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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Shirley C. Robinson, Administrative Law Judge

APPELLATE CASE NO.: 2020-001072

ADMINISTRATIVE LAW COURT CASE NO.: 17-ALJ-07-0441-CC
ADMINISTRATIVE LAW COURT CASE NO.: 17-ALJ-07-0444-CC

Trident Medical Center, LLC, d/b/a Trident Medical Center
and Summerville Medical Center,.....Petitioner/Respondent,

v.

South Carolina Department of Health and Environmental Control
and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....Respondents,

Of Which, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is the.....Appellant.

AND

CareAlliance Health Services, d/b/a Roper St. Francis
Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis
Xavier Hospital, Inc., Roper Mount Pleasant Hospital and
Roper St. Francis Berkeley Hospital,.....Petitioner/Respondent,

v.

South Carolina Department of Health and Environmental Control
and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....Respondents,

Of Which, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is the.....Appellant.

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STATEMENT OF THE CASE

Petitioner Trident adopts Respondent MUSC's Statement of the Case, with the following addition:

MUSC's CON Application, which was filed with the Department on 6 June 2017, was "double published" in the State Register on 23 June 2017. (R. pp. 3714, 3716). "Double publishing" occurs when public notice that an application has been received by the Department appears in the same State Register at the same time as the public notice announcing the application has been deemed complete. (R. p. 2215:17–2216:5).

STANDARD OF REVIEW[1]

The Administrative Law Court ("ALC") heard this matter and issued its Final Order containing its findings of fact and conclusions of law pursuant to the contested case review authority granted by S.C. Code Ann. § 1-23-600 (Supp. 2019). Under that authority, the ALC sits as the fact finder in a *de novo* hearing with the presentation of evidence and testimony and is free to draw its own conclusions therefrom. *See Risher v. S.C. Dep't of Health & Envtl. Control*, 393 S.C. 198, 207, 712 S.E.2d 428, 433 (2011) (acknowledging the ALC as "the ultimate finder of fact" in a contested case proceeding).

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

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

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

[1] MUSC was required to provide the Standard of Review pursuant to Rule 208(B)(d) but failed to do so. For the convenience of the Court, Trident provides it here.

> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-610(B) (Supp. 2019). "In determining whether the ALC's decision was supported by substantial evidence, this Court need only find, looking at the entire record on appeal, evidence from which reasonable minds could reach the same conclusion that the ALC reached." *Hill v. S.C. Dept. of Health & Envtl. Control,* 389 S.C. 1, 9-10, 698 S.E.2d 612, 617 (2010). "The mere possibility of drawing two inconsistent conclusions from the evidence does not prevent a finding from being supported by substantial evidence." *Jones v. S.C. Dep't of Health & Envtl. Control*, 384 S.C. 295, 304, 682 S.E.2d 282, 287 (Ct. App. 2009) (citations and internal quotations omitted).

STATEMENT OF THE FACTS

The Certificate of Need Program

This case arises under the Certificate of Need ("CON") program for health care facilities and services. The framework of the CON program is established by three central sources: the State Certification of Need and Health Facility Licensure Act found at S.C. Code Ann. §§ 44-7-110, *et seq.* (2018 and Supp. 2019) (the "CON Act"); the regulations set forth at S.C. Code Ann. Regs. 61-15 (Supp. 2019); and the State Health Plan, prepared by the Department at least once every two years as directed by S.C. Code Ann. § 44-7-180 (2018) (collectively the "CON Law"). The stated goals of the CON Act are to "promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120 (2018). These goals are implemented through the requirement that a provider apply for, and receive, a CON from South Carolina Department of Health and Environmental Control (the "Department") prior to establishing a new health facility or service,

adding beds, making large capital expenditures, or acquiring medical equipment when the total project cost exceeds a certain threshold amount. S.C. Code Ann. §§ 44-7-120 and 44-7-160 (2018). A freestanding emergency department[2] ("FSED") is one of the services for which a CON is required.

Under the CON Act, the Department is prohibited from granting a CON to an applicant unless the "application complies with the South Carolina Health Plan, Project Review Criteria, and other regulations." S.C. Code Ann. § 44-7-210(B) (2018). The specific "Project Review Criteria" are listed in the regulations, *see* S.C. Code Ann. Regs. 61-15, § 802 (Supp. 2019). The State Health Plan lists which Project Review Criteria should apply to specific projects, *see* S.C. Code Ann. § 44-7-180(B)(4), and the Department then ranks the Project Review Criteria in order of importance when conducting the specific review. *See* S.C. Code Ann. Regs. 61-15, § 304 (Supp. 2019). The State Health Plan standards and the Project Review Criteria are, however, separate and distinct requirements that must be met as part of the CON application process. *See MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 1, 9, 664 S.E.2d 471, 475 (2008). "[N]o project may be approved unless it is consistent with the State Health Plan." S.C. Code Ann. Regs. 61-15, § 801(3) (Supp. 2019). The Department must consider the State Health Plan in effect at the time a CON Application is filed (for this case, the 2015 State Health Plan), and the Department may consider the policies and standards of a subsequently-promulgated State Health Plan. *See* S.C. Code Ann. § 44-7-225 (2018).

[2] "'Freestanding emergency service,'" also referred to as an off-campus emergency service, means an extension of an existing hospital emergency department that is an off-campus emergency service and that is intended to provide comprehensive emergency service. The hospital shall have a valid license and be in operation to support the off-campus emergency service." S.C. Code Ann. § 44-7-130.

The State Health Plan includes an inventory of existing health services, the projections of need for additional services and facilities, and standards for distributing most facilities and services across the state's regions, known as "service areas." *See* S.C. Code Ann. § 44-7-180(B). Each facility or service has its own unique criteria that are evaluated when the Department considers whether to allow an addition. For example, relatively high utilization rates are expected as part of an application to add a linear accelerator in South Carolina, *see* R. p. 6054, and daily occupancy rates are part of the assessment to add residential treatment beds for children. *See* R. p. 6026. Although some services, such as inpatient hospital beds, are assigned a facility-specific need calculation, *see* R. p. 5975, freestanding emergency services do not have a facility-specific need calculation within the State Health Plan. (R. p. 19, ¶ 21; R. p. 2232:12–2233:9; R. p. 6062; R. pp. 5884-5885). Freestanding emergency services also are unique in that they do not have "service areas" defined in the State Health Plan. Rather, applicants seeking to add freestanding emergency services define for themselves the geographic bounds, or "service area," which they intend to serve. (R. p. 19, ¶ 20; R. p. 2086:7–12).

A decision by the Department to grant or deny a CON may be appealed to the Department Board and further for a *de novo* contested case hearing before the ALC. S.C. Code Ann. § 44-1-60(F) (2018). Under the CON Act, the issues considered during the contested case are limited to the issues presented to or considered by the Department's staff. S.C. Code Ann. § 44-7-210(E) (2018). Because the contested case is *de novo*, the ALC can consider any evidence related to issues presented to or considered by the Department. *See Marlboro Park Hosp. v. S.C. Dep't of Health & Envtl. Control*, 358 S.C. 573, 579, 595 S.E.2d 851, 854 (Ct. App. 2004) (holding that the law limits a contested case hearing to the ***issues*** presented or considered by DHEC staff but does not limit ***evidence*** concerning those issues).

The Parties

Trident is an efficient, established, long-time provider of medical care and emergency services in the community in which MUSC seeks to add a freestanding emergency department. (R. pp. 1730:2–1731:8; R. p. 1780:18–22; R. p. 1781:5–24; R. p. 1782:8–15; R. p. 2360:14-19; R. p. 5703). Trident owns and operates two acute care hospitals in the tri-county area: Trident Medical Center, a Level II trauma center in North Charleston; and Summerville Medical Center, a community hospital in Summerville. In addition, Trident owns and operates two freestanding emergency departments, Centre Pointe Medical Center in North Charleston and Moncks Corner Medical Center in Moncks Corner. (R. pp. 1600:19–1601:22). During the pendency of the contested case, Trident received a Certificate of Need to construct a freestanding emergency department at 1624 N. Main Street, Summerville, Berkeley County ("Trident's Summerville FSED")[3], 0.25 miles from the MUSC's original proposed FSED location. (R. p. 2135:5–6; MUSC Exh. 008–R. pp. 4043, 4049, and 4516).

Trident's corporate parent, Hospital Corporation of America, began offering health services to the tri-county area at the request of the local community in the early 1970s when it built Trident Medical Center to replace dilapidated hospitals in Berkeley and Dorchester Counties. (R. pp. 1594:17–1595:15, R. p. 1596:9-23). The tri-county area now sees positive population growth year after year. (R. p. 1129:6-22; R. p. 2454:4-18). Concomitantly, Trident has invested millions of dollars developing health care services in Berkeley, Dorchester, and Charleston Counties, including spending $50 to $60 million in recent years on emergency departments and services, increasing efficiency and improving throughput at those facilities. (R. p. 1597:1-25; R. p. 1604:5-

[3] The Department approved the application for Trident's Summerville FSED on 25 September 2017. (R. p. 2193:8-14).

21; R. p. 1606:3-9; R. p. 1609:11-19; R. p. 1610:5–1611:3; R. p. 1665:6-19; R. p. 6406). Trident is not tax-exempt, and its 2018 contribution to the tax base was $34 million. (R. p. 1604:17-21). In addition, Trident provided $51 million in charity care in 2018. (R. p. 1604:8-16).

MUSC is a tax-exempt governmental entity, operating an academic medical center and a level I trauma center on the Charleston peninsula in Charleston County. (R. p. 2206:12-16). MUSC offers hospital, specialty, and emergency services at its location in downtown Charleston, through its 100 outreach locations, and by way of its Medicare Accountable Care Organization ("ACO"). (R. pp. 3162, 3673). MUSC does not operate any emergency departments in the tri-county area of Berkeley, Charleston, and Dorchester other than its downtown Charleston location, and it does not own or operate any freestanding emergency departments in any county. (R. p. 900:19-21; R. p. 3072:20-23). In recent years, MUSC has aggressively pursued new opportunities, including borrowing $137 million to purchase four hospitals outside of the tri-county area and applying for and receiving initial CON approval[4] to construct a $325 million acute care hospital in Berkeley County. (R. p. 900:21-23; R. p. 1071:17-20; R. p. 1969:2-16; R. p. 2510:1-3; R. pp. 2511:18–2512:1).

MUSC's emergency department on its downtown campus has experienced problems managing patient flow, and many patients leave without treatment or wait for excessive periods of

[4] MUSC's CON approval for its Berkeley County hospital has, however, been conditioned by the ALC in a way that touches this case. MUSC's hospital CON depends on MUSC "honoring its original declaration that upon opening MUHA Berkeley, its [proposed Nexton/Summerville] FSED, if operating, will be closed." *CareAlliance Health Services, et. al. v. S.C. Dep't of Health & Envtl. Control*, Docket Nos. 18-ALJ-07-0358-CC, 18-ALJ-07-0360-CC, 18-ALJ-07-0366-CC, 2020 WL 5503670 at *24 (September 4, 2020).

time to see providers or be admitted for further care. (R. pp. 904:12–907:11). Although a redesign and renovation would improve its patients' experiences, MUSC has spent only $1.7 million on its emergency department downtown in the last five to six years. (R. p. 1072:4-11). MUSC has applied for, and has now received, a CON to add additional inpatient beds on its downtown campus to alleviate some of its boarding problems in its emergency department and to improve emergency department wait times and throughput. (R. p. 2556:16-19; R. p. 2558:4-7; R. p. 968:9-15; R. pp. 6416, 6438). MUSC has, however, neither significantly redesigned or renovated its downtown emergency room, nor sought a CON to do so in the future, in at least seven years. (R. p. 1047:2-8; R. p. 2384:14-25).

Trident and MUSC share at least one common trait, however, in their commitment to examine all those who arrive at the emergency department seeking medical services. Specifically, the hospital parties to this contested case are subject to the federal Emergency Medical Treatment and Labor Act ("EMTALA"), which requires on and off-site emergency departments to perform an emergency medical screening examination on any person who presents requesting such assistance. *See* 42 U.S.C. § 1395dd *et. seq*. EMTALA prohibits any emergency department from conditioning an emergency screening examination on a patient's ability to pay. (R. p. 1952:6-20).

This Particular CON Application

This case has been, from the very beginning, a fact-finding adventure. What began in June 2017 with MUSC's application for a newly constructed FSED with a helipad and a "clinical decisions unit," located in the planned unit community of Nexton, culminated with a ten-day trial, including twelve witnesses and over two hundred exhibits, evaluating a proposed project not in Nexton but in a repurposed restaurant location in downtown Summerville. (R. pp. 6323-6325; R.

p. 6350; R. p. 2754:10-15). Both proposed locations were a mile or less away from Trident's approved Summerville FSED. (R. p. 1915:9-15; R. p. 2423:9-13; R. p. 2434:2-7; R. p. 2470:1-3; MUSC Exh. 008–R. pp. 4043, 4049, and 4516; R. p. 5695). MUSC altered its plans several times after the Department completed its review of MUSC's CON application and well into the litigation that is before this Court now. (R. pp. 6323-6325; R. pp. 6351-6352; R. pp. 6367-6368).

Between June of 2017 when it filed its application and the contested case hearing, MUSC consulted with a Texas-based for-profit company about how best to establish a freestanding emergency department presence in the community presently served by Trident and Roper. (R. p. 2041:4-21; R. p. 2474:2-23; R. p. 2488:18-25). The Texas consultant recommended several changes to MUSC's proposal that the Department had approved, including a location change, deletion of the helipad, and reconfiguration of the rooms and services to be provided. (R. p. 1876:1-18; R. p. 2546:1-21). In the months leading up to the contested case, MUSC decided to add urgent care services to its proposal (R. pp. 6323-6325; R. pp. 6353-6366) then reversed course and removed urgent care services from its proposal. (R. pp. 6367-6368). As of the first day of trial, the proposal was back to emergency services only. (R. pp. 2549:12–2550:10).

The months leading up to the trial were confusing and challenging from a discovery perspective, as each time it seemed that MUSC had decided what project it would defend, another version appeared. Discovery motions abounded, and MUSC vigorously opposed Trident's attempts to obtain discovery from the Texas company. (R. pp. 6678-6705). When Trident ultimately obtained the hard-fought discovery and conducted a 30(b)(6) deposition in Texas, it learned that the Texas company had recommended MUSC make the changes based on the "quantity of traffic counts, quality of traffic counts, relative success of surrounding retailers, relative population, and relative population growth." (R. p. 2584:1-12). MUSC's Texas consultant

used its proprietary algorithm to calculate that a free-standing emergency department location on Main Street in Summerville would be superior to MUSC's proposed location in Nexton because of the characteristics of the area, including household density and payor mix of persons within a thirteen-minute drive. (R. pp. 2528:8–2529:12; R. pp. 308:16–313:9, 329:2–330:2, 352:7-24, and R. pp. 461-462, 463-465). Notably, neither ease of access for MUSC's ACO patients nor convenience for traffic-weary MUSC patients who traveled downtown for emergency medical services was part of the calculation. (R. p. 2041:4-10; R. pp. 6344-6349). What remained for MUSC was "an exact duplicate copy of the [freestanding emergency department] that [Trident] will have less than a mile away." (R. p. 1691:4-7).

Based on the testimony and evidence before it, the ALC issued its Final Order reversing the Department's award of a CON to MUSC for its FSED (the one in Summerville, not the one in Nexton). The ALC chastised MUSC and the Department for entering a mid-trial oral defense agreement on which they based objections to cross-examination of the Department's decision-maker. (R. p. 69, ¶¶ 68-70).

In its brief, MUSC raises five grounds for its appeal of the Final Order of the ALC, which reflect almost entirely disagreements with the facts as decided by the ALC. MUSC contends that the ALC should have agreed with it regarding likelihood of patient redirection; that the ALC should have agreed with it regarding capacity of existing providers; that the ALC should have agreed with it that the project is needed and not duplicative; that the ALC should have held that the proposal complied with the CON Act; and that the ALC should have remained silent rather than noting that the oral joint-defense agreement "smacks of unfairness." (R. p. 69, ¶ 69). Because the findings and conclusions of the ALC are supported by substantial evidence in the record and

the law, MUSC's arguments fail. *See Dreher v. S. C. Dep't of Health & Envtl. Control*, 412 S.C. 244, 249, 772 S.E.2d 505, 508 (2015)("[Appellate courts] are limited 'to determining whether the ALC's findings were supported by substantial evidence or were controlled by an error of law.'"(internal citation omitted)).

ARGUMENT

I. THE ADMINISTRATIVE LAW COURT APPROPRIATELY EVALUATED ALL OF THE EVIDENCE PRESENTED AT TRIAL AND FOUND FACTS THAT SUPPORT ITS CONCLUSIONS OF LAW, INCLUDING ITS CONCLUSION THAT MUSC FAILED TO SATISFY STANDARD 6 OF THE 2015 STATE HEALTH PLAN.

As its first argument, MUSC contends that the ALC should have found facts other than the ones it did. Brief of Appellant, pp. 18 – 30. In a series of assertions that disregard entirely the standard of review, MUSC argues that certain facts should be *res ipsa* "obvious" (Brief of Appellant p. 29) and that the ALC "gives too little weight to" certain of MUSC's arguments. Brief of Appellant p. 22. As this Court well knows, however, the role of an appellate court in reviewing an ALC's decision in a contested case is limited. *Spartanburg Reg'l Med. Ctr. v. Oncology & Hematology Assocs. of S.C., LLC*, 387 S.C. 79, 90, 690 S.E.2d 783, 789 (2010). The appellate court's "scope of review" is limited to "whether there is substantial evidence to support the ALC's findings and/or whether the ALC made an error of law." *Id.* (affirming the ALC decision and noting an "abundance of evidence to support" the ALC's findings). "When finding substantial evidence to support the ALC's decision, the [appellate] Court need only determine that, based on the record as a whole, reasonable minds could reach the same conclusion." *Murphy v. S.C. Dep't of Health & Envtl. Control*, 396 S.C. 633, 639, 723 S.E.2d 191, 194–95 (2012). *See also Kiawah Dev. Partners, II v. S.C. Dep't of Health & Envtl. Control*, 422 S.C. 632, 636, 813 S.E.2d 691, 693 (2018) (holding the reviewing court "need only find evidence from which reasonable minds could

reach the same conclusion as the ALC"). Here, each and every challenged fact is supported by substantial evidence in the record in this case, and thus this assignment of error is wholly without merit.

A. THE ADMINISTRATIVE LAW COURT'S CONCLUSION OF LAW THAT MUSC FAILED TO DOCUMENT SUFFICIENTLY THE SOURCE OF ITS PATIENTS IS SUPPORTED BY NUMEROUS FINDINGS OF FACT WHICH ARE IN TURN SUPPORTED BY HOURS OF TESTIMONY AND A MULTITUDE OF EXHIBITS.

Standard 6 requires the applicant "demonstrate **where** the potential patients for this service will come from and **why** they are not being adequately served by the existing services in the area." (R. p. 5885). Far from confusing the concept of patients and visits, the ALC heard testimony from numerous witnesses – including MUSC's witnesses - that "patients" and "visits" are not synonymous. MUSC produced evidence that 20,000 or so patient encounters originated in MUSC's target zip codes. But, without any information about how many of those patient encounters were distinct individuals, the ALC weighed the evidence and concluded that visit numbers are not equivalent to patients. Because MUSC did not convince the ALC of "where the potential patients . . . will come from," the ALC correctly held Standard 6 was not met. The ALC was not confused, and this Court should not be either.

1. NO PARTY DISPUTED MUSC'S CLAIM THAT SOME PATIENTS DRIVE TO THE PENINSULA TO RECEIVE CARE AT MUSC, AND THE ALC FOUND FACTS ACCORDINGLY.

MUSC attempts to manufacture confusion surrounding the difference between patients and visits.[5] All three parties utilized "visits" and "patients" at various times during the trial, with the

[5] MUSC's counsel clarified this point for the Court after an objection by Roper's counsel (R. p. 1526:6-23:

MR. WESTBROOK: Ms. Platt, at our deposition it was my understanding, correct me if I'm wrong, that you had no disagreement, no reason to dispute the numbers of patients who, from these ZIP codes, were represented in Mr. Levitt's ZIP code analysis that actually went to MUSC.

context determining the meaning. (R. p. 917:2-16; R. p. 972:5-10; R. pp. 1059:6–1060:9; R. p. 1132:4-8; R. p. 1489:5-15; R. pp. 1930:20–1931:20; R. p. 2822:19-25). But no one, least of all the ALC, was confused by this. As the Department explained, MUSC "identifie[d]the number of visits that MUSC has provided to patients" who live in the various targeted zip codes. (R. p. 1373:1-25) (emphasis added). Trident's expert also explained that "the number of unique patients that are in there is something less than the total number of visits, because some of these folks, because of health reasons or whatever, may have gone to the emergency department more than once in a given period of time." (R. pp. 1944:19–1945:8). Accordingly, the ALC's finding of fact that the number of patients who travel from the zip codes to the downtown emergency department is unknown is fully supported by substantial record evidence. As the ALC explained,

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

(R. p. 62, fn.54). Indeed, had the ALC found as MUSC now argues, that 20,000 unique patients were shown to be traveling from the proposed service area to the downtown MUSC emergency room, such a finding would have been unsupported by the record.

Furthermore, the ALC did not impermissibly shift any burden to MUSC. Standard 6 requires the applicant demonstrate not where its visits will come from, but where its patients will

---

I realize you have a number of other reasons that you dispute his analysis, but the ones who actually went to MUSC for ED services.

MS. HOLLINGSWORTH: And, Your Honor, I don't mean to object. I would ask, Mr. Westbrook, could you clarify that it's ED visits and not patients?

MR. WESTBROOK: Oh, I'm ---

MS. HOLLINGSWORTH: Is that what you're asking the witness ---

MR. WESTBROOK: Right. I'm sorry. I'm completely sorry. ED visits, not patients of course. Yes.

come from, and show why "**they** are not being adequately served by the existing services in the area." (R. p. 5885) (emphasis added). The ALC correctly held that MUSC had shown that 20,000 visits were initiated by persons from the target zip codes, but that those visits did not reflect unique patients. Without any evidence of where the visits come from (are they 1,000 cancer patients each visiting the downtown MUSC facility twice per month, or 20,000 vacationers each visiting the downtown MUSC facility once per year?), MUSC could not show "why **they** are not being adequately served." The "they" in Standard 6 must be identified for the demonstration to occur, which MUSC simply did not do.

2. MUSC WAS UNABLE TO EXPLAIN WHY SOME PATIENTS DRIVE TO THE PENINSULA TO RECEIVE EMERGENCY CARE.

Standard 6 requires that the applicant do more than state that patients need a new service: the law requires the applicant demonstrate "why." (R. p. 5885). However, the answer to any "why" question requires context. Trident does not dispute that MUSC provides specialty care and operates the tri-county area's only level 1 trauma center at its facility in downtown Charleston. And, at the time of the Department's review of the application, MUSC presented a proposal that purported to capitalize on those characteristics. But, by the time of trial, MUSC's proposed project no longer included the unique features it touted to the Department. (R. p. 1878:19-22).

The slide presentation exhibit to which MUSC directs this Court's attention on page 21 of its brief, for appellate review of the ALC's decision no less, supported MUSC's *original* project, in Nexton – the facility that would be new construction, with a helipad and a special clinical decisions unit – *not* the project that the ALC considered at trial. (R. pp. 3670-3671). MUSC had changed locations and layout at least twice by the time of trial, and its proposed FSED no longer

included the components that it had presented to the Department as distinguishing features. (R. pp. 2390:8–2392:22; R. p. 2387:19-23; R. p. 2523:11-20; R. p. 2777:1-9; R. pp. 6327-6329; R. p. 6312). The original FSED was described by MUSC as "unique" within South Carolina because it alone would offer a clinical decision unit. (R. p. 2389:17-25; R. p. 2922:2-16; R. pp. 3165, 3175, 3670). MUSC's representatives asserted that the helipad would allow it to serve a higher acuity patient base. (R. p. 2399:19-23; R. p. 3694). However, no unique features survived by the time of trial. (R. pp. 1460:21–1462:5; R. p. 1530:14-18; R. pp. 1916:8–1917:17). The proposal before the ALC was essentially a carbon copy of the existing freestanding emergency departments already present in the market. (R. p. 1691:4-7; R. pp. 2729:21–2730:5). Therefore, the slides presented to the Department for review of the *original project* were of minimal evidentiary relevance to the ALC's decision.

Without mentioning the differences in the two proposals, MUSC compounds its obfuscation by pointing this Court to the slide describing the downtown MUSC ED, which is neither the Nexton project from the CON application nor the proposed project evaluated at trial. (R. p. 3687). Brief of Appellant at 21. That people travel to the downtown MUSC emergency department, an academic teaching center with a national reputation for specialty care, was never in doubt. But MUSC's task was to demonstrate why those same patients will instead seek service at an ordinary freestanding emergency department in downtown Summerville. And this it did not do.

In addition to learning that the proposed project was no longer distinguishable from other providers in the area, the ALC also heard evidence that no one knew why patients were traveling past existing providers to seek care in MUSC's ED downtown. MUSC did not submit data to the Department or at trial explaining or addressing why its patients in Dorchester, Charleston, and

Berkeley Counties were bypassing existing providers and traveling to MUSC in downtown Charleston for emergency services. (R. p. 2409:6-24). The Department decision maker explained that MUSC "didn't provide, kind of, a data analysis on reasons given for bypassing other facilities, we just knew that they were." (R. p. 2409:22-24). Trident's health planning expert explained, "These are folks who have been traveling downtown, driving past multiple existing providers to go downtown to receive services. So it'd lead one to believe that maybe there's something more than just geography that's dictating why they're going to the Medical University." (R. p. 1926:17-25). Trident's expert further opined that "if patients are traveling downtown now to the Medical University, they're not doing it because of lack of access to emergency care, they're doing it for other reasons." (R. p. 1951:16-22). And finally, "I think we've heard different reasons put forth such as they have an existing relationship with the specialist at MUSC downtown, they feel like they're going to get a different type of care if they go to an academic teaching hospital. Whatever the reason is it's not a reason of lack of access to care." (R. p. 3084:16-23). Because MUSC claims that its traveling patients are the ones in need of a new FSED service, the burden is very much on MUSC to show "why **they** are not being adequately served by the existing providers." (R. p. 5885) (emphasis added). This burden was not met. Substantial evidence supports the ALC's finding.

3. MUSC FAILED TO CONVINCE THE ALC THAT ITS PENINSULA PATIENTS WOULD REDIRECT TO A NORTH AREA FREESTANDING EMERGENCY DEPARTMENT.

Contrary to MUSC's assertions, the ALC is not required to award any particular amount of weight to the testimony it receives from an applicant. Rather, the ALC is free to weigh more heavily certain evidence over other evidence, as it is the judge of credibility. *MRI at Belfair, LLC v. S.C. Dep't of Health & Envtl. Control*, 394 S.C. 567, 577, 716 S.E.2d 111, 116 (Ct. App. 2011)

(holding that in the face of conflicting evidence, "as the fact finder, the ALC could weigh the evidence and assess each witness's testimony and credibility prior to ruling").

MUSC asserts that the "ALC gives too little weight to the concept of convenience. . . ." Brief of Appellant at 22. However, in the words of Trident's health planning expert, "[I]t's called a certificate of need, not a certificate of convenience." (R. p. 3109:6-24). *See Dema v. Tenet Physician Servs.-Hilton Head, Inc.*, 383 S.C. 115, 122, 678 S.E.2d 430, 433 (2009) (explaining that no private right of action is implied by the CON Act because it is "intended to advance the quality of healthcare provided in this State for all people receiving the care, not for a particular individual"). At trial, MUSC explained that "seeing our patients where they want to be seen and when they want to be seen is the most important thing." (R. p. 2562:15-17). MUSC further explained that what it would "like to offer – is the alternative that if [patients who choose MUSC for primary care] are seeking emergency room care in the North Charleston, Summerville area that we have something that is in network that can be offered to them." (R. p. 2661:18-25). Convenience, however, is not a standard or a criterion under CON Law to evaluate appropriateness of adding freestanding emergency services. Therefore, MUSC's argument must fail.

Moreover, in contrast to MUSC's naked assertion that added convenience would garner patients, the ALC heard myriad evidence contradicting MUSC's patient shift projections. To begin, MUSC's health planning expert did not include Roper's Northwoods FSED or Trident's Centre Pointe FSED in the maps he prepared for the Department. (R. p. 5703; R. p. 2799:3-21). And, MUSC's own Texas consultant's recommendation cast doubt on MUSC's patient origin projections. (R. pp. 1928:20–1929:2). Experts testified at trial that "the expectation that you're going to shift a significant number of those [patients] to a brand new freestanding ED I just think

it's unrealistic" (R. p. 1930:2-5). and that MUSC's position that its existing patients would redirect to a FSED was unreasonable. (R. pp. 3003:13–3006:8; R. p. 3009:11-18).

MUSC's expert countered with repeated statements that he made "assumptions": assumptions that the patient would choose the shorter travel time (R. p. 2789:18-23), assumptions of a "range of redirection" (R. pp. 2790:6–2791:3), and 50, 60, or 75% redirection percentages because MUSC "assumed a larger percentage of those would stop because of the convenience and location." (R. p. 2795:4-21). Most telling, however, is that this final answer, "We **assumed** a larger percentage of those would stop because of the convenience and location" was in response to a direct examination question from MUSC's trial counsel: "**How did you come up with those percentages?**" (R. p. 2795:4-5) (emphasis added). They assumed.

MUSC's expert was unable to explain why MUSC chose to predict the shift that it did, and instead said he simply "assumed." MUSC's projections were without any mathematical basis. (R. p. 1926:5-8). It is not surprising that the ALC found evidence of actual experience from existing freestanding emergency departments, *see e.g.* R. p. 6310-6311; R. p. 5719; R. p. 2964:1-18 more credible than naked assertions. There is simply no basis on which MUSC can assert that the ALC's findings lack substantial supportive evidence.

Faced with overwhelming evidence in testimony and exhibits, MUSC mischaracterizes the ALC's finding of fact #70. Brief of Appellant at 24. The ALC wrote:

> 70. Dr. Hall, MUSC's Medical Director for the main emergency department similarly testified that 'three, four and fives' were the acuity levels of the patients that would show up at the FED. (Tr. 270:6-12)

(R. p. 32, ¶ 70). Finding of Fact 70 relies on the following lines of the transcript as its basis:

> Q: And in terms of those ESI codes that we were talking about, as I understood your opinion when we talked at your deposition, that most of the patients that are going to show up at the freestanding ED are the level threes and fours. Is that right?
> A: Yeah, three, four and fives.

(R. p. 1016:6-12). Contrary to MUSC's assertion, the ALC does not use the word "only" in its finding. The ALC cited the exchange on which it based its finding of fact, and the ALC accurately reflected the very words used by Dr. Hall. MUSC itself described a "common theme[] among freestanding EDs" to be a "[t]ypically low to moderate acuity of patients." (R. p. 6340). In the face of substantial evidence supporting Finding of Fact 70, MUSC attempts to assign error to something the ALC simply did not say.

Beyond this misstatement, however, MUSC sows additional confusion when it argues that all emergency departments treat more moderately ill and injured patients than catastrophically ill and injured patients. Brief of Appellant at 24. No party has disagreed with this statement. However, Trident's and Roper's experts demonstrated that freestanding emergency departments provide care to *proportionally more low-acuity* patients than do emergency departments located on a hospital campus. (R. p. 1128:10-23; R. p. 1634:9-19; R. p. 1808:2-20). In other words, every emergency department treats numerous low-acuity patients, but FSEDs have a greater percentage of low-acuity patients than do the main hospital emergency departments. A freestanding emergency department is unlikely to simply serve a subset in similar proportion to all acuities seen at the trauma center facility. (R. p. 3009:11-25). The evidence thus demonstrated that the acuity levels for the patients MUSC proposes to shift are relevant to the reasonability of the predicted shift. (R. p. 2255:4-10; R. p. 2256:12-16; R. pp. 6392–6399). And, actual experiences of Roper's freestanding emergency departments bear this out: patient populations in a freestanding emergency

department and patients in a main hospital emergency department are not similar in acuity. (R. pp. 3007:6–3009:18; R. p. 6310).

MUSC did not address age or acuity in hypothesizing patient shift from the emergency department in its level 1 trauma center to a FSED near downtown Summerville. (R. p. 3684; R. p. 1480:1-10; R. p. 1489:16-21; R. pp. 6389–6399). MUSC's failure to address the differing acuity of patients seen at different facilities rendered its evidence less persuasive to the ALC. The ALC is entitled to favor more persuasive evidence when formulating its findings of fact. *See Maull*, 411 S.C. at 359, 768 S.E.2d at 408. The findings are supported by substantial evidence and must stand. *See Hill*, 389 S.C. at 13, 698 S.E.2d at 618.

4. MUSC'S FAILURE TO CONSIDER PATIENT ACUITY RENDERED MUSC'S EVIDENCE LESS PERSUASIVE ON THE QUESTION OF PATIENT ORIGIN AND LIKELY SHIFT.

Conclusion of Law #30 reads as follows:

> 30. Additionally, MUHA's shift projections are flawed. MUHA utilized billing codes versus acuity levels and did not take acuity into account in making its projections. Also, MUHA's representation that it assumed no (or even little) market shift and intended only (or even primarily) a shift of its existing patients,[55] is unrealistic.
>
> [55] "We are seeking to treat our patients at a location closer to their residence. We're relying on only our patients. We're not assuming a market share shift and therefore it won't have any impact on existing providers." (Tr. 2161:17-22).

(R. p. 62). MUSC reframes this conclusion in its argument to this Court, inserting causation where none appears, representing to this Court that "[t]he ALC concluded that MUSC's shift projections were flawed **because they were based on billing codes rather than triage levels**." Brief of Appellant at 26 (emphasis added). The ALC concluded no such thing. The ALC did not hold that use of acuity levels is *required*; rather, it held that MUSC's attempt to rely on billing codes did not

establish to the ALC's satisfaction "where the potential patients . . . will come from and why they are not being adequately served . . . ." (R. p. 5885). Findings of fact 63 through 77, replete with record citations, support Conclusion of Law 30. (R. pp. 31-34).

MUSC repeatedly mischaracterizes Conclusion of Law 30. MUSC argues to this Court on page 27 that "the ALC concluded that compliance with Standard 6 required MUSC to base its shift projection, or at least adjust them, by ESI acuity levels." Reading Conclusion of Law 30, reflected in its entirety above, reveals this is simply not true. MUSC alleges that the ALC "mandate[d] this novel and unreasonably restrictive requirement." Brief of Appellant at 28. Again, there is no such mandate anywhere in the ALC's Order.

The reality is this: MUSC projected that a specific proportion of all of its patients who live in the North Area would redirect themselves from a level 1 trauma service in an academic medical center to an ordinary FSED in downtown Summerville, based on location alone. MUSC did not convince the ALC, given the expansive complexity of care provided at the downtown hospital, that this broad-brush estimate approach to predicting patient shift was realistic. Moreover, the ALC heard evidence that actual experiences of freestanding emergency rooms operated by existing hospitals contradicted MUSC's projections. (R. p. 3007:6-21; R. p. 3008:16-23). MUSC's attempt, using data from billing codes, to prove that the identified patients would shift was not successful, and the finder of fact in this matter – the ALC – was "unconvinced." (R. p. 62, ¶ 31). As the ALC explained in Conclusion of Law 31[6]:

> 31. … MUHA assumed a percentage would shift but presented no information regarding why the patients from its

[6] MUSC criticizes the ALC Order for being "overly dismissive of MUSC's telehealth services, especially in the era of COVID-19." Brief of Appellant at 25. This contested case was heard beginning June 22, 2019, eight months before COVID-19 was so named and six months before the first U.S. case of COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/cdcresponse/about-COVID-19.html. There is no mention of COVID-19 in the record.

proposed zip codes will transition to a satellite FED other than it was more convenient. [56]

[56] "It is a guess." (Tr. 1181:3)

(R. p. 62). The ALC based Conclusion of Law 31 on the ALC's Findings of Fact numbers 63-77, which in turn were based on testimony and exhibits as cited in the Order. (R. pp. 31-34).

The ALC is the judge of credibility and reliability of evidence in a contested case. *See Risher,* 393 S.C. at 207-08, 712 S.E.2d at 433. MUSC may disagree with the ALC's findings and conclusions, but disagreement by a party does not create reversible error. *DIRECTV, Inc. & Subsidiaries v. S.C. Dep't of Revenue*, 421 S.C. 59, 81, 804 S.E.2d 633, 644 (Ct. App. 2017). MUSC presented its case using data that the ALC found unreliable and unpersuasive. Conversely, Roper and Trident presented substantial evidence that the ALC found credible and to which the ALC cited in supporting its findings of fact. The ALC did not err.

B. THE ADMINISTRATIVE LAW COURT CORRECTLY FOUND, ON THE BASIS OF SUBSTANTIAL EVIDENCE, THAT PATIENTS ARE ADEQUATELY SERVED BY EXISTING PROVIDERS.

1. MUSC'S FAILURE TO DEMONSTRATE THAT EXISTING PROVIDERS LACK CAPACITY TO TREAT ADDITIONAL PATIENTS RENDERED MUSC'S EVIDENCE LESS PERSUASIVE ON THE QUESTION OF WHY PATIENTS ARE NOT ADEQUATELY SERVED.

MUSC had the burden to demonstrate (1) where the potential patients will come from; and (2) why "they are not being adequately served by the existing services in the area." (R. p. 5885). The ALC, as the trier of fact, "ha[d] the task of assessing the credibility, persuasiveness, and weight of the evidence presented." *Jones v. Leagan*, 384 S.C. 1, 12, 681 S.E.2d 6, 12 (Ct. App. 2009). Early in its planning process for the FSED, MUSC's own internal documents noted that the "competition [is] offering overlapping services." (R. p. 6333). In later attempting to show patients are inadequately served, however, MUSC relied on a *res ipsa* theory: because some patients travel

past other providers, they must be inadequately served. However, that patients travel past existing providers to seek care from MUSC does not speak for itself to prove other providers are inadequate options. Indeed, even MUSC is conflicted in arguing this point to this Court, as it first asserts that its services are so unique that patients travel long distances to receive them, Brief of Appellant at 21, but later argues that "[i]t is obvious" that patients would not "go to all this trouble" to travel to the peninsula "if existing services were adequate." Brief of Appellant at 29. MUSC's own expert was unable – even on direct examination by MUSC's counsel - to explain why patients would drive past existing providers. Specifically, he said "Some [patients] would still consider -- continue to go to the peninsula for certain reasons. Personal preference, acuity, you know, whatever the number -- whatever the reason. Not everybody that lives in a zip code would then say well you have to go to this freestanding ED, you can't go to the peninsula." (R. p. 2790:15-21).

Not only did MUSC rely on an assumption that merely driving past an existing provider means services are inadequate, MUSC also was unable to rebut Trident's evidence that existing providers can, currently do, and will continue to adequately serve the three county service area. Here again, MUSC attempts to manufacture a legal error by misrepresenting the ALC's words, claiming the ALC "read[] into Standard 6 a lack of capacity requirement." Brief of Appellant at 29. This is not what the ALC held.

The actual conclusion of law about which MUSC complains is here:

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

> **not able to be adequately served by existing providers.** These existing facilities have medical personnel that are competent and qualified and have demonstrated efficient operation.

(R. p. 62, ¶ 32) (emphasis added). MUSC introduced evidence only that some patients (an unknown number of patients but leading to 20,000 or so visits) drove past existing providers, for unknown reasons. (R. p. 2409:22-24). There was no testimony that patients were turned away by existing providers, or that existing providers lack qualified staff. To the contrary, Trident and Roper introduced voluminous evidence indicating otherwise, proving to the ALC's satisfaction that potential patients are in fact adequately served, now and in the future. MUSC argued a logical fallacy - patients drive past providers so there must be inadequate service - and the ALC was unpersuaded. This is not error.

2. THE ALC FOUND BASED ON SUBSTANTIAL EVIDENCE THAT EXISTING PROVIDERS HAVE AVAILABLE CAPACITY.

MUSC baldly asserts that the ALC erred in finding existing providers have capacity to serve current and additional patients in the service area; MUSC's brief includes eight lines of text to support this argument. Brief of Appellant p. 29-30. In contrast, the ALC included **nine pages of findings of fact**, supported by more than seventy record citations, twenty footnotes, and four charts, illuminating its findings regarding capacity of existing providers to serve the potential patients in this service area. (R. pp. 34-42). Substantial evidence to support the ALC's findings of fact abounds.

Immediately after objecting to the ALC evaluating capacity of Trident and Roper, MUSC posits, without citation to any law, that the ALC should have considered MUSC's capacity constraints. Brief of Appellant at 30. This statement, supported by no law, lacks merit. Moreover, the ALC did find that MUSC has capacity constraints in its hospital emergency department. (R. p.

49, ¶ 123). A single provider's overcrowding is not dispositive, and in this case the ALC appropriately considered all providers in the service area when it determined MUSC's target patients already are adequately served by available emergency services.

3. PUBLIC CHOICE FOR A PARTICULAR PROVIDER AND PATIENT CONVENIENCE ARE NOT RELEVANT CONSIDERATIONS FOR FREESTANDING EMERGENCY SERVICES.

On this point, all parties agree: "There is no criterion that specifically addresses public choice and convenience." Brief of Appellant at 30. MUSC asserts, nonetheless, that to "ignore the importance of public choice is to ignore reality." *Id.* However, the health care market is not as simplistic as MUSC would lead this Court to believe. "In most instances, the government allows market forces to determine the appropriate supply of a product, and consumers to purchase the amount of that product that meets their needs. However, the market for healthcare services is not a normal market, and it is this recognition that led to the development of health planning authorities and ultimately to CON programs." Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 Ky. L.J. 201, 209–10 (2017). To underscore this point, there is not a single South Carolina case that supports MUSC's demand that the ALC unilaterally add convenience or public choice to its calculation.

The cases to which MUSC directs this Court's attention in arguing for a new "convenience" criteria are all readily distinguishable. The first case to which MUSC points involved a request by a hospital to relocate its own acute care beds from one campus to another. *Trident Med. Ctr. v. S.C. Dep't of Health & Envtl. Control*, 412 S.C. 341, 356, 772 S.E.2d 177, 185 (Ct. App. 2015). The State Health Plan's provision for acute care bed relocation read at that time as follows: "Changes in the delivery system due to health care reform have resulted in the consolidation of facilities and the establishment of provider networks. These consolidations and agreements may

lead to situations where affiliated hospitals may wish to transfer beds between themselves *in order to serve their patients in a more efficient manner.* (emphasis added)." *Id.* The hospital's request to relocate the beds was affirmed by this Court because efficiency was demonstrated and "the approval . . . would not exceed the need for hospital facilities in the service area." *Id.* at 362, 772 S.E.2d at 188. In that case, for that particular service, efficiency was an explicit part of the standard, and a showing of need had been made. *See id.* Neither of these factors exist in this case.

MUSC cites another relocation case in which two providers were each allowed to move a linear accelerator from one site within the service area to another. *Carolina Reg'l Cancer Ctr. LLC v. S.C. Dep't of Health & Envtl. Control,* Docket Nos. 11-ALJ-07-0629-CC, 11-ALJ-07-0639-CC, 2015 WL 2159497 (Apr. 30, 2015). In allowing these moves, the ALC explained, "Because Ford and CRCC propose to *relocate* linear accelerators that are already operating in the service area rather than *add* linear accelerators to the service area, these relocations do not change the need for services in the service area or the linear accelerator capacity in the service area." *Id.* at *18 (emphasis in original). Again, context matters. In the case before the Court today, no one is proposing to relocate an existing service; rather, MUSC is proposing to add a new and duplicative one. The need calculations are necessarily different.

Finally, MUSC is incorrect that the courts sometimes consider CON to be about patient choice[7]. MUSC directs the Court's attention to another ALC order which approved two applicants adding linear accelerators to Horry County because, as the Court held, "there is a need for two additional linear accelerators in the [three county] Service Area under the 2012-2013 State Health Plan." *Grand Strand Reg'l Med. Ctr., LLC, v. S.C. Dep't of Health & Envtl. Control*, Docket No.:

[7] MUSC did not contend at trial that Trident and Roper do not provide quality emergency care. (R. p. 935:15-18).

2012-ALJ-07-0090-CC, 2014 WL 5303338, at *1 (Mar. 10, 2014). Each applicant argued that it alone should have received a CON to the exclusion of the other party. *Id.* In response to one applicant's argument that its competitor would have a higher reimbursement rate and thus be costlier, the ALC disagreed, noting that "there is currently no real price competition in Horry County as it relates to radiation therapy services, because there is only one provider." *Id.* at *13. From this statement sprang the footnote MUSC quotes to this Court: "CRCC contends that competition is not referenced in the PRC or the purposes of the CON Act. While not directly referenced therein, competition enhances the negotiating power of payors and the choices and quality that may be available for the residents of South Carolina, all of which are related closely to the purposes of CON Act." *Id.* at *13, n. 31. The ALC was addressing whether prices would decrease if patients had more choices, not asserting that patients should have access to their particular provider of choice. *Id.* This case, like the others, offers no support to MUSC's argument.

II. THE ADMINISTRATIVE LAW COURT CORRECTLY APPLIED THE 2017-2018 STATE HEALTH PLAN TO MUSC'S APPLICATION.

The 2017-2018 State Health Plan differed from the 2015 State Health Plan in that it removed Standard 6 and added a travel time provision. (R. p. 2430:6-18; R. p. 6062). The ALC exercised the discretion afforded by the CON Act to consider the 2017-2018 State Health Plan in addition to the 2015 State Health Plan. S.C. Code Ann. § 44-7-225 (2018). (R. p. 49, n. 47).

A. MUSC CANNOT RAISE A DUE PROCESS CHALLENGE TO THE CON STATUTE FOR THE FIRST TIME ON APPEAL.

MUSC asserts for the first time on appeal that the ALC violated its due process rights when the ALC applied the 2017-2018 Plan and its standards to MUSC's application. Brief of Appellant, p. 32. MUSC did not raise this issue at trial or in its Motion to Reconsider the Final Order filed on

June 8, 2020 (R. pp. 6778-6784), which motion was denied on July 6, 2020. (R. pp. 1-9). A constitutional issue raised for the first time on appeal is not preserved for review by this Court. *See Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 519, 560 S.E.2d 410, 417 (2002) ("[I]ssues not raised to and ruled on by the ALJ are not preserved for appellate consideration."); *Grant v. S.C. Coastal Council*, 319 S.C. 348, 356, 461 S.E.2d 388, 392 (1995) ("This appeal is Grant's first mention of any deprivation of due process and, therefore, this issue is not preserved."). MUSC's belated allegation of constitutional error should be rejected.

B. THE ALC FOUND BASED ON SUBSTANTIAL EVIDENCE THAT EXISTING PROVIDERS HAVE AVAILABLE CAPACITY AND MUSC'S FACILITY-SPECIFIC CONSTRAINTS ARE NOT DETERMINATIVE.

Relief of overcrowding in a specific emergency department is neither a Project Review Criterion in regulations nor a consideration listed in the State Health Plan when evaluating an application for freestanding emergency services. *See* S.C. Code Ann. Regs 61-15 § 802; R. p. 6062; R. pp. 5884-5885. The 2017-2018 Plan reads:

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

(R. p. 6062). MUSC asserts that the ALC ignored MUSC's capacity constraints and that MUSC's capacity constraints alone satisfy the 2017-2018 Plan. Neither of these statements is true. As to the first, the ALC did not ignore MUSC's downtown problems. The ALC found as fact that "MUSC's downtown emergency department is constrained." (R. p. 49, ¶ 123).

In the context of finding, however, that MUSC's downtown emergency department is capacity constrained while other area providers have excess capacity, (R. p. 39, ¶ 90), the ALC

correctly noted that MUSC's capacity constraints alone are not enough to allow approval of the project. "Freestanding emergency services do not have a facility-specific need calculation within the Plan." (R. pp. 2232:12–2233:9; R. p. 19, ¶ 21). The ALC clearly understood what the Department's decision maker explained at trial: the evaluation of a freestanding emergency department application requires consideration of the need in an area, not the need of a particular facility. (R. pp. 2232:12–2233:9). MUSC's downtown constraint "is not a criterion that the Court may consider," (R. p. 49, ¶ 123) (emphasis added), and had the ALC held otherwise it would have been an error.

MUSC would have the ALC rewrite the 2017-2018 Plan to state that the applicant must demonstrate "capacity constraints within one existing emergency department," or "capacity constraints within its own emergency department," either of which would be inconsistent with the Plan as a whole and ultra vires to the role of the ALC. The ALC correctly held, therefore, that while "[i]t is uncontroverted that MUHA has efficiency challenges in its own emergency departments . . . neither the regulations nor the Plans consider facility-specific needs when evaluating applications to add freestanding FED services." (R. p. 68, ¶ 60).

C. THE ALC CORRECTLY HELD THAT THE PLAN'S LANGUAGE REGARDING A "FIFTEEN MINUTE TRAVEL TIME" REFERS TO TRAVEL TIME FOR A PATIENT TO AN EMERGENCY SERVICES PROVIDER, NOT TRAVEL TIME FROM ONE EMERGENCY PROVIDER TO ANOTHER EMERGENCY PROVIDER.

As a preliminary point to this argument, MUSC is mistaken when it asserts that the ALC's decision rested on approved but not yet operational providers for any of its findings or holdings, including for those regarding travel time. MUSC's selective quotation is misleading, so again, the entire finding of fact that MUSC challenges is here:

> 83. Ms. Murdock testified that while certain project review criteria address "existing" facilities, the Department looked at approved

> facilities for purposes of planning: "as part of our general purposes of CON and guiding establishment where these services are needed, I think we need to look towards what will exist in the future [e.g., approved facilities] in addition to what exists now." (Tr. 1353:11-1354:5). Ms. Platt concurred with this approach. (Tr. 726:1-18; Tr. 2240:14-2241:25.)[27] The Court concurs with the Department and Roper St. Francis that approved facilities should be considered for purposes of health care planning as it is consistent with the stated purpose of the CON Act outlined in Section 44-7-120 of the South Carolina Code:
>
> [The purpose of the CON Act is to] promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure high quality services are provided in health facilities in this State.
>
> S.C. Code Ann. § 44-7-120 (2018).
>
> [27] Mr. Levitt testified that it depended upon the project and standards and opined that one should only consider existing providers. (Tr. 2203:7-21).

(R. p. 36, ¶ 83). The ALC ultimately finds that:

> **[e]ven if the Court were to exclude [all approved but not yet operational capacity]**, from its capacity calculations on the basis that they were not 'existing' and operational as of the conclusion of the contested case hearing, **there would still be sufficient capacity in the service area to treat an additional 64,900** (289,000 – 225,000 = 64,900) patients without adding another FED or hospital-based emergency room. As an aside, there was also no evidence regarding excessive wait times at the facilities in MUHA's proposed service area. *See also* (Tr. 2244:3-2246:1).

(R. p. 38, ¶ 88) (emphasis added). There is simply no basis to assert that the ALC erroneously relied on approved but not completed capacity for its findings of fact.

All of the patients proposed to be served by MUSC currently reside within fifteen minutes of an existing (not merely proposed) emergency services provider. (R. p. 6308; R. p. 3001:15-18; R. p. 49, ¶ 124; R. p. 67, ¶ 55). Nonetheless, MUSC argues that the relevant "need" and "travel time" are of providers, not patients. In other words, MUSC's argument is that a need exists for a

new emergency service when *that new emergency service* will have a "travel time of greater than 15 minutes to an existing emergency department in the service area." This is nonsensical. The State Health Plan must be read as a whole, and there is no part where the "need" of a facility is considered in the document (or where a facility has a travel time, for that matter). *See Sparks v. Palmetto Hardwood, Inc.*, 406 S.C. 124, 129, 750 S.E.2d 61, 63 (2013) (noting that words within "a single statutory scheme" must be construed consistently and "in context"). Certificate of Need is just such a "single statutory scheme," and travel time provisions throughout the State Health Plan refer to travel times for patients. *See e.g.* R. p. 5975 (stating that for general hospital beds "the goal [is] having beds available within approximately thirty (30) minutes' travel time for the majority of the residents of the State"); R. p. 6004 (stating "[p]sychiatric beds are planned for and located within sixty minutes' travel time for the majority of the residents of the State"); R. p. 6067 (explaining that "[b]ecause nursing facilities are located within approximately thirty (30) minutes' travel time for the majority of the residents of the State and at least one nursing facility is located in every county, no justification exists for approving additional nursing facilities or beds that are not indicated as needed in this Plan"). There is no logical way to read the travel time requirement or goal of the 2017-2018 Health Plan other than intending to make emergency services available to citizens of South Carolina.

D. BECAUSE THE ALC REVIEWED SUBSTANTIAL EVIDENCE AND DID NOT FIND ANY BENEFITS OF IMPROVED ACCESSIBILITY IN MUSC'S APPLICATION, THE BALANCING TEST BETWEEN BENEFIT OF IMPROVED ACCESSIBILITY AND DETRIMENT OF UNNECESSARY DUPLICATION IS LEFT ONLY WITH DETRIMENTS OF UNNECESSARY DUPLICATION.

Both the 2015 State Health Plan and the 2017-2018 State Health Plan required the Department and the ALC to weigh the "adverse effects of duplication" with the benefits of

improved accessibility. *See* R. p. 5885; R. p. 6062. In the 2015 State Health Plan, which the ALC was required to consider, the adverse effects of duplication are "equally weighed" with benefits of improved accessibility. In the 2017-18 State Health Plan, improved accessibility "will outweigh" the adverse effects of duplication, with accessibility having been explained in the prior sentence as the fifteen minute travel time standard.

MUSC did not demonstrate that any persons in the proposed service area will experience improved accessibility. MUSC's entire argument is that it will serve patients who by definition already access emergency services at MUSC. (R. p. 5701). MUSC has provided evidence that some people who live in the proposed service area have received emergency services at its academic medical center campus downtown in the past. (R. p. 2801:6-18). These patients utilize MUSC at present, and they also have access to other emergency providers within fifteen minutes of their homes. (R. pp. 1471:8–1472:1; R. pp. 1477:22–1478:19; R. p. 6308). MUSC has simply hypothesized that some of those patients would rather visit a freestanding emergency department *operated by MUSC*.

However, the relevant inquiry for the ALC was whether the community in which the new service is proposed to be located lacks access to emergency services. (R. p. 1892:18-23; R. pp. 2232:23–2233:9; R. pp. 2253:7–2254:3). Neither patient choice nor opportunity to compete play a role in determining whether the project improves access. (R. pp. 3023:17–3024:10). The evidence introduced by the parties at trial established conclusively that the patients presently have access, but MUSC would like to give them an additional option. (R. p. 2679:1-14; R. p. 6308). MUSC's desire to add a service where none is needed cannot support a Certificate of Need.

In the present case, MUSC could not show any improvement in access, but adverse effects are evident. The balancing test in the 2017-2018 Plan decrees that "[t]he benefits of improved accessibility will outweigh the **adverse effects of duplication** in evaluating applications for this service." (R. p. 6062) (emphasis added). MUSC asserts that the bolded language refers to Regulation 61-15 § 802, which is the list of Project Review Criteria. However, the CON Act establishes that they are distinct requirements. According to the CON Act, the State Health Plan must include "a general statement as to the **project review criteria** considered most important in evaluating Certificate of Need applications for each type of facility, service, and equipment, including a finding as to whether the benefits of improved accessibility to each such type of facility, service, and equipment may outweigh the **adverse effects caused by the duplication** of any existing facility, service, or equipment." S.C. Code Ann. § 44-7-180 (emphasis added). The Project Review Criteria, including one titled "Adverse Effects on Other Providers," comprise separate subsections of the regulations. *See* S.C. Code Ann. Reg. 61-15 § 802. "It is a classic canon of statutory construction that courts must give effect to every provision and word in a statute and avoid any interpretation that may render statutory terms meaningless or superfluous." *Discover Bank v. Vaden*, 396 F.3d 366, 369 (4th Cir. 2005) (internal quotation and citation omitted). To give meaning to both measures, "adverse effects caused by duplication" in the statute must be read as distinct from "Adverse Effects on Other Providers" which appears in the regulation. *See id.*

In cases such as this one, the distinction between the measures is particularly meaningful. The ALC found that there were no Adverse Effects on Other Providers, as that term is defined in the regulation (staffing and census would not be harmed). (R. pp. 45-47, ¶¶ 112, 116). But, there is an adverse effect of duplication, specifically, violating the cost containment purpose of the CON Act. (R. p. 48, ¶120). In some circumstances, such an adverse effect of duplication might be

outweighed by benefits to the community as a whole from improved accessibility. In this case, however, there is no benefit of improved accessibility, so the balance tips sharply toward a negative net result. As the ALC continued at page 59, paragraph 63, when "adverse effects of duplication" is given a meaning consistent with the cost-containment purposes of the CON Act, wasted resources for an unnecessary (and governmentally-funded) expenditure are readily apparent. (R. p. 68, ¶ 63; R. pp. 1912:11–1913:23, R. pp. 2500:23–2501:4, R. pp. 2509:21–2510:6). Balanced against a zero improved accessibility score, any adverse effect controls.

Trident proved by a preponderance of the evidence that MUSC's target population already has robust emergency service options within a fifteen minute travel time. Thus, because there is no improved accessibility as a result of the Proposed Project, the existence of any adverse effect of duplication controls the relevant balancing test, under either State Health Plan, 2015 or 2017-2018.

III. THE ADMINISTRATIVE LAW COURT CORRECTLY CONCLUDED THAT MUSC'S APPLICATION DID NOT COMPLY WITH THE REQUIRED STATE HEALTH PLAN PROJECT REVIEW CRITERIA.

MUSC again asserts that the ALC should have found its evidence more persuasive and that its failure to do so is reversible error. Such is not the law, however. "The mere possibility of drawing two inconsistent conclusions from the evidence does not prevent a finding from being supported by substantial evidence." *Jones v. S.C. Dep't of Health & Envtl. Control*, 384 S.C. at 304, 682 S.E.2d at 287 (citations and internal quotations omitted). Reasonable findings that are supported by substantial evidence are upheld by the appellate court. *Hill,* 389 S.C. at 9-10, 698 S.E.2d at 617.

A. THE ADMINISTRATIVE LAW COURT CORRECTLY HELD THAT THE DEPARTMENT MAY NOT UNILATERALLY CHANGE THE STATE HEALTH PLAN ONCE ADOPTED.

Trident respectfully submits that to the extent MUSC may be perceived as challenging the ALC's determination that the Department lacks authority to remove or ignore Project Review Criteria, *see* R. p. 61, ¶ 25, this issue is deemed abandoned. *See, e.g., HHHunt Corp. v. Town of Lexington*, 389 S.C. 623, 635, 699 S.E.2d 699, 705 (Ct. App. 2010) (deeming argument abandoned when appellant failed to proffer any legal theory); *R & G Const., Inc. v. Lowcountry Reg'l Transp. Auth.*, 343 S.C. 424, 437, 540 S.E.2d 113, 120 (Ct. App. 2000) (deeming issue on appeal abandoned when argument in brief is conclusory only).

B. THE ADMINISTRATIVE LAW COURT WEIGHED EVIDENCE FROM ALL PARTIES REGARDING COMMUNITY NEED FOR THE PROJECT AND FOUND AS FACT THAT THERE IS NONE.

MUSC argues to this Court that MUSC's evidence should have swayed the ALC. Such an argument is not a proper ground for reversal. *See, e.g., Jones*, 384 S.C. at 304, 682 S.E.2d at 287. Nonetheless, Trident notes the following findings of fact in response to MUSC's contentions, each of which is supported by record evidence noted by the ALC or in this Brief *supra*, or both.

Section 802(2)(a): The ALC found facts, including the below examples and others explained in Respondent's Brief *supra* at Section I (A)(2), supporting its conclusion that the target population for the project was not "clearly identified." Specifically:

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

(R. p. 31, ¶ 67).

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

(R. p. 41, ¶ 98).

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

(R. p. 43, ¶ 104). *See also* Respondent's Brief *supra* section I (A)(2).

Section 802(2)(b): The ALC did not dispute population growth in the area but found it of limited value in evaluating MUSC's proposed project. Specifically:

> 93.While the Court does not dispute population and emergency room visit growth in the tri-county area, the trend in the growth of emergency department visits indicates that it slowed in 2016, and that it actually declined in 2017. (Tr. 2359:16-2361:16): (MUSC Ex. 37).

(R. p. 40, ¶ 93).

> 98. While MUHA stated that the exploding population growth in the proposed service area provided a basis for its need of the FED, this contradicts MUHA's position that it would only (or even primarily) be serving or redirecting patients who are already being treated by MUSC at its downtown emergency departments. *See* (Tr. 1977: 12-23; 2161:19-22). If MUHA was only seeking to redirect its own patients to the new FED for its stated purposes of providing better access for its existing patients and alleviating capacity constraints at its downtown emergency departments, the growth in population and emergency department visits in Berkeley County would seem irrelevant.

(R. pp. 41-42, ¶ 98).

Section 802(2)(c): The ALC disagreed that MUSC showed any residents of the targeted zip codes "**needed** FED services closer to their homes" (emphasis added); rather, MUSC wanted to serve them closer to their homes. Specifically:

> 68. MUHA provided no basis, insight, or information for its assumption as to why some of its patients who resided in Berkeley, Charleston, and Dorchester Counties were already bypassing other hospital-based emergency rooms as well as FEDs to seek treatment at MUSC on the peninsula. (Tr. 1663:1-24).[19] While pertinent to Standard 6's requirement that an applicant demonstrate why patients are not being adequately served by existing services in the area, the fact that a patient chooses to bypass an existing provider does not mean that existing health resources in the service area are inadequate. (Tr. 1664:14-24).
>
> [19] Mr. Sullivan testified that "[I]f patients are traveling downtown now to the Medical University, they're not doing it because of lack of access to emergency care, they're doing it for other reasons." (Tr. 1205:16-22).

(R. p. 32, ¶ 68).

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

(R. p. 43, ¶ 103). *See also* Appellee's Brief *supra* section I (B)(3).

Section 802(2)(e): The ALC disagreed with MUSC that utilization projections were "sufficient to justify the expansion or implementation of the proposed service." Specifically:

> 93. While the Court does not dispute population and emergency room visit growth in the tri-county area, the trend in the growth of emergency department visits indicates that it slowed in 2016, and that it actually declined in 2017. (Tr. 2359:16-2361:16): (MUSC Ex. 37). There is no indication that there is going to be a

> consistent dramatic increase in emergency department visits going forward. (Tr. 2361:1-11).

(R. p. 40, ¶ 93).

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

(R. p. 38, ¶ 86).

Next, MUSC erroneously asserts that the reasons why patients drive past one provider to another are unimportant. To the contrary, understanding why residents drive past one facility to another is, in fact, very important, to Community Need Documentation. *See* S.C. Code Ann. Regs. 61-15 § 802(2). When the applicant relies on *res ipsa* as its method to determine the level of need ("The reasons why . . . is [sic] less important than the undisputed fact that they are doing it" Brief of Appellant p. 39) and naked beliefs as a statistical methodology ("MUSC believes a percentage of these North Area patients would redirect . . . ." Brief of Appellant p. 39), the ALC is entitled, and perhaps obligated, to disagree. *See DIRECTV, Inc. & Subsidiaries*, 421 S.C. at 82, 804 S.E.2d at 645.

C. THE ADMINISTRATIVE LAW COURT WEIGHED EVIDENCE FROM ALL PARTIES REGARDING DISTRIBUTION (ACCESSIBILITY) OF EMERGENCY SERVICES AND FOUND AS FACT THAT RESIDENTS OF THE SERVICE AREA ALREADY ENJOY ROBUST ACCESS TO MULTIPLE PROVIDERS OF EMERGENCY SERVICES.

In alleging that the ALC concluded accessibility was not relevant, MUSC misleadingly omits a significant portion of the ALC's conclusion of law. The conclusion at issue[8] reads in its

[8] MUSC labels this conclusion ¶ 38, but the quote in MUSC's brief is from ¶ 39.

entirety as follows:

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

(R. p. 64, ¶ 39) (emphasis added). Needless to say, when one omits the underscored portion, as MUSC did in on page 40 of its brief to this Court, the meaning changes. As written by the ALC, however, the conclusion is entirely appropriate – it is supported by findings of fact, which are in turn supported by record evidence. Trident respectfully declines to argue a manufactured issue.

The ALC correctly identified MUSC's proposed project as an unnecessary duplication of services as explained in this brief *supra* at section I(B)(2). MUSC makes unsupported statements contending otherwise and finishes with a grand statement that "log jams and delays" experienced by its patients in its challenged downtown emergency department are themselves "a public need." There is no law offered to support this proclamation. This argument is deemed abandoned. *HHHunt Corp.*, 389 S.C. at 635, 699 S.E.2d at 705 (deeming argument abandoned when appellant failed to proffer any legal theory).

D. THE ADMINISTRATIVE LAW COURT WEIGHED EVIDENCE FROM ALL PARTIES REGARDING MEDICALLY UNDERSERVED GROUPS AND FOUND AS FACT THAT UNDERSERVED RESIDENTS PRESENTLY ARE SERVED BY EXISTING PROVIDERS.

"Duplication and modernization of services must be justified," and "[u]nnecessary duplication of services and unnecessary modernization of services will not be approved." S.C. Code Regs. Ann. 61-15 § 802(3)(a) (emphasis added). MUSC, however, proposed that it would serve its own existing patients and not increase access for any underserved group. (R. p. 2228:6-11; R. p. 5701). EMTALA grants a federal right to receive an emergency medical screening to

anyone who presents to an emergency room, regardless of ability to pay. (R. p. 3130:8-16; R. p. 17, ¶ 11). Accordingly, the ALC concluded:

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

(R. p. 65, ¶ 44). Because residents in MUSC's defined service area, including the medically underserved, currently have easy access to both freestanding and hospital-based emergency room services within a fifteen minute drive time, (R. p. 44, ¶ 107), MUSC's proposed project does not increase access or otherwise improve it. For this reason, the conclusion that underserved persons do not benefit from the project is included in the ALC's Order and supports the conclusion that the project is an unnecessary duplication of services. (R. p. 64, ¶¶ 40, 41).

IV. THE ADMINISTRATIVE LAW COURT CORRECTLY CONCLUDED, AFTER FINDING FACTS FROM SUBSTANTIAL EVIDENCE, THAT MUSC'S APPLICATION IS INCONSISTENT WITH THE CON ACT BECAUSE IT UNNECESSARILY DUPLICATES EXISTING SERVICES.

The purpose of the CON Act is to "promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities" in South Carolina. S.C. Code Ann. § 44-7-120. The ALC's conclusions of law that MUSC's proposed project is inconsistent with the State Health Plan and violates the purposes of the CON Act are supported by multiple findings of fact based on record evidence. For example:

> 107. As to duplication of services, evidence at the contested case hearing was that the location of MUHA's proposed FED is less than 10 miles of multiple providers of emergency services, including Trident Medical Center and Summerville Medical Center. (Roper St.

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

(R. p. 44, ¶ 107).

Health planning is meant to be a process by which need is identified and services are added to address the need – the planning "guide[s] the establishment of health facilities and services which will best serve public needs . . . ." S.C. Code Ann. § 44-7-120. MUSC's application and trial testimony turns health planning on its head and posits that if the service is added, the patients will (probably) come. For this reason, among many others, the ALC properly reversed the Department's decision.

V. THE ADMINISTRATIVE LAW COURT CORRECTLY HELD THAT RESPONDENTS ORALLY ENTERING A "JOINT DEFENSE AGREEMENT," MID-TRIAL AND ASSERTING IT TO PREVENT PETITIONERS FROM THOROUGHLY EXAMINING THE AGENCY DECISION-MAKER DURING TRIAL, VIOLATES THE SPIRIT OF THE APA.

Petitioners were surprised to learn during the examination of the Department's decision maker (and in the seventh day of testimony in the *de novo* hearing), that the Department and MUSC had met in private two days prior to discuss previous testimony as well as the Department's upcoming testimony. (R. pp. 2291:9–2295:7). The meeting was revealed when the Department's counsel asserted attorney-client privilege to prevent the Department's CON Director, Margaret Murdock, from describing "conversations with MUSC's representatives about this project since [her] deposition." (R. pp. 2291:7–2292:14). After a recess, briefing from all parties, and pointed questioning from the ALC, the Department's counsel indicated she "would be willing to withdraw the objection and have Ms. Hollingsworth continue with the questions regarding the meeting on Friday, subject to it not waiving the Department's attorney-client privilege regarding, again, communications between just the Department's in-house counsel and just the Department." (R. pp. 2295:8–2297:11). Despite the withdrawal of the Department's objection, the oral defense agreement remained intact. Trident submits that there can be no joint defense agreement between the Department and MUSC, and the ALC appropriately chastised the Respondents for creating the appearance of duplicity by purporting to enter one mid-trial and without sufficient common interests to support it.

A. THE COMMON INTEREST DOCTRINE REQUIRES MORE THAN A "JOINT STRATEGY."

Respondents MUSC and the Department alleged they shared a "joint defense privilege," which is "more properly identified as the common interest rule." *In re Grand Jury Subpoenas,* 902 F.2d 244, 249 (4th Cir. 1990) (internal quotations and citations omitted). "The common

interest doctrine is not a privilege in itself, but is instead an exception to the waiver of an existing privilege. The doctrine protects the transmission of data to which the attorney-client privilege or work product protection has attached when it is shared between parties with a common interest in a legal matter." *Tobaccoville USA, Inc. v. McMaster*, 387 S.C. 287, 295, 692 S.E.2d 526, 531 (2010) (internal quotation omitted). "To extend the attorney-client privilege between or among them, parties must (1) share a common interest; (2) agree to exchange information for the purpose of facilitating legal representation of the parties; and (3) the information must otherwise be confidential." *Friday Investments, LLC v. Bally Total Fitness of the Mid-Atl., Inc.*, 788 S.E.2d 170, 177 (N.C. Ct. App. 2016) (citing *United States v. Schwimmer*, 892 F.2d 237, 243–44 (2d Cir.1989)), *aff'd as modified*, 370 N.C. 235, 805 S.E.2d 664 (2017).

"[C]ommon interest assertions by government agencies must be carefully scrutinized." *Hunton & Williams v. U.S. Dept. of Justice*, 590 F.3d 272, 274 (4th Cir. 2010). When analyzing common interest assertions by government agencies, courts should "be attentive both to when a common interest is formed and to what communications lie within the scope of that interest." *Id.* at 287. "For the doctrine to apply, an agency must show that it had agreed to help another party prevail on its legal claims at the time of the communications at issue because doing so was in the public interest." *Id.* at 274. A "mere 'indicia' of joint strategy as of a particular point in time are insufficient to demonstrate that a common interest agreement has been formed." *Id.* at 285.

B. MUSC AND THE DEPARTMENT DID NOT, AND DO NOT, SHARE A "COMMON INTEREST."

"[A] party seeking to rely on the common interest doctrine must demonstrate that the specific communications at issue were designed to facilitate a common legal interest; a business or commercial interest will not suffice." 6 James Moore et al., *Moore's Federal Practice* § 26.49 (3d ed. 2013). "The key consideration is that the nature of the interest be identical, not similar,

and be legal, not solely commercial." *Duplan Corp. v. Deering Milliken, Inc.*, 397 F. Supp. 1146, 1172 (D.S.C. 1974). Here, at best the Department and MUSC had similar interests - if "winning" can be so considered - but no common interest. As the Department's counsel explained, MUSC and the Department, midway through trial, "felt that their interests were aligned" because "we would both – both Respondents would be presenting their Respondent's cases this week." (R. pp. 2294:17–2295:2).

The Department's loyalty is owed to the state of South Carolina, not any one constituent. The Department is charged, by statute, "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities." S.C. Code Ann. § 44-7-120. The Department has statutory and regulatory obligations to exchange information with persons other than the applicant. *See e.g.*, S.C. Code Ann. Regs. 61-15 § 308 (providing that department considers information from "other persons concerning the application, data, . . . and other information"); *Id.* 61-15 § 305 (stating that an affected person is entitled to receive notice of the review cycle for an application). "Basic principles of due process entitle a person involved in a dispute with an administrative agency to an adjudication of the dispute by a fair, impartial, and unbiased administrative body." *Port Elsewhere II v. S.C. Dep't of Labor, Licensing, and Regulation*, No. 05-ALJ-11-0201-AP, 2006 WL 639406, at *5 (Feb. 10, 2006) (*citing* S.C. Const. art. I, § 22; *Ross v. Med. Univ. of S.C.*, 328 S.C. 51, 492 S.E.2d 62 (1997) and *Garris v. Governing Bd. of S.C. Reinsurance Facility*, 333 S.C. 432, 511 S.E.2d 48 (1998)). The Department cannot have a "common interest" by "agreeing to help" one of several members of its regulated community "prevail on its legal claims." *Hunton & Williams,* 590 F.3d at 274.

MUSC, on the other hand, has no statutory obligation to South Carolina's citizens or the state regarding cost containment, prevention of duplication of services, guidance in the location of health services, or ensuring development of quality care options. Indeed, MUSC need not even take consistent positions with the Department regarding the very project it seeks to build, as MUSC today has been approved to receive a Certificate of Need for a hospital in Nexton that obligates it to shutter the very FSED it seeks to build with this pending appeal. *CareAlliance Health Services, et. al. v. S.C. Dep't of Health & Envtl. Control*, Docket Nos. 18-ALJ-07-0358-CC, 18-ALJ-07-0360-CC, 18-ALJ-07-0366-CC, 2020 WL 5503670 at *24 (September 4, 2020). And tellingly, although it was the Department's decision that was reversed in this case, the Department did not notice an appeal.

C. MUSC AND THE DEPARTMENT EVIDENCED NO DESIRE TO IMPLEMENT A JOINT LEGAL STRATEGY UNTIL MS. MURDOCK WAS ON THE STAND TESTIFYING, NEGATING THE POSSIBILITY OF ANY JOINT DEFENSE AGREEMENT.

The "joint defense privilege protects communications between an individual and an attorney for another when the communications are 'part of an on-going and joint effort to set up a common defense strategy.'" *Matter of Bevill, Bresler & Schulman Asset Mgmt. Corp.*, 805 F.2d 120, 126 (3d Cir. 1986) (internal citation omitted) (emphasis added). There is no basis in law, in any jurisdiction, for parties to suddenly shield themselves from participation in an ongoing trial by the allegation of a joint defense agreement.

MUSC and the Department vigorously contested Trident's motion for summary judgment in February of 2019; the ALC itself noted that the *de novo* nature of the contested case would allow it to review whatever project details MUSC established by the time of trial. (R. p. 108). In asserting the joint defense agreement at trial, the Department took a contrary position, arguing that it should not disclose details it learned from MUSC about changes to the application under review. (R. p.

2292:1-5). The Department and MUSC created precisely the trial by ambush that eviscerates the public CON process and erodes public confidence in government as a whole. Neither the ALC nor this Court should countenance subterfuge, and the ALC's criticism of the dubious joint defense agreement should stand.

CONCLUSION

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

Respectfully submitted,

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April 5, 2021
Columbia, South Carolina

THE STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable Shirley C. Robinson, Administrative Law Judge

APPELLATE CASE NO.: 2020-001072

ADMINISTRATIVE LAW COURT CASE NO.: 17-ALJ-07-0441-CC
ADMINISTRATIVE LAW COURT CASE NO.: 17-ALJ-07-0444-CC

Trident Medical Center, LLC, d/b/a Trident Medical Center
and Summerville Medical Center,.....Petitioner/Respondent,

v.

South Carolina Department of Health and Environmental Control
and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....Respondents,

Of Which, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is the.....Appellant.

AND

CareAlliance Health Services, d/b/a Roper St. Francis
Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis
Xavier Hospital, Inc., Roper Mount Pleasant Hospital and
Roper St. Francis Berkeley Hospital,.....Petitioner/Respondent,

v.

South Carolina Department of Health and Environmental Control,
and Medical University Hospital Authority d/b/a
MUSC Health Emergency Services,.....Respondents,

Of Which, Medical University Hospital Authority d/b/a
MUSC Health Emergency Services is the.....Appellant.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that this Brief of Respondent Trident Medical Center, LLC complies with Rule 211(b), SCACR.

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