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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Ralph King Anderson III, 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 is the Appellant/Respondent,

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 are the
.....Respondent/Appellants.

PETITIONER/RESPONDENT’S RETURN TO MOTION TO EXPEDITE

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 Appellant/Respondent Prisma Health – Midland’s (PHM) Motion to Expedite (the “Motion” herein) filed on February 17, 2021. As noted in PHM’s Motion, a nearly identical request was made to the Supreme Court in conjunction with PHM’s Motion to Certify Case for Review, which

the Supreme Court denied by Order dated February 8, 2021. For the reasons further addressed herein, LMC respectfully requests that the Court deny PHM's Motions.

PROCEDURAL BACKGROUND

PHM and Respondent/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) (collectively "LifePoint") have each appealed from 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 COPA¹ 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 Motion, purports to allow for PHM's proposed acquisition of acute care facilities owned by LifePoint and 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 LifePoint as the Providence Health acute care hospitals (Providence Health (HTL-0928), Providence Health – Northeast (HTL-0929) in Richland County, and a freestanding emergency department in Fairfield County operating under HTL-0929), as well as the Kershaw Health acute care hospital (HTL-0101) in Kershaw County. (PHM Mot., Exhibit 3 at 1 & n.1).

¹ Pursuant to the Health Care Cooperation Act (COPA Act), a certificate of public advantage (COPA) is defined 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).

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**). Preliminary matters presented to the ALC included a Motion to Expedite filed by PHM and a Motion to Intervene filed by LifePoint. 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 LifePoint both appealed following the ALC's Order Denying Cross-Motions for Summary Judgment (Summ. J. Order, Ex. 1 to PHM's Mot.), and the subsequent Order clarifying the finality of that decision (Clarification Order, Ex. 2 to PHM's Mot.), with PHM's Notice of Appeal filed December 8, 2020, and LifePoint's Notice of Appeal filed December 17, 2020. PHM waited nearly three weeks before filing the Motions to Certify Case and to Expedite in the Supreme Court², and more than a week passed following denial of those Motions before expedited treatment was sought from this Court. PHM also took the entire 30 days from the filing of its Notice of Appeal to submit its Appellant's Initial Brief, yet asks this Court to significantly decrease the time allotted for preparation of the Record on Appeal and submission of Final Briefs according to the timeline proposed in the Motion. PHM Mot., p. 13. LMC submits that there are no grounds to support the expedited treatment requested by PHM.

² The Motion to Certify was initially filed incorrectly with this Court on December 29, 2020, and thereafter was forwarded to the Supreme Court for consideration on January 4, 2021. LMC filed a Return on January 8, 2021.

STANDARD OF REVIEW

PHM moves this Court pursuant to Rule 240, SCACR, to expedite the briefing schedule and hearing in these appeals. PHM Mot., p. 2. As no rule or other authority explicitly provides for a right to expediency in these or similar circumstances, the motion is “addressed to the discretion of the Court.” *Furman v. Nelson*, 208 S.C. 249, 251, 37 S.E.2d 741, 742 (1946). The Court should decline to extend grace to the movant and deny the request when the motion is based upon improperly stated facts. *See Bilton v. Best Western Royal Motor Lodge*, 282 S.C. 634, 639, 321 S.E.2d 63, 66 (Ct. App. 1984) (refusing to consider facts outside the record appearing without consent or permission as required by the appellate court rules); *see also* Rule 212, SCACR.

REGULATORY AND FACTUAL BACKGROUND

LMC craves reference to the Regulatory and Factual Background set forth in its Return to PHM’s Motions to Certify Case and to Expedite the Proceeding, which was filed with the Supreme Court on January 8, 2021, with copy to this Court. PHM’s Motion restates nearly verbatim the same Introduction, Procedural Background, Regulatory Background and Factual Background as set forth in the request to the Supreme Court seeking certification and expedited treatment. PHM Mot., pp. 2-9. One surprising difference, however, is that PHM has apparently abandoned the claim that expedited treatment is necessary based on the transaction closing date agreed to in the Asset Purchase Agreement (APA) for the proposed transaction. *See* PHM Mot., n.10; *see also* Order Denying Mot. Exp., pp. 3-4.

Both in the request to the ALC in June 2020, and the request to the Supreme Court in December, PHM asserted that expedited scheduling was warranted because the APA entered

between PHM, LifePoint, Prisma Health, and others³, provided for a closing date on or before March 2, 2021, absent which LifePoint was empowered to terminate the agreement and retain the \$10,000,000 deposit paid to LifePoint by Prisma. *See* Order Denying Mot. Expedite, p. 3; *see also* PHM Mot. at Ex. 9, Attach. B. PHM now states that this Motion “is based on the same COVID-19 ground and uses the same COVID-19 arguments ant [sic] exhibits, as did the portion of PHM’s motion seeking expedited treatment before the Supreme Court.” PHM Mot., pp. 12-13. By footnote, PHM mentions the Supreme Court filing “argued as a ground for expedition that unless the APA is closed on or before March 2, 2021, LPNT, at its sole option, terminate [sic] the transaction and keep the \$10,000,000 earnest money.” *Id.* at n.10. PHM does not explain why this argument made to the Supreme Court (and the ALC), which was the leading argument to both, is no longer raised. The omission is even more puzzling⁴ in light of the expedited schedule proposed, which seeks oral argument “as soon as reasonably practicable” after a March 12, 2021 deadline to serve final briefs. *See id.* Taking the Motion at face value, however, the impact of COVID-19 on PHM does not warrant expedited treatment or a rushed review.

³ According to the APA provided to this Court at Attachment B to Mr. Isley’s Affidavit (Ex. 9), the executing parties to the proposed transaction consist of 18 separately identified companies.

⁴ To add to the mystery surrounding the terms of the transaction, which have seemingly changed in light of PHM’s abandonment of the primary argument made in the two earlier requests for expedited treatment, LifePoint’s Return to PHM’s Motion filed February 19, 2021, inexplicably asserts the following: “In this case, Providence and Kershaw became obligated to sell their assets to Prisma after the parties received the Department’s Decision that the sale could be consummated without affecting Prisma’s existing COPA.” LifePoint Ret. Mot. Exped., p. 4. Made without reference to any evidence in the record, the statement is also entirely at odds with PHM’s repeated assertion that “unless the APA is closed on or before March 2, 2021, LPNT, at its sole option, terminate [sic] the transaction and keep the \$10,000,000 earnest money.” PHM Mot., n.10; *see also* Order Denying Mot. Exped., p. 3.

ARGUMENT

A. Improperly Asserted Facts

PHM's sole basis for expedited treatment, with the associated curtailments of briefing time allotted for all parties, is the COVID-19 pandemic⁵. PHM Mot., pp. 9-12. PHM again regurgitates nearly verbatim the argument presented to the Supreme Court, with the notable reference to vaccination added since the December filing. *Id.* at p. 9. As support for the Motion, PHM offers the affidavits of Malcolm Isley and Michael Bundy that were previously executed for the Supreme Court filing on December 22, 2020 (Exs. 9 & 13 respectively to PHM's Motion), both of which include information that does not appear in the record below. PHM did not seek permission from the Court or consent from the parties in order to interpose new facts or evidence in support of expedited treatment. *See* Rule 212, SCACR. While judicial notice of the existence of the coronavirus pandemic as a fact may be reasonable, PHM's request for judicial notice of "the strain on the Midlands hospitals and patients' ability to access treatment and to be vaccinated" (PHM Mot., p. 9) is beyond the limits of the rule. *See Masters v. Rodgers Dev. Group*, 283 S.C. 251, 256, 321 S.E.2d 194, 197 (Ct. App. 1984) ("Appellate courts are generally reluctant to notice adjudicative facts when even those facts may be absolutely reliable.") PHM's Motion then proceeds with a plethora of factual representations about the "impact" of the pandemic on patient access to and affordability of medical treatment, including factual assertions regarding various financial assistance policies, COVID crisis response strategies, and staffing shortages experienced by PHM. *See* PHM Mot., pp. 10-12. These allegations rely on the affidavits created after the record was closed and other evidence not presented in the underlying proceeding. *See id.* at Ex. 9 at

⁵ To the extent LifePoint's Return could be construed to allege other reasons why expedited treatment is purportedly appropriate, the allegations should be disregarded because LifePoint did not make such a request by motion or joinder. *E.g.* Rule 240, SCACR.

Exhibit D & Ex. 13. Because the facts supporting the Motion are improperly asserted in violation of Rule 212, SCACR, LMC submits PHM is not entitled to grace and the Motion for an expedited schedule should be denied. *See Bilton*, 282 S.C. at 639, 321 S.E.2d at 66.

B. Charity Care

If the Court entertains PHM's Motion despite the newly stated facts, the allegations still do not support the extraordinary relief sought by PHM. The "Charity Care Policy" referenced in PHM's Motion, attached as Exhibit D to Mr. Isley's December Affidavit is a Prisma Health "Financial Arrangements and Assistance" Policy with an "Effective Date" of 2020, and unlike Exhibits A, B and C to the Affidavit, Exhibit D was never part of the record below. According to the document, the policy is intended to balance Prisma Health's desire to "provid[e] financial assistance to patients who cannot afford to pay all or a part of their bill" and the "imperative that reimbursement from patients or other responsible parties be optimized." PHM Mot., Ex. 9 at Exhibit D, p. 1. While it states that all "facilities" of Prisma Health are available without discrimination, it is only emergency services that will not be denied because of inability to pay. *See id.* This is so because of a federal mandate that all hospitals are subject to, including LMC and the LifePoint hospitals. *See* 42 U.S.C. § 1395dd. For non-emergent services, Prisma Health's Policy provides that "[s]atisfactory financial arrangements are required before elective services are rendered." *Id.* Prisma Health provides free care for individuals meeting the eligibility criteria "with an income level at or below 200% of the Federal Poverty Guideline (FPG)." Income levels above 200% up to 400% FPG receive discounted care based on a sliding scale that changes annually. PHM Mot., Ex. 9 at Exhibit D, pp. 1, 5.

PHM's commitment to free or discounted medical services for patients unable to pay is not unique or superior to the commitments of many other hospital providers in South Carolina,

including LMC. PHM’s statement that “LMC’s charity care is limited to families with income levels up to 200% of the FPL” is incorrect, apparently based on a brochure from 2015 according to PHM’s footnote citation, and is not based on LMC’s actual program description. See https://www.lexmed.com/docs/patients/lexington_health_financial_assistance_policy.pdf (last visited March 1, 2021). Rather than a more “limited” scope of benefit, LMC’s financial assistance actually extends beyond hospital-based services to include urgent care services, whereas Prisma Health’s Policy does not include urgent care services. See *id.*; see also PHM Mot., Ex. 9 at Exhibit D. Moreover, LMC provides financial assistance for patients with income levels up to 400% of Federal Policy Level (FPL) just like Prisma Health, and also publishes a 50% discount for uninsured patients that are not otherwise eligible under the income guidelines. Importantly and to the point of the merits of PHM’s argument, although the ALC was not presented with the charity care policies of any of the parties, it did not find PHM’s argument that its allegedly superior charity care policy was a uniquely compelling reason to expedite the hearing. See Order Denying Mot. Exped., n.6. LMC submits this Court should find likewise and refuse to expedite this proceeding.

C. Safety Net Services and Pandemic Response

PHM’s lengthy discussion of safety net services and its pandemic response protocols is also disconnected from any facts presented to the ALC. See PHM Mot., pp. 11-12. PHM states “[w]hile the ALC dismissed the deleterious effects of COVID-19 on PHM and the LPNT hospitals in denying the Motion to Expedite below because all hospitals are suffering the effects of COVID-19, not all hospitals and patients suffer equally.” PHM Mot., p. 11. PHM then proceeds with a discussion of safety net providers and the scarcity of resources faced by PHM’s hospitals in late

2020. *See id.* Even if South Carolina had a recognized classification for a “safety net” hospital⁶, which is not evidenced anywhere in the record, the designation has no bearing on the burden facing all hospital providers in South Carolina and elsewhere around the country in responding to the pandemic. Furthermore, PHM’s claim that “[a]s the safety net provider, PHM is the health care provider of last resort in the Midlands Area” makes no sense and lacks merit. *Id.* at p. 11.

Furthermore, the picture of doom painted by PHM stands in stark contrast to its public persona – as Prisma Health’s website proclaims it to be “South Carolina’s largest private, non-profit healthcare system, and second-largest private company” and boasts its stable of “18 hospitals; 21-county service area; . . . [and] \$4.3 billion total operating revenue.” *See* <https://www.prismahealth.org/about-prisma-health> (last visited March 1, 2021). Similarly hollow is the suggestion that LifePoint’s hospitals are floundering or failing, as there is no evidence that LifePoint, whose last publicly filed financial statement⁷ reflected \$4.8 billion in revenues and \$66 million in net income, cannot infuse the Providence and Kershaw facilities with any capital needed to withstand the economic uncertainties of COVID-19. To the contrary, Prisma readily agreed to a \$10,000,000 gamble in order to secure a chance to purchase the competing assets (PHM Mot., Ex. 9 at Exhibit B), and agreed to the deal’s terms just three days after DHEC’s decision was published on February 28, 2020, obviously disregarding the rights of third parties to seek review of the agency’s decision. *See* S.C. Code Ann. § 44-1-60.

Finally, it should not be overlooked the means by which PHM will fulfill its desire to “have the immediate ability to . . . access staffing without having to use travelers” following its

⁶ Using the definition provided in PHM’s Motion at page 11, LMC is a safety net hospital because it offers access to care regardless of ability to pay and cares for a substantial share of uninsured, Medicaid, and other vulnerable populations.

⁷ Available at https://www.sec.gov/Archives/edgar/data/1301611/000130161118000017/lpnt-20180930x10q.htm#Financial_Statements (last visited March 1, 2021).

“integration” of the LifePoint assets. As told to DHEC, PHM plans to pillage the more lucrative services lines from Providence Hospital to benefit its existing hospitals before ceasing operation of the acute care facility – presumably then PHM expects to redirect some nursing staff to its other hospitals in the area, with the less desirable personnel presumably being let go. See Prisma Ltr. to DHEC, Ex. C to LMC Pet. Admin. Review at pp. 6 & 9.⁸ PHM’s desire to implement these plans sooner than later is not reason to expedite appellate review, particularly given the counter-intuitive nature of the plans in light of “the health care related burden on uninsured, under-insured and indigent patients who currently utilize Providence Downtown” PHM Mot., p. 11.

LifePoint’s Return to PHM’s Motion to Expedite

In response to PHM’s Motion, LifePoint belabors the “uncertainty caused by protracted litigation” and the “continued delay in resolution of the status” as to blame for staffing and retention issues experienced by Providence, issues not mentioned in PHM’s Motion. LifePoint Ret. Mot. Exped., pp. 4-5. As aptly noted by the ALC, however, “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 event can occur.” Order Denying Mot. Exped., p. 5. Also relevant to the complaints lodged by LifePoint is the ALC’s observation that, “[e]ven 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.” *Id.* at p. 6. It is undisputed that a COPA is not required for health care providers to acquire assets or enter mergers, and PHM has never disputed its ability to purchase LifePoint’s assets in a manner that complies with the laws

⁸ It is also unclear how the Fairfield County freestanding ED would continue to operate once PHM closed Providence Hospital as an acute care facility, as the freestanding ED operates under Providence Hospital’s license as an outpatient department of that hospital.

applicable to such transactions, including federal and state antitrust laws. *See* Order Denying Mot. Expedite at p. 4 & n.5; *see also* S.C. Code Ann. Regs. 61-31 § 103. LifePoint's allegations of uncertainty regarding the transaction then, even if appropriate to be considered in review of PHM's Motion, also fail to support expedited appellate review of DHEC's decision regarding the COPA issued to Baptist Health System and Richland Memorial Hospital.

CONCLUSION

For the reasons set forth above, LMC respectfully requests that the Court deny PHM's Motion to Expedite.

Respectfully submitted,

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Dated: March 1, 2021

EXHIBIT A

***(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

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*.

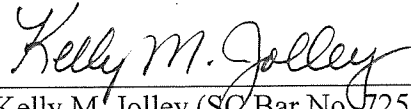
11. Rather than the proscribed, detailed, and transparent review process, the Department inexplicably “conducted a review without public notice or hearing” based only on the “persuasive” writings of PHM and its representations as to the benefits of the transactions and dire consequences should the Department’s 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



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.

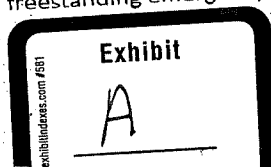
Dear Mr. O'Halla:

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.

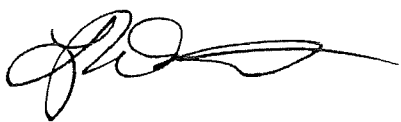
In addition, PHM will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require PHM to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will, as a part of its ongoing monitoring process, 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)



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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SCHEC – Office of General Counsel
2600 Bull Street
Columbia, SC 29201

Exhibit

B

S.C. Department of Health and Environmental Control

2600 Bull Street, Columbia, SC 29201 (803) 253-7412 www.scdhec.gov

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)

RECEIVED

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

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.

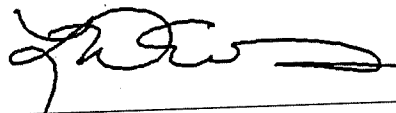
February 20, 2020, letter requesting an Attorney General opinion). By letter dated February 25, 2020, the Attorney General's office opined that DHEC's interpretation "would likely be given considerable deference by the courts as a reasonable interpretation." See Exhibit 7 (February 25, 2020, Attorney 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.

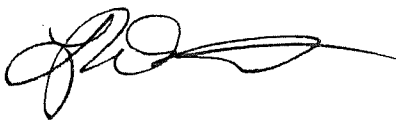
In addition, PHM will negotiate with managed care payers in good faith and in a fair and equitable manner. This does not require PHM to contract with every payer regardless of terms, or that contracted prices must be the same for all payers. The Department will, as a part of its ongoing monitoring process, 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

1242

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:

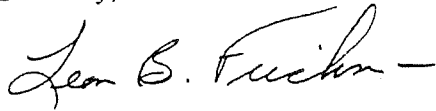
The Board of Health and Environmental Control
Attention: Clerk of the Board
Office of the Commissioner
2600 Bull Street
Columbia, South Carolina 29201

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,

A handwritten signature in cursive script, reading "Leon B. Frishman", followed by a horizontal line.

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

or
Jail
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

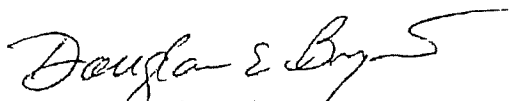
Re: COPA-97-01
Certificate of Public Advantage
BR Health System, Inc.
Columbia, South Carolina

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

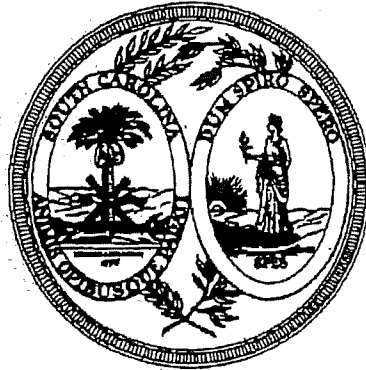
DEB/vmm

Enclosure

cc: The Honorable Charles M. Condon

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

South Carolina Department of Health and Environmental Control



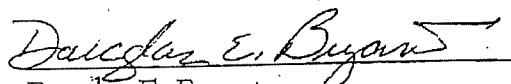
CERTIFICATE OF PUBLIC ADVANTAGE

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

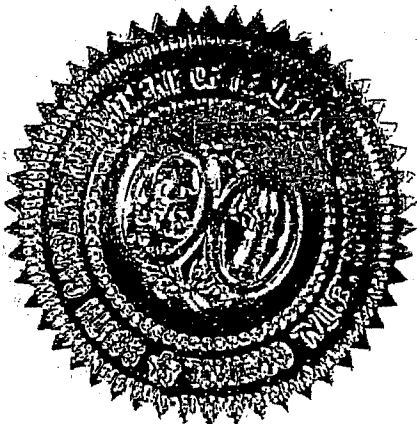


EXHIBIT 4

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. Brazell
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.

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

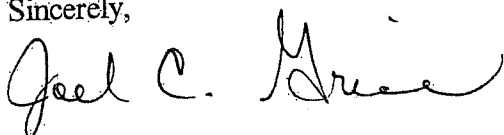
However, it must be the decision of the payer and not be required as a condition of a contract with the System or its affiliate. This does not include exclusive contracts with third party payers that may be in effect on this date or their renewals as provided for in the existing contract.

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

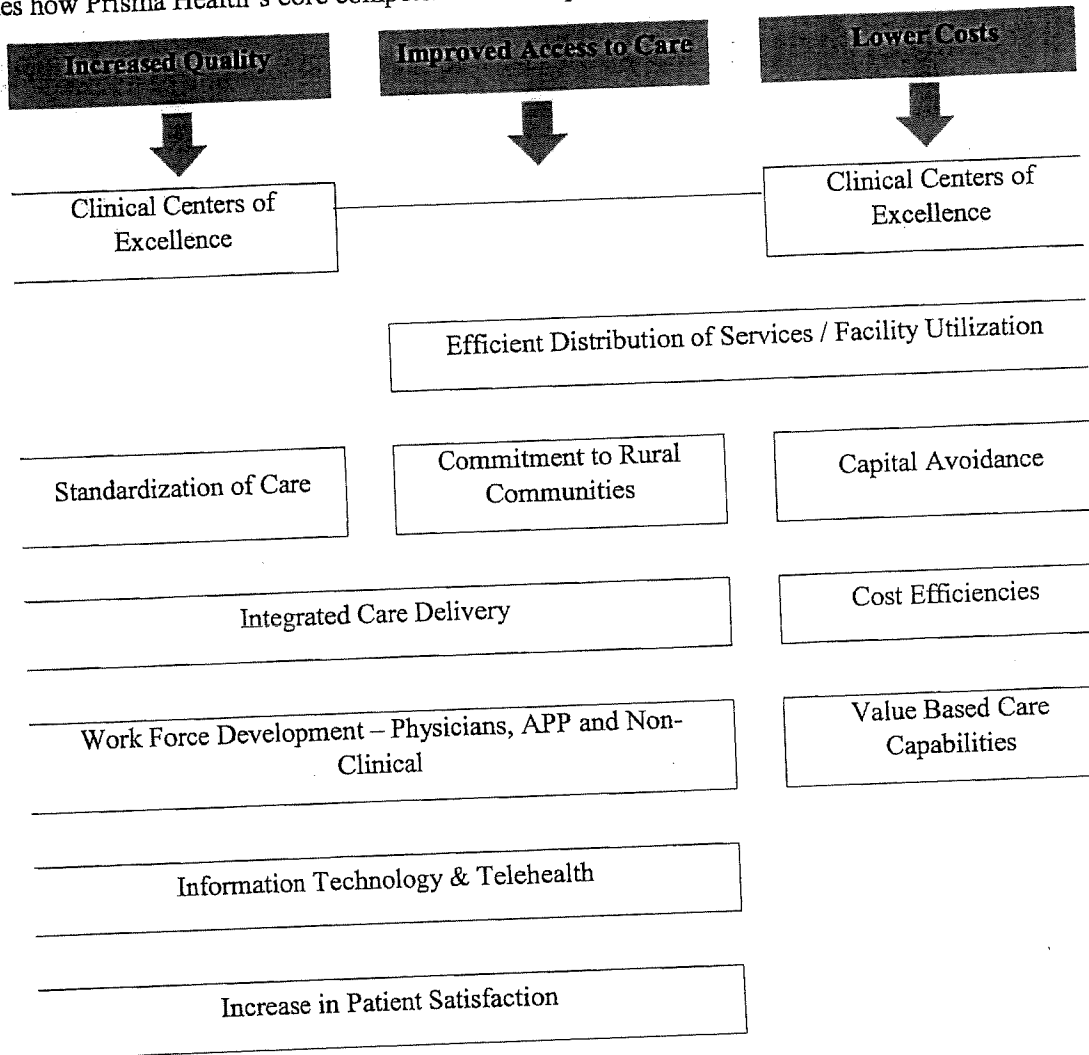
In addition to the community benefits, we believe the Transaction will have little to no effect on the competitive landscape in the COPA Service Area. If you believe that you need any further information in order to evaluate our proposed transaction, please let us know immediately and we will respond.

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.

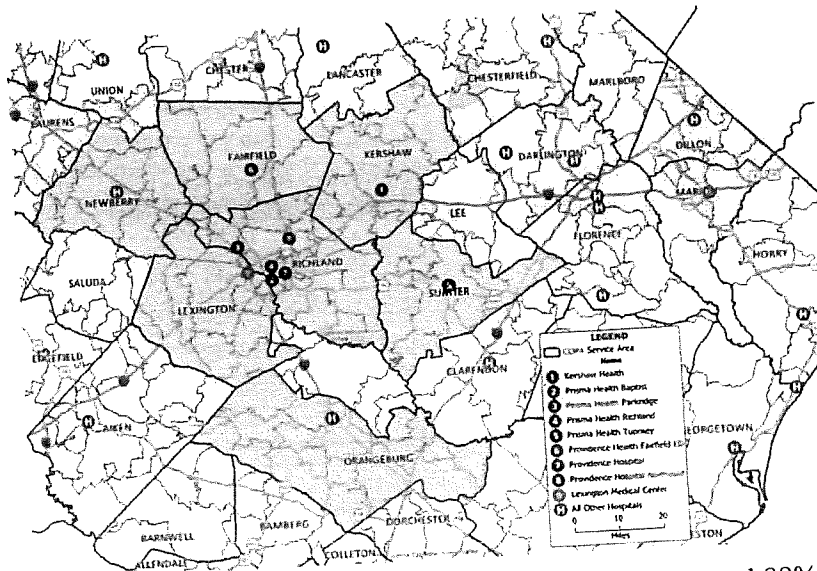
We believe that the Transaction has material and immediate benefits to the community and will improve the access to health care and the health of the citizens in the Midlands of South Carolina. The table below outlines how Prisma Health's core competencies will span multiple areas of community benefit:



1. The original COPA geographic region remains unchanged.

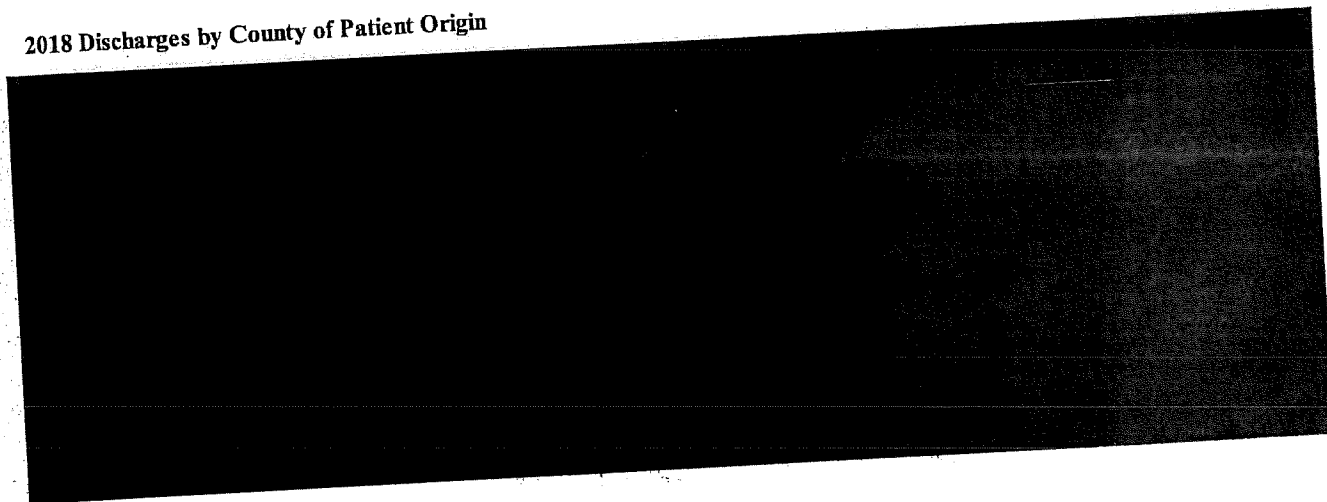
The geographic region ("Service Area") of the existing COPA is comprised of the following seven counties:

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

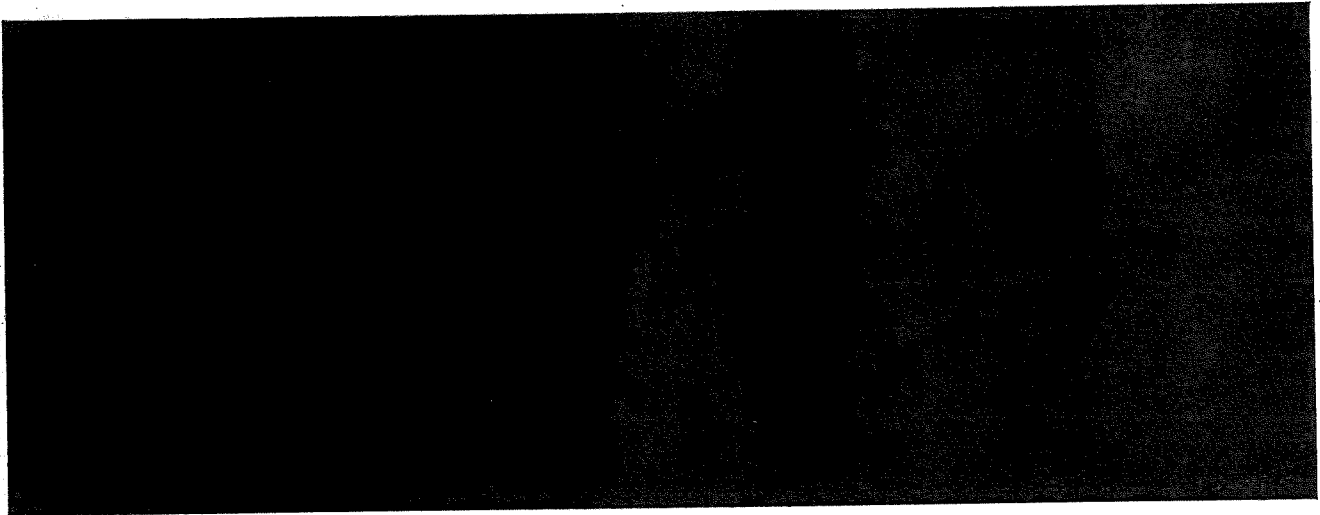
2018 Discharges by County of Patient Origin



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 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)

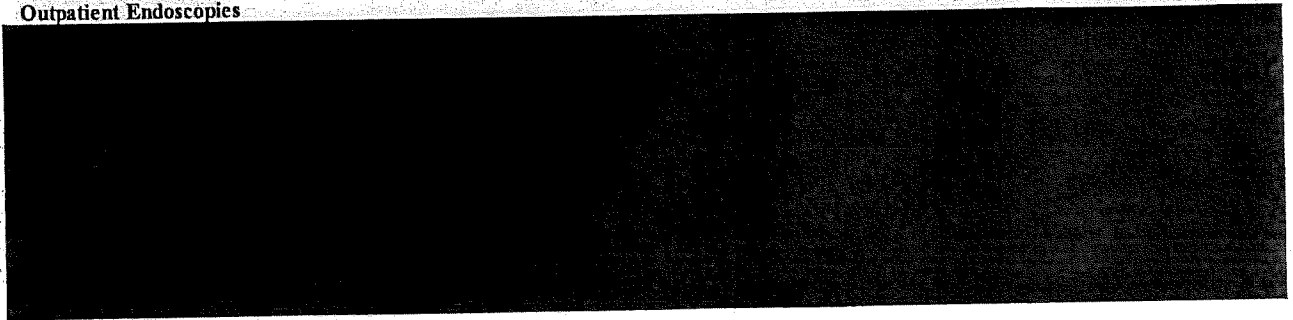
¹¹ In 2003, 35,771 procedures were performed in ASFs in the Service Area. In 2018, that number grew to 55,543.

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

Outpatient Surgeries/Procedures

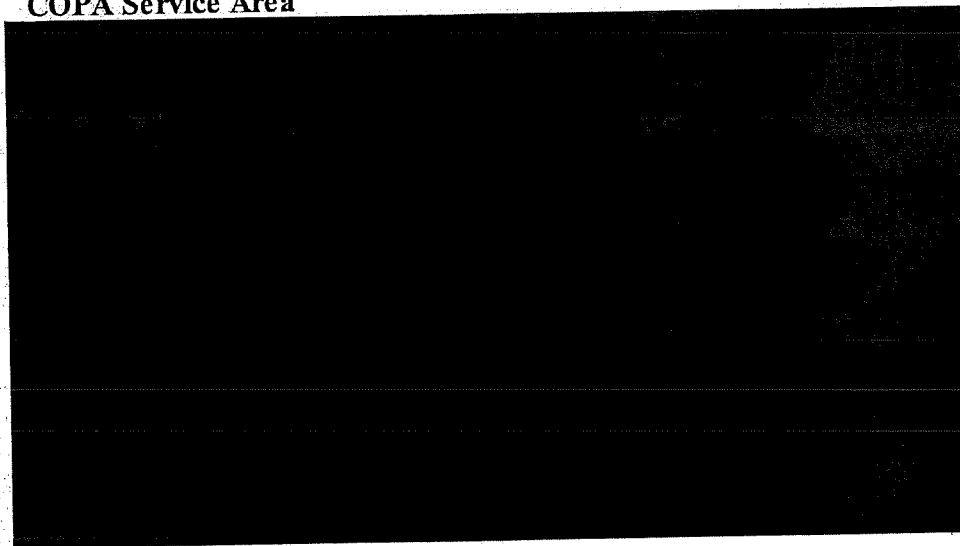


Outpatient Endoscopies



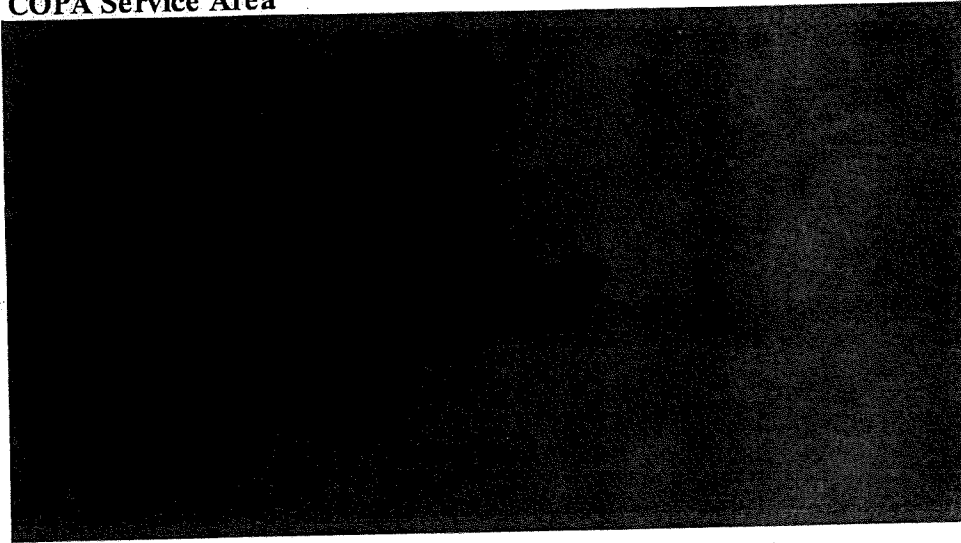
The Prisma Health–Midlands facilities currently capture 33% of the ambulatory surgery share, and post-transaction that capture only reaches 40%. The majority of the market share will still be provided by competitors in the Service Area.

**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.

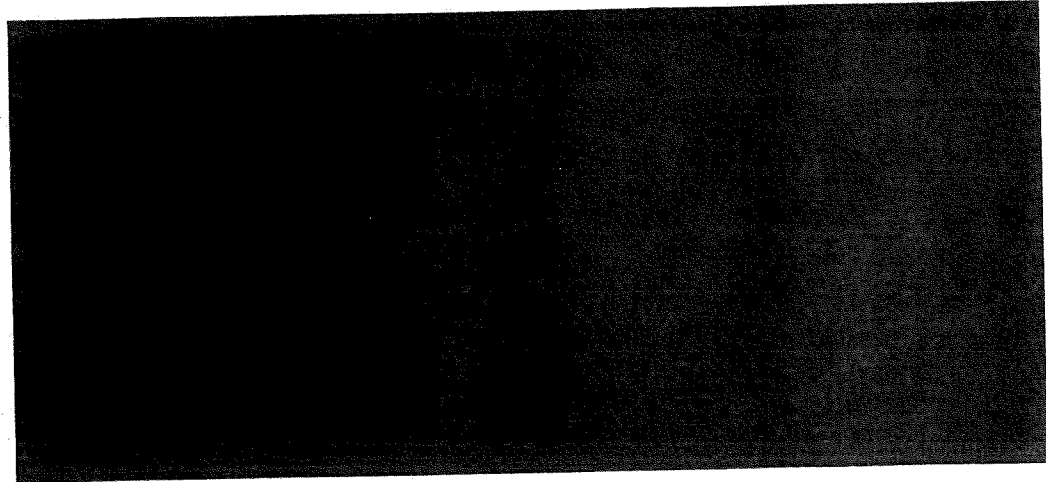
- C. Under the COPA Conditions, DHEC will monitor and oversee, *inter alia*, the rates charged at the former LPNT facilities as part of Prisma Health–Midlands. Please note however that any pricing concern at these facilities is materially mitigated insofar as the vast majority of LPNT's revenue (rates)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

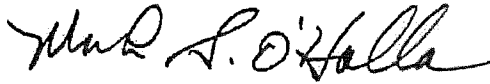
²⁰ For purposes of this analysis, Prisma Health—Midlands revenue is approximately \$1.8 billion

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

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:

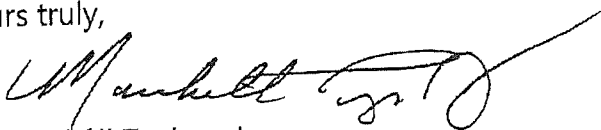
The department also may establish conditions for approval that are reasonably necessary to ensure that the cooperative agreement and the activities engaged under it are consistent with this article and its purpose to promote cooperation and limit health care costs, protect against abuse of private economic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

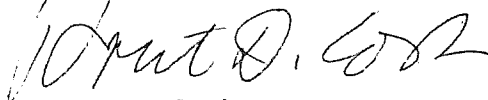
Page 8

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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 black 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 of 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)

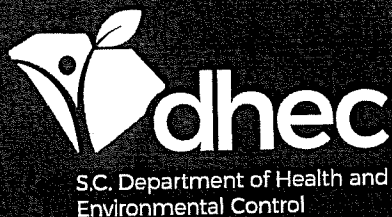
EXHIBIT 9

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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JOLLEY LAW GROUP, LLC


Chelsea N. Shelton

May 14, 2020
Hilton Head Island, South Carolina

EXHIBIT B
(Order Denying Motion to Expedite)

**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 DENYING
	)	MOTION TO EXPEDITE
	)	
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 Expedite (Motion) filed by Prisma Health – Midlands (PHM) on June 22, 2020. PHM seeks to expedite the contested case in this matter in which Lexington County Health Services District, d/b/a Lexington Medical Center (LMC) contests the decision of the South Carolina Department of Health and Environmental Control (Department) to amend a Certificate of Public Advantage¹ (COPA-97-01) held by PHM. On June 29, 2020, LMC filed a response in opposition to PHM’s Motion. On July 6, 2020, PHM filed a Reply. Based upon a thorough review of the Motion and the parties’ filings, I conclude the Motion must be denied for the reasons below.

BACKGROUND

On or about October 23, 1996, Baptist Healthcare System of South Carolina, Inc., (Baptist Hospital) and Richland Memorial Hospital applied for a COPA 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 [sic] 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.

FILED

July 14, 2020

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 curtesy generally encouraged in the practice of law in this State. *See* Rule 11(a), SCRCP (“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

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

EXHIBIT C
(Order re: Motion to Intervene)

**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 [sic] 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 (SCRPC), which also discusses intervention in an action. Specifically, Rule 24(a), SCRPC, “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), SCRPC, “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.

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

RECEIVED

Mar 01 2021

SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Ralph King Anderson III, 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 is the Appellant/Respondent,

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 are the
.....Respondent/Appellants.

PROOF OF SERVICE

The undersigned hereby certifies that on March 1, 2021, she caused a copy of the foregoing
Petitioner/Appellant's Return to Motion to Expedite to be served upon all parties of record by
email addressed as follows:

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Celeste T. Jones, Esq.
Pamela A. Baker, Esq.
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Jennifer J. Hollingsworth
Member
Admitted in SC

March 1, 2021

VIA ELECTRONIC MAIL

ctappfilings@sccourts.org
The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
1220 Senate Street
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Columbia, SC 29211

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Mar 01 2021

SC Court of Appeals

***Re: Lexington County Health Services District, d/b/a Lexington Medical Center vs. South Carolina Department of Health and Environmental Control and Prisma Health – Midlands, et al.
Appellate Case No.: 2020-001610***

Charleston

Charlotte

Columbia

Greensboro

Greenville

Hilton Head

Myrtle Beach

Raleigh

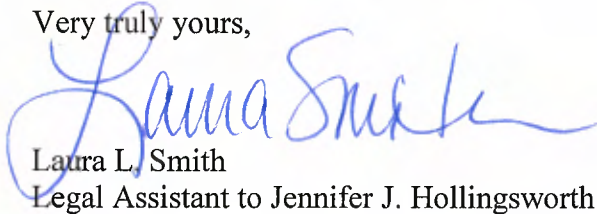
Dear Ms. Kitchings:

Enclosed for filing, please find *Petitioner/Respondent's Return to Motion to Expedite and Supplemental Designation of Matter to Be Included in Record on Appeal* in the above referenced matter. Please file the originals and return the file-stamped copies to me.

By copy of this letter, I am hereby serving all counsel of record with copies of the same.

With highest regards, I remain,

Very truly yours,



Laura L. Smith
Legal Assistant to Jennifer J. Hollingsworth

/lls

Enclosures

The Honorable Jenny Abbott Kitchings
March 1, 2021
Page 2

cc: David B. Summers, Esquire (*via electronic mail*)
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M. Elizabeth Crum, Esquire (*via electronic mail*)
Celeste T. Jones, Esquire (*via electronic mail*)
Pamela Baker, Esquire (*via electronic mail*)
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