DRAFT 2020 South Carolina Health Plan Public Comment Submission						
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Name	Facility Represented (If any)	Chapter	Subsection (If Applicable)	Comment/Change/Clarification	Public Comment	DHEC Staff Response
Todd Gallati	Summerville Medical Center			Change	Remove Level III from CON review, only requiring CON review for RPC and Level IV.	Do not recommend adoption of this change. Level III NICU support Very Low Birth Weight Babies (VLBWB) and have outcomes tied to volume.
Todd Gallati	Summerville Medical Center			change	Related to VLBWB, change the 100 volume requirement prospective versus 3-year average	Do not recommend adoption of this change. Requires regulatory update outside the scope of Plan revision.
Todd Gallati	Summerville Medical Center			comment	Increase transparency about 100 volume requirement for exiting Level III and above facilities and address what actions taken if number of births and/or VLBW volumes are not maintained by an existing Level III, RPC, or Level IV facility.	Do not recommend adoption of this change. Requires regulatory update outside the scope of Plan revision.
Todd Gallati	Trident Medical Center/Summerville Medical Center			change	Reconsider porposed bed need methodology using a statewide bed need methodology	Recommend Reconsideration
John C. Willingham	UHS, Inc South Carolina representing - The Carolina Center for Behavioral Health, Greer - Lighthouse Behavioral Hospital, Conway - Palmetto Lowcountry Behavioral Health, Charleston - Three Rivers Behavioral Health, Columbia	7	Paragraph 2	Comment	We strongly support the elimination of the service areas and the change to, "a statewide basis to serve the needs of the population."	DHEC Staff appreciates this comment.
John C. Willingham	UHS, Inc South Carolina representing - The Carolina Center for Behavioral Health, Greer - Lighthouse Behavioral Hospital, Conway - Palmetto Lowcountry Behavioral Health, Charleston - Three Rivers Behavioral Health, Columbia	7	Paragraph 4	Comment	We support this allowance. Paragrap 4 allows for the facility bed increases based upon individual occupancy levels. Applying the allowances in paragraph 4 to the RTF occupancy levels contained in the draft results in the potential of an additional 90 beds statewide above the plan	DHEC Staff appreciates this comment.
John C. Willingham	UHS, Inc South Carolina representing - The Carolina Center for Behavioral Health, Greer - Lighthouse Behavioral Hospital, Conway - Palmetto Lowcountry Behavioral Health, Charleston - Three Rivers Behavioral Health, Columbia	7	Paragraph 5	Change	Paragraph 5 should be deleted from the Plan. It allows for the addition of up to 20 additional beds for, "a specialty unit". It is redundent, given the other Plan allowances to add beds. Furthermore, it would be virtually impossible to monitor the ongoing specialized use of the beds, creating the potential for the beds to be converted for general use.	Do not recommend adoption of this change. Monitoring for compliance with approved CON is responsibility of DHEC.

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John C. Willingham	UHS, Inc South Carolina representing - The Carolina Center for Behavioral Health, Greer - Lighthouse Behavioral Hospital, Conway - Palmetto Lowcountry Behavioral Health, Charleston - Three Rivers Behavioral Health, Columbia	7	RTF Bed Need Methodology	Change	We support an increase in the RTF bed need methodology. However, the increase from 41.4 beds per 100,000 to 70 beds is excessive. We recommend a 50% increase, tather than the 69% increase that is in the draft. A 50% increase would change the beds per 100K to 62 rather than the Draft of 70. This would result in 63 additional beds. The rate in the draft Plan could easily result in over-bedding, creating the very issues that the CON program was developed to prevent. The Draft's increase, combined with the allowances in paragraph 4, could result in an additional 242 beds, an inordinate 38% increase. Alternatively, 62 beds per 100K population would result in 63 new beds or a 24% increase, which is more than sufficent. All projections, calculations, and recommendations are based upon the corrected total Plan bed need of 781.	Do not recommend adoption of change.
Mike Rowley	SpringBrook Behavioral Health	7	page 67	Change	Correction: SpringBrook was a 68 bed facility in 2018. Per 2018 JAR there were 23,226 patient days with a 94% occupancy rate.	DHEC Staff will review and correct errors as needed.
Mike Rowley	SpringBrook Behavioral Health	4	Facility by Region	Change	Correction: SpringBrook was a 38 bed facility in 2018. The correct occupancy rate is 72%.	Do not recommend adoption of change. See footnote 1 in Plan Chapter 4 inventory.
Richard Schulz and Kristin Manske	Spartanburg Rehabiliation Institute (SRI) and Greenwood Regional Rehabilitation Hospital	5	New section (2)	Change	A favorable need determination for new or expanded comprehensive physical rehabilitation services will not normally be made unless bed need exists under the current State Health Plan.	Do not recommend adoption of change.
Richard Schulz and Kristin Manske	Spartanburg Rehabiliation Institute (SRI) and Greenwood Regional Rehabilitation Hospital	5	Paragraph 2 (Now Paragraph 3)	Change	Need projections are based on the actual utilization of the facilities in the service area.	Recommend adoption of change with modification.
Richard Schulz and Kristin Manske	Spartanburg Rehabiliation Institute (SRI) and Greenwood Regional Rehabilitation Hospital	5	New section (4)	Change	Special Circumstances for Approval of Expanded Capacity at Hospitals with Comprehensive Physical Rehabilitation Services: An existing facility that can demonstrate an 80% or greater occupancy rate for the most recent year can apply to add up to ten additional beds, outside of the need identified in the Plan. An existing facility that can demonstrate a 90% or greater occupancy rate for the most recent year can apply to add up to fifteen additional beds outside of the need identified in this Plan.	Recommend adoption of change with modification.
Richard Schulz and Kristin Manske	Spartanburg Rehabiliation Institute (SRI) and Greenwood Regional Rehabilitation Hospital	5	New section (5)	Change	Special Circumstances for Approval of New Comprehensive Physical Rehabilitation Services: A favorable determination for new comprehensive physical rehabilitation servicess may be made outside of the need identified in this State Health Plan if the applicant demonstrates need through an alternative methodology which must include at a minimum, consideration of the following topics: a: Population demographices and dynamics b: Availability, utilization, and quality of like services in the service area and, c: Market Conditions.	Recommend adoption of change with modification.

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Elizabeth Fletcher	Spartanburg Regional Healthcare System	8		Comment	On behalf of Spartanburg Regional Healthcare System, I appreciate the opportunity to comment on the Draft 2020 South Carolina Health Plan. The comments are suggested in regards to the procedures that are currently being performed in cardiac catheterization laboratories. Cardiologist are performing a wider range of procedures than in the past. The procedures are minimally invasive and highly technical such as structural heart procedures which include Trans-catheter Aortic Valve Replacement, Trans-catheter Mitral Valve Repair, Left Atrial Appendage Closure, Atrial and Ventricular Defect Closure. Implantable devices such as pacemakers, defibrillators, cardiac rhythm monitors, pulmonary pressure sensors are performed by the Cardiologist or Electrophysiologist. In addition, new technologies such as the percutaneous ventricular assist devices provide better cardiac perfusion and are used more often or instead of intra-aortic balloon pump.	No action required.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Definitions	Change	SRHS recommends the definition of a "Comprehensive Catheterization Laboratory" be updated as follows to more accurately describe the procedures being performed in a comprehensive catheterization laboratory: "Comprehensive Catheterization Laboratory" means a dedicated room or suite of rooms in which PCIs as well as diagnostic and therapeutic catheterizations, **structural heart, peripheral vascular, electrophysiology and or implantable cardiac devices** are performed, in a facility with on-site open heart surgery backup.	Recommend adoption of change with modification.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Definitions	Change	SRHS recommends the definition of "Therapeutic Catheterization" be updated as follows to more accurately describe procedures that are considered therapeutic catheterizations: "Therapeutic Catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants, **Structural Heart procedures, Peripheral Vascular procedures, Electrophysiology procedures and Implantable Cardiac Devices**. ~~and Cardiac Valvuloplasty.~~	Recommend adoption of change with modification.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Scope of Services	Change	SRHS recommends item "3.k" be added under Scope of Services: **k. Facilities planning to perform structural heart procedures, need to consider Cardiac CT and/or Cardiac MRI**	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.

Name	Facility Represented (If any)	Chapter	Subsection (If Applicable)	Comment/Change/Clarification	Public Comment	DHEC Staff Response
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Standards	Change	SRHS recommends that Standard 1 be updated to add diagnostic equivalents in support of the recommended changes to the Comprehensive Cardiac Catheterization Laboratory and Therapeutic Catheterization definitions Standard 1. The capacity of a fixed cardiac catheterization laboratory shall be 1,200 procedures per year, as measured on an equivalent basis. Each adult diagnostic cardiac catheterization shall carry a weight of 1.0 procedures, while each adult therapeutic catheterization performed in the fixed laboratory shall carry a weight of 2.0 procedures. For pediatric and adult congenital catheterization labs, diagnostic catheterizations shall carry the weight of 2.0 procedures, therapeutic catheterizations shall carry the weight of 3.0 procedures, **structural heart procedures shall carry a weight of 3.0 procedures, implantable cardiac devices shall carry a weight of 2.0 procedures**, electrophysiology (EP) studies shall carry the weight of 2.0 procedures, **peripheral vascular diagnostic shall carry a weight of 1.0 procedure, peripheral vascular therapeutic shall carry a weight of 2.0 procedures** and biopsies performed after heart transplants shall carry the weight of 1.0 procedures. The capacity of mobile cardiac catheterization labs will be calculated based on the number of days of operation per week.	Recommend adoption of change with modification.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Standards	Change	In the Emergent and Elective PCI without On-Site Cardiac Backup section, SRHS recommends that Standard 8.c. be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. Standard 8. c. The hospital must acquire an intra-aortic balloon pump (IABP) **or percutaneous ventricular assist device** dedicated solely to this purpose.	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Standards	Change	In the Emergent and Elective PCI without On-Site Cardiac Backup section, SRHS recommends that Standard 9.e. be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. Standard 9.e. For catheterization labs in facilities without on-site surgical backup, there must be formalized written protocols in place for immediate (emergency transport beginning with 30 minutes and arriving at surgical facility within 60 minutes) and efficient transfer of patients to the nearest cardiac surgical facility that are reviewed and tested on a regular basis. Applicants must provide documentation of an agreement with an ambulance or transport service capable of advanced life support and intra-aortic balloon pump **or percutaneous ventricular assist device** and that guarantees a 30 minute or less response time from contact.	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Standards	Change	In the Emergent and Elective PCI without On-Site Cardiac Backup section, SRHS recommends that Standard 9.f. be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. Standard 9.f. The catheterization laboratory must be well-equipped, with optimal imaging systems, resuscitative equipment, intra-aortic balloon pump (IABP) **or percutaneous ventricular assist** support, and must be well-stocked with a broad array of interventional equipment.	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.

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Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Standards	Change	In the Emergent and Elective PCI without On-Site Cardiac Backup section, SRHS recommends that Standard 9.f. be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. Standard 9.f. The cardiac care unit nurses must be adept in hemodynamic monitoring and IABP or **percutaneous ventricular assist** management.	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	8	Definitions	Change	In the Open Heart Surgery section, SRHS recommends that the definition of Open Heart Surgical Program be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. "In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon or **percutaneous ventricular assist** and prolonged cardiopulmonary partial bypass."	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	Glossary		Change	SRHS recommends that the definition of Open Heart Surgical Program be updated to include percutaneous ventricular assist device to accurately reflect techologies currently in use. Open Heart Surgical Program: In addition, open heart programs must have the ability to implement and apply circulatory assist devices such as intra-aortic balloon or **percutaneous ventricular assist** and prolonged cardiopulmonary partial bypass.	DHEC Staff believes additional consideration is needed before final recommendation can be made about this change.
Elizabeth Fletcher	Spartanburg Regional Healthcare System	Glossary		Change	SRHS recommends the definition of "Therapeutic Catheterization" be updated as follows to more accurately describe procedures that are considered therapeutic catheterizations: "Therapeutic Catheterization" refers to a PCI or cardiac catheterization during which, in addition to any diagnostic catheterization procedure, any or all of the following interventional procedures are performed: PTCA; Thrombolytic Agent Infusion; Directional Coronary Atherectomy; Rotational Atherectomy; Extraction Atherectomy; Coronary Stent Implants, **Structural Heart procedures, Peripheral Vascular procedures, Electrophysiology procedures and Implantable Cardiac Devices**. ~~and Cardiac Valvuloplasty.~~	Recommend adoption of change with modification.
Shelley Pifer	Lexington Medical Center	3	General Hospitals	Comment	LMC is only in support of the "Statewide Bed Need" for counties that do not have existing hospitals. This will give DHEC Staff guidance on potential competing CON applications for hospital development in these counties. However, LMC is not in support of the "Statewide Bed Need" methodology for all other counties with established facilities. The current methodology is sufficient.	Recommend adoption of change with modification.
Shelley Pifer	Lexington Medical Center	8	Cardiac Catheterization	Comment	LMC is in support of the proposal in this section, to include a provision for TAVR procedures to be provided in approved facilities which also offer comprehensive cath services.	DHEC Staff appreciates this comment.
Shelley Pifer	Lexington Medical Center	8	Open Heart	Comment	LMC requests that DHEC Staff review the reporting of 4 open heart surgery units by Providence Health. In June 2010 LMC received approval for the development of a comprehensive cardiac program to include open heart surgery through an arrangement with Providence Hospital for the relocation of one open heart surgery suite from Providence Hospital.	DHEC Staff will review and correct errors as needed.
Shelley Pifer	Lexington Medical Center	10	Utilization Chart	Comment	LMC would like to request the addition of a marker within the ASF utilization table, to differentiate which ASF's are general and which are specialty only.	Recommend adoption of change.

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Shelley Pifer	Lexington Medical Center			Comment	LMC would like to provide a comment on hybrid operating rooms and if they should be included in the SC State Health Plan. Hybrid operating rooms are currently reviewed based on the equipment cost threshold as determined in Regulation 61-15. This should be maintained and hybrid operating rooms should not be added as a new chapter or subsection in the State Health Plan at this time.	DHEC staff appreciates this comment. There is no plan to add hybrid operating rooms to the Plan at this time.
Shelley Pifer	Lexington Medical Center		All	Comment	LMC is in support of the removal of cost containment as a project review criteria in all chapters.	DHEC staff appreciates this comment.
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Jerry Chapman	Carolina Center for Behavioral Health	4	Chart	Comment	Upon review of the Draft 2020 South Carolina Health Plan, it appears that the bed count attributed to The Carolina Center for Behavioral Health is not accurate. The plan does not reflect that CON SC-18-35 for 10 Substance Abuse beds was implemented on 8/1/19 at the same time that CON SC-17-09 was implemented resulting in a total of 39 Substance Abuse beds at The Carolina Center.	DHEC Staff appreciates this comment in regards to **Chapter 6.** Recommend adoption of change.
Craig Self	Bon Secours St. Francis Xavier Hospital, Mount Pleasant Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	3	General Hospitals	Comment	The proposed alternative statewide bed need methodology was to have originated from the need to reflect bed availability in the (8) counties without a hospital. The proposed methodology results in a 66% increase in available beds statewide, and >90% increase in available beds in Regions 3 and 4 (refer to attached chart). This is a significant increase in available beds, in spite of the shift towards outpatient treatment, declining hospital inpatient stays nationwide, and a statewide inpatient occupancy rate of only 53% in 2018. A typical industry standard rate for expansion is 75% occupancy. For these reasons, please consider the following alternative which will meet the stated intention: An allowance of up to 50 beds for the construction of an economical unit is available to service areas without a hospital (similar to the current allowances for service areas and hospitals indicating a need).	DHEC Staff will review and correct errors as needed.
Craig Self	Bon Secours St. Francis Xavier Hospital, Mount Pleasant Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	3	General Hospitals	Comment	General Bed Need Chart for Berkeley County (Total) states 100 "staffed/approved" beds. In 2018 there were no staffed beds, and 128 beds were approved.	DHEC Staff appreciates this comment and recommend delineating licensed, staffed, and CON approved beds in the General Bed Chart to eliminate confusion.
Craig Self	Bon Secours St. Francis Xavier Hospital, Mount Pleasant Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	4	Community Psychiatric Beds	Comment	The proposed allowance of up to ten additional psychiatric beds for a facility with at least a 90% occupancy rate as reported on the most recent Joint Annual Report (JAR) is supported.	DHEC Staff appreciates this comment.
Craig Self	Bon Secours St. Francis Xavier Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	9		Comment	In the Megavoltage Visits Chart, please insert a "total capacity" column beside "units" so that providers are able to calculate an individual hospital's utilization rate.	Recommend adoption of this change.
Craig Self	Bon Secours St. Francis Xavier Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	9		Comment	Our Manager of Radiation Therapy suggested a number of the "Relevant Definitions" be edited for accuracy, and proposed the following verbiage for consideration:	No action required.

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					3D-CRT uses the results of multimodality imaging such as MRI, PET, CT, Ultrasound, and specialized Imaging Fusion and Treatment Planning software to map the precise location of the tumor. The treatment plan is designed to deliver radiation beams from different angles to match the shape of the tumor while minimizing radiation damage to normal tissues.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
					Electronic Portal Imaging Devices (EPIDs) have been developed because of the increased complexity of treatment planning and delivery techniques. The most common treatment imaging or IGRT is captured with on board imaging, radiographic kilovolts (KV) and Cone Beam CT. These images are accessed with digital online software. All imaging is used for pre-treatment verification with Intensity Modulated Radiation Therapy (IMRT) and with some 3D-CRT cases.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
					Under the "Fractionation" definition, Hypofractionation should refer to radiation treatment given in a shorter time frame, 1-5 treatment sessions.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
					Stereotactic Body Radiation Therapy (SBRT) is an external beam therapy method used like surgery, that delivers a very high dose of radiation to extracranial targets within the body. SBRT techniques can be used for Lung, Spine, and Liver.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
					Stereotactic Radiosurgery (SRS) is an external beam therapy method used like surgery, that delivers a very high dose of radiation to cranial targets, that can be malignant or benign tumors.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
					Under the "Linear Acclerator (LINAC)": The Linac produces high energy X-Rays or Electrons that conform to a tumor shape. The Linac will deliver precise treatment plans that destroy cancer cells while sparing normal structures. The Linac is in a special room that is shielded and constructed with concrete and lead. This design prevents the radiation beams from leaving the room. The capacity standards for a linear accelerator vary by the capability of the equipment and are addressed in the Standards below.	Do not recommend adoption of this change. DHEC Staff recently updated definitions o include language substantially similar to that proposed in this comment.
Craig Self	Bon Secours St. Francis Xavier Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	9		Comment	The automatic assignment of Linac capacity based on the equipment description (vs. a hospital's request) is supported.	DHEC Staff appreciates this comment.
Craig Self	Roper Hospital Ambulatory Surgery - Berkeley and Roper Hospital Ambulatory Surgery & Pain Management - James Island	10	Ambulatory Surgical Facilities	Comment	The project review criteria "Adverse Effects on Other Facilities" should not be removed from the list of most important review criteria in evaluating applications for new ambulatory surgical facilities.	Do not recommend adoption. Project review criteria maybe added to suit application review.

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Craig Self	Bon Secours St. Francis Xavier Hospital, Mount Pleasant Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley	10	Freestanding Emergency Hospital Services	Comment	To better address the Program's goals to prevent unnecessary duplication of services and guide the establishment of services to best suit public needs we recommend the addition of CON standards that factor the service area's ED capacity constraints, use rates, and travel time.	Do not recommend adoption. Current standards address compacity restraints and travel time.
Craig Self	Roper Hospice Cottage	11	Inpatient Hospice Facilities	Change	Roper Hospital, Inc. submitted the 2018 Joint Annual Report for Roper Hospice Cottage on November 7, 2019 (extension granted). Please update the utilization chart to reflect 163 admissions, 840 total patient days, and a 34% occupancy rate with a footnote: utilization reflects the August 30 - Dec. 31 dates of operation.	DHEC Staff will review and correct errors as needed.
Craig Self	Bon Secours St. Francis Xavier Hospital, Mount Pleasant Hospital, Roper Hospital, and Roper St. Francis Hospital - Berkeley			Comment	The completion and submission of Joint Annual Reports by the deadline is necessary in order for the State Health Plan to accurately reflect many service area needs (e.g. rehab beds). Monetary penalties should be assessed against non-compliant providers.	DHEC Staff appreciates this comment.
John A. Pablo, MD	St. Joseph's / Candler		Linear Accelerators	Change	We would respectfully ask that you reconsider the thresholds for linear accelorators set forth in the plan and either keep them as they are, which requires a justification for the threshold, or, in the alternative, we request that the Department employ a system whereby treatments are weighted by treatment type, reflecting an average time per treatment, as is done in other states with CON programs.	Recommend adoption of change with modification.
Todd Gallati	Trident Medical Center/Summerville Medical Center		All	Change	Trident Health is very concerned about the proposed changes to the bed need methodology for general hospital beds in the 2020 Draft South Carolina Health Plan (Draft Plan). Trident believes that the proposed use of a statewide bed need methodology, whereby the higher of the two bed need methodologies are chosen, will lead to the approval of unneeded general hospital beds in the tri-county area of Berkeley, Dorchester and Charleston Counties specifically, and across South Carolina generally. Trident Health would like for the Department Staff and the State Health Planning Committee to reconsider its proposed bed need methodology using a statewide bed need methodology.	Recommend reconsideration
Terry Josey	McLeod Regional Medical Center	3	General Hospitals	Clarification	We believe that Standard 7 (as enumerated in the draft) could be clarified to state in lines two and three, "the projected bed need for the service area" instead of "the projected bed need for the facility," as a new facility proposed under this Standard would not have any projected bed need in the applicable South Carolina Health Plan.	Do not recommend adoption of change. Standard allows existing facilities to utilize its own bed need at an additional location within the service area.
Monica Vehige	McLeod Loris Seacoast Hospital	8	Cardiac Catheterization	Comment	We support the changes proposed in this chapter regarding the minimum number of historical and projected procedures required for developing a new service. We believe these changes are consistent with the latest guidelines and recommendations from SCAI/ACC/AHA. Further, given the recent expansion in coverage by CMS in non-hospital settings, we support the continued requirement that cardiac catheterization labs must be located within a hospital, but that the standards relating to the required number of procedures performed in those hospitals be lowered to reflect current guidelines, as proposed.	DHEC Staff appreciates this comment.
Monica Vehige	McLeod Loris Seacoast Hospital	8	Cardiac Catheterization	Clarification	We suggest adding language to Standard 9 to clarify that applicants proposing to establish elective and emergent PCI programs at the same time may do so, such as by adding the following language: "Hospitals with diagnostic laboratories may propose to develop primary PCI and elective PCI simultaneously."	Recommend adoption of this change.

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Monica Vehige	McLeod Loris Seacoast Hospital	8	Cardiac Catheterization	Change	We support the changes proposed in this chapter regarding the minimum number of historical and projected procedures required for developing a new service. However, we propose removing the minimum number of projected diagnostic procedures for applicants proposing primary or elective PCI, consistent with SCAI/ACC/AHA guidelines, which reference only the recommended minimum number of PCI procedures. As the Department is no doubt aware, for purposes of the JAR and CON applications, hospitals report patients having both a diagnostic and a therapeutic procedure during the same visit only under the therapeutic category; thus, some patients who would have been included in the diagnostic count prior to development of PCI services are instead only included as PCI if they receive therapeutic treatment. It is unclear why there is a need for a minimum number of diagnostic procedures (which means diagnostic only procedures) for a facility performing PCI; in general, the majority of patients in a facility performing PCI would have a diagnostic procedure before being converted to a PCI case.	Do not recommend adoption of this change.
Monica Vehige	McLeod Loris Seacoast Hospital	8	Cardiac Catheterization	Change	Under Standard 8.b and 9.a, we propose that the requirement regarding the reporting in the most recent JAR be revised to include reporting for the most recent 12-month period prior to the filing of the CON application, with the requirement that the data be provided in the CON application in the same format as reported in the most recent JAR. While we understand the need for a documented source of data, a CON application is also subject to signed certification and assurances, and the historical data contained therein should be considered as accurate as data reported on the JAR, particularly if the Standard requires that it be reported in the same format/with the same detail.	Recommend adoption of change.
Terry Josey	McLeod Regional Medical Center	9	Relevant Definitions	Comment	Under "Helical-tomotherapy," the first line includes the acronym "IRMT" which should read "IMRT." This edit should be reflected in the Glossary as well, if approved.	Recommend adoption of this change.
Terry Josey	McLeod Regional Medical Center	9		Comment	We support the proposed changes to this chapter, particularly the Certificate of Need Projections and Standards for Radiotherapy. We believe the changes provide greater clarity without unnecessary repetition.	DHEC Staff appreciates this comment.
Terry Josey	McLeod Regional Medical Center	11	Home Health	Clarification	We would ask that Standard 8 have language added to clarify the method by which the "two years after initiation of services in a county" will be measured, whether by JAR filed following the two-year period, direct inquiry by the Department following the second anniversary of the service initiation, or other means.	Do not recommend adoption of this change.
Terry Josey	McLeod Regional Medical Center	Glossary		Comment	We support the proposed changes to the Glossary.	DHEC Staff appreciates this comment.
Yarley Steedly, Abby Fairbank, & Pat Aysse	American Heart Association	8	Cardiac Catheterizations; Emergent and Elective PCI without On-Site Cardiac Backup		k. Applicants must agree to participate in the South Carolina STEMI Mission Lifeline Program (which may include: Get With The Guidelines-CAD enrollment, participation in Mission: Lifeline Regional Reports, participation in AHA/TJC Heart Attack Certification Programs, and/or participation in Mission: Lifeline Regional and/or State meetings).	Recommend adoption of change.

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Patrick Downes	East Cooper Medical Center	10	FEHS - Standard 2	Change	All off-campus emergency services must be an extension of an existing hospital's emergency service in the same county, unless the applicant is proposing to establish a freestanding emergency service in a county that does not have a licensed hospital at the time the CON application is submitted for the freestanding emergency department. The hospital must have a license that is in good standing and must be in operation to support the off-campus emergency services.	Do not recommend adoption of this change.
Mark Nosacka	Piedmont Medical Center	3	Standard 4	Change	The bed need for the service area with no licensed hospital or where no Joint Annual Report data has been provided for the planning period used for calculating need in the Plan is the greater of the combined bed need for all individual hospitals in the service area or the statewide utilization bed need for the service area.	Recommend adoption of change with modification.
Wayne Harris	AnMed Health Medical Center	3	General Bed Need (chart)		General Bed Need 2018 Pt Days for Age 65 & Over does not match 2018 SC JAR Report for AnMed Health Medical Center. **Value for Age 65 & Over** should be 44,701 less 907 Psych days = **43,794**. Therefore, the **total of 2018 patient days for AnMed Health Medical Center in the General Bed Need chart should be 77,578** (not 74,509).	DHEC Staff will review and correct errors as needed.
Edward H. Bender	South Carolina Hospital Association	3			The South Carolina Hospital Association ("SCHA") would like to thank the State Health Planning Committee and the DHEC Certificate of Need staff for their diligent work on the 2020 draft State Health Plan. After reviewing the plan we wish to comment on the change to the bed need methodology in Chapter 3. Access to healthcare in rural areas of South Carolina is of the utmost importance to SCHA and we applaud DHEC's efforts to create need for acute care beds in those rural counties currently without hospitals. However, the newly created methodology has some unintended consequences and we are asking the Committee reexamine whether or not the statewide bed need calculation is best way to provide access to care in rural South Carolina. Specifically, the new methodology creates a dramatic increase in overall bed need in South Carolina. In addition to creating bed need in the counties without hospitals, the statewide utilization method also created bed need nine counties that otherwise would not have shown need. In fact, York County saw a 222 bed need increase using this new methodology. Furthermore, the new methodology creates at least a sixty percent (60%) increase in overall bed need in South Carolina. This substantial increase in bed need seems inconsistent with the decline in inpatient stays nationwide and the shift towards outpatient treatment. Accordingly, SCHA asks the Committee to reevaluate its use of this new bed need methodology. As always, SCHA is ready to work with DHEC and others to ensure additional access to health care is available to rural South Carolina. Thank you again for your efforts on the 2020 draft State Health Plan.	Recommend Reconsideration

Name	Facility Represented (If any)	Chapter	Subsection (If Applicable)	Comment/Change/Clarification	Public Comment	DHEC Staff Response
Sarah Bacik	MUSC Health	3	Standard 4	Change	MUSC Health appreciates the opportunity to submit comments on the *Draft 2020 South Carolina Health Plan.* Chapter 3, General Bed Need MUSC Health applauds the Department's efforts to increase access to inpatient care, especially in rural counties without any hospital to serve the community, by applying the statewide utilization bed need methodology to capture bed need in areas where the Department is unable to measure actual utilization, either because there is no hospital or because hospital beds have been approved but have not been operationalized. However, in more populated counties with existing licensed hospitals having lower occupancy rates, there may be unintended consequences resulting from a blanket application of the statewide utilization methodology to the service area where there is a significant excess service area bed capacity but the statewide utilization methodology shows bed need. One way to avoid these unintended consequences is to limit application of the statewide utilization methodology when it shows a positive bed need but the service area shows excess service area bed capacity. MUSC Health offers the following additional language (underlined) to Standard 4: 4. The bed need for the service area is the greater of the combined bed need for all individual hospitals in the service area or the statewide utilization bed need for the service area. EXCEPTION: if the statewide utilization bed need is greater than the service area bed need, the service area bed need will control and apply if: a. the 2024 projected population of the service area is greater than 100,000; and b. the occupancy rate for each of the individual hospitals in the service area is less than 70%; and c. the combined bed need for all individual hospitals in the service area is negative.	Recommend adoption of change with modification.