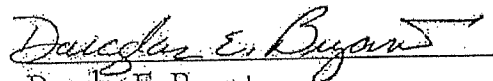
This Certificate of Public Advantage, No. COPA-97-01, is issued to BR Health System, Inc., (the System) for the incorporation of a nonprofit entity to operate the hospitals of the Sponsoring Organizations as a single unit. The Sponsoring Organizations include (1) Baptist Healthcare System of South Carolina, Inc., Columbia and Hasley, South Carolina and (2) Richland Memorial Hospital, Columbia, South Carolina.

In reaching this decision, the Department has determined that the applicants have demonstrated that the likely benefits resulting from the agreement outweigh the likely disadvantages from the agreement. The Department has also determined that the reduction in competition likely to result from the agreement is reasonably necessary to obtain the benefits likely to result.

This represents the Department's final decision regarding this agreement. This decision is subject to each condition described in the approval dated May 8, 1997.

In Witness Whereof I have hereunto set my hand and the seal of the Department of Health and Environmental Control this the 6th day of October, 1997.




Douglas E. Bryant
Commissioner

MEMORANDUM

M. Elizabeth Crum

ecrum@mcnair.net
T 803.753.3240
F 803.933.1484

Via Email

TO: Louis W. Eubank
Margaret (Maggie) P. Murdock
MaryJo Roue
Eva Johnson
Ashely C. Biggers, Esquire

CC: Howard P. West, Esquire, Joseph J. Blake, Jr., Esquire

FROM: M. Elizabeth Crum, Esquire

DATE: October 11, 2017

RE: Newco and Affiliation between UAO/GHS and PH

As we discussed in our respective meetings, below is a description of our understanding of the ownership of hospitals and other health care facilities and providers both before the Newco transaction and after the Newco transaction. Attached please see charts showing the ownership of Palmetto Health hospitals before the transaction and the Upstate Affiliate Organization d/b/a Greenville Health System ("UAO/GHS") hospitals before the transaction and the ownership for both PH and UAO/GHS after the transaction.

The Parties

The Affiliation Agreement ("Agreement") between Palmetto Health and SCO (as defined below) contemplates a new company, now incorporated as SC Health Company ("Newco"), would be established and become effective at closing.

Strategic Coordinating Organization ("SCO") is a South Carolina nonprofit corporation and the parent organization of a comprehensive integrated health care system that includes hospitals and other licensed health care facilities and services¹ serving the Upstate region of South Carolina. Those hospitals and

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1221 Main Street
Suite 1600
Columbia, SC 29201

Mailing Address
Post Office Box 11390
Columbia, SC 29211

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¹ Health care facilities and services are used as specified in the State Certificate of Need and Health Facility Licensure Act (CON Act) and are licensed as required under the CON Act and applicable Department of Health and Environmental Control (DHEC) regulations (DHEC regulations).

Louis W. Eubank
Margaret (Maggie) P. Murdock
MaryJo Roue
Eva Johnson
Ashley Biggers, Esq.
October 11, 2017
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other health care facilities and services are currently owned and operated by and post transaction closing, will continue to be operated/owned by UAO/GHS. The licenses, permits, and certificates for these hospitals, other health care facilities and services are currently issued to UAO/GHS as the owner/operator of the hospital and other health care facilities and services. Post transaction, UAO/GHS will still hold the licenses, permits and certifications for these hospitals, other health care facilities and services

The Agreement contemplates at the closing of the transaction, Newco will become the member and parent organization of UAO/GHS. This will be accomplished by merging the SCO with and into UAO/GHS with UAO/GHS being the surviving entity of that merger and the Newco becoming the sole member of the UAO/GHS.

Palmetto Health is and will continue to be a comprehensive, integrated health care system that includes hospitals and other licensed health care facilities and services serving the Midlands region of South Carolina. Palmetto Health is the sole member of Palmetto Health Tuomey, a South Carolina nonprofit corporation which owns and holds the license, permits, and certificates for Palmetto Health Tuomey Hospital and its other health care facilities and services. The remaining hospitals, health care facilities and services are currently owned by and the licenses, permits, and certificates are currently issued in the name of Palmetto Health as the owner of the health care facilities and services. At closing, the organizational documents of Palmetto Health will be amended to add the Newco as a member of Palmetto Health with certain rights and powers reserved to it.

UAO/GHS and Palmetto Health are also the only two members of Baptist Easley Hospital ("BEH"), a South Carolina nonprofit corporation. UAO/GHS and Palmetto Health are equal members in BEH. BEH owns Baptist Easley Hospital and holds the license, permits, and certificates for the hospital. The Agreement does not contemplate impacting or changing BEH.

The Transaction

SCO and Palmetto Health entered into the Agreement to create Newco. Newco is intended to support UAO/GHS, Palmetto Health, and any future members provide health care and related educational activities more efficiently and effectively. It intends to accomplish this by providing overall strategic direction, coordination, other elements of corporate support, and other services to UAO/GHS and Palmetto Health. Newco will also coordinate academic relations and affiliations of UAO/GHS and Palmetto Health.

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Margaret (Maggie) P. Murdock
MaryJo Roue
Eva Johnson
Ashley Biggers, Esq.
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Newco will be a non-profit corporation, without members, with a tax-exemption based on its status as a supporting organization of UAO/GHS and Palmetto Health. The Newco Board will initially be 16 persons – 6 elected by SCO, 6 elected by Palmetto Health, the current CEOs of SCO and Palmetto Health (who will serve jointly as Newco's co-CEOs until December 31, 2019 and will leave the Newco board when they cease being co-CEOs), and two at large members elected by those 14 persons. However, once the initial terms of those initial directors expire, the Newco Board will become self-perpetuating with requirements to assure involvement by persons within the geographic areas served by UAO/GHS and Palmetto Health.

Upon completion of the change in corporate structures described below and the closing of this transaction, UAO/GHS and Palmetto Health will remain in existence and responsible for the operations of their respective hospitals and other health care facilities and services, and will retain title to their real property and the medical and non-medical equipment and other personal property involved in their delivery of health care services. No state (DHEC, LLR, etc.) or federal license, permit, or certificate (whether administered by DHEC or not) required for the operation of the hospitals, other health care facilities and services and physicians and physician practice groups will change. The Medicare provider numbers for all UAO/GHS and Palmetto Health existing hospitals, other health care facilities and services and employed physicians and physician practice groups will stay the same. Newco will not have legal title to or operate any hospital, other health care facility or service and is not required to obtain or have any license, permit, or certificate for a hospital or other health care facility or service as a condition of the transaction closing.

After the transaction closes, UAO/GHS and Palmetto Health will remain in existence with their own boards. These corporations will continue to deliver health care through their respective hospitals, other health care facilities and services and physicians and physician practice groups, and will continue participating directly in healthcare education. The boards of both entities will be active and will retain, among other things, primary oversight of the delivery and quality of services through their respective hospitals, other health care facilities and services, physicians and physician practice groups and other employees, compliance with capital and operating budgets and operating plans established by Newco, medical staff credentialing, and community health initiatives relating to community health status assessment and improvement. Additionally, both UAO/GHS and Palmetto Health will remain obligated to perform their respective contractual obligations in existence as of the closing, which include real property leases, personal property leases, and license agreements. Palmetto Health will continue to meet its obligations under its Certificate of Public Advantage (COPA). No change to the COPA is being sought, is required, or

Louis W. Eubank
Margaret (Maggie) P. Murdock
MaryJo Roue
Eva Johnson
Ashley Biggers, Esq.
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will be made as a result of this transaction since there will be no change in the services provided or service area served.

Corporate Structure After the Transaction

At the consummation of the transaction, Newco will become the sole member of UAO/GHS.

At the consummation of the transaction, Newco will become an additional member of Palmetto Health, along with Baptist Healthcare System of South Carolina, Richland Memorial Hospital, and Tuomey Foundation.

Attached are three organizational charts: 1) Palmetto Health ownership/facility structure prior to the transaction closing; 2) UAO/GHS ownership/facility structure at the closing of the transaction closing; and 3) the Palmetto Health and UAO/GHS ownership/facility structures after the transaction closing. As you can see, no hospital, other healthcare facility or service will change as a result of the transaction.

Conclusion

The transaction contemplated by the Agreement does not change Palmetto Health's provision of services or the service area as described by the COPA that Palmetto Health and the Department entered into pursuant to S.C. Code Ann. § 44-7-330. S.C. Code Ann. §§ 44-7-510, et seq. is not implicated by the transaction.

As described above, there will not be change of ownership, health care facility location or health care facility name² as a result of the transaction contemplated by the Agreement. Therefore, the transaction does not implicate either licensure or certification requirements. Please do not hesitate to call me if you have any questions or concerns about the above. My direct line number is 803-753-3240. Thank you for your attention to this matter.

MEC:vjh

² The hospitals and other health care facilities have to get new licenses if there is: 1) a change of ownership either by purchase or lease, 2) change of name, or 3) change in bed complement. See: S.C. Regs. 61-16 § 201(G) (hospitals); 61-91 § 103(K) (ambulatory surgery facility); 61-77 § 102(I) (home health); et seq.

Crum, Liz

From: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>
Sent: Wednesday, November 1, 2017 4:31 PM
To: Crum, Liz; Biggers, Ashley; Murdock, Margaret P.
Subject: Re: Any word on a response to my letter regarding

Hi Liz,

Ashley is planning to come to my office in the morning to review your letter and the original COPA file. If there is any need for additional follow-up after, we'll definitely reach out. I would expect we can let you know something either way by the end of the week.

- Louis

Louis Eubank, Chief
Bureau of Healthcare Planning and Construction
S.C. Dept. of Health & Environmental Control
Office: (803) 545-3652
Mobile: (803) 730-0523
Connect: www.scdhec.gov [Facebook](#) [Twitter](#)



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From: Crum, Liz <LCrum@MCNAIR.NET>
Sent: Wednesday, November 1, 2017 3:44:56 PM
To: Biggers, Ashley; Eubank, Louis W.; Murdock, Margaret P.
Subject: Any word on a response to my letter regarding

No CHOW and COPA not implicated in the GHS/PH transaction? Sorry to bug you but ☺ thx, Liz

MCNAIR
ATTORNEYS

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Shareholder
lcum@mcnair.net | 803 753 3240 Direct

McNair Law Firm, P.A.
Columbia Office 1221 Main Street | Suite 1800 | Columbia, SC 29201
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Crum, Liz

From: Crum, Liz <lcrum@burr.com>
Sent: Tuesday, November 21, 2017 1:20 PM
To: 'Ashley C. Biggers (biggerac@dhec.sc.gov)'
Subject: Sorry to bother you again. Any luck in getting me

Importance: High

An email or something in writing saying that the Department agrees with my letter of October 11 re COPA and CHOW. This is the last thing that PH and GHS are waiting on. Thx, Liz

Crum, Liz

From: Biggers, Ashley <biggerac@dhec.sc.gov>
Sent: Tuesday, November 21, 2017 5:41 PM
To: Crum, Liz
Subject: Your letter of October 11, 2017

Liz,

We are in agreement with your letter of October 11, 2017.

Thanks,
Ashley

Ashley C. Biggers
Chief Counsel for Health Regulation
S.C. Dept. of Health & Environmental Control
Office: (803) 898-3362
Mobile: (803) 354-2928
Connect: www.scdhec.gov [Facebook](#) [Twitter](#)



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Prisma Health--Midlands interpretation of sec. 508 I will call to discuss tomorrow. Best,
Liz

Crum, Liz <lcrum@burr.com>

Thu 2/6/2020 5:45 PM

To: Taylor, W. Marshall <taylorwm@dhec.sc.gov>; Biggers, Ashley <biggerac@dhec.sc.gov>

Cc: Howard West <Howard.West@prismahealth.org>; Malcolm Isley <Malcolm.Isley@prismahealth.org>; David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>; O'Daniel, Donna <dodaniel@burr.com>

📎 1 attachments (592 KB)

4719_001.pdf;

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MS • NC • SC • TN

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To: Ashley C. Biggers
Marshall Taylor

From: M. Elizabeth Crum

Date: February 6, 2020

Interpretation of Reg. 61-31 § 508

As set forth below, we believe the following is the proper interpretation of Reg. 61-31 § 508, which is consistent with the Legislative findings of the COPA Act, the CON Act and DHEC State health mission to promote and protect the public health. <https://www.scdhec.gov/about-dhec/about-us>

Our Supreme Court has repeatedly emphasized that "[t]he cardinal rule of statutory interpretation¹ is to ascertain and effectuate the intent of the legislature." *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). The primary rule of statutory construction/interpretation in this State is to give intent to the purposes of the legislature.

"The cardinal rule of statutory construction is a court must ascertain and give effect to the intent of the legislature." *State v. Scott*, 351 S.C. 584, 588, 571 S.E.2d 700, 702 (2002) (citing *Charleston Cnty. Sch. Dist. v. State Budget & Control Bd.*, 313 S.C. 1, 437 S.E.2d 6 (1993)); *Florence [174] Cnty. Democratic Party v. Florence Cnty. Republican Party*, 398 S.C. 124, 128, 727 S.E.2d 418, 420 (2012). "What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will." *Scott*, 351 S.C. at 588, 571 S.E.2d at 702 (quoting *Norman J. Singer, Sutherland Statutory Construction* § 46.03 at 94 (5th ed. 1992)). Therefore, "[i]f a statute's language is plain, unambiguous, and conveys a clear meaning 'the rules of statutory interpretation are not needed and the court has no right to impose another meaning.'" *Id.* (quoting *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000)); see also *State v. Pittman*, 373 S.C. 527, 561, 647 S.E.2d 144, 161 (2007) ("All rules of statutory construction are subservient to the maxim that legislative intent must prevail if it can be reasonably discovered in

¹ Regulations are interpreted using the same rules of construction as statutes." *Murphy v. S.C. Dep't of Health and Envtl. Control*, 396 S.C. 633, 639, 723 S.E.2d 191, 195 (2012); see *S.C. Ambulatory Surgery Ctr. Ass'n v. S.C. Workers' Comp. Comm'n*, 389 S.C. 380, 389, 699 S.E.2d 146, 151 (2010)

the language used.") (citing *McClanahan v. Richland Cnty. Council*, 350 S.C. 433, 438, 567 S.E.2d 240, 242 (2002)). The Court must construe statutory language in light of the intended purpose of the statute, and "[t]his Court will not construe a statute in a way which leads to an absurd result or renders it meaningless." *Florence Cnty. Democratic Party*, 398 S.C. at 128, 727 S.E.2d at 420.

State v. Cty. of Florence, 406 S.C. 169, 173-74, 749 S.E.2d 516, 518 (2013) (emphasis added) However, our Supreme Court has long held that "Courts will reject the ordinary meaning of the words used in a statute *however plain it may be*, when to accept such meaning would defeat the plain legislative intent." *Greenville Baseball, Inc. v. Bearden*, 200 S.C. 363, 20 S.E.2d 813, 815 (1942) (emphasis added); see *Kiriakides v. United Artists Commc'ns, Inc.*, 312 S.E. 271, 275, 440 S.E.2d 364, 366 (1994) ("[h]owever plain the ordinary meaning of the words used in a statute may be, the courts will reject that meaning when to accept it would lead to a result so plainly absurd that it could not possibly have been intended by the Legislature or would defeat the plain legislative intention. ").

Statutory interpretation requires that "the statute must be read as a whole and sections which are a part of the same general statutory law must be construed together and each one given effect. Accordingly, we read the statute as a whole and should not concentrate on isolated phrases within the statute." *Centex Int'l, Inc. v. S.C. Dep't of Revenue*, 406 S.C. 132, 139, 750 S.E.2d 65, 69 (2013) (alteration in original) (emphasis added) (citations omitted). The primary guide to statutory construction of a word or phrase is to consider the language as a whole in light of its manifest purpose. Courts should not give particular words a significance clearly repugnant to the meaning the whole statute or destructive of its obvious intent. *Amisub of S.C., Inc. v. S.C. Dep't of Health & Envtl. Control*, 407 S.C. 583, 597, 757 S.E.2d 408, 416 (2014). Further, statutes dealing with the same subject matter must be construed *in pari materia* and must be construed together to produce a single harmonious result. *Joiner ex rel. Rivas v. Rivas* 342 S.C. 102, 536 S.E.2d 372 (2000).

In addition, it is proper to consider the title or caption of an act in aid of construction to show the intent of the legislature. *Father v. S.C. Dept. of Social Services*, 345 S.C. 57, 545 S.E.2d 523 (Ct. App. 2001), referencing *Joytime Distrib. & Amusement v. State*, 338 S.C. 634, 649, 528 S.E.2d 647, 655 (1999) and 73Am.Jur.2d *Statutes* § 98 at 322 (1974) ["[I]t is a generally accepted view of the United States that resort may be had to the title of an act as an aid of interpretation."].

The meaning of "might" or "might materially" is not defined in either the COPA or COPA Regs. so its meaning must be interpreted in the first instance by DHEC. *Ferguson Fire & Fabrication, Inc. v. Preferred Fire Prot., L.L.C.*, 409 S.C. 331, 343, 762 S.E.2d 561, 567 (2017).

With the above in mind, we are firmly of the opinion that Prisma Health—Midlands' interpretation is § 508 is correct and complies with the legislative intent and the DHEC mission to promote and protect the public health. "DHEC is charged with promoting and protecting the health of the public" (DHEC mission). As part of its mission, DHEC oversees the CON and COPA statutes and regulations. The CON and COPA Acts are in Chapter 7 (Hospitals, Tuberculosis Camps, and Health Service District). All of DHEC's actions in administering its duties under the COPA Act and regs, must promote and be done with an eye to accomplishing the DHEC mission

to promote and protect the public health of the citizens of South Carolina.² To our knowledge, this is a case of first impression where parties to a COPA Agreement (Agreement) have presented DHEC with a request under § 508 to bring additional assets under the existing Agreement conditions. In interpreting and applying the provisions of § 508 to Prisma Health—Midlands' request to add the Life Point assets (Transaction), as a creature of statute, DHEC must apply § 508 in light of the COPA Act legislative findings, the CON purposes and DHEC's public health mission, as discussed below.

First, the COPA Act contains specific legislative findings, which provide:

The General Assembly makes the following findings:

(1) that the cost of improved health technology and scientific methods contributes significantly to the increasing cost of health care;

(2) that cooperative agreements among hospitals health care purchasers, and other health care providers would **foster improvements in the quality of health care** for South Carolinians, **moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open;**

(3) that **federal and state antitrust laws may prohibit or discourage cooperative agreements that are beneficial to South Carolinians and that such agreements should be encouraged;** and

(4) that competition as currently mandated by federal and state antitrust laws **should be supplanted by a regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition.**

S.C. Code Ann. § 44-7-505. (Emphasis added). These legislative findings make it clear that the legislative intent is for DHEC to administer the COPA program as a regulatory program that permits and regulates cooperative agreements. The Department has ongoing monitoring responsibilities, including the right to revoke a COPA during its existence, if DHEC determines that the benefits no longer outweigh the disadvantage. Being a party to a COPA Agreement does not relieve a person from complying with the provisions of the CON Act and its purposes.

Since this Transaction involves the purchase of health care facilities, DHEC must also consider the purposes of the CON Act. It is noteworthy that the Legislative findings of the COPA Act dovetail with the legislative purposes of the CON Act, which are: "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann., § 44-7-120 The CON Act and the COPA Act are two of the major programs that DHEC administers in promoting and protecting the public health. Under the statutory construction rubric of reading

² To our knowledge, the only other time in SC that a COPA Agreement's conditions have been amended or updated was in November, 2003 when DHEC reduced some of the original conditions for then Palmetto Health that had been satisfied during the first five years and were no longer relevant.

statutes in *para materi*, in interpreting § 508, DHEC should look at the legislative findings of the COPA Act and the purposes of the CON Act together, since they are both statutes that deal with the same subject matter, i.e., promotion and protection of health care in this State. The fact that the Acts should be read together is buttressed by the fact that when the COPA Act was enacted in 1994, it was part of an act that both established the COPA Act and established a task force to conduct a study regarding open-heart surgery and therapeutic cath services with the results being delivered to DHEC for use in the CON program. *See Father v. S.C. Dept. of Social Services*, 345 S.C. 57, 545 S.E.2d 523 (Ct. App. 2001) (proper to consider the title of an act in aid to show the intent of the legislature.) As the title of Act 437, 194 Acts and Joint Resolutions shows, the Legislature intended that the COPA and CON Acts be considered together.³

Section 508 provides:

If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires another review. A change in the application will be considered substantial if the Department believes that the change materially changes the reasons for approval, might materially impact the benefits or disadvantages to the community to be served, or will change the service area of the original application. The addition or deletion of a party to the agreement does not necessarily constitute a substantial change unless the Department believes that the above mentioned criteria will occur.

Section 508 clearly authorized DHEC to approve changes to the COPA Agreement conditions without another review unless DHEC considers the change to be substantial. Section 508 only identifies three circumstances where DHEC staff can make a determination that the change is substantial, thereby requiring another review: 1) the change materially changes the reasons for approval; 2) the change might materially impact the benefits or disadvantages to the community; and 3) the original service area application will be changed. Based on our earlier meetings, the only statutory interpretation question at issue is how DHEC interprets “the change might materially impact”.

First, it is clear that § 508 requires that DHEC initially determine whether the change is a substantial one. If DHEC determines the change is substantial because it “might materially impact the benefits or disadvantages to the community to be served”, then DHEC can require another review. There is no provision in the regulation for the Department to use another review to make the determination that the Transaction constitutes a substantial change. In our meeting February 5, 2020, DHEC specifically stated that it had NOT made a determination that the Transaction constituted a substantial change.

Second, the threshold for what constitutes a material change to an existing COPA Agreement should be high and not low. In light of the COPA Act legislative findings and DHEC’s public health, the regulatory phrase “might materially impact” should be interpreted to mean “it is more probable than not that the change will materially impact.” Reading the word “might” literally

³ Our Constitution has the one title one subject mandate for bills introduced into the General Assembly.

does not comport with the COPA legislative findings, the CON Acts or the public health mission of DHEC. Literally “might” is defined: “used to say that something is possible”. *Merriam Webster Dictionary*. Under such interpretation, there is virtually no change that could be made to an existing COPA that would not need a new, lengthy, extensive public hearing. In using the word “might”, the Legislature intended to give DHEC the ability to determine whether it is more probable than not that a change would materially impact the benefits or disadvantages to the community. Taken the literal interpretation to its logical conclusion, today if Prisma Health—Midlands Richland sought to build a new hospital in Richland County with the 157 bed need in the Draft 2020 SHP, that “might” materially impact the COPA and we would have to go back through the public review process.

An expansive interpretation of the word “might” is contrary to the COPA Act legislative finding that Agreements “foster improvements in the quality of health care, moderate cost increases, improve access to needed services in rural areas, and enhance the likelihood that rural hospitals can remain open.” It is also contrary to the DHEC mission to promote and protect the health of the public. As discussed below, the existing Conditions do exactly that—foster improvements in quality health care, moderate cost increases and improve access to needed services in rural areas. In this regard, Prisma Health—Midlands has agreed to maintaining inpatient services in Kershaw County open for at least five years and to put additional resources in to the facility and to place and/or expand primary care and urgent care services in Lower Richland and North Richland/Kershaw counties, both underserved rural areas of Richland and Kershaw counties.

Interpreting “might materially impact” to mean it is more probably than not a change would materially impact” also complies with the legislative finding that cooperative agreements are beneficial to South Carolinians and should be encouraged. Making it very time intensive and expensive to add assets, utilizing a literal “might” threshold does not carry out the legislative findings that cooperative agreements are beneficial to South Carolina and should be encourage.

Prisma Health—Midlands’ interpretation complies with the General Assembly’s finding that the COPA program should “permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers when the benefits outweigh the disadvantages caused by their potential adverse effects on competition.” The legislative charge is to permit and encourage cooperative agreements, which do not include putting artificial “low threshold” barriers to changes to existing Agreements. Interpreting “might materially” to mean “more probably than not a change would materially impact” meets the legislative finding that permits and encourages cooperative agreements between hospitals.

The analysis for the CON purposes and the DHEC public health mission is identical to the above.

Third, § 508 does require DHEC’s to review the Transaction not in a vacuum but in the context of the existing Conditions to determine if, based on those conditions there is a substantial change. DHEC has the absolute right to add conditions if there is a material change to the benefits

or disadvantages.⁴ The health care landscape in the Midlands area has, as is the nature of health care, evolved since 1996 and 1997 when the original COPA application was filed and the original review undertaken. The issue now is how the Conditions that DHEC has been regulating Prisma Health-Midlands under apply to the Transaction. The review should be focused on whether the Transaction will create additional disadvantages not whether there will be additional benefits. The COPA has already determined that the benefits of the Palmetto Health affiliation outweighed the disadvantages for the Midlands Community. Thus, if there are no additional disadvantages, whether there are additional benefits from the Transaction is only better for the community.

There are 13 current COPA Conditions that, under Prisma Health—Midlands request, would be applied to the Transaction.

When the Agreement was approved in 1997, HCA had approximately 10.7% of the licensed beds in the Midlands service area and in 2020, LMC has 22.3 % of the licensed beds in the Midlands service area. HCA's (PD/PNE) projected bed need has **declined approximately 24%**. LMC's bed need has increased from 226 in the 1997 SHP to 569 in the 2020 Draft SHP or **an increase of approximately 252% since 1997**. As a review of the 1997 to 2020 inpatient inventory demonstrates, the change in inpatient is not the players but the ever-growing competition from LMC⁵ and the diminution in competition from Life Point facilities. Now, LMC annually delivers the most babies in the Midlands area while Prisma Health-Midlands is still the PRC and shoulders all of the Level III and Intensive care. While HCA is no longer in the service area, LMC has replaced and surpassed it as a competitor. Additionally, LMC participated in the COPA process, specifically requesting that DHEC add a condition, which DHEC did.⁶

In considering DHEC's public health mission, it is not sufficient just to look at the benefits or disadvantages of the Transaction from an inpatient standpoint. As DHEC is aware, health care has been and will continue to move from inpatient based to outpatient based. The Department can take notice of all of the outpatient services, including employed physicians, clinics, ASFs, etc that LMC has. There is no lack for competition in the service area.

Section 402(b) of Reg. 61-31 contains the criteria that DHEC must review in determining whether to approve a COPA application. As you see from below, each of the 5 identified criterion is already addressed by an existing Condition that prohibits the Transaction from creating a disadvantage. This section provides:

2. In evaluating the disadvantages likely to result from the agreement, the Department shall consider but is not limited to:

⁴ During the life of the Agreement, there have been allegations that the COPA Conditions were not being followed. DHEC promptly, at least once with SLED's assistance followed up on the complaint.

⁵ As a hospital district, just like Spartanburg Regional, LMC is not subject either to the COPA, state or federal antitrust laws.

⁶ The Palmetto affiliation approved by the COPA was a larger "merger" than is the current Transaction.

a) the likely adverse impact, if any, on the ability of the health care purchasers to negotiate optimal payment and service arrangements with the health care providers or health provider networks;

- *Condition 9* (can't contract for exclusive services);
- *Condition 10* (Prisma Health—Midlands can't condition contracts with suppliers, vendors, or group purchasing organization that prevent them from contracting with other providers in the Midlands Area)

b) the extent of any reduction in competition among health care providers, purchasers, or other persons furnishing goods or services to or in competition with health care providers or purchasers that is likely to result directly or indirectly from the health care cooperative agreement;

- *Condition 4* (must report prospective plans to change clinical services before making changes);
- *Condition 5* (provide access to competing licensed facilities to services not offered by such facility in core service area on non-discriminatory terms and conditions and cost restricted to equal to the lowest of the amount which would be received from patients insured by Premier PPO, Cigna or Aetna);
- *Condition 9*;
- *Condition 11* (DHEC can amend conditions to include "lowering prices should unexpected events lead to abnormally high margins from operation.")

c) the likely adverse impact, if any, on patients in the quality, availability, and price of health care services;

- *Condition 2* (the 10% tithe, which Prisma Health—Midlands has agreed to raise to 15% to include all of the existing services and add Accountable Communities and Medical neighborhood Approach, keeping Kershaw Health and adding health services to the Lower Richland and North Richland/Kershaw County areas)
- *Condition 4*,
- *Condition 5*,
- *Condition 6* (maintain a relationship with USC SOM);
- *Condition 9*
- *Condition 11*.

d) the extent to which the agreement may increase the costs of prices of health care at a hospital or other health care provider which is a party to the agreement;

- *Condition 11*
- *Condition 3* (reporting capital expenditures avoided)

e) the extent to which services to Medicaid, indigent, or charity care patients are adversely impacted by the agreement.

- *Condition 2*

In addition to the five listed criteria, 402.2 may consider other issues. The Conditions, as is obvious from their breadth, go far beyond the five listed criteria.

Prisma Health—Midland's interpretation that the phrase "might materially impact" should be interpreted as "it is more probable than not that the change will materially impact" effectuates the legislative findings that 1) cooperative agreements foster improvement in quality of health care; 2) moderate costs increases, improve access to needed services, particularly in rural areas; and 3) that such agreements are beneficial to South Carolina and establishment is encouraged; and the COPA program should permit and encourage COPA agreements as long as the benefits outweigh the disadvantages. The Transaction will not add any new services not already being provided by Prisma Health—Midlands and will allow Prisma Health—Midlands after meeting the regulatory requirements under the Conditions and the CON Act, to establish centers of excellence, reduce unnecessary duplication, address staff shortages, open more existing licensed beds, and provide additional outpatient services, screening and well care benefits. In short, Prisma Health—Midlands interpretation of § 508 is in accord with the legislative findings of the General Assembly. The Transaction will allow Prisma Health—Midlands to help promote and protect public health with better access to health care closer "to home."

MEC

word version of the

Crum, Liz <lcrum@burr.com>

Thu 2/20/2020 5:55 PM

To: Robert Cook - SC Attorney General's Office (bcook@scag.gov) <bcook@scag.gov>; Taylor, W. Marshall <taylorwm@dhec.sc.gov>; Biggers, Ashley <biggerac@dhec.sc.gov>
Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>

 1 attachments (36 KB)

43025868_1.docx;

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PDF I just sent. Thanks and please do not hesitate to ask if you have any questions. Best, Liz

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February 20, 2020

Robert Cook, Esquire
Solicitor General
SC Attorney General's Office
Attorney General's Office
Rembert C. Dennis Office Bldg.
Post Office Box 11549
Columbia, SC 29211

Re: Interpretation of Reg. 61-31 § 508

Dear Mr. Cook:

We are submitting this letter on behalf of our client, Prisma Health—Midlands. The South Carolina Department of Health and Environmental Control (Department or DHEC) has requested an interpretation from the Attorney General regarding the Department's authority under S.C. Code Ann. Reg. 61-31 § 508. Section 508 provides, in relevant part: "If an applicant amends, alters, or otherwise changes the agreement after receipt of a Certificate of Public Advantage, the Department will decide whether or not the amendment is substantial and thereby requires another review," (emphasis added). Assuming that DHEC determines that Prisma Health--Midlands request to add the Life Point assets, discussed below, might materially impact the benefits or disadvantages to the Midlands community, does the phrase "another review" require the Department to utilize the review process outlined for new Certificate of Public Advantage COPA applications in §§ 303, 304 and 305. As discussed in detail below, the phrase "another review" does not require the Department to employ the same review process required for a new or initial COPA application and authorized the Department to determine what type of additional review, including an internal review, it needs to conduct, based on the circumstances of each unique matter.

BACKGROUND

Pursuant to the Health Care Cooperative Act (Act) and S.C. Code Ann. Reg. 61-31, the Department of Health and Environmental Control (DHEC or Department)¹ is the state agency charged with interpreting and administering the Certificate of Public Advantage (COPA) program, regulated by the Act. In 1997, after an extensive review, including a review by the Attorney General's office, the Department issued a COPA² for the affiliation of the Baptist Healthcare System of South Carolina, Inc. and Richland Memorial Hospital to become Palmetto Health. Palmetto Health has changed its name to Prisma Health—Midlands. Prisma Health—Midlands notified the Department that it wants to purchase the assets of Life Point (LPNT or Life Point), including the Providence Downtown, Providence Northeast, Kershaw Health hospitals (Assets), and has requested that the Department approve modification of the COPA Conditions to make the LPNT assets a part of and subject to the COPA Conditions.

DISCUSSION

The COPA Regulations (61-31) (Regs.) were adopted to implement the legislative intent: 1) to establish “a state regulatory program to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers which would otherwise violate federal or state anti-trust laws when the benefits outweigh disadvantages caused by their potential adverse effects on competition”; and 2) to encourage cooperative agreements because “cooperative agreements among hospitals, health care purchaser, and other health care providers will foster improvements in the quality of health care for South Carolinians.” *See also*; “Findings”, S.C. Code Ann. § 44-7-505

While Prisma Health—Midlands is firmly convinced that the Asset purchase, in light of the given the level of competition in the Midlands, would not materially impact the benefits or disadvantages to the community, assuming that DHEC concludes the Transaction *might* materially impact the benefits or disadvantages to the community, the question becomes what was the legislature intent of the phrase “another review” in Reg. 61-31 § 508.

¹ Section 44-7-530 of the Act provides: A health care provider, health care purchaser, or health provider network may negotiate and enter into cooperative agreements with other health care providers or health provider networks or health care purchasers if the likely benefits resulting from the agreements outweigh any likely disadvantages resulting from the agreements. Parties to a cooperative agreement may apply to the department for a certificate of public advantage.” The Department is charged with promulgating regulations to regulate and administer the Act. S.C. Code Ann. § 44-7-5470(D).

² Prisma Health also made a Hart Scott Rodina filing and received approval from the Federal Trade Commission for the affiliation.

In interpreting statutes or regulations, the cardinal rule of construction is to give meaning to the legislative intent.

The cardinal rule of statutory construction is to ascertain and effectuate the legislative intent whenever possible." *Perry v. Bullock*, 409 S.C. 137, 140, 761 S.E.2d 251, 253 (2014) (quoting *State v. Baucom*, 340 S.C. 339, 342, 531 S.E.2d 922, 923 (2000)). "All rules of statutory construction are subservient to the one that legislative intent must prevail if it can be reasonably discovered in the language used, and that language must be construed in light of the intended purpose of the statute." S.C. Prop. & Cas. Ins. Co. Guar. Ass'n v. Brock, 410 S.C. 361, 367, 764 S.E.2d 920, 922 (2014) (quoting *McClanahan v. Richland Cty. Council*, 350 S.C. 433, 438, 567 S.E.2d 240, 242 (2002)). "The plain language of a statute is considered the best evidence of the legislature's intent." *Perry*, 409 S.C. at 140, 761 S.E.2d at 253. "When interpreting an undefined statutory term, the Court must look to its usual and customary meaning." *Id.* at 140-41, 761 S.E.2d at 253.

In interpreting a statute, [w]ords must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute's operation. Further, the statute must be read as a whole and sections which are a part of the same general statutory law must be construed together and each one given effect. Accordingly, we read the statute as a whole and should not concentrate on isolated phrases within the statute. *Centex Int'l, Inc. v. S.C. Dep't of Revenue*, 406 S.C. 132, 139, 750 S.E.2d 65, 69 (2013) (alteration in original) (emphasis added) (citations omitted).

Protection and Advocacy for People with Disabilities, Inc. v. Buscemi, 417 S.C. 267, 273-274, 789 S.E.2d 756, 760 (2016). See also: *Smith v. Tiffany*, 419 S.C. 548, 555-556, 799 S.E.2d 479, 483 (2017).

Additionally, when faced with an undefined term in a statute or regulation, a court must interpret a term giving it its usual and customary meaning. *Adoptive Parents v. Biological Parents*, 315 S.C. 535, 446 S.E.2d 404 (1994). The words found in a statute must be given their "plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute's operation." *Sloan v. Hardee*, 371 S.C. 495, 499, 640 S.E.2d 457, 459 (2007). Also, we must construe the various provisions, if possible, consistently with the rule that statutes dealing with the same subject matter are in *pari materia* and must be construed together, if possible, to produce a single, harmonious result, *Joiner ex rel. Rivas v. Rivas*, 342 S.C. 102, 536 S.E.2d 372 (2000); see also: *Amisub of S.C., Inc. v. S.C. Dep't of Health & Envtl. Control*, 407 S.C. 583, 598, 757 S.E.2d 408, 416 (2014).

Clearly, the legislative intent of the Act and Reg. 61-31 is to make it easier for South Carolina health care providers to enter into and to maintain ongoing COPA Agreements. *See*: S.C. Code Ann. § 44-7-505; Reg. 61-31 § 101. The Prisma Health—Midlands Agreement has been in effect for almost twenty-three (23) years. Prisma Health—Midlands has been reporting annually as required by the Agreement and the Department has been actively monitoring the Prisma Health—Midlands Agreement since its issuance in 1997.

Reg. 61-31 § 308, (Project Changes During Review Period) sets forth the process that DHEC must use when the applicant makes an amendment during the initial application review process. Notably, § 308 specifically requires the Department review the amendments and notify the applicant if the amendment constitute a new application. In that case, the regulation expressly mandated that the review process set forth in §§ 301, 302 and 303 be followed and the review is counted as “though the amendment were a new application.” On the other hand, § 508 (Changes After Receipt of a Certificate of Public Advantage) regulates amendments to the operational COPA agreement, which in this case includes conditions imposed by the Department on Prisma Health—Midlands pursuant to § 312. Section 508 simply provides that if the Department determines that the amendment is substantial “another review” is required. Clearly, if the Legislature had meant that the § 508 review be done pursuant to §§ 301, 302 and 303, it would have required that in § 508 just as it did in § 308.

Neither the words “another” nor the word “review” are defined in the Act or Regs. Thus, the phrase “another review” must be interpreted in its plain and ordinary meaning *Merriam Webster* defines “another” as: “different or distinct from the one first considered”. <https://www.merriam-webster.com/dictionary/another> “Review” is defined as: “an act or the process of reviewing”; ... “to study material again : make a review”. <https://www.merriam-webster.com/dictionary/review> *Black’s Law Dictionary* defines “review” as: “1. Consideration, inspection or reexamination of a subject or thing.” Applying the South Carolina rules of statutory interpretation set forth above, the phrase “another review” does not require DHEC to apply the review process required to for a pending COPA application. Again, applying the above rules of statutory construction, the phrase “another review” is not a limiting phrase but a phrase allowing DHEC to fashion the type review it deems appropriate under the circumstances of the change sought under § 508. This review can be limited to an internal DHEC review based on materials provided by Prisma Health—Midlands, on materials DHEC receives from other state agencies such as the office of Revenue and Fiscal Affairs or other materials DHEC has in its possession as the agency responsible for overseeing and regulating health care facilities and services in this State.

Our courts have long held that Article V courts and the Administrative Law Court should give deference to an agency’s interpretation of statutes and regulations the agency is charged with administering. *Kiawah Development Partners, II v. South Carolina Department*, 411 S.C. 16, 766 S.E.2d 707 (2014) (“Accordingly, the deference doctrine properly stated provides that where an agency charged with administering a statute or regulation has interpreted the statute or regulation,

Robert Cook, Esquire
February 20, 2020
Page 5

courts, including the ALC, will defer to the agency's interpretation *absent compelling reasons*. We defer to an agency interpretation unless it is 'arbitrary, capricious, or manifestly contrary to the statute.' (emphasis added); *A. O. Smith Corporation v. South Carolina Department of Health and Environmental Control*, 428 S.C. 189, 833 S.E.2d 451 (Ct. App.); *Murphy v. South Carolina Department of Health & Environmental Control*, 396 S.C. at 636–38, 723 S.E.2d at 192–94. The phrase “another review” can be properly interpreted by the Department as an expansive, not limiting, phrase to allow DHEC to fashion the review process—internal or external. The phrase does not limit the Department to conducting the same review process it would have to use in § 308 for a change during review of an initial COPA.

Finally, and importantly, interpreting the phrase “another review” to allow DHEC to fashion the nature of the review on a case by case basis of change to COPA agreements it is already monitoring supports the legislative purpose of the Act and Reg. 61-31, namely to encourage cooperative agreements in order to improve the quality of health care in this state. Such an interpretation is a reasonable, not arbitrary or capricious, particularly given the legislative intent. Difference should be given to such a DHEC interpretation because there is no compelling reason to conclude otherwise.

Thank you for your time and consideration of this matter. Please do not hesitate to contact me should you have any questions.

Very truly yours,

M. Elizabeth Crum

Cc: Howard P. West, Esq.
Marshall Taylor, Esq.
Ashley C. Biggers, Esq.
David B. Summer, Esq.

MEC

Re: questions and comments

Crum, Liz <lcrum@burr.com>

Wed 2/26/2020 1:13 PM

To: Biggers, Ashley <biggerac@dhc.sc.gov>

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On Feb 26, 2020, at 1:05 PM, "Biggers, Ashley" <biggerac@dhc.sc.gov> wrote:

[EXTERNAL EMAIL]

Liz,

I just left you a voice mail message to let you know about a few changes that have been made, and to provide answers to a few questions posed yesterday evening.

Please let me know if you'd like to arrange a time to talk further.

Thank you,
Ashley

Ashley C. Biggers
Chief Counsel for Health Regulation
S.C. Dept. of Health & Environmental Control
Office: (803) 898-3362
Mobile: (803) 354-2928
Connect: www.scdhec.gov [Facebook](#) [Twitter](#)

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Proposed DHEC Condition	Prisma Health Response
14. Prior to signing APA, provide evidence to DHEC that PH sponsoring boards, and county govt. councils of Richland, Fairfield, and Kershaw are aware of transaction.	Not necessary and will not agree.
15. Within 18 months of the determination letter, System will submit CON application for a freestanding ED in northern area of City of Columbia- 29203. If granted, use best efforts to implement.	Commit to a comprehensive study of emergency services in NE City of Columbia with other stakeholders to develop a plan for emergency and urgent care services within a population health model. Such study will be completed within 18 months of the transaction closing date.
16. Within 12 months submit for review and approval a plan to provide primary care and urgent care services to Lower Richland County. If approved, being operation within 12 months of approval.	Prisma Health will provide primary care services to the Lower Richland community within 24 months of the transaction closing date. No department review and/or approval.
17. Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department for review and approval a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.	Already covered under Condition #4, not necessary, and will not agree. We will be creating centers of excellence, consolidating programs, streamlining operations, and re-structuring services. We will comply with Condition #4. Patients currently receiving services from the Seller will continue to be treated by the Buyer post transaction.
18. "In any instance wherein the System determines to close a licensed general hospital, System shall increase by 10% the amount of indigent care provided to patients within the System who qualify for indigent care pursuant to a reasonable indigent care plan. Such plan shall be submitted to the Department for review and approval on an annual basis as part of the System's annual COPA report to the Department."	Prisma Health will provide to the Department its charity care policy as part of the annual COPA report. If we close a general hospital in the area, those patients would be seen at other Prisma Health care sites under the same charity care policy. Patients currently receiving services from the Seller will continue to be treated by the Buyer post-transaction.
19. System needs to offer a Level 1 trauma services at Richland, and "levels of perinatal services currently provided at Richland Hospital" and at least 9 separately licensed emergency departments with the system. Failure to do so shall lead to immediate revocation of COPA.	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements, the State Health Plan, CON regulations, licensing requirements, volume, reimbursement, payment, or costs for providing these services. Prisma Health will not commit to keeping a minimum number of EDs open.
20. In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispossessions related to physician	Not necessary and will not agree.

practices, surgical centers, imaging centers, radiation therapy facilities, or substance abuse and treatment facilities.	
Increase the Tithe to 15%	Agree.

Document

Biggers, Ashley <biggerac@dhec.sc.gov>

Thu 2/27/2020 4:24 PM

To: lcrum@burr.com <lcrum@burr.com>

Cc: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

📎 1 attachments (138 KB)

2020.02.27 DHEC Response to Prisma Response to Conditions.pdf;

As discussed.

Thanks,
Ashley

Ashley C. Biggers

Chief Counsel for Health Regulation

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PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSE	DHEC RESPONSE
14. Prior to signing APA, provide evidence to DHEC that PH sponsoring boards, and county govt. councils of Richland, Fairfield, and Kershaw are aware of transaction.	Not necessary and will not agree	The language "local controlling boards of the Sponsoring Organizations" will be replaced by reference to Prisma Health – Midlands Board. This notification will remain "prior to signing APA." Will remove notification requirement for the government county councils.
15. Within 18 months of the determination letter, System will submit CON application for a freestanding ED in northern area of City of Columbia- 29203. If granted, use best efforts to implement.	Commit to a comprehensive study of emergency services in NE City of Columbia with other stakeholders to develop a plan for emergency and urgent care services within a population health model. Such study will be completed within 18 months of the transaction closing date.	We can add language that says CON application will be filed EITHER in zip code 29203 OR in a similarly disadvantaged and underserved area of Richland County; And we will extend to 24 months (not 18 months).
16. Within 12 months submit for review and approval a plan to provide primary care and urgent care services to Lower Richland County. If approved, being operation within 12 months of approval.	Prisma Health will provide primary care services to the Lower Richland community within 24 months of the transaction closing date. No department review and/or approval.	We are fine with extending from 12 to 24 months. We will remove the department review and/or approval requirement. We will keep in the "urgent care" services (in addition to primary care services).
17. Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department for review and approval a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.	Already covered under Condition #4, not necessary, and will not agree. We will be creating centers of excellence, consolidating programs, streamlining operations, and re-structuring services. We will comply with Condition #4. Patients currently receiving services from the Seller will continue to be treated by the Buyer post transaction.	Condition #4 was removed after it was pointed out to be redundant by the COPA holder We will keep #17 (#17 in original draft) but we will remove "review and approve" language. We will add language requiring to "notify us of any deviations to your plan."

18. "In any instance wherein the System determines to close a licensed general hospital, System shall increase by 10% the amount of indigent care provided to patients within the System who qualify for indigent care pursuant to a reasonable indigent care plan. Such plan shall be submitted to the Department for review and approval on an annual basis as part of the System's annual COPA report to the Department."	Prisma Health will provide to the Department its charity care policy as part of the annual COPA report. If we close a general hospital in the area, those patients would be seen at other Prisma Health care sites under the same charity care policy. Patients currently receiving services from the Seller will continue to be treated by the Buyer post- transaction.	We already changed this in the most recent draft to address questions / concerns raised following review of the first draft: We reduced to 5% the amount of charity care and clarified that the baseline is the previous FY (5% over previous FY).
19. System needs to offer a Level 1 trauma services at Richland, and "levels of perinatal services currently provided at Richland Hospital" and at least 9 separately licensed emergency departments with the system. Failure to do so shall lead to immediate revocation of COPA.	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements, the State Health plan, CON regulations, licensing requirements, volume, reimbursement, payment, or costs for providing these services. Prisma Health will not commit to keeping a minimum number of EDs open.	As to Level 1 trauma services and perinatal services, we are okay with adding a 5-year parameter, and adding language that says "subject to no material changes in applicable law." As to "level" of perinatal services, we already specified it means the level of services provided by the hospital as an RPC (not utilization/volume). As to 9 separately licensed EDs, we will reduce the number to 8 (accounting for the removal of Easley from the COPA in a previous year). We are willing to place a 5-year parameter on this condition as well. We will also remove the language that says the failure to do so shall lead to immediate revocation of the COPA. We will tweak the "uninterrupted" language to allow for the closure of an ED after a CON app for a new FSED is filed but before a decision is made (and/or final), to allow for the possible closure of Providence hospital and ED before a new FSED is approved and/or built open.

20. In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispossessions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance abuse and treatment facilities.	Not necessary and will not agree	The Department deems it reasonably necessary to have this information on an annual basis, in the annual report, to actively perform the Department's monitoring duties under COPA.
Increase the Tithe to 15%	Agree.	Resolved (Agreed on 15%)
NEW:		The above changes are predicated upon adding language that will make clear that the conditions will be evaluated for necessity and compliance on an annual basis, and conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance and need for continuation.

RE: Document

Crum, Liz <lcrum@burr.com>

Thu 2/27/2020 4:27 PM

To: Biggers, Ashley <biggerac@dhec.sc.gov>

Cc: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

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Thx, got it. Hope you have a well-earned PTO. ☺ Liz



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M. Elizabeth "Liz" Crum • *Counsel*

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360 Attorneys. 19 Offices. 1 Firm. Southeast Strong.

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From: Biggers, Ashley <biggerac@dhec.sc.gov>

Sent: Thursday, February 27, 2020 4:24 PM

To: Crum, Liz <lcrum@burr.com>

Cc: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

Subject: Document

[EXTERNAL EMAIL]

As discussed.

Thanks,
Ashley

Ashley C. Biggers

Chief Counsel for Health Regulation

S.C. Dept. of Health & Environmental Control

Office: (803) 898-3362

Mobile: (803) 354-2928

Connect: www.scdhec.gov [Facebook](#) [Twitter](#)

[REDACTED]

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Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v2

Malcolm Isley <Malcolm.Isley@prismahealth.org>

Fri 2/28/2020 10:10 AM

To: Murdock, Margaret P. <murdocmp@dhec.sc.gov>; Biggers, Ashley <biggerac@dhec.sc.gov>; Eubank, Louis W. <EUBANKLW@dhec.sc.gov>

Cc: O'Daniel, Donna <dodaniel@burr.com>; lcrum@burr.com <lcrum@burr.com>

 1 attachments (24 KB)

Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v2.DOCX;

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Per conversation with Liz.

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PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
14. Prior to signing APA, provide evidence to DHEC that PH sponsoring boards, and county govt. councils of Richland, Fairfield, and Kershaw are aware of transaction.	Not necessary and will not agree	The language "local controlling boards of the Sponsoring Organizations" will be replaced by reference to Prisma Health —Midlands Board. This notification will remain "prior to signing APA." Will remove notification requirement for the government county councils.	Prior to signing APA, provide evidence to DHEC that Prisma Health-Midlands board is aware of the transaction.
15. Within 18 months of the determination letter, System will submit CON application for a freestanding ED in northern area of City of Columbia- 29203. If granted, use best efforts to implement.	Commit to a comprehensive study of emergency services in NE City of Columbia with other stakeholders to develop a plan for emergency and urgent care services within a population health model. Such study will be completed within 18 months of the transaction closing date.	We can add language that says CON application will be filed EITHER in zip code 29203 OR in a similarly disadvantaged and underserved area of Richland County; And we will extend to 24 months (not 18 months).	Commit to a comprehensive study for the need for emergency services in NE City of Columbia with DHEC and other stakeholders. The study will result in a plan addressing the issues identified in the study. Such study and plan will be completed within 18 months of the transaction closing date.
16. Within 12 months submit for review and approval a plan to provide primary care and urgent care services to Lower Richland County. If approved, being operation within 12 months of approval.	Prisma Health will provide primary care services to the Lower Richland community within 24 months of the transaction closing date. No department review and/or approval.	We are fine with extending from 12 to 24 months. We will remove the department review and/or approval requirement. We will keep in the "urgent care" services (in addition to primary care services).	Prisma Health will provide primary care and/or extended primary care hours and/or urgent care services to the Lower Richland community within 24 months of the transaction closing date.

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
17. Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department for review and approval a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.	Already covered under Condition #4, not necessary, and will not agree. We will be creating centers of excellence, consolidating programs, streamlining operations, and re-structuring services. We will comply with Condition #4. Patients currently receiving services from the Seller will continue to be treated by the Buyer post transaction.	Condition #4 was removed after it was pointed out to be redundant by the COPA holder We will keep #17 (#17 in original draft) but we will remove "review and approve" language. We will add language requiring to "notify us of any deviations to your plan."	Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.
18. "In any instance wherein the System determines to close a licensed general hospital, System shall increase by 10% the amount of indigent care provided to patients within the System who qualify for indigent care pursuant to a reasonable indigent care plan. Such plan shall be submitted to the Department for review and approval on an annual basis as part of the System's annual COPA report to the Department."	Prisma Health will provide to the Department its charity care policy as part of the annual COPA report. If we close a general hospital in the area, those patients would be seen at other Prisma Health care sites under the same charity care policy. Patients currently receiving services from the Seller will continue to be treated by the Buyer post-transaction.	We already changed this in the most recent draft to address questions / concerns raised following review of the first draft: We reduced to 5% the amount of charity care and clarified that the baseline is the previous FY (5% over previous FY).	All acquired facilities will be subject to Prisma Health's charity care policy. In the event System determines to close a licensed general hospital, System will provide the Department with a plan that addresses how indigent care patients will be accommodated.
19. System needs to offer a Level 1 trauma services at Richland, and "levels of perinatal services currently provided at Richland Hospital" and at least 9 separately licensed emergency departments with the system. Failure to do so shall lead to immediate revocation of COPA.	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements, the State Health Plan, CON regulations, licensing requirements, volume, reimbursement, payment, or costs for providing these services.	As to Level 1 trauma services and perinatal services, we are okay with adding a 5-year parameter, and adding language that says "subject to no material changes in applicable law." As to "level" of perinatal services, we already	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements, the State Health Plan, CON regulations, licensing requirements, volume, reimbursement, payment, or costs for providing these services.

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
	Prisma Health will not commit to keeping a minimum number of EDs open.	specified it means the level of services provided by the hospital as an RPC (not utilization/volume). As to 9 separately licensed EDs, we will reduce the number to 8 (accounting for the removal of Easley from the COPA in a previous year). We are willing to place a 5-year parameter on this condition as well. We will also remove the language that says the failure to do so shall lead to immediate revocation of the COPA. We will tweak the "uninterrupted" language to allow for the closure of an ED after a CON app for a new FSED is filed but before a decision is made (and/or final), to allow for the possible closure of Providence hospital and ED before a new FSED is approved and/or built open.	Prisma Health will commit to maintaining not less than seven (7) emergency departments, unless otherwise approved by DHEC, for at least five (5) years after the transaction closing date.
20. In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispositions related to physician practices, surgical centers, imaging	Not necessary and will not agree	The Department deems it reasonably necessary to have this information on an annual basis, in the annual report, to actively perform the Department's monitoring duties under COPA.	In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispositions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance abuse and treatment facilities.

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
centers, radiation therapy facilities, or substance abuse and treatment facilities.			
Increase the Tithe to 15%	Agree.	Resolved (Agreed on 15%)	
NEW:		The above changes are predicated upon adding language that will make clear that the conditions will be evaluated for necessity and compliance on an annual basis, and conditions that contain specified time period for compliance.	The above changes are predicated upon adding language that will make clear that the conditions will be evaluated for necessity and compliance on an annual basis, and conditions that contain specified time period for compliance.

Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v4

Malcolm Isley <Malcolm.Isley@prismahealth.org>

Fri 2/28/2020 12:30 PM

To: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>; Biggers, Ashley <biggerac@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

Cc: lcrum@burr.com <lcrum@burr.com>; O'Daniel, Donna <dodaniel@burr.com>

 1 attachments (24 KB)

Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v4.DOCX;

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This is what we can and will agree to. Thank you. Malcolm

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PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
14. Prior to signing APA, provide evidence to DHEC that PH sponsoring boards, and county govt. councils of Richland, Fairfield, and Kershaw are aware of transaction.	Not necessary and will not agree	The language "local controlling boards of the Sponsoring Organizations" will be replaced by reference to Prisma Health —Midlands Board. This notification will remain "prior to signing APA." Will remove notification requirement for the government county councils.	Prior to signing APA, provide evidence to DHEC that Prisma Health-Midlands board is aware of the transaction.
15. Within 18 months of the determination letter, System will submit CON application for a freestanding ED in northern area of City of Columbia- 29203. If granted, use best efforts to implement.	Commit to a comprehensive study of emergency services in NE City of Columbia with other stakeholders to develop a plan for emergency and urgent care services within a population health model. Such study will be completed within 18 months of the transaction closing date.	We can add language that says CON application will be filed EITHER in zip code 29203 OR in a similarly disadvantaged and underserved area of Richland County; And we will extend to 24 months (not 18 months).	Commit to conducting a comprehensive study of access to emergency, urgent and/or extended primary care services in the NE City of Columbia or other disadvantaged area in NE Richland County. Based upon this study, Prisma Health will develop a plan addressing issues identified in the study for presentation to and input from DHEC. Such study and plan will be completed within 18 months of the transaction closing date.
16. Within 12 months submit for review and approval a plan to provide primary care and urgent care services to Lower Richland County. If approved, being operation within 12 months of approval.	Prisma Health will provide primary care services to the Lower Richland community within 24 months of the transaction closing date. No department review and/or approval.	We are fine with extending from 12 to 24 months. We will remove the department review and/or approval requirement. We will keep in the "urgent care" services (in addition to primary care services).	Prisma Health will provide primary care and/or extended primary care hours and/or urgent care services to the Lower Richland community within 24 months of the transaction closing date.

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
17. Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department for review and approval a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.	Already covered under Condition #4, not necessary, and will not agree. We will be creating centers of excellence, consolidating programs, streamlining operations, and re-structuring services. We will comply with Condition #4. Patients currently receiving services from the Seller will continue to be treated by the Buyer post transaction.	Condition #4 was removed after it was pointed out to be redundant by the COPA holder We will keep #17 (#17 in original draft) but we will remove "review and approve" language. We will add language requiring to "notify us of any deviations to your plan."	Prior to closing or permanently reducing number of licensed facilities or beds, System shall submit to department a specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by such change. Prisma Health will also notify DHEC of any deviations to such plan. This is in addition to any notifications or approvals under CON statutes and SC Health Plan.
18. "In any instance wherein the System determines to close a licensed general hospital, System shall increase by 10% the amount of indigent care provided to patients within the System who qualify for indigent care pursuant to a reasonable indigent care plan. Such plan shall be submitted to the Department for review and approval on an annual basis as part of the System's annual COPA report to the Department."	Prisma Health will provide to the Department its charity care policy as part of the annual COPA report. If we close a general hospital in the area, those patients would be seen at other Prisma Health care sites under the same charity care policy. Patients currently receiving services from the Seller will continue to be treated by the Buyer post-transaction.	We already changed this in the most recent draft to address questions / concerns raised following review of the first draft: We reduced to 5% the amount of charity care and clarified that the baseline is the previous FY (5% over previous FY).	All acquired facilities will be subject to Prisma Health's charity care policy. The current charity care policy will be included in the annual COPA report. In the event System determines to close a licensed general hospital, System will provide the Department with a plan that addresses how indigent care patients will be accommodated.
19. System needs to offer a Level 1 trauma services at Richland, and "levels of perinatal services currently provided at Richland Hospital" and at least 9 separately licensed emergency departments with the system. Failure to do so shall lead to immediate revocation of COPA.	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements; the State Health plan, CON regulations, licensing requirements, volume, reimbursement, payment, or costs for providing these services.	As to Level 1 trauma services and perinatal services, we are okay with adding a 5-year parameter, and adding language that says "subject to no material changes in applicable law." As to "level" of perinatal services, we already	Prisma Health will maintain Level 1 trauma services and serve as a regional perinatal center for at least five (5) years post-transaction close date subject to no material changes in program requirements, state law and regulations, and federal law and regulations. Prisma Health will commit to maintaining not less than seven (7) emergency

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
	Prisma Health will not commit to keeping a minimum number of EDs open.	specified it means the level of services provided by the hospital as an RPC (not utilization/volume). As to 9 separately licensed EDs, we will reduce the number to 8 (accounting for the removal of Easley from the COPA in a previous year). We are willing to place a 5-year parameter on this condition as well. We will also remove the language that says the failure to do so shall lead to immediate revocation of the COPA. We will tweak the "uninterrupted" language to allow for the closure of an ED after a CON app for a new FSED is filed but before a decision is made (and/or final), to allow for the possible closure of Providence hospital and ED before a new FSED is approved and/or built open.	departments, unless otherwise approved by DHEC, for at least five (5) years after the transaction closing date.
20. In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispositions related to physician practices, surgical centers, imaging	Not necessary and will not agree	The Department deems it reasonably necessary to have this information on an annual basis, in the annual report, to actively perform the Department's monitoring duties under COPA.	In addition to notification requirements contained in the COPA, the System shall notify the Department through its annual COPA report of any acquisition or dispositions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance abuse and treatment facilities.

PROPOSED DHEC CONDITION	PRISMA HEALTH RESPONSES	DHEC RESPONSES	PMH RESPONSE
centers, radiation therapy facilities, or substance abuse and treatment facilities.			
Increase the Tithe to 15%	Agree.	Resolved (Agreed on 15%)	
NEW:		The above changes are predicated upon adding language that will make clear that the conditions will be evaluated for necessity and compliance on an annual basis, and conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance and need for continuation.	The conditions will be evaluated for necessity and compliance on an annual basis. Conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance and the parties may mutually agree to adjust the time period.

Re: Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v4

Eubank, Louis W. <EUBANKLW@dhec.sc.gov>

Fri 2/28/2020 2:20 PM

To: Malcolm Isley <Malcolm.Isley@prismahealth.org>; Biggers, Ashley <biggerac@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

Cc: lcrum@burr.com <lcrum@burr.com>; O'Daniel, Donna <dodaniel@burr.com>

📎 1 attachments (273 KB)

CONFIDENTIAL_DRAFT STAFF DECISION IN RE PRISMA HEALTH MIDLANDS COPA_2-28-2020.pdf;

Please see attached draft. To the degree it seemed appropriate to meet the intent and commitment of both parties, what your suggested edit had labeled "NE City of Columbia" was amended to "northern City of Columbia" and "NE" was removed from "NE Richland County". If anything was missed among the drafts in creating this document, please assume it was a simple error and let me know what, if any, corrections need to be made. I look forward to your response as soon as possible, with the hopes of signing a final document within the hour.

Best,

Louis

Louis Eubank, Chief

Bureau of Healthcare Planning and Construction

S.C. Dept. of Health & Environmental Control

Office: (803) 545-3652

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From: Malcolm Isley <Malcolm.Isley@prismahealth.org>

Sent: Friday, February 28, 2020 12:28 PM

To: Eubank, Louis W. <EUBANKLW@dhec.sc.gov>; Biggers, Ashley <biggerac@dhec.sc.gov>; Murdock, Margaret P. <murdocmp@dhec.sc.gov>

Cc: lcrum@burr.com <lcrum@burr.com>; O'Daniel, Donna <dodaniel@burr.com>

Subject: Doc#_43077508_v_1_2020.02.27 DHEC Response to Prisma Response to Conditions v4

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February 28, 2020

Mr. Mark S. O'Halla
President and Chief Executive Officer
Prisma Health
300 East McBee Avenue
Suite 300
Greenville, SC 29601

Re: Review of the Certificate of Public Advantage ("COPA") held by Prisma Health – Midlands (Formerly the Palmetto Health Alliance) and update to the conditions as set forth therein.

Dear Mr. O'Halla:

In December 2019, your organization submitted to the South Carolina Department of Health and Environmental Control ("Department") notice of a proposed transaction wherein Prisma Health – Midlands ("PHM") would acquire certain assets currently owned by LifePoint Health ("LPNT")¹ in the Richland County, Fairfield County, and Kershaw County market area. The Department received additional documentation from PHM in support of this transaction in February 2020. Pursuant to S.C. Code Regs. 61-31,§ 508, the Department determined that the proposed changes resulting from the transaction might materially impact the benefits or disadvantages to the community to be served. The Department therefore undertook another review of the COPA.²

As a result of that review, and having given substantial consideration to all information provided by PHM to the Department regarding the proposed transaction, the Department has determined that the ongoing conditions of the COPA shall be amended as follows to provide for the addition of the LPNT assets:

¹ To include Providence Health (HTL-0928), Providence Health – Northeast (HTL-0929), KershawHealth (HTL-0101), and a freestanding emergency department in Fairfield County operating under HTL-0929.

² As noted in an Attorney General opinion issued to the Department on February 25, 2020, the review conducted under Section 508 does not necessarily require the same degree of review and analysis as is undertaken for an application for a COPA.

1. PHM will provide a full report to the Department every other year which will include, at a minimum, responses to the questions in Regulation 61-31, Health Care Cooperative Agreements, Section 502 (B); the previous fiscal year's independent audited financial statements; and information which will enable the Department to evaluate each of the conditions listed below. In years when a full report is not required, PHM will provide the Department an abbreviated report which will include, at a minimum, an annual audited financial statement plus a description of the programs and services PHM provides through its Community Outreach Programs as described in Condition 2, as well as the required reporting as described in Conditions 17 and 19. All reports, full and abbreviated, may require additional information the Department feels is necessary to adequately evaluate PHM's compliance with the COPA and the COPA conditions. These annual reports are due to the Department no later than 120 days after the end of each fiscal year. In addition, PHM will provide a revised three (3) year forecasted financial statement, which may be based upon its most recently Board approved budget and Board accepted audited financial report, and which projects three (3) years forward from the end of the most recent fiscal year. PHM will also make available to the Department all of its managed care contracts for inspection, if necessary, which will be considered proprietary and not subject to disclosure.
2. PHM will provide fifteen percent (15%) of its "excess revenues over expenses" to fund public health initiatives and community outreach programs. Efforts funded with this money, as a community benefit, will be evaluated each year as a part of the information required in Condition Number 1. The evaluation will be based on the benefits, changes, and/or accomplishments that occur because of the activities and services provided by the programs and for which the program is held accountable. The evaluation will consider whether these programs are reaching populations that might otherwise not receive such services without the Certificate of Public Advantage.
3. As a part of the information required in Condition Number 1, PHM will report on the nature, source and amount of capital expenditures avoided during the preceding fiscal year. In addition, PHM will report major operational savings that can be documented as they relate to the acquisition of the LPNT assets. Costs used to document the above savings must be specific to the acquisition, that is, savings that occurred because of the acquisition and not savings that would have been realized even if the acquisition had not occurred.
4. PHM will provide access to competing licensed facilities for those services not offered by such facility in the core service area upon non-discriminatory terms and conditions to any competing licensed facility that requests such access. For services not offered by competing licensed facilities in the core service area, PHM will give them terms and conditions equal to the lowest of the amount which would be received from patients insured by any of PHM's three largest commercial payers. That PHM will continue this access for which it is the sole

provider until such time as a competing licensed facility offers the service, and will terminate only in the event that South Carolina repeals its Certificate of Need laws or that such laws otherwise cease to be applicable. Additionally, PHM must make available to the Department, upon request, names of any facilities, to include terms and conditions, to which services have been offered.

5. PHM will continue a relationship substantially similar to the relationship set forth in the affiliation agreement between Prisma Richland Hospital and the University of South Carolina School of Medicine and continue to support medical education. If a clinical service is determined to be located at only one Sponsoring Organization's facility, the medical graduate medical, and allied health education programs will have access to that clinical service at the facility in which the service is to be located, to the extent that is necessary to complete the education and training as required by the program.
6. Should PHM change controlling interest by purchase, lease, assignment, management contract, transfer or comparable arrangement, the new operating entity as a condition of the change will adhere to all the conditions of this approval and all representations put forth in the Certificate of Public Advantage application and subsequent submissions.
7. As part of the information required in Condition Number 1, "generally accepted accounting principles" consistently applied, but excluding extraordinary revenue and expenses, losses on extinguishments of debt and the impact of any mark to market adjustments on derivative instruments, will be used to calculate net of revenues over expenses in the annual report for determining the 15% public health commitment and that such financial statements will be certified by an independent auditor. However, should any of these other items result in cash gains or losses, they may be included in net revenues over expenses.
8. Neither PHM nor any of their affiliates, may enter into a contract that by its terms precludes third party payers from contracting with other hospitals in the core service area identified by the Sponsoring Organizations. This does not prevent third party payers from unilaterally choosing not to contract with a hospital that is competitive.

However, it must be the decision of the payer and not be required as a condition of a contract with PHM or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

In addition, PHM will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require PHM to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will, as a part of its ongoing monitoring process, investigate consistent complaints from employers and

managed care payers to ensure compliance with this condition and will take appropriate regulatory action when necessary.

9. Except to the extent required by vendors, suppliers or Group Purchasing Organizations ("GPOs"), neither PHM, nor its affiliates, shall condition any contracts with suppliers, vendors, or GPOs that preclude or limit such suppliers, vendors, or group purchasing organizations to contract with other providers in the core service area identified by the Sponsoring Organizations.
10. The Department may amend these conditions to include, but not be limited to, the lowering of prices should unexpected events lead to abnormally high margins from operations.
11. PHM will adhere to the commitments it has outlined in its "Summary of System Commitments and Proposed DHEC Monitoring" in its application and all other representations made in the Certificate of Public Advantage application and all of its subsequent submissions, to the extent that they are consistent with the conditions of this approval, and that may not be specifically described in these conditions.
12. PHM will pay to the Department an annual monitoring fee to cover the actual cost of audits and monitoring. This fee will be used by the Department in whatever manner solely for the purpose of monitoring these conditions.
13. Prior to the final execution of the Asset Purchase Agreement ("APA") by and between PHM and LPNT regarding those assets outlined the December 2019 and February 2020 submissions to the Department by PHM, PHM shall submit to the Department evidence that the Board of PHM is aware of the transaction.
14. PHM will conduct a comprehensive study of access to emergency, urgent, and/or extended primary care services within the northern City of Columbia or other disadvantaged area of Richland County. Based upon this study, PHM will develop a plan to address those issues identified in the study for presentation to, and input from, the Department. Such a study will be completed within eighteen (18) months of the closing date of the transaction.
15. Within twenty-four (24) months of the closing date of the transaction, PHM will begin provision of primary care, and/or extended-hours primary care, and/or urgent care services to the Lower Richland community.
16. Prior to closing or permanently reducing the number of licensed facilities or beds held by PHM, PHM shall submit to the Department for review and approval its specific plan for the transfer of those services, beds, patients, medical professionals, and/or other staff affected by

such a change. This requirement shall be in addition to those requirements set forth in S.C. Code 44-7-110 *et seq.*, and the *South Carolina Health Plan*.

17. All acquired facilities will be subject to the charity care policy of PHM. The current charity care policy in force at the time of submission will be included in PHM's annual COPA report. In the event PHM determines to close a licensed general hospital, PHM will provide the Department with a plan that addresses how indigent care patients will be accommodated.
18. PHM will maintain Level 1 trauma services and serve as a Regional Perinatal Center for at least five (5) years following the date of closing of the transaction, subject to no material change in program requirements, state law or regulations, and federal law or regulations. Further, PHM will commit to operating no less than seven (7) emergency departments, unless otherwise approved to do so by the Department, for at least five (5) years following the date of closing of the transaction.
19. In addition to the requirements set forth in the *Health Care Cooperation Act*, S.C. Code Ann. Sections 44-7-500 through 44-7-590, the *Health Care Cooperative Agreements Regulation*, S.C. Code Ann. Regs. 61-31, and these Conditions, PHM shall notify the Department through its annual COPA report of any acquisitions or dispossessions related to physician practices, surgical centers, imaging centers, radiation therapy facilities, or substance use and treatment facilities.
20. These Conditions will be evaluated for necessity and compliance on an annual basis. Those Conditions that contain specified time periods will be evaluated at the end of that specified time period for compliance, and PHM and the Department may mutually agree to adjust the specified time period.

Your continued cooperation and compliance is greatly appreciated. Please do not hesitate to contact me with any questions you might have.

Very Respectfully,

Louis Eubank, Chief
Bureau of Healthcare Planning & Construction

EXHIBIT B

To Response and Cross-Motion

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control Prisma Health -
Midlands,

Respondents.

Docket No.: 20-ALJ-07-0108-CC

AFFIDAVIT OF ARMAND BALSANO

1. I have personal knowledge of the facts stated herein.
2. I am a healthcare planning consultant with over 30 years of experience in the healthcare arena. I have served as an expert witness in the areas of healthcare planning and financial feasibility for administrative hearings in South Carolina, North Carolina, Georgia, Florida, Kentucky, and Alabama. I have also served as a consultant for projects involving anti-trust issues and review. A CV outlining my education and experience is included as Attachment A.
3. I was engaged by Lexington Medical Center to assist in the opposition to DHEC's Decision to amend COPA-97-01 at the request of Prisma Health-Midlands (PHM).
4. As part of my engagement and specifically in considering a response to PHM's Motion for Summary Judgment, I have reviewed the following documents:
 - DHEC FOIA documents.
 - Documents produced by PHM in discovery.
 - Prehearing Statements for all parties.
 - Briefing and Orders on scheduling, intervention and summary judgment.
5. The COPA issued in 1997 approved a transaction proposed by Baptist Healthcare System of South Carolina, Inc. (BHS) and Richland Memorial Hospital (RMH), whereby BHS and RMH would be jointly operated as a single unit by a newly formed nonprofit entity to be called BR Health System, Inc. (BR Health). The transaction was the subject of an application filed by BHS and RMH with an extensive public review process, which included a public hearing and culminated in a record of more than 1,500 pages.

6. At the time of the review and approval of BHS and RMH's application, the alternatives to the proposed combined system in the core service area were LMC and "Columbia/HCA-Providence Hospital." According to the 1996 COPA application, Columbia/HCA was "uniformly viewed as a very significant constraint on the System and as a significant competitive threat to Richland and Baptist." (DHEC FOIA 0059). Columbia/HCA was a focus of the competitive landscape discussions in the COPA application, described to "provide more than enough competition to prevent the JOA from having an adverse effect on the ability of purchasers to negotiate favorable rates." (DHEC FOIA 0062). According to the COPA application:

In fact, one employer went so far as to say that separately, Baptist and Richland would not be able to compete against Columbia/HCA, and that if the System were not created, Columbia/HCA would buy one of the hospitals and completely dominate the market. (DHEC FOIA 0063).

7. It is my understanding from the Letter of Intent produced in this contested case that Prisma Health desires to acquire assets owned by LifePoint Health and intends to use its affiliate, PHM, as the buyer. I have not reviewed the complete Asset Purchase Agreement that was executed after DHEC's decision, but understand that the Court has received information from PHM demonstrating that the COPA is a condition of the proposed transaction between Prisma and LifePoint. To date, LMC has not received a copy of the documents that were submitted to the Court.
8. From the information available to me regarding the transaction between Prisma/PHM and LifePoint, it is my opinion that if the transaction could be considered a change to COPA-97-01, review of that proposed change requires more than the internal desk review by DHEC staff that preceded the DHEC decision.
9. I agree with the determination by DHEC that the transaction proposed by PHM, which is the acquisition of assets of competing hospitals in the market, is a substantial change to COPA-97-01. In my opinion, this substantial change requires a new COPA application and review.
10. In the 23 years since COPA-97-01 was issued, there have been significant changes to virtually every aspect of the relevant healthcare market. I have preliminarily looked at publically available information such as population, patient days and discharge data to highlight the significance of the proposed transaction in the current competitive landscape.
11. In 1997, the geographic region or service area was identified as consisting of the following seven counties: Richland, Lexington, Kershaw, Sumter, Orangeburg, Newberry and Fairfield. The 1997 estimated total population of these counties was a combined 818,324 residents. The 2019 estimate shows a population of 1,034,743, reflecting an increase of 216,419 additional residents or 26.4 percent.
12. Hospital utilization, like most healthcare services, is disproportionately weighted towards the 65 years and older age cohort. This age cohort saw even more dramatic increases. The 1997 population age 65+ was 88,748. By 2019, the 65+ age cohort had grown 84.9 percent

to a total of 164,100 residents. The demographic changes alone during the intervening 23 years would appear to constitute the need for the submission and review of a new COPA application.

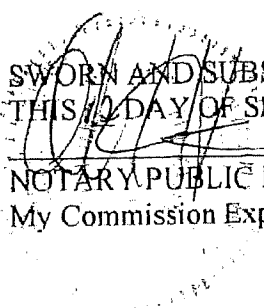
13. The development of the Prisma Health system and other changes during this period have also resulted in changes to the competitive landscape:

- There are ten hospital providers located in the geographic region or service area. Of these, the four Prisma Hospitals (Prisma Health Baptist Parkridge, Prisma Health Baptist, Prisma Health Richland, and Prisma Health Tuomey Hospital) have the highest number of provider patient days. Collectively in 2018, Prisma Hospitals reported a total of 327,952 patient days of care, which represents 56.5 percent of the total 580,785 patient days for all ten hospitals.
- With the inclusion of Providence Health, Providence Health Northeast, and Kershaw Health, Prisma's share of total provider patient days jumps to 66.5 percent.
- The two Providence Hospitals (Providence Health and Providence Northeast) and Kershaw Health have a primary service area that would include Richland, Lexington and Kershaw Counties. These three Primary Service Area (PSA) Counties account for 79 percent of admissions at Providence Health, 77 percent of admissions at Providence Health Northeast, and 86 percent of admissions at Kershaw Health.
- There are seven hospitals in the PSA of Richland, Lexington and Kershaw Counties. This subset of PSA providers reflects a higher degree of Prisma dominance. The three Prisma Hospitals in this PSA (Prisma Health Baptist Parkridge, Prisma Health Baptist, and Prisma Health Richland) currently provide 282,805 patient days of care of the total 474,201, resulting in a capture of 59.6 percent.
- With the inclusion of Providence Health, Providence Health Northeast, and Kershaw Health, Prisma's share of total provider patient days jumps to 71.9 percent within the PSA.

14. From the standpoint of health planning and due diligence, it is my opinion that the demographic changes and changes in the competitive landscape support the necessity of a new COPA application.

FURTHER AFFIANT SAYETH NOT.


Armand Balsano


SWORN AND SUBSCRIBED BEFORE ME
THIS 12 DAY OF SEPTEMBER, 2020.

NOTARY PUBLIC FOR THE STATE OF GEORGIA
My Commission Expires: 7/30/21

EXHIBIT C

To Response and Cross-Motion

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 2/18/2020 1:29:44 PM
To: Marshall Taylor (marshall.taylor@dhec.sc.gov) [marshall.taylor@dhec.sc.gov]; 'Ashley C. Biggers (biggerac@dhec.sc.gov)' [biggerac@dhec.sc.gov]
CC: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) [davidsummer@parkerpoe.com]
Subject: FW: Bob, we met this morning at DHEC. If you have

Do you want to come over here to meet and we can call Bob from here. Might be easier in the room together. Liz



AL * DE * FL * GA
MS * NC * SC * TN

M. Elizabeth "Liz" Crum * *Counsel*

1221 Main St., Suite 1800, Columbia, South Carolina 29201
main 803-799-9800 * fax 803-753-3278 * cell 803-331-1185
lcrum@burr.com * www.burr.com

360 Attorneys. 19 Offices. 1 Firm. Southeast Strong.

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From: Bob Cook <BCook@scag.gov>
Sent: Tuesday, February 18, 2020 1:27 PM
To: Crum, Liz <lcrum@burr.com>; Marshall Taylor (marshall.taylor@dhec.sc.gov) <marshall.taylor@dhec.sc.gov>; 'Ashley C. Biggers (biggerac@dhec.sc.gov)' <biggerac@dhec.sc.gov>
Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>
Subject: RE: Bob, we met this morning at DHEC. If you have

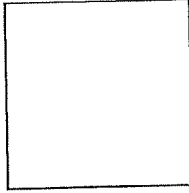
[EXTERNAL EMAIL]

Call me at 734-3792

Robert D. Cook
Solicitor General
S.C. Attorney General's Office
P.O. Box 11549
Columbia, S.C. 29211
P: 803-734-3736
F: 803-734-3524

From: Crum, Liz <lcrum@burr.com>
Sent: Tuesday, February 18, 2020 1:26 PM
To: Bob Cook <BCook@scag.gov>; Marshall Taylor (marshall.taylor@dhec.sc.gov) <marshall.taylor@dhec.sc.gov>; 'Ashley C. Biggers (biggerac@dhec.sc.gov)' <biggerac@dhec.sc.gov>
Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>
Subject: RE: Bob, we met this morning at DHEC. If you have

Suits us. Marshall/Ashley? Liz



AL * DE * FL * GA
MS * NC * SC * TN

M. Elizabeth "Liz" Crum * Counsel

1221 Main St., Suite 1800, Columbia, South Carolina 29201
main 803-799-9800 * fax 803-753-3278 * cell 803-331-1185
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From: Bob Cook <BCook@scag.gov>

Sent: Tuesday, February 18, 2020 1:24 PM

To: Crum, Liz <lcrum@burr.com>; Marshall Taylor (marshall.taylor@dhsc.sc.gov) <marshall.taylor@dhsc.sc.gov>; 'Ashley C. Biggers (biggerac@dhsc.sc.gov)' <biggerac@dhsc.sc.gov>

Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>

Subject: RE: Bob, we met this morning at DHEC. If you have

[EXTERNAL EMAIL]

Can't we do this by phone?

Robert D. Cook
Solicitor General
S.C. Attorney General's Office
P.O. Box 11549
Columbia, S.C. 29211
P: 803-734-3736
F: 803-734-3524

From: Crum, Liz <lcrum@burr.com>

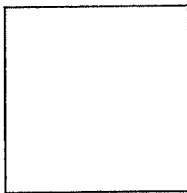
Sent: Tuesday, February 18, 2020 12:55 PM

To: Bob Cook <BCook@scag.gov>; Marshall Taylor (marshall.taylor@dhsc.sc.gov) <marshall.taylor@dhsc.sc.gov>; 'Ashley C. Biggers (biggerac@dhsc.sc.gov)' <biggerac@dhsc.sc.gov>

Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com) <davidsummer@parkerpoe.com>

Subject: RE: Bob, we met this morning at DHEC. If you have
Importance: High

Thanks, Bob. Ashley, Marshall, David and I will be at your office at 3 pm today. I promise we will not take too much of your time. Liz



AL * DE * FL * GA
MS * NC * SC * TN

M. Elizabeth "Liz" Crum * Counsel

1221 Main St., Suite 1800, Columbia, South Carolina 29201
main 803-799-9800 * fax 803-753-3278 * cell 803-331-1185
lcum@burr.com * www.burr.com

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From: Bob Cook <BCook@scag.gov>

Sent: Tuesday, February 18, 2020 11:42 AM

To: Crum, Liz <lcum@burr.com>; Marshall Taylor (marshall.taylor@dhec.sc.gov) <marshall.taylor@dhec.sc.gov>;
'Ashley C. Biggers (biggerac@dhec.sc.gov)' <biggerac@dhec.sc.gov>

Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com)
<davidsummer@parkerpoe.com>

Subject: RE: Bob, we met this morning at DHEC. If you have

[EXTERNAL EMAIL]

That is fine but I don't have much time.

Robert D. Cook
Solicitor General
S.C. Attorney General's Office
P.O. Box 11549
Columbia, S.C. 29211
P: 803-734-3736
F: 803-734-3524

From: Crum, Liz <lcum@burr.com>

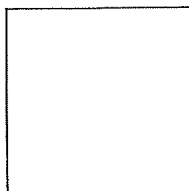
Sent: Tuesday, February 18, 2020 11:39 AM

To: Bob Cook <BCook@scag.gov>; Marshall Taylor (marshall.taylor@dhec.sc.gov) <marshall.taylor@dhec.sc.gov>;
'Ashley C. Biggers (biggerac@dhec.sc.gov)' <biggerac@dhec.sc.gov>

Cc: David B. Summer, Jr. - Parker, Poe, Adams & Bernstein L.L.P. (davidsummer@parkerpoe.com)
<davidsummer@parkerpoe.com>

Subject: Bob, we met this morning at DHEC. If you have

15 minutes to talk sometime this afternoon after 3 pm, Marshall, Ashley, David and I would love to talk to you together about a possible letter regarding "another review". Thx in advance for your time. Best, Liz



AL * DE * FL * GA
MS * NC * SC * TN

M. Elizabeth "Liz" Crum * Counsel

1221 Main St., Suite 1800, Columbia, South Carolina 29201
main 803-799-9800 * fax 803-753-3278 * cell 803-331-1185
lcum@burr.com * www.burr.com

360 Attorneys. 19 Offices. 1 Firm. Southeast Strong.

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Message

From: Crum, Liz [lcrum@burr.com]
Sent: 2/25/2020 2:51:37 PM
To: Bob Cook [BCook@scag.gov]
Subject: RE: did you get the opinion from Marshall?

It was a Perfect legal interpretation! Hope your brief is filed! Best, liz

**BURR
FORMAN
MCNAIR**

AL • DE • FL • GA
MS • NC • SC • TN

M. Elizabeth "Liz" Crum • *Counsel*

1221 Main St., Suite 1800, Columbia, South Carolina 29201

main 803-799-9800 • fax 803-753-3278 • cell 803-331-1185

lcrum@burr.com • www.burr.com

360 Attorneys. 19 Offices. 1 Firm. Southeast Strong.

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From: Bob Cook <BCook@scag.gov>
Sent: Tuesday, February 25, 2020 2:34 PM
To: Crum, Liz <lcrum@burr.com>
Subject: RE: did you get the opinion from Marshall?

[EXTERNAL EMAIL]

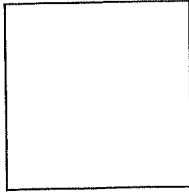
So I assume it was what was needed?

Robert D. Cook
Solicitor General
S.C. Attorney General's Office
P.O. Box 11549
Columbia, S.C. 29211
P: 803-734-3736
F: 803-734-3524

From: Crum, Liz <lcrum@burr.com>
Sent: Tuesday, February 25, 2020 2:33 PM
To: Bob Cook <BCook@scag.gov>
Subject: Re: did you get the opinion from Marshall?

Yes, thank you soooooo much. Best, Liz

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MS * NC * SC * TN

M. Elizabeth "Liz" Crum * *Counsel*

1221 Main St., Suite 1800, Columbia, South Carolina 29201
main 803-799-9800 * fax 803-753-3278 * cell 803-331-1185
lcum@burr.com * www.burr.com

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On Feb 25, 2020, at 2:30 PM, Bob Cook <bcook@scag.gov> wrote:

[EXTERNAL EMAIL]

Robert D. Cook
Solicitor General
S.C. Attorney General's Office
P.O. Box 11549
Columbia, S.C. 29211
P: 803-734-3736
F: 803-734-3524

Message

From: Elizabeth Crum [mecrum522@gmail.com]
Sent: 7/23/2020 11:10:50 AM
To: Crum, Liz [lcrum@burr.com]
Subject: Text 11/7/19

[EXTERNAL EMAIL]

Rick, any chance we can talk at lunch for 5 minutes. In MUSC CON hearing but will break for lunch at mid day. Want to talk about whether we can agree that all we need to do is amend the COPA agreement along the lines David and I talked about with you and Rupi. Thx, Liz

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 8/13/2020 3:27:38 PM
To: Oken, Melissa [MOken@burr.com]
Subject: Marshall. 2/27/20

Marshall, this is Liz. We are closer. Who can I talk to you tomorrow about the draft that Ashley sent me this afternoon she copied she didn't copy you I don't think that she copied Lewis and Maggie. Can I meet with you tomorrow? Obviously I don't want to meet with your client without a lawyer there. We ROK on a couple of them completely. There are a couple that we have just minor edits like an end or so who can I meet with tomorrow. If you want to have staph there I can get Malcolm down too. Thx, Liz

That is great news. Let me touch base with Ashley this evening. I may ask her to call in if we are talking finalizing things. I have meetings in the am but Ashley may have some availability by phone in the morning. I am not suggesting that we can agree to everything. We cannot agree to # 15, 18 9r 19. Need to talk more. We are OK with # 14, 16 with minor edit, 17, 20 and an edit on 21. Liz

9r is supposed to be or. Liz

Ashley said she would ring you a ring around 930 in the morning. Don't want to switch up lawyers this late in discussion if not necessary.

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M. Elizabeth "Liz" Crum
Counsel
Columbia
Direct: 803-753-3240
Cell: 803-331-1185

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 8/13/2020 3:29:59 PM
To: Oken, Melissa [MOken@burr.com]
Subject: Marshall 3/17/20

Marshall, sorry to bother you. Know you have your hands full. I asked Ashley whether anyone from Prisma or on their behalf could contact DHEC board members during the rfr for the Copa staff decision. She did not know and suggested I call you. Left a voicemail this morning. In the meantime we are not contacting any board members. We don't want to do anything that would upset the apple cart. We really appreciate knowing your thoughts on that. It's somewhere between contacting board members for the State Health Plan and not being able to contact board members once a con is filed. There's a specific statutory requirement on the c o n. Thanks Liz hang in there. If there's anything I can do to help let me know
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M. Elizabeth "Liz" Crum
Counsel
Columbia
Direct: 803-753-3240
Cell: 803-331-1185

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 8/13/2020 3:34:47 PM
To: Oken, Melissa [MOken@burr.com]
Subject: Marshall 4/19/20

I thought the 48 hours under the policy ran Friday? I am assuming that Denise, as the board Clerk, confirm that each of the board members received the package. I would hope that DHEC would go ahead and send out the declination letter, as long as no member did not request additional time or ask for review within the 48-hour period. You stay safe too. Don't get wet and keep your alert system own. I'm going for a walk before the rain starts. Talk Monday. Sorry to bother you on the weekend. Thanks Liz
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M. Elizabeth "Liz" Crum
Counsel
Columbia
Direct: 803-753-3240
Cell: 803-331-1185

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 8/13/2020 3:39:13 PM
To: Oken, Melissa [MOken@burr.com]
Subject: Marshall 4/19/20

No worries. I have been covered up today. Let me check on it for you.

Thx, much. Liz

Still under consideration.

Not sure I understand what under consideration means? The, Liz

Has someone asked for more time to consider? Liz

Do you have time for a quick call with David and me either later today or tomorrow morning. Liz

Yes. I have a couple meetings first thing. Will tomorrow around 1030 work?

That works. Thx, I will send out a call in number. Have a good evening. Thx, Liz

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M. Elizabeth "Liz" Crum
Counsel
Columbia
Direct: 803-753-3240
Cell: 803-331-1185

Message

From: Crum, Liz [lcrum@burr.com]
Sent: 8/13/2020 12:05:44 PM
To: Oken, Melissa [MOken@burr.com]
Subject: Text 2/13/20

Marshall, David and I just met with General Wilson. We would love to talk with you. Let me know if you can talk now or if there's a time later on this afternoon. We can talk. Thanks, Liz. You can call me by send me a text on my cell and we'll call. Thanks. Bye. Bye.

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M. Elizabeth "Liz" Crum
Counsel
Columbia
Direct: 803-753-3240
Cell: 803-331-1185

EXHIBIT D

To Response and Cross-Motion

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

DOCKET NO. 20-ALJ-07-0108-CC

**RESPONDENT SOUTH CAROLINA
DEPARTMENT OF HEALTH AND
ENVIRONMENTAL CONTROL'S
RESPONSES TO PETITIONER'S
FIRST REQUESTS FOR ADMISSION**

GENERAL OBJECTIONS

RESPONSES TO REQUESTS FOR ADMISSION

1

RESPONSE TO REQUEST FOR ADMISSION NO. 1:

Admit that DHEC's February 28, 2020, letter states "Pursuant to S.C. Code Regs. 61-31, § 508, the Department determined that the proposed changes resulting from the transaction might materially impact the benefits or disadvantages to the community to be served. The Department therefore undertook another review of the COPA," but deny that DHEC made the afore-quoted determination in its February 28, 2020 letter to the extent it implies DHEC made the determination on that date. DHEC provided written notice of its afore-quoted determination in its February 28, 2020 letter.

REQUEST FOR ADMISSION NO. 2:

Admit or Deny: DHEC did not make a determination in its staff decision dated February 28, 2020, that the likely benefits resulting from the transaction proposed by Prisma Health – Midlands outweighed the likely disadvantages.

RESPONSE TO REQUEST FOR ADMISSION NO. 2:

Admit.

REQUEST FOR ADMISSION NO. 3:

Admit or Deny: DHEC did not make a determination in its staff decision dated February 28, 2020, that the reduction in competition likely to result from the transaction proposed by Prisma Health – Midlands is necessary to obtain the benefits likely to result.

RESPONSE TO REQUEST FOR ADMISSION NO. 3:

Admit.

REQUEST FOR ADMISSION NO. 4:

Admit or Deny: DHEC did not publish notice in the State Register of its receipt of Prisma Health Midlands's request to amend, alter or otherwise change the COPA originally issued in 1997.

RESPONSE TO REQUEST FOR ADMISSION NO. 4:

Admit.

REQUEST FOR ADMISSION NO. 5:

Admit or Deny: The proposed transaction is a cooperative agreement between Prisma Health Midlands and LifePoint Health for the acquisition of assets by Prisma Health – Midlands.

RESPONSE TO REQUEST FOR ADMISSION NO. 5:

Deny.

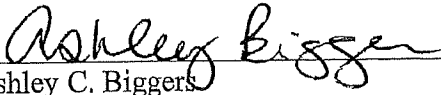
REQUEST FOR ADMISSION NO. 6:

Admit or Deny: Prisma Health – Midlands and LifePoint Health did not submit an application to the Department for a certificate of public advantage.

RESPONSE TO REQUEST FOR ADMISSION NO. 6:

Admit.

This 27th day of July, 2020


Ashley C. Biggers
biggerac@dhec.sc.gov
Vito W. Wicevic
wicevivm@dhec.sc.gov
Meredith W. Sella
sellamw@dhec.sc.gov
South Carolina Department of Health and
Environmental Control
2600 Bull Street
Columbia, SC 29201
(803) 898-3350 (telephone)
(803) 898-3367 (fax)

*Attorneys for Respondent South Carolina
Department of Health and Environmental
Control*

RECEIVED

Jan 08 2021

SC Court of Appeals

EXHIBIT F

To LMC's Return

LMC's Response to Motion to Clarify & Motions to Reconsider

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District
Inc., d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control, Prisma Health-
Midlands, Providence Hospital, LLC d/b/a
Providence Health, Providence Health
Northeast and Providence Health Fairfield,
and Kershaw Hospital, LLC d/b/a
KershawHealth Medical Center,

Respondents.

Docket No. 20-ALJ-07-0108-CC

**PETITIONER'S RESPONSE TO
MOTION TO CLARIFY AND MOTIONS
TO RECONSIDER (ALTER OR AMEND)
BY RESPONDENTS**

Petitioner, Lexington County Health Services District, Inc., d/b/a Lexington Medical Center (LMC), hereby submits this Response to the Motions filed by Respondent Prisma Health-Midlands (PHM) and Respondents Providence Hospital, LLC d/b/a Providence Health, Providence Health Northeast and Providence Health Fairfield, and Kershaw Hospital, LLC d/b/a KershawHealth Medical Center ("LifePoint" or "LPNT"), both on November 12, 2020, and which seek reconsideration and/or clarification of the Court's Order Denying Cross-Motions for Summary Judgment (Order).

STANDARD OF REVIEW

The Rules of Procedure for the Administrative Law Court (SCALC) allow a party to "move for reconsideration of a final decision of an administrative law judge in a contested case to alter or amend the final decision" SCALC Rule 29(D) (emphasis added). Because the denial of summary judgment does not terminate the action, Rule 29(D) would not appear to be a mechanism by which Respondents obtain relief from the Order. However, this Court has previously entertained

a similar motion filed in response to an interlocutory ruling as a means to clarify a prior order. *CareAlliance Health Svcs., et al. v. S.C. Dept. of Health and Envtl. Control*, 2019 WL 3816796 *1 (S.C. Admin. Law J. Div. Aug. 5, 2019).

DISCUSSION

I. MOTION BY LIFEPOINT

As to the Motion filed by LifePoint, LMC generally agrees that the Order can be distilled to “two dispositive legal conclusions in support of the denial” of both summary judgment motions. LPNT Mot., p. 2. The Court summarizes the two dispositive conclusions at Page 7 of the Order:

For the reasons below, the Court concludes the Agreement underling the transaction does not qualify as a cooperative agreement requiring a new application. However, the Court further concludes because the acquisition of the Assets by PHM does not qualify as the kind of transaction that is regulated under the COPA Act, and the Assets are not part of the original cooperative agreement underlying the existing COPA, the Assets cannot be subsumed into the existing COPA.

Order, p. 7. LMC believes the above language directly identifies the two key conclusions of the Order, as compared to LifePoint’s framing¹ in its Motion. Postured as reconsideration, LifePoint’s Motion asserts that the Court’s “conclusions of law . . . have the effect of ending this matter insofar as contested case review by the ALC is concerned,” and asks the Court to “clarify that the effect of its Order is to overturn the Department’s decision and to end the case” LPNT Mot., pp. 3-4. LMC agrees that the effect of the Order is to overturn the Department’s Decision of February 28, 2020, which is the subject of this contested case. LMC also agrees that it is the framing by the Court of the legal issues raised by summary judgment that led the Court to deny both motions “because ‘neither parties’ interpretation of the law’ is correct.” LPNT Mot., p. 3 (quoting Order, p. 12). LMC disagrees with LifePoint’s assertion, however, “that no further motions for summary

¹ LifePoint’s description of the “second dispositive legal conclusion” identifies what is more aptly described as the Court’s discussion of facts and arguments relevant to the second conclusion quoted above from Page 7. *See* LPNT Mot., p. 2.

judgment can be asserted by the parties in this case.” *Id.*, p. 4. This assertion is logically inconsistent with the current procedural posture of the case, as the relevant jurisprudence is that “denial of a motion for summary judgment does not bar a party from making a later motion for summary judgment based on matters not involved in the decision on the first motion.” *Crosswell Enter., Inc. v. Arnold*, 309 S.C. 276, 279, 422 S.E.2d 157, 159 (Ct. App. 1992) (holding the trial court has the power to permit a second dispositive motion following a first unsuccessful motion prior to trial).

In the Order, the Court’s decision frames its analysis around whether the proposed transaction is a “cooperative agreement” under the COPA Act, rather than whether DHEC properly approved the proposed transaction by way of amendment to COPA-97-01. *See* Order, p. 6. Because the Court disagrees with LMC’s interpretation of “cooperative agreement,” instead accepting the arguments of PHM and DHEC that “the proposed transaction is not a cooperative agreement as defined in the HCCA” (DHEC Resp. in Opp. to Cross-Mot. Summ. J., p. 3), the Court declined to grant judgment in favor of LMC “to the extent LMC asks this Court to find as a matter of law that the addition of the Assets requires a new COPA application.” (Order, p. 10). The Order does not otherwise identify disputed material facts, and the facts were fully developed at the hearing on the motions. Given the Court’s Order and dispositive conclusions regarding the transaction proposed by PHM, LMC submits summary judgment is appropriate² on the primary legal argument raised in its Petition for Administrative Review and Request for Contested Case Hearing, also addressed in its Prehearing Statement: “DHEC does not have the authority to ‘update’ or ‘amend’ the ongoing

² LMC continues to disagree with the interpretation now adopted by the Court that a “cooperative agreement” under Code Section 44-7-510 cannot be a single health care provider’s agreement to acquire the assets of another health care provider. *See* Order, p. 9; *see also* S.C. Code Ann. § 44-7-510. However, LMC believes the Court’s conclusion on the definition of “cooperative agreement” does not eliminate the propriety of summary judgment.

conditions of COPA-97-01, originally issued to BSH and RMH on October 6, 1997, in order to include PHM's proposed acquisition of LPNT's assets." LMC Prehr'g Stmt., pp. 2-3; *see also* 10A Wright, Miller & Kane, *Federal Practice and Procedure* § 2720 (4th ed. Supp. 2020) (addressing that in nonjury cases involving cross-motions for summary judgment, court may render judgment on the merits if nothing more to be offered and no prejudice to the parties). In light of the Court's stated intention to address LifePoint's request for clarity, LMC will await further direction from the Court on the question of whether DHEC's Decision is void and unenforceable because PHM cannot subsume the LPNT Assets into COPA-97-01 by way of amendment. *Cf. Celotex Corp. v. Catrett*, 477 U.S. 317, 326 (1986) (addressing widely acknowledged power of district courts to enter summary judgment *sua sponte* where losing party has notice of need to prove case).

II. MOTION BY PRISMA HEALTH-MIDLANDS

A. Clarification as to Finality of the Order

First, LMC disagrees with PHM's revisionist history regarding COPA-97-01, which is factually inaccurate,³ and misleadingly characterizes the Court's Order as finding, "as a matter of law, that DHEC did not have the authority to issue a COPA reserving the right to impose future additional conditions." PHM Mot., p. 6. LMC finds nothing in the Order that can conceivably be considered a finding that DHEC "lacked the authority" to issue COPA-97-01 with the condition in Paragraph 20 regarding the discretion to make future amendments. However, while LMC disagrees with PHM's evaluation of the Court's Order, LMC agrees that "there no longer appears to be a case or controversy before this Court" (PHM Mot., p. 6) and that the parties would benefit

³ For example, the "Procedural Status" of PHM's Motion asserts, "As the Court is aware, PHM has to execute the APA on or before March 2, 2021 or lose a minimum of \$5,000,000 and more probably \$10,000,000." PHM Mot., p. 2. The APA was executed on March 2, 2020. Furthermore, DHEC's letter approving COPA-97-01 was issued to BHS and RMH, not PHM, and based on the application submitted by BHS and RMH, not PHM.

from clarification of the Order to reflect the finality of this contested case.

B. Points for Reconsideration to Alter or Amend

Although the Motion raises several points, PHM essentially makes two arguments: the Court improperly and “*sua sponte*” addresses issues of which “PHM had neither notice nor opportunity to address” or the Court erred as a matter of law. *See* PHM Mot., pp. 6-11.

1. *Sua Sponte* Issues

None of the issues identified in the Motion are contrary to the principle cited by PHM in *Henry v. Chambron*, 304 S.C. 351, 355, 404 S.E.2d 518, 521 (Ct. App. 1991), which is that judgment must be in accordance with the theory on which the case was tried. In *Glass v. Glass*, 276 S.C. 625, 628, 281 S.E.2d 221, 222 (1981), the Supreme Court held, “[a] judgment or decree, whether in law or equity, must conform to both the pleadings and the proofs and be in accordance with the theory of action on which the pleadings are framed and the case was tried.” PHM does not identify any findings or conclusions that violate these holdings.

As to issues (a) and (d) in PHM’s Motion, which discuss the “kind of transaction” proposed by PHM and how the assets to be acquired relate to the existing COPA, PHM’s demand for reconsideration lacks merit. Indeed, it is absurd to suggest LMC (and PHM and DHEC) did not raise these issues in the pleadings and proof arguing about whether COPA-97-01 may be modified to provide for the proposed transaction. *See e.g.*, PHM Mot. Summ. J., pp. 13, 19; LMC Resp. Opp. & Cross-Mot. Summ. J., pp.12, 14-19.

Similarly as to issues (b), (c) and (f), the Court need not amend or reconsider the Order as to issues or questions raised by the parties. PHM’s issue (b) complains the Court *sua sponte* addresses “whether COPA-97-01 can be amended under the facts of this case” (PHM Mot., p. 8), a claim contradicted by Section II, Paragraphs 1-5 of LMC’s Petition for Administrative Review,

as well as LMC's Prehearing Statement, which specifically includes the following statement: "LMC submits that DHEC does not have the authority to 'update' or 'amend' the ongoing conditions of COPA-97-01, originally issued to BSH and RMH on October 6, 1007, in order to include PHM's proposed acquisition of LPNT's assets." LMC Prehr'g Stmt, pp. 2-3. Similar discussion of LMC's position is found at pages 12 and 14-19 of LMC's Cross-Motion for Summary Judgment. PHM offers nothing to suggest the Court's findings or conclusions are erroneous, only that PHM purportedly lacked notice – an allegation contradicted by the foregoing filings. These same filings also contradict PHM's claim that whether the LifePoint assets can be subsumed into COPA-97-01 was not raised to the Court. *See* PHM Mot., p. 9 at (d).

PHM's issue (c) challenges the Court's authority to "raise and rule" on whether the proposed transaction "completely changed the nature of the original cooperative agreement." PHM Mot., p. 8. Again, the similarity and dissimilarity of the facts underlying the proposed transaction and those underlying the cooperative agreement between BHS and RMH was addressed by all parties. In fact, PHM's Motion for Summary Judgment was the first to liken DHEC's review of the proposed transaction to its experience monitoring COPA-97-01 since 1997. *See* PHM Mot. Summ. J., p. 19. DHEC's Response in Support of PHM's Motion for Summary Judgment also speaks to the Department's review of the proposed transaction in light of the issued COPA-97-01 at Page 5-6 and 8. Given the evidence and arguments presented by the parties, the Order's discussion of the impact of the proposed transaction on the original cooperative agreement is appropriate and need not be reconsidered.

PHM also asserts that the issue of whether the proposed transaction complies with the purposes of the COPA Act was not raised by LMC. *See* PHM Mot., p. 9 at (f). The Court is in fact obligated to consider the purposes of the regulatory scheme for which it has been asked by all

parties to answer questions of statutory construction,⁴ as the “[c]ardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature.” *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Clearly there can be no surprise or prejudice to PHM that the Court considered the purposes of the COPA Act in the Order. *See Dargan v. Graves*, 252 S.C. 641, 648, 168 S.E.2d 306, 309 (1969); *see also* PHM Mot. Summ. J., p. 14.

Finally, while LMC respectfully disagrees with the Court’s conclusion that a “cooperative agreement” as defined in the COPA Act⁵ excludes single purchaser asset acquisitions (Order, p.9), the Court’s ruling on this issue adopts a position put forth by Respondents. As PHM argued in brief and at oral argument, “[u]pon execution of the APA, the single entity, PHM, will be operating all of the health care facilities, personnel, etc.” PHM Reply & Resp. to Cross-Mot. Summ. J., p. 13. PHM also asserted, “[a] single purchaser does not fall within the unambiguous language defining a ‘cooperative agreement’ as an acquisition of assets by two or more or a group.” *Id.*, p. 14. DHEC also pursued this interpretation in its Response in Opposition to LMC’s Cross-Motion for Summary Judgment. DHEC Resp. in Opp., p. 3 (“The proposed transaction is a simple sale or transfer of assets from one entity, LifePoint, to another entity, PHM. This is not an acquisition of assets among or by two or more health care providers.”) As the Order comports with Respondents’ interpretation of “cooperative agreement,” the demand for reconsideration cannot be sustained.

2. Errors of Law

PHM’s claim that the Court committed two errors of law also fails to adequately support reconsideration of the Order. PHM first claims that the “Order legislates that a COPA is a stagnant

⁴ More inexplicable is PHM’s assertion at footnote 11 that “LMC did not even mention, must less discuss, the purposes of the COPA Act in its Prehearing Statement or in its Motion.” PHM Mot. at fn. 11. LMC directs PHM to Page 17 of the Cross-Motion for LMC’s *direct quote* of the General Assembly’s legislative intent in enacting the COPA Act. *See also* S.C. Code Ann. § 44-7-520.

⁵ S.C. Code Ann. § 44-7-510(3).

determination based on the original application and cannot later be modified to add additional assets.” PHM Mot., p. 10. This theory stems from PHM’s belief that the Court “misapprehends or misconstrues the PHM JOA and the relationship between the Agreement and the continuing conditions DHEC requires PHM to operate under.” *Id.* Not only is this argument made without citation to any substantive discussion or analysis in the Order, but relies on new documents not previously provided anywhere in the already voluminous record. *See id.* & Ex. 15. If for no other reason, the Court should reject this allegation of error as being expressly contradicted by the Court’s finding at Footnote 5 regarding the Department’s authority to amend or modify COPAs. *See* Order, p. 7 at n.5 (“Since there appears to be no controversy over the Department’s general authority to approve amendments to COPAs, there is no issue for the Court to resolve in this regard.”) The Court should also decline to entertain PHM’s request given the reliance on irrelevant documents not found anywhere else in the record. Finally, PHM’s request asks the Court to address hypothetical questions⁶ unrelated to the question presented in this case, demanding an opinion “on merely abstract or theoretical matters” that must be refused. *Wallace v. City of York*, 276 S.C. 693, 694, 281 S.E.2d 487, 488 (1981).

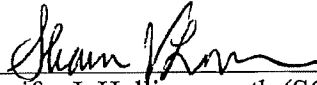
Similarly, PHM’s second alleged error demands an affirmative finding regarding Regulation 61-31 § 508 that falls beyond the scope of the Order, as the Court expressly declined to engage in an analysis of the regulation in light of the other dispositive findings by the Court. *See* Order, pp. 12-13. Simply put, neither of the errors alleged by PHM warrant reconsideration to alter or amend the Court’s ruling.

⁶ PHM asks the Court to affirmatively “find that neither the COPA Act and Regulations nor COPA-97-01 prevent PHM from acquiring new assets or prohibit DHEC from regulating the acquisitions under the conditions of the COPA, provided the Department determines to approve modified conditions pursuant to Reg. 61-31 § 508.” PHM Mot., p. 11.

CONCLUSION

For the reasons stated herein, LMC agrees that the Court's conclusions, as stated in the Order, would resolve the case or controversy before this Court if presented in a final order. Accordingly, LMC has no objection to LPNT's and PHM's request for clarification regarding the impact of the Order on the pending contested case and whether it voids the DHEC staff's amendment of the conditions of COPA-97-01 so as to provide for PHM's acquisition of LPNT's assets, primarily given the Court's conclusion that "PHM cannot use an amendment to subsume the Assets it purchased into the Richland Memorial Hospital and Baptist Hospital COPA." Order, p. 10. However, LMC respectfully requests the Court deny PHM's Motion to Reconsider, vacate the Department's Decision, and for such other and further relief as the Court deems just and proper.

Respectfully submitted,



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Dated: November 23, 2020

**STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT**

Lexington County Health Services District,
d/b/a Lexington Medical Center,

Petitioner,

vs.

South Carolina Department of Health and
Environmental Control and Prisma Health-
Midlands,

Respondents.

Docket No. 20-ALJ-07-0108-CC

This is to certify the foregoing *Petitioner's Response to Motion to Clarify and Motions to Reconsider (Alter or Amend)* has been served upon counsel of record addressed as shown below, this 23 day of November, 2020.

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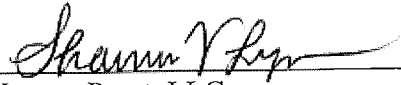
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