THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

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

FINAL BRIEF OF APPELLANT

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STATEMENT OF ISSUES ON APPEAL

1. Whether the Administrative Law Court erred in concluding that MUSC failed to document where potential patients for its proposed FED would come from and why they are not being adequately served by existing providers, given that MUSC identified 25 North Area zip codes from which MUSC Medical Center receives over 24,000 annual ED visits and which are closer to the proposed FED and existing providers than they are to downtown Charleston.

2. Whether the Administrative Law Court erred in its application and conclusions regarding the 2017-18 State Health Plan, when it required MUSC to meet new requirements not in place when MUSC filed its application, refused to consider MUSC's capacity constraints, and misinterpreted the travel time requirement.

3. Whether the Administrative Law Court erred in concluding that MUSC's application did not comply with the regulatory criteria of Community Need Documentation, Distribution (Accessibility), and Medically Underserved Groups, when its analysis disregarded the actual language of those criteria.

4. Whether the Administrative Law Court erred in concluding that MUSC's application did not comply with the purposes of the CON Act, when its approval would fulfill a public need by benefitting residents of the North Area, involve no unreasonable costs, and promote the provision of high-quality emergency services.

5. Whether the private meeting during trial between Co-Respondents MUSC and DHEC violated the spirit of the South Carolina Administrative Procedures Act.

STATEMENT OF THE CASE

This is an appeal from a contested case hearing before the South Carolina Administrative Law Court ("ALC"). In June 2017, the Medical University Hospital Authority, d/b/a Medical University Hospital Services ("MUSC" or "MUHA")[1], filed an application with the South Carolina Department of Health and Environmental Control ("DHEC") to obtain a Certificate of Need ("CON") to establish a freestanding emergency department ("FED" or "FSED") in Berkeley County, South Carolina. (MUSC CON Application, R. 3155). The application was opposed by Trident Medical Center, LLC, d/b/a Trident Medical Center and Summerville Medical Center ("Trident"), and also by CareAlliance Health Services, d/b/a Roper St. Francis Healthcare, Roper Hospital, Inc., Bon Secours-St. Francis Xavier Hospital, Inc., Roper Mount Pleasant Hospital, and Roper St. Francis Berkeley Hospital ("Roper"). (Jt. Ex. 1 at DHEC CON 000440-453, R. 3594-3607).

On September 25, 2017, DHEC issued a staff decision approving the application. (DHEC Decision Letter, R. 3705). On October 6, 2017, Roper filed a Request for Final Review ("RFR") with the DHEC Board. (Roper RFR, R. 122). On October 16, 2017, Trident also filed an RFR. On November 15, 2017, the DHEC Board declined further review. (DHEC letter, R. 183). Both Roper and Trident subsequently filed Requests for Contested Case Hearings with the ALC. (Roper Request, R. 110). The ALC consolidated the two cases and held a contested case hearing July 22 – August 2, 2019. On May 28, 2020, the ALC issued an Order reversing DHEC's decision and denying MUSC's application. (Order, R. 10). MUSC filed a motion to reconsider (MUSC Motion to Alter or Amend, R. 6778), which the ALC denied. (ALC Order, R. 1). On July 31, 2020, MUSC

[1] The Medical University Hospital Authority d/b/a MUSC Health Emergency Services was referred to during trial as "MUSC." This naming convention continues in Appellant's Brief except when use of Medical University Hospital Authority or "MUHA" is necessary for clarity.

appealed the ALC's order denying MUSC's application and the order denying the motion to alter or amend. (Notice of Appeal, R. 6794).

STATEMENT OF FACTS

I. The Certificate of Need Process

The State Certification of Need and Health Facility Licensure Act (the "CON Act") governs the establishment of medical facilities and projects in South Carolina. *See* S.C. Code Ann. §§ 44-7-110 through 385. The General Assembly enacted the CON Act "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State." S.C. Code Ann. § 44-7-120. The General Assembly designated DHEC as "the sole state agency for control and administration of the granting of Certificates of Need and licensure of health facilities and other activities necessary to be carried out under" the CON Act. S.C. Code Ann. § 44-7-140. The General Assembly also directed DHEC to promulgate regulations necessary to carry out DHEC's CON duties. S.C. Code Ann. § 44-7-150(3); S.C. Code Ann. Regs. 61-15 §§ 101 through 802.

Section 44-7-160 provides that a person or "health care facility" must obtain a CON before undertaking certain enumerated activities, such as constructing a new health care facility, changing the existing bed complement of a health care facility, making capital expenditures by or on behalf of a health care facility in excess of a certain threshold prescribed by regulation, or acquiring medical equipment that is to be used for diagnosis and treatment if the total project cost is in excess of an amount established by regulation. *Amisub of S.C., Inc. v. S.C. Dep't of Health & Envtl. Control*, 403 S.C. 576, 587, 743 S.E.2d 786, 792 (2013), *citing* S.C. Code Ann. § 44-7-160.

To obtain a CON, a provider submits an application to DHEC that describes how the proposed project meets the applicable regulatory criteria. S.C. Code Ann. § 44-7-200; *see* S.C. Code Ann. Regs. 61-15 § 802 (providing 33 categories of project review criteria that may be

considered). The CON Act also requires DHEC to publish a South Carolina Health Plan (the "State Health Plan" or "Plan"), with which CON applications must show compliance. S.C. Code Ann. § 44-7-180. In the State Health Plan, DHEC establishes CON standards for specific categories of healthcare services. S.C. Code Ann. Regs. 61-15 § 106. DHEC, the ALC, and the Court of Appeals "shall consider" the State Health Plan in place at the time the application was filed and "may consider" the current Plan when making this decision. S.C. Code Ann. § 44-7-225.

Once DHEC deems a CON application complete, "affected persons" are notified and may oppose the application. *See* S.C. Code Ann. § 44-7-210(A). An "affected person" includes a person or entity "located in the health service area in which the project is to be located and who provide[s] similar services to the proposed project." S.C. Code Ann. § 44-7-130(1) & (15). After reviewing the application, DHEC issues a staff decision approving or denying the CON application and notifies the applicant and affected persons. S.C. Code Ann. § 44-7-210(C); S.C. Code Ann. § 44-1-60(C) & (D). The applicant or an affected person may make a written request for final review of the staff decision on the CON application by the DHEC Board. *Id.*; S.C. Code Ann. § 44-1-60(E). If the DHEC Board grants the request for review, the DHEC Board conducts the review and issues a final agency decision on the CON application. S.C. Code Ann. § 44-1-60(F). If the DHEC Board declines the request for review, the DHEC staff decision becomes the final agency decision on the CON application. S.C. Code Ann. § 44-7-210(C) & (D); S.C. Code Ann. § 44-1-60(E) & (F). The applicant or an affected person may then request a contested case hearing before the ALC. S.C. Code Ann. § 44-1-60(G); S.C. Code Ann. § 44-7-210(E); *see Amisub*, 403 S.C. at 589, 743 S.E.2d at 793.

The ALC conducts a *de novo* hearing and determines whether to approve or deny the CON application. *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). After the ALC issues its decision, an aggrieved party may appeal to this Court. S.C. Code Ann. § 44-7-220.

II. The Tri-County Area and the North Area

The MUSC application identifies the service area for its proposed FED as Berkeley, Dorchester, and Charleston Counties (the "Tri-County Area"). (Jt. Ex. 1 at DHEC CON 000022, R. 3176). The Tri-County Area population has been growing in recent years, especially the "North Area" of Berkeley County, Dorchester County, and northern Charleston County. (Tr. at 1707:8-17, 1978:7-9, R. 2453, 2724, MUSC Ex. 32, R. 5695E). The primary service area for MUSC's proposed Berkeley County FED consists of 25 North Area zip codes[2] in which the population is projected to grow 8.5 percent from 2019-2024, compared to a statewide projected growth of 5.9 percent. (MUSC Exs. 30-31, R. 5694 C-D). Growth is particularly strong along the I-26 corridor near Summerville, where new housing and industry developments are being built. (Tr. at 1707:19 – 1708:9, at 768:11-21, R. 2453-2454, 1514). As acknowledged by Trident's health planning expert, Daniel J. Sullivan, the proposed site for the MUSC FED is "proximate to the fastest growing communities in the Tri-County area." (Tr. at 1244:3-10, R. 1990).

Not only is the population growing in the Tri-County Area, the volume of emergency department ("ED") visits is growing as well. (Tr. at 1980:4 – 1981:15, R. 2726-2727; Jt. Ex. 1 at DHEC CON 000524, R. 3678). From 2015-2017, the growth in ED visits for residents of the Tri-County Area was 5.1 percent, significantly higher than the statewide growth of 1.9 percent. (MUSC Ex. 35, R. 5696). Growth in ED visits for Berkeley County residents during this period was over 17 percent. (*Id.*) From 2012-2017, Tri-County Area hospitals experienced a growth in

[2] Three of the zip codes in MUSC's proposed service area are Post Office Box zip codes, which do not have population estimates. (MUSC Exs. 30-31, R. 5694 C-D).

ED visits of 23.1 percent. (MUSC Ex. 37, R. 5698). While ED volume growth at MUSC has been flat, due in part to capacity constraints, ED visits to MUSC from Berkeley County increased over 21 percent from 2015-2018. (MUSC Ex. 34, R. 5695A; Tr. at 2104:22 – 2105:2, R. 2850-2851).

At the time of trial, there were six existing ED providers in the North Area. Two are hospitals owned by Trident: Trident Medical Center ("TMC") in North Charleston and Summerville Medical Center ("Trident SMC" or "SMC") in Summerville. (Tr. at 384:23-24, at 902:1-6, R. 1130, 1648). The other four existing providers are FEDs, each owned by either Trident or Roper. (Tr. at 1237:13 – 1239:3, R. 1983-1985). Roper Northwoods and Trident's Centre Point are in northern Charleston County. (Tr. at 1237:21 – 1238:13, R. 1983-1984). Roper and Trident each also own an FED in Moncks Corner. (Tr. at 1238:14-19, R. 1984).

Of the six existing EDs in the North Area, only TMC and Trident SMC are within a 15-minute drive of MUSC's proposed FED site, but that is only without heavy traffic. At 8:00 a.m. and 3:00 p.m., when traffic is heavy, the average drive time from MUSC's proposed site to TMC or SMC ranges from 18-30 minutes. (MUSC Ex. 60 at 31, R. 5711, Tr. at 2140:11 – 2141:15, R. 2886-2887).

III. MUSC's Hospital-Based Emergency Departments

MUSC Medical Center is South Carolina's only academic medical center and the state's highest ranked hospital by *U.S. News and World Report*. (Jt. Ex. 1 at DHEC CON 000008, R. 3162). MUSC has three hospital-based emergency departments in downtown Charleston: an Adult ED, a Pediatric ED, and a Chest Pain Center, all operating under the MUSC Medical Center's license. (Tr. at 1701:12 - 1702:2, R. 2447-2448). The Adult ED is located in the MUSC Medical Center's University Hospital, located downtown on the Charleston Peninsula. The Adult ED is a

Level I trauma center[3] (Jt. Ex. 1 at DHEC CON 000008, R. 3162), the highest level of trauma center and one resourced to treat acute trauma patients. MUSC is the only Level I trauma center in the Tri-County Area. (Tr. at 136:19 – 137:6, R. 882-883, Jt. Ex. 1 at DHEC CON 000008, R. 3162). MUSC's Adult ED is accredited by the Joint Commission as a comprehensive stroke center. (Tr. at 136:14-16, R. 882). The Adult ED has 41 treatment rooms, but 12 of those are reserved for mental health patients and are typically full, leaving 29 rooms for medical (as opposed to mental health) emergency patients. (Tr. at 137:9-10, at 138:1-5, at 1701:20-23, R. 883, 884. 2447).

The Pediatric ED is also located in University Hospital and is also a Level 1 trauma center. (Tr. at 144:16-18, R. 890). MUSC intends to move the Pediatric ED to the new Shawn Jenkins Children's Hospital ("Jenkins"), also in downtown Charleston, once that facility opens, which, at the time of trial, was expected to be in 2019. (Tr. at 1702:3-8, R. 2448). Currently, the Pediatric ED has twelve emergency treatment rooms, in addition to an "E pod" of four treatment rooms used only for pediatric mental health emergency patients. (Tr. at 144:16 – 145:9, R. 890-891). After the Pediatric ED moves to Jenkins, it will have 20 treatment rooms. (Tr. at 146:6-8, R. 892).

MUSC's Chest Pain Center is located about a block away from University Hospital in MUSC's Ashley River Tower. (Tr. at 1701:25 - 1702:2, R. 2447-2448). The Chest Pain Center is accredited by the Joint Commission as a certified primary heart attack center. (Tr. at 142:18-19, R. 888). In the past, the Chest Pain Center primarily treated patients with cardiovascular, gastrointestinal, and cancer-related complaints. (Tr. at 142:20-24, R. 888). In the last few years,

[3] The trial transcript misstates the testimony of MUSC expert Dr. Gregory Hall, the Medical Director of MUSC's Adult ED. According to the transcript, Dr. Hall testified that MUSC's Adult ED was a Level II trauma center. (Tr. at 136:16-18, R. 882). In fact, Dr. Hall testified that the Adult ED is a Level I trauma center.

however, MUSC has expanded the scope of services provided at the Chest Pain Center in order to help relieve capacity issues at the Adult ED. (Tr. at 143:9, R. 889). Today, the Chest Pain Center provides a broad scope of emergency services, but only to adults. (Tr. at 142:25 – 143:9, at 144:1-2, R. 888-889, 890). The Chest Pain Center has ten treatment rooms, one of which is used for triage. (Tr. at 143:10-13, at 144:1-7, R. 889, 890).

All total, MUSC's three EDs have 67 treatment rooms, but 16 of these are reserved for mental health patients, leaving 51 treatment rooms for medical emergency patients (29 at the Adult ED, 12 at the Pediatric ED, and 10 at the Chest Pain Center). (Tr. at 149:22 – 150:4, at 151:5-10, R. 895-896; 897). After the Pediatric ED relocates to Jenkins, MUSC will have 59 total treatment rooms (29 at the Adult ED, 20 at the Pediatric ED, and 10 at the Chest Pain Center). (Tr. at 146:6-8, at 149:22 – 150:4, at 151:5-10, R. 892, 895-896, 897).

IV. Capacity Constraints at MUSC

MUSC applied for the Berkeley County FED CON, in part, to relieve capacity constraints at its Adult ED in downtown Charleston. (Tr. at 1977:12 – 1979:2, at 158:2-7, R. 2723-2725, 904). These constraints are evidenced by three key operational metrics. First, the Adult ED's door-to-doctor time has increased the last two to three years to where it now is 45-47 minutes, when it should average about 37 minutes. (Tr. at 158:12-24, at 159:35, R. 904, 905). Similarly, the Adult ED's door-to-discharge times have worsened over the past three years, rising from 187 to 220 minutes – 40 minutes longer than its goal of 180 minutes. (Tr. at 159:6 – 160:11, R. 905-906). Finally, the left without treatment ("LWOT") rate, which is the percentage of patients who present to an ED but leave before receiving any treatment, is five to eight percent, when it should be less than three percent. (Tr. at 160:12 – 161:8, at 172:1-5, R. 906-907, 918, MUSC Ex. 18, R. 5694 A-B; *see* Order at 8, ¶¶ 9, 10, R. 17).

Renovation or expansion of MUSC's downtown facilities is not a reasonable solution to alleviating these constraints. MUSC is essentially landlocked. (Tr. at 2148:18-19, R. 2894). Over the past several years, MUSC has constructed the new Children's Hospital and Ashley River Tower and has expanded the Adult ED. (Tr. at 1758:19 – 1759:1, R. 2504-2505). At this point, to alleviate constraints in any meaningful way would require a complete redesign of the Adult ED, which MUSC Medical Center's CEO, Dr. Patrick Cawley, testified would cost approximately $50 million. (Tr. at 1759:9-16, R. 2505). MUSC has implemented various other measures to address its high-volume problems, such as moving inpatients into hallways and using telehealth initiatives. (Tr. at 162:8 – 163:16, R. 908-909). Unfortunately, these measures have not eliminated the operational issues resulting from high volumes. (Tr. at 163:17-20, R. 909). Overall, MUSC's occupancy rate is approximately 90 percent, the highest of any hospital in the state. (Tr. at 2114:1-9, R. 2860).

The Adult ED also has high volumes of mental health patients, which raise other capacity issues. (Tr. at 163:21-164:2, R. 909-910). Out of safety concerns, the Adult ED has dedicated twelve ED beds for mentally ill patients. (Tr. at 164:2-20, R. 910). While this improved conditions for mental health patients, it had an adverse effect on throughput and LWOT rates for medical patients at the Adult ED. (Tr. at 164:16 – 165:7, R. 910-911). The twelve dedicated mental health beds, called the "D pod" area, typically remain full, while patients wait for beds to open at MUSC's Institute of Psychiatry. (Tr. at 165:25 – 166:2, at 167:1-7, R. 911-912; 913). The Institute of Psychiatry is a 100-bed hospital, but its occupancy rate is 109 percent. (Tr. at 2113:24 – 2114:1, R. 2859-2860).

A separate, though related, capacity problem is boarding. Most days, MUSC has 20-30 "boarders," commonly neurologic or mental health patients, waiting in the ED for hours for an

inpatient or observation bed to open at University Hospital, Ashley River Tower, or the Institute of Psychiatry. (Tr. at 166:13 – 167:7, at 237:17-24, at 1703:15-17, at 1869:8-13, R. 912-913, 983, 2449, 2615). MUSC has taken several steps to try alleviating the boarding issues, but the problem remains unresolved. (Tr. at 167:8 – 168:18, R. 913-914).

The operational inefficiencies resulting from high volumes, complex cases, compartmentalized spaces, high-volume mental health patients, and boarders have led to MUSC's poor door-to-doctor, door-to-discharge, and LWOT metrics. (Tr. at 170:17 – 171:1, R. 916-917). Diverting even a few ED patients from MUSC's downtown campus to the new Berkeley County FED would improve the delays, wait times, and other capacity constraints that exist at the Adult ED. (Tr. at 172:16-25, R. 918).

MUSC teaches medical, nursing, and pharmacy students, as well as fellows and residents. (Tr. at 1710:2-6, R. 2456). Many will work in an ED in the future. (Tr. at 1710:6-8, R. 2456). MUSC needs, therefore, to provide them with an ED environment in which they can learn. (Tr. at 1710:8-10, R. 2456). As described above, however, MUSC's Adult ED is already constrained from too many patients and boarders. Adding more students, fellows, and residents to the ED makes it even more crowded and difficult. (Tr. at 1710:11-15, R. 2456). The Berkeley County FED would help relieve capacity constraints at the Adult ED, creating a better teaching and learning environment. (Tr. at 172:16-25, R. 918). It would also provide the FED as a new teaching environment for MUSC and its students, fellows, and residents. (Tr. at 1979:13-23, R. 2725).

V. MUSC's Application

A. Timing of the Application

On April 12, 2017, Trident filed a CON application to build an FED in Summerville. (MUSC Ex. 8 at M08.001, R. 4040). Less than two months later, on June 6, MUSC filed its FED

application, in order to meet the deadline for DHEC to review its application comparatively with the SMC application, in the event DHEC determined the applications were competing.[4] (Tr. at 1974:4 – 1976:14, at 1265:20 – 1267:8, R. 2720-2722, 2011-2013, Jt. Ex. 1 at DHEC CON 000001, R. 3155). As it turned out, DHEC decided there was a need for both FEDs, determined they were not competing, and approved both applications. (Tr. at 1976:25 – 1977:1, at 1238:20-25, R. 2722-2723, 1984). At the time both applications were submitted, the 2015 State Health Plan was in effect. (Tr. at 1333:4-8, R. 2079).

B. Reasons for MUSC's Application

One reason behind MUSC's Berkeley County FED project is to relieve capacity constraints at MUSC's Adult ED in downtown Charleston. (Tr. at 158:2-7, at 1977:12 – 1979:2, R. 904, 2723-2725). The principal reason, however, is to improve access for North Area residents who wish to receive ED services from MUSC. (Tr. at 1711:22 – 1712:3, at 1977:19-23, R. 2457-2458, 2723). Annually, MUSC receives over 24,000 ED visits from residents of the 25 North Area zip codes that MUSC has identified as the primary service area for the proposed FED. (Tr. at 2051:17-22, at 2397:3-12, R. 2797, 3143, MUSC Ex. 60 at 17, R. 5708). This represents approximately 25 percent of MUSC's total ED visits. (Tr. at 155:19 – 156:1, R. 901-902). The geographic center of each of the 22 geographic zip codes in the primary service area is closer in drive time to MUSC's proposed FED site than to MUSC Medical Center on the Charleston Peninsula. (MUSC Ex. 40, R. 5701, Tr. at 2043:2-23, R. 2789). MUSC's health planner and expert witness, David S. Levitt, assumed that

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

a certain percentage of patients from each of these zip codes would, if given the choice, prefer to go to the new MUSC FED rather than drive to MUSC Medical Center. (Tr. at 2043:21-23, R. 2789). Not only would the new FED be a quicker drive time, but FEDs generally are also more convenient and have shorter wait times than hospital-based EDs. (Tr. at 1249:14 – 1250:2, at 2050:16 – 2051:3, R. 1995-1996, 2796-2797). This is particularly true for MUSC's downtown EDs, where parking and finding one's way can be a challenge. (Tr. at 2050:4-18, R. 2796). In addition, as discussed *supra* at 9, capacity constraints in MUSC's downtown EDs result in long wait times. (Tr. at 158:12 – 161:8, R.904-907).

Based on proximity and travel times, Mr. Levitt estimated a percentage of ED volume for each of the 25 zip codes that would shift from MUSC Medical Center to the new FED. (Tr. at 2049:4-21, R. 2795, MUSC Ex. 40, R. 5701). As a result, he projected a total of over 15,000 ED visits that would shift to the FED each of its first three years of operation. (Jt. Ex. 1 at DHEC CON 000531, R. 3685).

Trident criticized Mr. Levitt's analysis on grounds that it was unlikely that ED patients would drive past Trident and Roper's existing ED providers to seek services at MUSC's new FED. (Tr. at 1183:3 – 1184:5, R. 1929-1930). The evidence shows, however, that great numbers of MUSC ED patients from the North Area already drive past existing providers in the North Area and continue traveling all the way down the Charleston Peninsula for ED services at MUSC. (Tr. at 2055:6-18, R. 2801, MUSC Ex. 60 at 17, R. 5708). In particular, Trident criticized MUSC for including zip code 29406 in its service area, in part because 29406 is the zip code where Trident Medical Center is located. (Tr. at 1183:5 – 1184:5, R. 1929-1930). Notwithstanding that fact, in MUSC's 2016 Fiscal Year, MUSC's downtown ED received 4,483 visits from residents of zip code 29406. (MUSC Ex. 44, R. 5704).

Trident's planning expert, Mr. Sullivan, testified that his standard practice in drafting CON applications is to identify a small group of zip codes from which the applicant expects to draw 75-80 percent of its patients, as well as a secondary area from which the remaining 20-25 percent will "in-migrate." (Tr. at 1253:17-25, R. 1999). Mr. Levitt's approach for the MUSC FED application was similar. He identified seven zip codes from which MUSC's proposed FED would expect to draw 78.4 percent of its patients. (MUSC Ex. 44, R. 5704). The remaining 21.6 percent would in-migrate from the other 18 zip codes Mr. Levitt included in the primary service area. (*Id.*; Tr. at 2059:13 – 2060:17, R. 2805-2806).

C. Age and Acuity Issues

Mr. Sullivan and Roper's expert, Kathryn M.T. Platt, criticized Mr. Levitt's analysis for failing to calculate age or acuity adjustments to his projected shift of patients from MUSC's downtown ED to the new Berkeley County FED. (Tr. at 635:12-19, at 1185:21-25, at 2263:21 – 2264:7, R. 1381, 1931, 3009-3010). However, both Mr. Sullivan and Ms. Platt acknowledged that, in past FED applications they had drafted, their patient shift projections did not include calculations for age or acuity adjustments. (Tr. at 782:23 – 783:12, at 1260:7 – 1262:2, at 1262:16 – 1263:9, R. 1528-1529, 2006-2008, 2008-2009).

Nevertheless, Roper and Trident argued that MUSC shift projections should be decreased to adjust for pediatric patients. FED physicians, however, are able to evaluate and stabilize all patients, including children. (Tr. at 2063:23 – 2064:4, at 2065:24 – 2066:19, at 2093:9-18, R. 2809-2810, 2811-2812, 2839). Trident's Centre Point FED even has four dedicated pediatric treatment spaces. (Tr. at 2093:23 – 2094:7, R. 2839-2840). The opening of MUSC's new Shawn Jenkins Children's Hospital should not affect the number of pediatric patients presenting to the new Berkeley County FED because Jenkins, like MUSC's current Pediatric ED, is in downtown

Charleston. (Tr. at 2095:4-19, R. 2841). What is more likely to affect the new FED is the 2019 opening of MUSC's North Charleston pediatric campus. (Tr. at 2095:19-22, R. 2841). This campus contains an ambulatory surgery center, an imaging center, and a medical office building, all dedicated to pediatrics. (Tr. at 2095:24 – 2096:1, R. 2841-2842). With the opening of this center, pediatric patients are now receiving specialized care in the North Area closer to the new FED than Jenkins will be. (Tr. at 2096:2-3, 13-17, R. 2842). It is a logical extension that pediatric patients will seek emergency services in the North Area, close to MUSC's pediatric campus. (Tr. at 2096:13-17, R. 2842).

Roper and Trident also argued that acuity adjustments should be made to MUSC's shift projections. (Tr. at 69:10-19, at 1189:3-7, at 1193:10-13, R. 815, 1935, 1939). The Emergency Severity Index ("ESI") is an index of acuity codes consisting of five levels, with Level 1 being the highest acuity and Level 5 the lowest. (Tr. at 138:22 – 139:1, at 1189:3-7, R. 884-885, 1935). Roper and Trident based their argument for acuity adjustments on the premise that FEDs primarily treat ESI Levels 3-5. (Roper Ex. 59 at 22, R. 6279, Tr. at 755:18 – 756:7, at 1194:23-25, R. 1501-1502, 1940). In fact, both FEDs and hospital-based EDs primarily treat Levels 3-5, simply because the majority of patients seeking ED services are Levels 3-5. (Tr. at 2078:12 – 2079:11, R. 2824-2825). At MUSC Medical Center's Adult ED in Fiscal Year 2016, 87.7 percent of the ED visits from the proposed Berkeley County FED service area were Levels 3-5. (MUSC Ex. 49, R.5704A). The percentages for each acuity level for MUSC's total ED visits were consistent with the projected percentages by acuity level for the proposed FED service area. (*Id.*; Tr. at 2068:2 – 2070:8, R. 2814-2816).

Mr. Levitt testified that MUSC's Berkeley County FED will comply with the American College of Emergency Physicians ("ACEP") guidelines, which require that all FEDs must be able, among other things, to:

i. Evaluate and stabilize any patient;

ii. Have advanced diagnostic and laboratory facilities;

iii. Have the same equipment as hospital EDs; and

iv. Be equipped to handle any medical emergency.

(MUSC Ex. 60 at 19, Tr. at 2063:23 – 2064:4, at 2065:24 – 2066:19, R. 2809-2810, 2811-2812).

MUSC's ED Director, Dr. Gregory Hall, testified that a high acuity patient can benefit from services at an FED. (Tr. at 185:24 – 186:17, R. 931-932). As Dr. Hall explained, many patients present to an ED with symptoms that may or may not be a serious medical problem. (*Id.*) In such cases, quick access to a provider is important. (*Id.*) If the FED physician determines that it would be appropriate, a patient can be stabilized and transferred to a hospital-based ED. (Tr. at 186:18-25, R. 932).

Finally, MUSC's shift analysis is similar to that contained in the Trident SMC FED application, was premised on the position that the majority of patients its new FED would serve would otherwise be served at an affiliated ED. (MUSC Ex. 8 at M08.34, R. 4073).

D. MUSC's Accountable Care Organization

Dr. David Louder, who testified on behalf of MUSC, is the Executive Director of the MUSC Health Alliance, a clinically integrated network ("CIN") that operates a Medicare Accountable Care Organization ("ACO"). (Tr. at 1876:5-8, at 1883:2-9, R. 2622, 2629). The Affordable Care Act provides for the establishment of Medicare ACOs that work with CINs to improve the quality of health care, lower the cost of health care, and increase patient satisfaction.

(Tr. at 1883:10 – 1884:24, at 1887:23 – 1894:22, R. 2629-2630, 2633-2640). MUSC's CIN includes MUSC hospitals (on the Charleston peninsula and elsewhere), MUSC outpatient facilities, MUSC-employed physicians, and approximately 40 providers in Carolina Family Care. (Tr. at 1898: 21 – 1901:1, R. 2644-2647). There are over 14,000 Medicare beneficiaries in MUSC's ACO. (Tr. at 1895:16 - 1896:7, R. 2641-2642). In 2017, 34 percent of these ACO beneficiaries resided in areas in and around North Charleston, Moncks Corner, and Summerville. (Tr. at 1897:3 – 1898:20, R. 2643-2644). An MUSC FED in Berkeley County would provide these North Area beneficiaries with a more geographically accessible, in-network option to obtain emergency care. (Tr. at 1933:1-9, at 1944:13-18, R. 2679, 2690).

MUSC's CIN and ACO will be better able to coordinate the care of beneficiaries, including accessing their MUSC medical records and integrating the emergency care they receive into plans of care that have already been developed by other MUSC providers. (Tr. at 1908:16 – 1910:11, at 1917:8-11, R. 2654-2656, 2663). Moreover, MUSC's CIN and ACO would be better able to assist these beneficiaries with their transition from the FED to inpatient care or, preferably, to outpatient care or home. (Tr. at 1908:22 – 1909:5, at 1913:11 – 1914:7, R. 2654-2655, 2659-2660). Effective care coordination at an MUSC FED in Berkeley County will result in higher quality care for the Medicare beneficiaries in MUSC's ACO, fewer inpatient admissions after emergency department visits, lower out-of-pocket costs, and cost savings for the Medicare program that will be shared with MUSC's ACO. (Tr. at 1909:15 – 1912:8, at 1917:8-22, at 1945:7-19, R. 2655-2658, 2663, 2691).

ARGUMENT

I. The ALC erred in concluding that MUSC failed to satisfy Standard 6 of the 2015 State Health Plan.

Standard 6 of the 2015 State Health Plan's section on Freestanding Emergency Services provides:

> The applicant must demonstrate need for this service by documenting where the potential patients for this proposed service will come from and why they are not being adequately served by the existing services in the area.

(2015 Plan at XI-5, R. 5885). The ALC erroneously concluded that MUSC failed to satisfy either prong of Standard 6. (Order at 52, ¶ 28, R. 61). As support, the ALC relied on factual findings that are arbitrary, capricious, and unsupported by substantial evidence.

A. The ALC erred in concluding that MUSC failed to document where potential patients for the FED would come from.

MUSC defined the service area for the FED as the Tri-County Area (Order at 22, ¶ 64, R. 31, Jt. Ex. 1 at DHEC CON 000022, R. 61, 3176) and its primary service area as 25 North Area zip codes within the Tri-County. (MUSC Ex. 40, R. 5701). Three of the 25 zip codes were Post Office Box zip codes, included because patients reported them as their mailing addresses. (Tr. at 2048:10-22, R. 2794). Based on proximity and travel times, MUSC's expert, Mr. Levitt, estimated a percentage of ED volume for each of the 22 zip codes (excluding the three Post Office Box zip codes) that would shift from MUSC Medical Center to the new FED. (Tr. at 2049:4-21, R. 2795; MUSC Ex. 40, R. 5701).

1. MUSC presented undisputed evidence that MUSC Medical Center receives over 24,000 annual visits from North Area residents who drive past existing ED providers to get to MUSC.

The ALC's conclusion that MUSC failed to document where the FED's potential patients would come from rests, in part, on an irrelevant, misleading, and arbitrary finding that an

"unknown" number of patients were driving past existing providers to obtain ED services from MUSC. (Order at 53, ¶ 29, R. 62). What the ALC finding fails to recognize is that ED volume is measured in visits. The number of different individuals that seek ED services in a year is less relevant than the number of visits, because each visit is a separate encounter that requires treatment. (*See* Tr. at 2076: 19 – 2077:20, R. 2822-2823).

For the purposes of health planning, neither Trident nor Roper challenged the use of "visits" and "patients" as essentially interchangeable terms. In fact, they themselves used the terms interchangeably. For example, during the rebuttal testimony of Trident's expert, Mr. Sullivan, the following exchange occurred:

> Q: ... MUSC has documented, and you don't dispute these numbers, do you, that from the service area that Mr. Levitt – those 25 zip codes that he listed, 24,000 ***patients*** a year have been and are driving to MUSC for ED services?
>
> A: I would agree with that.

(Tr. at 2397:3-9, R. 3143) (emphasis added). In an earlier exchange, Mr. Sullivan was even clearer:

> Q: Now, you do agree, I believe, do you not, that for the last several years 20,000 ***people*** or more from the zip codes that Mr. Levitt used for his service area, have been traveling down to MUSC for ED services. You don't dispute the fact that many, total 20,000 a year, are going down there for ED services, do you?
>
> A: No.

(Tr. at 1259:23 – 1260:6, R. 2005-2006) (emphasis added).

Similarly, Roper's expert, Ms. Platt, created and relied on trial exhibits that acknowledged that MUSC received over 24,000 ED visits annually from the North Area, using the terms "visits" and "patients" interchangeably. (Roper Ex. 59 at 21-33, R. 6278-6290). In her testimony, Ms.

Platt acknowledged "over 24,000 ***patients*** a year" from the North Area are "choosing" to travel to MUSC for ED services. (Tr. at 2307:20 – 2308:3, R. 3053-3054) (emphasis added).

It was also undisputed that six existing ED providers, each owned either by Roper or Trident, are closer to the 25 zip codes than MUSC Medical Center. (Tr. at 384:23-24, at 902:1-6, at 1237:21 – 1238:19, R. 1130, 1648, 1983-1984). In that sense, residents of those zip codes must "drive past" the existing providers to get to the Charleston Peninsula.

The burden of proof in a contested case hearing rests on the Petitioners. *Nat'l Health Corp. v. S.C. Dep't of Health and Envtl. Control*, 298 S.C. 373, 379, 380 S.E.2d 841, 844 (Ct. App. 1989). In this case, Petitioners failed to prove that MUSC had misrepresented or failed to show the number of North Area patients "driving past" existing providers to get to ED services at MUSC. Indeed, they did not even raise it as an issue or dispute that the relevant volume metric is 24,000 visits per year.

In short, the ALC's finding that MUSC presented evidence of an "unknown" number of patients driving past existing providers to choose MUSC for ED services is arbitrary and capricious. In addition, it erroneously shifts the burden of proof to MUSC to prove the number of such patients. MUSC proved the number of ED visits it receives annually from its targeted zip codes, which is what matters.

2. MUSC provided substantial evidence why North Area residents drive past existing providers to obtain ED services from MUSC.

The ALC found that MUSC "provided no basis, insight, or information" why patients from the 25 North Area zip codes drive past existing providers to obtain ED services from MUSC Medical Center. (Order at 23, ¶ 68; at 53, ¶ 29, R. 32, 62). The record, however, contains an abundance of such evidence.

The MUSC application states that MUSC Health, the clinical enterprise of the Medical University of South Carolina, "delivers transformational care shaped by world-class clinicians, health scientists, and educators who provide leading-edge care ...." (Jt. Ex. 1 at DHEC CON 000008, R. 3162). The application further notes that MUSC Medical Center is a teaching hospital[5], South Carolina's only academic medical center, the state's only nationally recognized children's hospital, a Level 1 Trauma Center, and ranked by *U.S. News and World Report* as the best hospital in South Carolina. (*Id.*) The record also contains a list of "differentiating factors" that distinguish MUSC Health and make it "unique compared to other providers." (Jt. Ex. 1 at DHEC CON 000020-21, R. 3174-3175).

- Ability to manage the most complex cases and around -the-clock readiness;
- Staffed with highly trained board-certified emergency physicians and a network of support personnel, ready to respond to any health crisis;
- Specialized, focused care not offered by other providers;
- State-of-the-art equipment, such as bedside ultrasound and a high-speed 64-beam CT scanner;
- Highly advanced specialists in every field of medicine; and
- Unlike non-teaching facilities, MUSC is able to provide a specialist in virtually any field to the patient's bedside 24 hours a day, seven days a week, every day of the year.

It is for such reasons that "patients seek care specifically at MUSC," according to an MUSC slide presentation contained in the DHEC record. (Jt. Ex. 1 at DHEC CON 000534, R. 3688). (*See also* Tr. at 156:12 – 157:2, at 189:4-11, R. 902-903, 935) (testimony of Dr. Hall).

[5] The ALC notes that MUSC's role as a teaching hospital is "laudable" but is not a criterion. (Order at 14, n.12, R. 23). Though not a criterion, MUSC's status as a teaching hospital is relevant to quality of care, reputation, patient choice, and public need.

3. MUSC provided substantial evidence why North Area residents now choosing to drive to MUSC Medical Center for ED services would redirect to the new FED.

The ALC concluded that "[w]ithout basis, insight, or information to support its assumption, MUHA posits that the majority of those patients will self-redirect to its freestanding emergency room[6] simply because it is more convenient." (Order at 53, ¶ 29, R. 62). The ALC added that "MUHA assumed a percentage would shift but presented no information regarding why the patients from its proposed zip codes will transition to a satellite FED other than it was more convenient." (*Id.*, ¶ 31, R. 62).

As an initial matter, these are patients already choosing MUSC because of its reputation for quality and the other reasons discussed above. Moreover, the ALC erroneously gives too little weight to the concept of convenience, a term which, in regard to FEDs, can mean many things. Drive time is certainly one element of convenience. Trident's expert, Mr. Sullivan, testified that over 85 percent of hospital-based ED patients arrive by car or another vehicle other than an ambulance. (Tr. at 1246:7-12, R. 1992). MUSC presented unrefuted evidence that drive times from the centers of its targeted zip codes to the new FED would range from "2-35 minutes less than to MUSC Medical Center." (MUSC Ex. 40, R. 5701).

There would be additional kinds of conveniences once a patient arrived at the FED. Simply finding one's way at MUSC Medical Center in downtown Charleston can be challenging. (Tr. at 2049:22 – 2050:18, R. 2795-2796). The FED would be more accessible, have a more comfortable environment, and have shorter wait times. (Jt. Ex. 1 at DHEC CON 000529, R.3683). Mr. Sullivan testified on cross-examination that these factors generally distinguish FEDs from hospital-based

[6] MUSC's proposed FED would be an offsite department of MUSC Medical Center, not a single room. The FED would consist of twelve rooms. (Tr. at 1908:13, R. 2654).

EDs. (Tr. at 1247:11-19, at 1249:14 - 1250:2, R. 1993, 1995-1996). Trident SMC's CON application for an FED in Summerville, filed in April 2017, states that FEDs "not only alleviate pressure on existing emergency services at hospitals, but they also improve access for residents of areas that previously had longer travel times to and waiting times for hospital-based emergency services." (MUSC Ex. 8 at M.08.022, R. 4061; Tr. at 1247:10-19, R. 1993).

Increased accessibility, a more comfortable environment, and shorter wait times would be especially pronounced when comparing MUSC's new FED to MUSC Medical Center's ED, given the latter's significant capacity constraints. (Tr. at 158:2-7, at 1977:12 – 1979:2, R. 904, 2723-2725).

The ALC further disregarded the particular benefits a Berkeley County FED would have for members of MUSC's Accountable Care Organization. *See supra* at 16-17. Medicare ACOs were established pursuant to the Affordable Care Act. (Tr. at 1883:13-20, R. 2629). Two of the purposes of ACOs are the same as two of the purposes of the CON Act: quality improvement and cost containment. (Tr. at 1883:10 – 1884:24, at 1887:23 – 1894:22, R. 2629-2630, 2633-2640); S.C. Code Ann. § 44-7-120. Approximately 34 percent of the 14,000 Medicare beneficiaries in the ACO live in and around North Charleston, Moncks Corner, and Summerville. (Tr. at 1897:3 – 1898:20, R. 2643-2644). An MUSC FED in Berkeley County would provide these North Area residents with a closer, in-network option to obtain emergency care. (Tr. at 1933:1-9, at 1944:13-18, R. 2679, 2690), resulting in cost savings and improved quality of care. (Tr. at 1908:16 – 1912:8; at 1913:11 – 1914:7; at 1917:8-22; at 1945:7-19, R. 2654-2658, 2659-2660, 2663, 2691). MUSC's ACO coordinates care for its beneficiaries seeking emergency services, resulting in high quality care, fewer inpatient admissions after ED visits, lower out-of-pocket costs, and cost savings for

the Medicare program. (Tr. at 1909:15 – 1912:8, at 1917:8-22, at 1945:7-10, R. 2655-2658, 2663, 2691).

The ALC concluded, as a matter of law, that it was "unconvinced that patients from the tri-county and beyond, who presently obtain services at [MUSC Medical Center], which includes a robust specialty practice, will necessarily seek services at MUSC's FED (and can be satisfied with telemedicine)." (Order at 53, ¶ 31, R. 62).

Of course, it has never been MUSC's position that its ED patients would "necessarily" redirect to the new FED, especially those who live "beyond" the Tri-County Area. As discussed above, however, the record contains substantial evidence why MUSC ED patients who live in the 25 targeted North Area zip codes would redirect. The ALC's comment about MUSC Medical Center's "robust specialty practice" may be triggered, in part, by its baseless finding that MUSC's FEDs serve ***only*** low acuity patients, specifically ESI acuity code levels 3-5. (Order at 23, ¶ 70, R. 32, citing Tr. at 270:6-12, R. 1016). The ALC cites MUSC's ED Director, Dr. Gregory Hall, as support for this proposition, but that was not Dr. Hall's testimony. On cross examination, the following exchange took place:

> Q: And in terms of those ESI codes that we were talking about, as I understand your opinion when we talked at your deposition, that ***most*** of the patients that are going to show up at the freestanding ED are levels 3 and fours. Is that right?
>
> A: Yeah, three, four, and fives.

(Tr. at 279:6-12, R. 1016) (emphasis added).

That FEDs serve "mostly" ESI levels 3-5 is of no consequence. As Dr. Hall explained later, the same is true of hospital-based EDs. (Tr. at 139:5-16, at 140:9-13, R. 885-886). As Mr. Levitt elaborated on, both freestanding and hospital-based EDs primarily treat ESI levels 3-5, simply because the majority of patients seeking any ED services are acuity levels 3-5. (Tr. at 2028:12 –

2029:11, R. 2774-2775). At MUSC Medical Center's Adult ED in Fiscal Year 2016, 87.7 percent of the ED visits from the proposed Berkeley County FED service area were Levels 3-5. (MUSC Ex. 49, R. 5704A). The percentages for each acuity level for MUSC's total ED visits were consistent with the projected percentages by acuity level for the proposed FED service area. (MUSC Ex. 49, R. 5704A, Tr. at 2068:2 – 2070:8, R. 2814-2816).

Mr. Levitt testified that MUSC's Berkeley County FED will comply with the American College of Emergency Physicians ("ACEP") guidelines and be able to serve all acuity levels. (MUSC Ex. 60 at 19, R. 5709A; Tr. at 2063:23 – 2064:4, at 2065:24 – 2066:19, R. 2809-2810, 2811-2812). Mr. Sullivan acknowledged on cross-examination that FEDs are able to evaluate and stabilize any patient, are open and staffed 24/7 by emergency physicians, have the same equipment as hospital-based EDs, and have the same licensure regulation as hospital-based EDs. (Tr. at 2383:11 – 2384:2, R. 3129-3130).

Dr. Hall agreed that MUSC's FED would be able to treat all acuity levels and emphasized the need that high acuity patients often have for quick access. (Tr. at 185:24 – 186:17, R. 931-932). In addition, Dr. Hall testified that MUSC emergency physicians not only provide clinical care, but they are also MUSC faculty members who train residents and keep up to date with the most comprehensive emergency medical care. (Tr. at 189:4-11, R. 935)[7]. MUSC emergency physicians work closely with MUSC specialists, directly and through MUSC's telehealth program, for which most MUSC clinical services have been credentialled. (Tr. at 190:10 – 192:5, R. 936-938).

[7] As noted *supra* at 21 n. 5, the ALC did not consider the relevance of MUSC's status as a teaching hospital. (*See* Order at 14, n.12, R. 23).

The ALC is overly dismissive of MUSC's telehealth services, especially in the era of COVID-19. (*See* Order at 53, ¶ 31, R. 62). It is undisputed that MUSC is heavily involved in telehealth and can deliver any kind of specialty services at the FED through telehealth. (Tr. at 1716:10-18, at 1717:13-15, R. 2462-2463). The ALC's skepticism over telehealth services has no basis in the record. As Trident SMC's CEO, Lisa Valentine, testified, Trident also relies heavily on telehealth in its ED services. (Tr. at 867:21 – 868:10, at 871:14 – 872:8, R. 1613-1614, 1617-1618. Trident's expert in ED nursing care, administration, and leadership, Joan Eccleston, also testified about the importance of telehealth services for complex cases at Trident's existing FEDs. (Tr. at 979:15 – 980:15, R. 1725-1726).

MUSC also presented evidence that, in its recent CON application for an FED, Trident assumed a majority of its hospital ED patients would redirect to the new FED. (MUSC Ex. 8 at M08.034, R. 4073). The ALC dismissed consideration of this evidence, observing that that application was not before it for a decision. Of course, it was not, but the position set forth in that application on ED patient redirection was certainly relevant to this case and should have been considered.

As Roper's expert in emergency services operations, Joy Huntington, testified, patients in need of ED services are vulnerable and afraid. (Tr. at 552:3-7, R. 1298). Ms. Huntington acknowledged that, if MUSC is allowed to build its FED, North Area patients who are choosing MUSC for their ED care will be able to receive that care from their chosen provider much more quickly than they do now, which is a significant benefit for those patients. (Tr. at 552:20 – 553:9, R. 1298-1299).

In short, an abundance of evidence in the record shows that MUSC's ED patients will likely behave the same as other hospitals' patients in a similar situation. When offered the alternative of

a closer, more accessible, more comfortable environment with quicker drive times, shorter wait times, and where any acuity level can be treated by their provider of choice, they will take it.

4. The ALC erred in concluding that MUSC was required to base its shift projections on acuity codes.

The ALC concluded that MUSC's shift projections were flawed because they were based on billing codes rather than triage levels. (Order at 53 ¶ 30, R. 62). As Dr. Hall explained, triage acuity levels are based on the patient's condition upon presentation at the ED, while the billing acuity level is based on the end diagnosis, after the evaluation of everything done for the patient. (Tr. at 140:22 – 141:7, R. 886-887). However, MUSC did not base its shift projections on either billing codes or triage levels. In a September 7, 2017 letter that MUSC's planner, Mr. Levitt, submitted to DHEC during staff review, he responded to criticism from Roper and Trident by noting that less than 1 percent of MUSC's ED services fell under the billing code for the highest acuity patients. (Jt. Ex. 1 at DHEC CON 000507, R. 3661). Mr. Levitt did not, however, base his shift projections on billing codes. Instead, the record shows that the shift projections are based on proximity, travel time, patient population, and population growth. (Jt. Ex. 1 at DHEC CON 000026, 000530-533, R. 3180, 3684-3687; MUSC Ex. 40, R. 5701; Tr. at 2043:10 – 2049:21, R. 2789-2795).

MUSC's planner, Mr. Levitt, identified 22 geographic zip codes (and three Post Office Box zip codes) in the North Area from which a significant number of residents currently choose to drive to MUSC Medical Center for ED services. The geographic center of each geographic zip code is closer in drive time to the proposed FED than it is to MUSC Medical Center. (Tr. 2043:2-23, R. 2709, MUSC Ex. 40, R. 5701). Based on proximity and travel times, Mr. Levitt estimated a percentage of ED volume for each of the zip codes that would likely shift from MUSC Medical Center to the new FED. (Tr. at 2049:4-21, R. 2795).

The ALC concluded that compliance with Standard 6 required MUSC to base its shift projections, or at least adjust them, by ESI acuity levels. (Order at 53, ¶ 30, R. 62). The ALC based its conclusion on arguments from Trident and Roper's experts, Mr. Sullivan and Ms. Platt, that MUSC should adjust its projections for both acuity and age. (Tr. at 635:12-19, at 1185:21-25, at 2263:21 – 2264:7, R. 1381, 1931, 3009-3010). Both Ms. Platt and Mr. Sullivan acknowledged, however, that, in past CON applications for FEDs they had drafted, their shift projections did not include age or acuity adjustments. (Tr. at 782:23 – 783:12; at 1260:7 – 1262:2; at 1262:16 – 1263:9, R. 1528-1529, 2006-2008, 2008-2009). Roper and Trident based their argument that MUSC should make acuity adjustments on the premise that FEDs primarily treat ESI Levels 3-5. (Roper Ex. 59 at 22, R. 6279; Tr. at 755:18 – 756:7; at 1194:23-25, R. 1501-1502, 1940). In fact, as discussed *supra* at 15, both FEDs and hospital-based EDs primarily treat ESI Levels 3-5, simply because the majority of patients seeking any ED services are Levels 3-5. (Tr. at 2078:12 – 2079:11, R. 2824-2825).

Courts must interpret the State Health Plan using the rules of statutory construction applied to regulations, with one caveat: each section of the State Health Plan "must be read as a whole." *Trident Med. Ctr. v. S.C. Dep't of Health and Envtl. Control*, 412 S.C. 341, 355, 772 S.E.2d 177, 184 (Ct. App. 2015). Accordingly, the words of the State Health Plan "must be given their plain and ordinary meaning without resorting to subtle or forced construction to limit or expand [the Plan's] operation." *S.C. Dep't of Revenue v. Blue Moon of Newberry, Inc.*, 397 S.C. 256, 261, 725 S.E.2d 480, 483 (2012). Neither Standard 6 nor the State Health Plan section on freestanding emergency services contain any language that suggests, much less requires, that a CON applicant must base or even consider ESI acuity codes to demonstrate where an FED's patients will come

from. (2015 Plan at XI-3 through 6, R. 5883-5886). The ALC misinterpreted Standard 6 to mandate this novel and unreasonably restrictive requirement.

B. The ALC erred in concluding that MUSC failed to document why potential patients are not being adequately served by existing providers.

1. The ALC erred in interpreting Standard 6 to require a CON applicant to document that existing providers lacked capacity.

The second prong of Standard 6 requires a CON applicant for an FED to document "why" potential patients "are not being adequately served." (2015 Plan at XI-5, R. 5885). As set forth above, MUSC documented that MUSC's Charleston EDs received over 24,000 ED visits each year from residents of 25 zip codes in the North Area. (Tr. at 2015:17-22, at 2397:3-12, R. 2761, 3143; MUSC Ex. 60 at 17, R. 5708). The evidence is undisputed that these patients are driving past six Trident or Roper-owned EDs to get to MUSC. (Tr. at 1183:5 – 1184:5, R. 1929-1930); s*ee supra* at 7, 13. They are doing so even though, for them, it means longer drives, longer wait times, and delays due, in part, to MUSC's well-documented capacity constraints. (MUSC Ex. 40, R. 5701, Jt. Ex. 1 at DHEC CON 000529, Tr. at 158:2-7, 1977:12 – 1979:2, 2049:22 – 2050:18, R. 904, 2723-2725, 2795-2796); *see supra* at 9-11, 21-26. It is obvious that thousands of patients would not go to all this trouble if existing services were adequate. Nevertheless, the ALC concluded that MUSC had failed to document that these patients are not being adequately served by the Roper and Trident EDs they choose to drive past. (Order at 53, ¶ 32, R. 62). The basis for the ALC's ruling was its finding that MUSC had failed to show existing providers lacked capacity to provide services. (*Id.*).

The ALC's conclusion is legal error. Standard 6 must be interpreted by giving effect to the plain and ordinary meaning of the standard's language, without resorting to subtle or forced construction to limit or expand the standard's operation. *See S.C. Dep't of Revenue*, 397 S.C. at 261, 725 S.E.2d at 483. There is no language in this standard that suggests, much less requires,

that a CON applicant must demonstrate that existing EDs lack capacity. For certain services, the State Health Plan expressly provides that existing providers must be at a certain capacity before a new provider can obtain a CON, *e.g.*, a linear accelerator. 2020 S.C. Health Plan at 85-88 (R. 6871-6874). FED is not one of these services. If DHEC and the South Carolina Health Planning Committee had wanted a capacity calculation satisfied before a new provider could establish an FED, they would have added such a provision to the State Health Plan. By reading into Standard 6 a lack of capacity requirement, the ALC has erroneously turned the second prong of the standard into a competitor capacity calculation.

2. The ALC erred in concluding that existing providers in the service area have available capacity.

The ALC found that there is sufficient existing capacity in the service area to meet the need for services. (Order at 53, ¶ 32, R. 62). Yet the November 2017 CON application by Trident SMC stated, "There is no question that SMC needs additional ED capacity." (MUSC Ex. 12 at M12.023, R. 5428). Similarly, Roper's 2016 application to relocate its Northwoods FED claimed that its ED volumes "have hovered close to capacity … with utilization exceeding 90%." Finally, MUSC is in the service area (Order at 22, ¶ 64, R. 31) and its capacity constraints are severe, *supra* at 9-11, yet the ALC concluded it could not consider them. (Order at 40, ¶ 123, R. 49); *see infra* at 32.

3. Public choice and convenience are relevant considerations in the determination of whether services by existing providers are adequate.

The ALC erred in refusing to consider public choice or convenience in its analysis. (Order at 34, ¶ 103, R. 43). As noted by the ALC, there is no criterion that specifically addresses public choice and convenience. Nevertheless, a number of courts have acknowledged their relevance to CON review. *See Trident Med. Ctr. v. S.C. Dep't of Health and Envtl. Control*, 412 S.C. 341, 356, 772 S.E.2d 177, 185 (Ct. App. 2015) (concluding "Roper is merely seeking to transfer beds that

are already available for use in the service area to a location in the very same service area ***that will be more convenient for its existing patients residing in Berkeley County***, who now travel to Roper's facility in downtown Charleston) (emphasis added); *Carolina Reg'l Cancer Ctr. LLC v. S.C. Dep't of Health and Envtl. Control*, Docket Nos. 11-ALJ-07-0629-CC, 11-ALJ-07-0639-CC, 2015 WL 2159497 at *6, *21 (Ap. 30, 2015) (reasoning that if the application were approved ***"[f]ewer people will be inconvenienced by the travel time*** necessary for radiation therapy") (emphasis added); *Grand Strand Reg'l Med. Ctr, LLC v. S.C. Dep't of Health and Envtl. Control*, Docket No. 2012-ALJ-07-0090-CC, 2014 WL 5303338, at *11, *19 (Mar. 10, 2014) (noting that "***choices and quality*** ... are related closely to the purposes of the CON Act.") (emphasis added).

To ignore the importance of public choice is to ignore reality. As Joy Huntington, Roper's expert in emergency services operations, testified, when Roper decided to establish its first FED, they did so because "we were asked by the Berkeley County population to bring our services to them ... And what I heard over and over from them is we want a choice." (Tr. at 472:12-19, R. 1218).

II. The ALC erred in concluding that MUSC failed to satisfy the 2017-18 State Health Plan.

The CON Act provides that the ALC "shall consider" the State Health Plan in effect at the time an application is filed, which, in this case, was the 2015 Plan. (Order at 11, ¶ 25, R. 20). The Act further provides that the ALC "may consider the current South Carolina Health Plan when making its decision." S.C. Code Ann. § 44-7-225. The current Plan in effect at the time of trial and at the time the ALC issued its Order of Judgment was the 2018-19 Plan, enacted July 12, 2018. (2018-19 Plan, R. 6108). In its Order, the ALC noted that the section on freestanding emergency services in the 2018-19 Plan was unchanged from that in the 2017-18 Plan and chose to consider

the 2017-18 Plan in making its decision.[8] (Order at 13, ¶ 32; at 57-59, R. 22, 66-68). Both differed from the 2015 Plan in that they eliminated Standard 6, but replaced it with a new sentence that stated: "The application must demonstrate need for this service by documenting capacity constraints within existing emergency departments in the service area and/or a travel time of greater than 15 minutes to an existing emergency department in the service area." (2017-18 Plan at 96; 2018-19 Plan at 99, R. 6062, 6211). In addition, the 2017-18 and 2018-19 Plans include another paragraph not in the 2015 Plan:

> Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for this service.

(2017-18 Plan at 96; 2018-19 Plan at 99, R. 6062, 6211). The 2015 Plan, by contrast, is silent about a desired travel time and provides that the benefits of improved accessibility will be "equally weighed" with the adverse effects of duplication. (2015 Plan at IX-4, 5, R. 5872, 5873).

A. The ALC erred by applying the capacity constraint and travel time requirements in the 2017-18 Plan to MUSC's FED application.

S.C. Code Ann. § 44-7-225 allowed the ALC to consider the current State Health Plan in effect at the time of the decision for certain purposes, *e.g.*, using a new Plan standard to interpret a standard in a former Plan that is ambiguous. However, interpreting section 225 as allowing the ALC to apply new, specific requirements found in new Plans enacted after a CON application is filed leads to absurd results and violates due process. It is fundamentally unfair to hold a CON applicant to standards or requirements that did not exist when the application was filed.

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[8] In places, the ALC Order also references a "2016-17 Plan:" (Order at 54, R. 63). Nothing in the record indicates that DHEC ever published a 2016-17 State Health Plan. The ALC construed S.C. Code Ann. § 44-7-225 as allowing it to consider any subsequent Plan to the Plan in effect at the time the application was filed. (Order at 10-11, ¶ 22, R. 19-20).

B. The ALC erred in concluding there were no capacity constraints in existing ED providers in the service area.

Even if it has been appropriate for the ALC to apply the capacity constraint requirement of the 2017-18 Plan, the ALC erred in its conclusion that existing providers had excess capacity.

First, the ALC disregarded statements by Trident in another CON application that its FED was at or near capacity. (MUSC Ex. 12 at M12-023, R. 5428). Second, although the ALC correctly found that MUSC's downtown ED is capacity constrained, it erroneously concluded this "is not a criterion that the Court may consider." (Order at 40, ¶ 123, R. 49). Of course, MUSC's undisputed capacity constraints is not a criterion, but that does not mean the ALC should not consider them. MUSC's constraints are relevant considerations in determining compliance with the 2017-18 Plan, and the ALC's conclusion that they must be ignored is an error of law. There is no language in this requirement that excludes a CON applicant's own ED capacity constraints from consideration. Moreover, all CON applicants for FEDs support their application with reference to capacity constraints at their hospital EDs. The MUSC ED is in the service area. (Order at 22, ¶ 64, R. 31; Jt. Ex. 1 at DHEC CON at 000022, R. 3176). It is undisputedly capacity constrained, (Order at 8, ¶ 9, R. 17) and its constraints satisfy the requirements of the 2017-18 Plan.

C. The ALC erred in concluding that MUSC failed to comply with the travel time requirement in the 2017-18 Plan.

Although the 2015 Plan section on FEDs says nothing about travel time, the 2017-18 Plan contains two separate references to travel time. First, the Plan has a paragraph that requires an applicant to demonstrate need in either of the two ways, by documenting:

1) "capacity constraints within existing emergency departments in the service area," and/or

2) "a travel time of greater than 15 minutes to an existing emergency department in the service area."

(2017-18 Plan at 96, R. 6062).

Next, under the heading "Relative Importance of Project Review Criteria," the Plan lists the five criteria "considered to be the most important in evaluating" CON applications for FEDs. (*Id.*) Following the list of criteria, there is a final paragraph in the FED section of the Plan: "Access to emergency medical services should be available within fifteen (15) minutes travel time for the majority of residents of the State. The benefits of improved accessibility will outweigh the adverse effects of duplication in evaluating applications for this service." (*Id.*)

The first travel time referenced, though not listed as a standard, is nonetheless a mandate. The applicant "***must***" show need either by documenting capacity constraints or by showing a travel time of greater than 15 minutes to an "***existing***" ED in the service area. (*Id.)* (emphasis added). The ALC erroneously stretched the State Health Plan's term "existing" to include providers where CON applications had been approved, but who were not yet operational. (Order at 27, ¶ 83, R. 36). Clearly, this requirement relates to need and the 15-minute travel time is measured from the applicant's proposed location to the nearest existing, i.e., operational ED. The second travel time referenced is an aspirational goal, not a requirement of the applicant. "Access" to ED services "***should be***" available within 15 minutes for the majority of state residents. Travel time in this context would have to be measured from existing EDs to population centers. Travel time in this context does not relate to need but to accessibility. (*Id.*) (emphasis added).

As discussed above, it is an error of law to apply mandatory requirements in a new Plan retroactively. *See supra* at 32. However, if the 2017-18 Plan were applied to MUSC's application, it would require MUSC to demonstrate need either by showing capacity constraints in service area EDs or by showing that the site of its proposed FED is more than 15 minutes from other ED providers. MUSC has demonstrated need in both these ways. It documented capacity constraints

in its ED at MUSC Medical Center, which the ALC erroneously refused to consider. (Order at 40, ¶ 123, R. 49). In addition, MUSC documented through Mr. Levitt's testimony and Google maps that the only EDs within 15 minutes of MUSC's proposed site are the hospital-based EDs at Trident Medical Center ("TMC") and Summerville Medical Center ("SMC") (MUSC Ex. 60 at 31, R. 5711; Tr. at 2140:11 – 2141:15, R. 2886-2887). However, neither TMC nor SMC are within 15 minutes of the MUSC site at 8:00 am or 3:00 pm. (*Id.*) During these hours of heavy traffic, the drive times from TMC and SMC to the MUSC site range from 18-30 minutes. (*Id.*) The 15-minute drive time requirement in the 2017-18 Plan does not identify a "heavy traffic" exception. MUSC has, therefore, satisfied the requirement.

D. The ALC misinterpreted and misapplied the balancing test in the 2017-18 Plan.

As noted above, the 2017-18 Plan provides: "The benefits of improved accessibility will ***outweigh*** the adverse effects of duplication." (2017-18 Plan at 96, R. 6062) (emphasis added). This was a change from the 2015 Plan, which provided: "The benefits of improved accessibility will be ***equally weighed*** with the adverse effects of duplication." (2015 Plan at XI-5, R. 5885) (emphasis added). The CON criterion entitled "Adverse Effects on Other Facilities" is set forth in Section 80.23 of DHEC Regulation 61-15. It describes two forms of relevant adverse effects on other facilities: (1) occupancy or use rates, and (2) staffing. The ALC correctly found that MUSC's project would not adversely affect occupancy or use rates or staffing of any other facilities. (Order at 59, ¶ 61, R. 68). Nevertheless, the ALC concluded it "cannot engage in a meaningful balancing test," as called for in the 2018-19 Plan. (Order at 59, ¶ 62, R. 68). The ALC reached this decision because of its arbitrary and capricious finding that MUSC's new FED would not improve accessibility for anyone in the service area. (Order at 58, ¶ 58, R. 67). In short, the ALC found that not one of the North Area residents, among all those who constitute the 24,000 visits annually

to MUSC, would find access improved by a freestanding ED closer to their homes. This finding flies in the face of a number of undisputed facts: the inherent improvements in accessibility that FEDs have over hospital-based EDs, shorter drive times, shorter wait times, the "way-finding" challenges of downtown Charleston and the MUSC Medical Center campus, and the overwhelming capacity constraints at MUSC's downtown EDs. *See supra* at 22, 23, 26.

III. The ALC erred in concluding MUSC's application did not comply with all project review criteria.

A. Priority Criteria

The 2015 Plan identifies the following as the most important criteria in evaluating CON applications for freestanding emergency services:

3) Compliance with the Need outlined in this Section of the Plan;

4) Community Need Documentation;

5) Distribution (Accessibility);

6) Resource Availability; and

7) Financial Feasibility.

(2015 Plan at XI-4, 5, R. 5884, 5885). During staff review, DHEC eliminated the criterion of "Resource Availability" from the list, because there was not then, nor is there now, any such criterion among all those contained in section 802 of DHEC Regulation 61-15. In its place, DHEC substituted the criterion of "Medically Underserved Groups." The ALC ruled that DHEC had no authority to change or reorder the priority criteria as they are listed in the relevant State Health Plan. (Order at 50-51, ¶ 23, R. 59-60); *but see* S.C. Code Ann. § 44-7-190(B); S.C. Reg. 61-15 § 304(1)(2). The ALC concluded that DHEC should have kept the "Resource Availability" criterion on the list of priority criteria. (Order at 52, ¶ 26, R. 61). The ALC also determined that DHEC

should have evaluated the impact MUSC's project would have on staffing resources.[9] (*Id.*). However, the ALC found that the MUSC project would have no significant effect on staffing. (Order at 54-55, ¶¶ 45-50, R. 63-64). The ALC also determined that MUSC complied with the criteria of "Financial Feasibility" and "Record of the Applicant." (Order at 57, ¶¶ 50, 51, R. 66). The ALC erroneously concluded that MUSC did not comply with the criteria of "Community Need Documentation," "Distribution (Accessibility)," or "Medically Underserved Groups." (Order at 54-56, R. 63-65).

B. Community Need Documentation

The Community Need Documentation criterion consists of five subparts:

a. The target population should be clearly identified as to the size, location, distribution, and socioeconomic status (if applicable).

b. Projections of anticipated population changes should be reasonable and based upon accepted demographic or statistical methodologies, with assumptions and methodologies clearly presented in the application. The applicant must use population statistics consistent with those generated by the State Demographer, State Budget and Control Board.

c. The proposed project should provide services that meet an identified (documented) need of the target population. The assumptions and methods used to determine the level of need should be specified in the application and based on a reasonable approach as judged by the reviewing body. Any deviation from the population projection used in the South Carolina Health Plan should be explained.

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

[9] DHEC's CON Director, Margaret Murdock, testified that, of the existing criteria in DHEC Regulation 61-15, the closest to "Resources Availability" was section 802.20, "Staff Resources." (Tr. at 1335:25 – 1336:3, R.2081-2082

e. Current and/or projected utilization should be sufficient to justify the expansion or implementation of the proposed service.

S.C. Reg. 61-15 § 802.2.

The ALC concluded that MUSC's application did not comply with the criterion but did not specify which subparts it failed to comply with. (*See* Order at 54-55, ¶¶ 36-37, R. 63-64).

Section 802.2(a) simply requires the applicant to clearly identify the target population. MUSC did this by identifying its primary target as the residents of 25 specific North Area zips now driving to MUSC Medical Center for ED services. (Tr. at 2051:17-22, at 2397:3-12, R. 2797, 3143 MUSC Ex. 60 at 17, R. 5708).

MUSC complied with section 802.2(b) in its projections of significant population growth in the Tri-County area generally and in the North Area particularly. (Tr. at 1707:8-17, 1978:7-9, R. 2453, 2724; MUSC Ex. 32, R.5694E). MUSC showed the population in its targeted 25 zip codes is projected to grow 8.5 percent from 2019-2024, compared to a statewide projected growth of 5.9 percent. (MUSC Exs. 30-31, R. 5694 C-D). Growth is particularly strong along the I-26 corridor near Summerville, close to MUSC's proposed FED site, as acknowledged by Roper's expert, Ms. Platt. (Tr. at 768:11-21, R. 1514). Trident's expert, Mr. Sullivan, testified that the proposed FED was "proximate to the fastest growing communities in the Tri-County area." (Tr. at 1244:3-10, R. 1990). DHEC's CON Director, Margaret Murdock, agreed, characterizing the North Area's population growth as "exploding," (Tr. 1348:1-11, R. 2094), but the ALC criticized DHEC for providing no data showing whether such growth would continue. (Order at 30, ¶ 91, R. 39). The ALC conceded that MUSC provided such data, yet criticized it with the comment "statistical information alone can be misleading." (*Id.*, ¶ 91, R. 39).

MUSC complied with section 802.2(c) by showing that it received over 24,000 annual ED visits of residents of the targeted North Area zip codes who needed FED services closer to their homes.

Section 802.2(d) applies only to a reduction, relocation, or elimination of a facility or service and is therefore irrelevant to the case at hand.

MUSC complied with section 802.2(e) by showing that over 15,000 ED visits will shift each year from MUSC Medical Center to the new MUSC FED, based on proximity, travel times and similar factors. (Jt. Ex. 1 at DHEC CON 000026-27, R. 3180-3181).

Without addressing the language of the criterion, the ALC concludes that MUSC fails to satisfy it because of its shift analysis:

> MUHA incorrectly focused on the population it currently serves in the community and suggested that a portion of that population would patronize its new FED in Berkeley County ***simply because they would choose a shorter travel time***. However, MUHA could not reasonably explain why these same patients were not choosing a shorter travel time already, as the targeted patients are currently bypassing existing hospital-based and other FEDs in favor of MUSC's downtown location. Without an understanding of why its patients are seeking emergency services downtown at MUSC's tertiary/quaternary level hospital, MUHA cannot reasonably expect those same patients to redirect to another lower acuity emergency facility ***simply because it is located in closer proximity to where they live***. This is especially the case when ***there are already lower acuity emergency options in the area with far better emergency department service metrics***.

(Order at 54, ¶ 36, R. 63) (emphasis added).

The reasons why North Area patients are driving past Roper and Trident facilities to MUSC for ED services is less important than the undisputed fact that they are doing it. Nevertheless, the evidence shows that MUSC is a premier medical center with a high reputation for quality and the only academic medical center in the state. The evidence also shows that the ED facilities North

Area patients are driving past to get to MUSC are all owned by Trident or Roper. (Tr. at 384:23-24, at 902:1-6, at 1237:7 – 1239:3, R. 1130, 1648, 1983-1985).

MUSC believes a percentage of these North Area patients would redirect to a new MUSC FED, not "simply because it is located in closer proximity to where they live," although that is a significant reason. The other reasons, introduced as evidence at trial, include shorter travel times, improved accessibility, greater convenience, a more comfortable environment, shorter wait times, an in-network option for ACO beneficiaries, access to MUSC specialists and quality, and the new FED's capability of providing services at all acuity levels. *See supra* at 21-26.

The existing Roper and Trident ED facilities in the area may be lower acuity options in theory, but they are apparently not options that thousands of North Area residents will accept. While the existing facilities may have "far better emergency department service metrics" than MUSC's capacity-constrained downtown ED (Order at 54, ¶ 36, R. 63), there is no evidence to suggest their metrics would be better than those of the proposed new MUSC FED.

MUSC's project satisfies all of the components of the Community Need criterion. It clearly identified its target population. Its assumptions and projections are clear and reasonable. Finally, it recognizes that, largely because of MUSC's reputation for quality and the number of MUSC ACO beneficiaries residing in the North Area, patients from that area are driving past existing providers to obtain ED services from MUSC in downtown Charleston and will continue to do so until MUSC's FED project is approved.

C. Distribution (Accessibility)

The Distribution (Accessibility) criterion consists of eight subparts:

a. Duplication and modernization of services must be justified. Unnecessary duplication of services and unnecessary modernization of services will not be approved.

b. The proposed service should be located so that it may serve medically underserved areas (or an underserved population segment) and should not unnecessarily duplicate existing services or facilities in the proposed service area.

c. The location of the proposed service should allow for the delivery of necessary support services in an acceptable period of time and at a reasonable cost.

d. The proposed facility should not restrict admissions. If any restrictions are applied, their nature should be clearly explained.

e. The applicant must document the means by which a person will have access to its services (e.g. outpatient services, admission by house staff, admission by personal physician).

f. The applicant should address the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, women, the elderly, handicapped persons, and other medically underserved groups, are likely to have access to those services bring proposed.

g. The facility providing the proposed services should establish provisions to insure that individuals in need of treatment as determined by a physician have access to the appropriate service, regardless of ability to pay.

h. Potential negative impact of the proposed project upon the ability and/or resources of existing providers to serve medically underserved groups must be considered.

S.C. Reg. 61-15 § 802.3. The ALC erroneously concluded that, with respect to this criterion, "increased accessibility and convenience ... are not relevant to the Court's inquiry." (Order at 55, ¶ 38, R. 64). The ALC's narrow and unreasonable reading of the scope of its inquiry ignores the very title of this criterion, which features the word "accessibility." Three of the criterion's subsections (e, f, and g) contain the word "access" and subsections b-d and h all stem from the concept of improved accessibility.

The ALC focuses on section 802.2(a), which provides that "unnecessary duplication of services ... will not be approved." Any duplication of services resulting from MUSC's new FED, however, is justified because it improves access for the thousands of North Area patients driving

to MUSC Medical Center for ED services and because it will relieve MUSC Medical Center's ED capacity constraints.

MUSC's FED will provide outpatient services in an area accessible to medically underserved groups. (MUSC Ex. 51, R. 5706, Tr. at 2152:10-15, at 2154:13 – 2155:23, R. 2898, 2900-2901); *see infra* at 43. MUSC addressed the extent to which medically underserved groups will have access to the FED. (*Id.*) MUSC will not place any limitations on patients in need of emergency services. (Jt. Ex. 1 at DHEC CON 000541, R. 3695). Petitioners offered no persuasive evidence that MUSC's project will adversely impact the ability or resources of existing providers to serve medically underserved groups. For all these reasons, MUSC's project complies with Criteria 3(b), (d), (e), (f), (g), and (h). MUSC's FED will be located 23.5 miles and 32 minutes from MUSC's downtown hospital, which is consistent with the distances and drive times between other area FEDs and their host hospitals. (MUSC Ex. 60 at 16, R. 5707A, Tr. at 1256:1 – 1257:16, at 2040:23 – 2042:7, R. 2002-2003, 2786-2788). For these reasons, the project complies with Criterion 3(c).

The ALC's conclusion that MUSC's FED would be an unnecessary duplication ultimately rests on its other conclusion that it is prohibited from considering MUSC's capacity constraints or any other "facility-specific needs." (Order at 55, ¶ 42, R. 64). MUSC's capacity constraints are more than a "facility-specific" need. The log jams and delays they create for MUSC's patients are a public need and therefore within the scope of the ALC's inquiry.

D. Medically Underserved Groups

The Medically Underserved Groups criterion contains four subparts:

a. The applicant should address the contribution of the proposed service in meeting the health needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (e.g. low income persons, racial and ethnic minorities, women, the

elderly, and handicapped persons), particularly those needs identified in the applicable South Carolina State Health Plan as deserving priority.

b. The extent to which medically underserved populations currently use the applicant's services should be considered in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved.

c. Consideration of the documented performance of the applicant in meeting its obligation, if any, under any applicable federal regulations requiring provision of uncompensated care, indigent care plan, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any civil rights access complaints against the applicant) should be given.

d. Consideration should be given to the extent to which Medicare, Medicaid, and medically indigent patients are served by the applicant.

S.C. Reg. 61-15 § 802.10.

The ALC concluded that MUSC does not comply with the criterion, but without referencing any of the four subparts. (Order at 55-56, ¶¶ 43-44, R. 64-65). Instead, the ALC concludes, as a matter of law, that MUSC failed to satisfy the criterion because its FED will not "have any material impact ... on the medically underserved population." (*Id.* at 56, ¶ 44, R. 65). That is not what the criterion requires. In approving this application, DHEC found it complied with all four components of the criterion, as they are specified in the regulation. (Jt. Ex. 1 at DHEC CON 000553, R. 3707). The record supports DHEC's decision.

MUSC's FED would not place any limitations on patients in need of emergency services. (Jt. Ex. 1 at DHEC CON 000541, R. 3695). The pro forma budget for the MUSC FED provides annual indigent care ranging from $4.1 – $4.38 million and bad debt from $4.9 – $5.17 million. (Jt. Ex. 1 at DHEC CON 000087, R. 3241). Collectively, indigent care and bad debt constitute over 20 percent annually of the FED's total revenue. (*Id.*) The payor mix of the 25 zip codes that make up the FED's primary service area is consistent with the payor mix of all MUSC's ED

patients. (MUSC Ex. 51, R. 5706). The three payors generally identified as indicators for medically underserved patients are Medicare, Medicaid, and Self Pay. (Tr. at 2152:10-15, R. 2898); S.C. Code Ann. Regs. 61-15 § 31(d). The payor mix from the 25 zip code primary service area is 70.1 percent Medicare, Medicaid, and Self-Pay. (MUSC Ex. 51, R. 5706). Zip code 29486, the zip code where both the MUSC FED and the SMC FED will be located, is part of a primary care Health Professional Service Area ("HPSA"). (Tr. at 2155:11-23, R. 2901). Zip code 29486 is not part of a CMS-designated Medically Underserved Area ("MUA"), but it is adjacent to a zip code that is. (Tr. at 2154:13 – 2155:10, R. 2900-2901). For all these reasons, MUSC's project complies with all the subparts of the criterion for Medically Underserved Groups.

IV. The ALC erred in concluding that MUSC's application did not comply with the purposes of the CON Act.

The purposes 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. As discussed throughout this Brief, the ALC made a number of erroneous conclusions that led it to further conclude MUSC's application did not comply with certain State Health Plan standards and regulatory criteria. The same erroneous conclusions led the ALC to further conclude that MUSC's application did not comply with the CON Act. (Order at 59, ¶¶ 65-67, R. 68).

MUSC's application would greatly improve access for thousands of North Area residents whose provider of choice for emergency medical services is MUSC. The proposed FED would also improve services at MUSC Medical Center's Adult ED by relieving its capacity constraints. For these reasons, the new FED would serve public needs. It is not, therefore, an "unnecessary" duplication. There is no evidence of unreasonable project costs, nor any dispute that MUSC

provides high quality services. For these reasons, it complies with the four purposes of the CON Act.

V. The private meeting during trial between co-Respondents MUSC and DHEC did not violate the letter or the spirit of the South Carolina Administrative Procedures Act.

MUSC counsel communicated privately with DHEC counsel and DHEC staff on several occasions during staff review and after the MUSC application was approved. (Order at 44-45, R. 53-54). The last occasion occurred during trial. Those present were MUSC counsel, DHEC counsel, and DHEC witness Margaret Murdock, who had not yet testified. (Order at 45, ¶ 140, R. 54). The ALC concluded that this last meeting "violated the spirit" of section 1-23-360 of the South Carolina Administrative Procedures Act ("APA") and "smacks of unfairness." (Order at 60, ¶ 69, R. 69).

The APA prohibits "members or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law ***in a contested case***" from communicating "directly or indirectly, in connection with any issue or fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate." S.C. Code Ann. § 1-23-360 (emphasis added). Section 1-23-360 does not apply to the communications between MUSC and DHEC in this case, and the meeting in question did not violate the statute's letter or spirit. Neither Ms. Murdock nor anyone else at DHEC had been assigned or has the authority to render a decision, to make findings of fact, or make conclusions of law in this or any other contested case. That is the role of the ALC. S.C. Code Ann. §§ 1-23-503(3), 1-23-600: § 44-1-60. DHEC and MUSC are co-Respondents in this contested case. An ex parte communication is one between a party and an adjudicator, not another party. *See Myers v. S.C. Dept. of Health and Human Servs.*, No. 12-ALJ-08-0173-AP, 2014 WL 717221, at *7 (S.C. Admin. Law Ct. Feb. 3, 2014). Accordingly, the communications between DHEC and

MUSC in this case were not ex parte. The APA does not prohibit co-parties from communicating privately about issues in a contested case.

CONCLUSION

MUSC respectfully requests that the Court reverse the ALC's denial of MUSC's application for a CON to establish a freestanding emergency department in Berkeley County.

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April 9, 2021

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
THE ADMINISTRATIVE LAW COURT

Shirley C. Robinson, Administrative Law Judge

Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

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

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that ***Appellant's Medical University Hospital Authority's Final Brief of Appellant*** *in the above-referenced matter complies with Rule 211(b), SCACR.*

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April 9, 2021

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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

Case No. 17-ALJ-07-0441-CC
Case No. 17-ALJ-07-0444-CC
Appellate Case No. 2020-001072

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

PROOF OF SERVICE

The undersigned hereby certifies that on April 9, 2021, a copy of ***Appellant's Medical University Hospital Authority's Final Brief of Appellant*** was served on all parties to the appeal by electronic mail and hand delivery as follows:

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