No. 260PA22 TENTH DISTRICT

****

SUPREME COURT OF NORTH CAROLINA

****

Jay Singleton, D.O.; and Singleton Vision Center, P.A.,

Plaintiffs-Appellants,

v.

North Carolina Department of Health and Human Services; Roy Cooper, Governor of the State of North Carolina, in his official capacity; Kody H. Kinsley, North Carolina Secretary of Health and Human Services, in his official capacity; Phil Berger, President Pro Tempore of the North Carolina Senate, in his official capacity; and Tim Moore, Speaker of the North Carolina House of Representatives, in his official capacity,

Defendants-Appellees.

From Wake County
No. COA21-558

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NEW BRIEF FOR PLAINTIFFS-APPELLANTS

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NEW BRIEF FOR PLAINTIFFS-APPELLANTS

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ISSUES PRESENTED

Dr. Jay Singleton wants to perform safe, affordable eye surgeries in his own operating room. He's a licensed physician and his eye clinic meets every relevant health and safety standard. His surgeries would be far less expensive than those at the only other nearby operating room: CarolinaEast hospital. But North Carolina's certificate of need (CON) law bans Dr. Singleton from competing. Helpful as his services would be, the CON law says they aren't "needed." That's what the law has said every year for over a decade, it's what the law says today, and it's what the law will say through at least 2025. Dr. Singleton just wants to give his patients a better option—but the market is closed.

The issues presented are:

1. Did Dr. Singleton state a claim that the CON law, as applied, violates North Carolina's law of the land clause (Art. I, § 19) when he alleged the law is not reasonably necessary to protect the public?

2. Did Dr. Singleton state claims that the CON law, as applied, violates North Carolina's exclusive privileges and anti-monopoly clauses (Art. I, §§ 32, 34) when he alleged the law grants an exclusive right to provide private services?

INTRODUCTION

The North Carolina Constitution draws lines the legislature can't cross. This Court's job is to enforce those lines so that our "rights . . . [stay] beyond the control of the Legislature." *Trs. of UNC v. Foy*, 5 N.C. 58, 83 (1805). That's what the Court did in a case called *Aston Park*. A prior version of the CON law, like the one here, banned a "superior" new hospital from competing with existing ones because a state agency saw no "need" for it. *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 547, 193 S.E.2d 729, 733 (1973). The Court held that the CON law violated the law of the land, exclusive privileges, and anti-monopoly clauses (Art. I, §§ 19, 32, 34). *Aston Park*, 282 N.C. at 551, 193 S.E.2d at 735–36.

But the legislature defied *Aston Park*. In 1978, it readopted the CON law draped in "[f]indings of fact" that the law would benefit the public. *See* N.C. Gen. Stat. § 131E-175. In 2010, the Court of Appeals held that the findings made *Aston Park* "moot." *Hope—A Women's Cancer Ctr., P.A. v. State*, 203 N.C. App. 593, 607, 693 S.E.2d 673, 683 (2010). And last year, despite Dr. Singleton's allegations that the findings are false and that the law violates the same three clauses raised in *Aston Park*, the Court of Appeals held that the "findings . . . show how the CON law affects the public welfare," *Singleton v. DHHS*, 284 N.C. App. 104, 115–16, 874 S.E.2d 669, 677–78 (2022), and dismissed his case.

That was error. Not just because the legislature can't overrule *Aston Park* with magic words. Not just because the Court of Appeals can't declare binding

precedent "moot." But because, as *Aston Park* affirms, Dr. Singleton stated claims under the original meanings of Article I, §§ 19, 32, and 34. When this Court reads state constitutional provisions, it looks to text, then history, then state precedent. *Cmty. Success Initiative v. Moore*, 384 N.C. 194, 213, 886 S.E.2d 16, 33 (2023). Ties go to individual rights, not state power. *Corum v. UNC ex rel. Bd. of Governors*, 330 N.C. 761, 783, 413 S.E.2d 276, 290 (1992) (citing *State v. Harris,* 216 N.C. 746, 6 S.E.2d 854 (1940)). Using that framework, Dr. Singleton stated valid claims.

First, he stated a claim under Article I, § 19. The legislature can't deprive any person of "liberty . . . but by the law of the land." History and state precedent show that "liberty" includes the fundamental right to earn a living. *King v. Town of Chapel Hill*, 367 N.C. 400, 408–09, 758 S.E.2d 364, 371 (2014) (citing *Roller v. Allen*, 245 N.C. 516, 518–19, 96 S.E.2d 851, 854 (1957)). They also show that the "law of the land" forbids economic statutes that exceed the police power—that are not "reasonably necessary" to protect the public. *Aston Park*, 282 N.C. at 551, 193 S.E.2d at 735 (quoting *State v. Ballance*, 229 N.C. 764, 51 S.E.2d 731, 735 (1949)). That makes this case straightforward: Dr. Singleton stated a claim when he alleged that excluding him from the market doesn't protect the public.

Second, he stated claims under Article I, §§ 32 and 34, which forbid the legislature from granting "monopolies" or "exclusive or separate emoluments or privileges . . . but in consideration of public services." Textually, both clauses are "categorical" restrictions—they apply even when the legislature really wants to

violate them. Richard Dietz, *Factories of Generic Constitutionalism*, 14 Elon L. Rev. 1, 7–19 (2022). And here, history and state precedent show that they ban the same thing: *exclusive rights* to provide *private services*. *See Aston Park*, 282 N.C. at 551, 193 S.E.2d at 736. Dr. Singleton thus stated a claim when he alleged that the CON law grants one private hospital an exclusive right to run an operating room in his area.

All told, enforcing the Constitution starts with rejecting the motion to dismiss. The provisions on which Dr. Singleton relies were part of our original Constitution. N.C. Const. (1776), Decl. of Rts. §§ 3, 12, 23. They "ought never to be violated, on any pretense whatsoever." *Id.*, Frame of Gov. § 44. The CON law is all pretense. It exists because the legislature decided its sheer will constitutes the "law of the land" and justifies "exclusive . . . privileges" and "monopolies." N.C. Const. art. I, §§ 19, 32, 34. As this Court has already held, that is not the law. *Aston Park*, 282 N.C. at 551, 193 S.E.2d at 735–36. The Court of Appeals' decision should be reversed.

STATEMENT OF CASE

Dr. Singleton filed this case on 22 April 2020 alleging that the CON law, as applied, violates Article I, §§ 19, 32 and 34. (R p 4). Defendants moved to dismiss under Rules 12(b)(6) and 12(b)(1). (R pp 51, 54). The Superior Court denied the 12(b)(1) motion but granted the 12(b)(6) motion. (R p 59). The Court of Appeals affirmed, holding that Dr. Singleton failed to state a claim under the law of the land clause. *Singleton*, 284 N.C. App. at 115–16, 874 S.E.2d at 677–78. The court also

treated his exclusive privileges and anti-monopoly claims as "procedural due process challenges" that required exhaustion of administrative remedies. *Id.* at 111, 874 S.E.2d at 675. This Court granted discretionary review on 1 September 2023.

STATEMENT OF GROUNDS FOR APPELLATE REVIEW

The Court of Appeals had jurisdiction under N.C. Gen. Stat. § 7A-27(b)(1). This Court has jurisdiction under N.C. Gen. Stat. § 7A-31(c).

STATEMENT OF FACTS

I. Dr. Singleton wants to provide more affordable eye surgeries than the hospital down the street.

Dr. Singleton is a licensed eye doctor and surgeon based in New Bern. (R p 11, ¶ 9). In 2004, he founded a full-service eye clinic, Singleton Vision Center, to provide quality care at an affordable price. (R pp 12–13, ¶¶ 10, 17–18). He provides all his non-surgical care at his clinic. (R p 14, ¶ 20). And, because his patients often need outpatient eye surgeries, he wants to provide those full-time as his clinic too. (R p 14, ¶¶ 20–25).

Dr. Singleton's surgeries would be safe. (R p 14, ¶¶ 24–26). His clinic has an operating room with all the equipment and staff needed to provide quality care. (R pp 12, 14, ¶¶ 11, 26). He's performed thousands of surgeries in his career and would follow the North Carolina Medical Board's guidelines. (R pp 14–15, ¶¶ 20–25, 29). And his clinic is accredited by the American Association for Accreditation

of Ambulatory Surgery Facilities, meaning it meets nationally recognized safety standards. (R p 15, ¶ 27).

Dr. Singleton's surgeries would also cost less than the only other local option. (R pp 12, 14, ¶¶ 11, 22). CarolinaEast—a private hospital two miles down the road—charges over $6,000 per procedure. (R p 14, ¶ 23). Dr. Singleton can perform eye surgeries at his clinic for a fraction of the price. For example, he can perform a cataract surgery for under $1,800. (R pp 9, 14–15, ¶¶ 1, 22–23, 30). Dr. Singleton wants to bring those savings to all of his patients. (R p 15, ¶¶ 30–31).

II. The CON law bans Dr. Singleton from competing with the hospital down the street.

But Dr. Singleton can't use his operating room without a certificate of need (CON). N.C. Gen. Stat. §§ 131E-176(16)(a), (u), -178(a). A CON is different from a facility license, which "ensure[s] safe and adequate treatment of . . . individuals in ambulatory surgical facilities." *Id.* § 131E-145. Far from ensuring safety, a CON reflects the Department of Health and Human Services' view that a new operating room is "needed" in the market. *Id.* §§ 131E-178(a), -183(a), -190(a). Dr. Singleton could—and happily would—get a facility license. (R pp 15, 31, ¶¶ 27–28, 129). But he can't get one without a CON. 10A N.C. Admin. Code 13C.0202(b).

CONs are scarce. The Department pronounces operating room "need" once a year in the State Medical Facilities Plan. N.C. Gen. Stat. § 131E-183(a). The Plan breaks the state into "service areas" and sets "need" two years in advance.

E.g., 2023 SMFP, https://tinyurl.com/234wvu8m, at 66. If the Plan declares no need for a new operating room, no CON will be available in that area for at least two years. *See* N.C. Gen. Stat. § 131E-183(a)(1) (stating the Plan "constitutes a determinative limitation on . . . operating rooms . . . that may be approved"). And without a CON, no new operating room can enter the market.

Dr. Singleton is in the Craven/Jones/Pamlico service area. (R p 27, ¶ 99). Since Dr. Singleton opened his center in 2004, the Plan has never shown a need for a new operating room in his area. (R p 27, ¶¶ 99–100). That's remained true every year since he filed this case. The 2021 Plan showed no need in 2023. 2021 SMFP, https://tinyurl.com/54y5zbas, at 70. The 2022 Plan showed none in 2024. 2022 SMFP, https://tinyurl.com/mvfm5m2c, at 71. The 2023 Plan shows none in 2025. 2023 SMFP, at 68. And the proposed 2024 Plan shows none in 2026. Proposed 2024 SMFP, https://tinyurl.com/56karyhy, at 69.

In fact, the only entity that has ever held a CON in Dr. Singleton's area is CarolinaEast. (R p 27, ¶¶ 101–03). And CarolinaEast—a large hospital with a billion-dollar annual budget—has told Dr. Singleton that if a CON ever opens up, it will oppose his application. (R pp 27, 30, ¶¶ 101, 118). That's no small threat. Contested applications trigger an administrative process that looks like litigation, costs hundreds of thousands of dollars, and takes years to resolve. (R pp 22–25, ¶¶ 73–92). Dr. Singleton (who has pro bono counsel in this case) doesn't have the resources to litigate against CarolinaEast in that process. (R p 30, ¶¶ 118–20).

Nor, again, is that even an option right now. No CON is available in Dr. Singleton's area. No CON has ever been available to him. And no CON will be available through at least 2025 (and likely far longer). The market—now and for years to come—is closed. (R pp 26–27, 29–30, ¶¶ 98–99, 114, 117).

III. Dr. Singleton alleged that excluding him from the market does not protect the public.

When the legislature readopted the CON law in 1978, it added "[f]indings of fact" about why the law was purportedly necessary. N.C. Gen. Stat. § 131E-175.[1] Boiled down, the findings assert that "maldistribution" of facilities raises costs and reduces access, so ensuring "that only appropriate and needed institutional health services are made available" will "control costs, utilization, and distribution of new health service facilities." *Id.* § 131E-175(1)–(4), (6)–(7).

Dr. Singleton's complaint challenged the findings both as applied to him and more broadly. Starting narrow, he alleged that banning him from offering more affordable surgeries than CarolinaEast does not benefit—and in fact harms—real patients. Specifically, he alleged:

- He can safely provide eye surgeries at his clinic because he is an experienced, licensed surgeon and his clinic meets all relevant health and safety standards. (R pp 12, 14–15, 28, ¶¶ 11, 24–30, 107).

- His patients need more affordable eye surgeries and he can provide them at his clinic for a fraction of the price charged by CarolinaEast. (R pp 22, 27, 29–30, ¶¶ 69, 104, 112–13, 123).

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[1] Five of the findings are irrelevant here. *See* N.C. Gen. Stat. § 131E-175(8)–(10) (regarding adult-home beds), (11)–(12) (regarding endoscopy services).

- Banning him from using his operating room "has nothing to do with protecting the health or safety of real patients" and is "without any real-world benefits to patient health or safety." (R pp 10–11, ¶¶ 3–4).

- There is no evidence that excluding him from the market "actually increases access to safe, affordable surgeries in the Craven/Jones/Pamlico service area" or "serves any other legitimate governmental purpose." (R pp 28, 33–34, ¶¶ 106, 148–49).

Dr. Singleton also challenged the CON law's findings more broadly. He alleged that, "[w]hatever their truth in 1978, these 'findings of fact' are false as a matter of fact today." (R p 18, ¶ 49). He gave two main reasons why.

First, the CON law was adopted at a time when Medicare and Medicaid reimbursed for services based on actual cost. (R pp 17–18, ¶¶ 44–48). Because that system rewarded wanton spending, prices soared. (R p 17, ¶ 44). The CON law's core premise is that the only way to control prices in a cost-based system is to ban new services unless they are "needed." (R p 18, ¶ 45). In 1984, however, Congress replaced the cost-based system with one that paid a fixed rate for each service—a shift that "eliminated the rationale" for the CON law. (R pp 18–19, ¶¶ 51–52).

Second, whatever the legislature may have thought in 1978, decades of evidence now shows that CON laws *raise* costs and *reduce* access to care. (R pp 19–21, ¶¶ 53–59, 63). That's why Governor Cooper relaxed the CON law during the pandemic: so doctors could enter the market and save lives. (R p 21, ¶ 64). It's also why this year's reform law—which exempts "urban" ambulatory surgical facilities from the CON law—is titled: "An Act to Provide North Carolina Citizens with

Greater Access to Healthcare Options." Sess. Law 2023-7 (codified at N.C. Gen. Stat. § 131E-176(21a)), https://tinyurl.com/2h3nvne4.[2]

In short, Dr. Singleton alleged that excluding him from the market doesn't protect real patients—it merely "protect[s] established healthcare providers from competition." (R pp 33–34, ¶¶ 147–50). This case asks whether that's a legitimate use of state power.

STANDARD OF REVIEW

This Court reviews Rule 12(b) dismissals de novo. *United Daughters of the Confederacy v. City of Winston-Salem ex rel. Joines*, 383 N.C. 612, 624, 881 S.E.2d 32, 43 (2022). The Court must treat Dr. Singleton's allegations as true, construe them in his favor, and decide whether he stated valid claims. *Id*. The case should proceed "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of a claim which would entitle [him] to relief." *Intersal, Inc. v. Hamilton*, 373 N.C. 89, 98, 834 S.E.2d 404, 411 (2019) (cleaned up). That's a "low bar." *Wray v. City of Greensboro*, 370 N.C. 41, 50, 802 S.E.2d 894, 900 (2017).

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[2] Dr. Singleton does not qualify for the new CON exemption, which applies only to ambulatory surgical facilities "in a county with a population greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census." Sess. Law 2023-7. Dr. Singleton is in Craven County, which had a population of 100,720 as of 2020. U.S. Census Bureau, *QuickFacts, Craven County, North Carolina*, https://tinyurl.com/yc5xpy9p.

CONSTITUTIONAL METHOD

Whether Dr. Singleton stated valid claims turns on the proper method for reading the North Carolina Constitution. The Court "begins with the text." *Cmty. Success Initiative v. Moore*, 384 N.C. 194, 213, 886 S.E.2d 16, 33 (2023). If the text is unclear, the Court looks to "the available historical record in an effort to isolate the provision's meaning at the time of its ratification." *Id.* (cite omitted). If history is unclear, the Court "seek[s] guidance from any on-point precedents." *Id.* (cite omitted). All the while, the Court seeks "a liberal interpretation in favor of its citizens." *Corum v. UNC ex rel. Bd. of Governors*, 330 N.C. 761, 783, 413 S.E.2d 276, 290 (1992) (cite omitted); *see also* Art. I, § 35 ("A frequent recurrence to fundamental principles is absolutely necessary to preserve the blessings of liberty.").

ARGUMENT

I. Dr. Singleton stated a claim that the CON law violates the law of the land clause.

Article I, § 19 forbids the legislature from depriving any person of "life, liberty, or property, but by the law of the land." Dr. Singleton stated a claim that the CON law, as applied, violates this clause. "Liberty" includes the fundamental right to earn a living. (Part A). And the "law of the land" prohibits statutes that exceed the police power. (Part B). At a minimum, that means economic laws must be "reasonably necessary" to protect the public. (Part C). Against this backdrop,

Dr. Singleton stated a claim when he alleged that excluding him from the market does not protect—and worse, harms—real patients. (Part D). The Court of Appeals' decision should be reversed.

A. Liberty includes the fundamental right to earn a living.

The phrase "life, liberty, or property" was in our original Constitution. N.C. Const. (1776), Decl. of Rts. § 12. At the time, "liberty" meant freedom of action. *See* T. Dyche & W. Pardon, *A New General English Dictionary* (1781), https://tinyurl.com/2bjarek9 ("in *common Speech*, *Liberty* is a freedom of doing any thing that is agreeable to a person's disposition, without the controul of another"); N. Webster, *American Dictionary of the English Language* (1828), https://tinyurl.com/bdhyta6z ("Freedom from restraint, in a general sense, and applicable to the body, or to the will or mind."). Liberty's standard usage, then, included basic human activities like working and trading for a living.

History confirms that meaning. The right to earn a living was deeply rooted in English common law. Timothy Sandefur, *The Right to Earn a Living*, 6 Chap. L. Rev. 207, 207–17 (2003). The English people long resisted the Crown's supposed "prerogative" to issue "exclusive rights to trade." *Id.* at 209; Steven Calabresi & Larissa Leibowitz, *Monopolies and the Constitution: A History of Crony Capitalism*, 36 Harv. J.L. & Pub. Pol'y 983, 989–1008 (2013). Their struggle bore fruit. In the seventeenth century, Coke wrote that the "fundamental laws of this kingdome" secured a right to conduct "lawful trade" because "a man's trade . . . maintaineth

his life." E. Coke, *The Third Part of the Institutes of the Laws of England* 181 (1644), https://tinyurl.com/55k8hdy7. William Penn decried restraints on "any . . . trade" as "against the liberty and freedom of the subject." W. Penn, *The Excellent Priviledge of Liberty and Property* 55–56 (1687), https://tinyurl.com/3kwux5kx. And Blackstone agreed that "[a]t common law every man might use what trade he pleased." 1 Blackstone, *Commentaries*, *427.

When North Carolinians sought independence, they claimed these same "rights of Englishmen." *Minutes of the Provincial Congress of North Carolina*, *1044 (Aug. 25–27, 1774), https://tinyurl.com/2x3934f5; *see also id.* at *547 (Apr. 4–May 14, 1776), https://tinyurl.com/2mm29w7p (similar).

Our Declaration of Rights, in turn, secures the right to earn a living. It was inspired by George Mason's Virginia Declaration of Rights, Frank Nash, *The North Carolina Constitution of 1776 and its Makers* 17 (1912), a document steeped in John Locke's natural rights philosophy, Steven Calabresi & Sofia Vickery, *On Liberty and the Fourteenth Amendment: The Original Understanding of the Lockean Natural Rights Guarantees*, 93 Tex. L. Rev. 1299, 1316–17 (2015). Mason "endorsed the Lockean ideal that all men retain some of their natural rights after subscribing to the social compact." *Id.* And for Locke, a core natural right we all retain is "[t]he *labour* of [our] body, and the *work* of [our] hands." J. Locke, *Second Treatise of Civil Government* § 27 (1690). That idea ran from Locke's "life, liberty and estate," *id.* § 87, to Mason's "enjoyment of life and liberty, with the means of acquiring and

possessing property," Va. Const. (1776), Bill of Rts. § 1, to North Carolina's "life, liberty, [and] property," N.C. Const. (1776), Decl. of Rts. § 12.

Another major thinker known to have influenced our Constitution was John Adams, whose advice the drafters specifically requested. J. Adams, *Thoughts on Government Letter* (1776), https://tinyurl.com/43kyd5s7. Adams urged them to foster "Happiness" and "Virtue"—a "People bold, brave and enterprizing," "industrious," who would seek "[s]ome Pleasure but more Business." J. Adams, *Letter to William Hooper* (Mar. 27, 1776), https://tinyurl.com/4w89e4y8. Like Locke, Adams saw labor as a practical source of our other rights. A government that secures property, he wrote, "implies liberty; because property cannot be secure unless the man be at liberty to acquire, use, or part with it, at his discretion." J. Adams, *Defence of the Constitutions of Government of the United States* (1787), https://tinyurl.com/yc8ba36r. For Adams, all natural rights were bound up: The *liberty* to work made *property* and *life* possible.[3]

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[3] *See* J. Adams, *Letter to the President of Congress, No. 49* (Apr. 19, 1780), https://tinyurl.com/2s3yb544 (because "the Activity of Mankind [has] its proper course [in] productive labour," man needs "liberty of exerting his Industry and Ingenuity, as he can make them the most productive"); J. Madison, *Property* (Mar. 29, 1792), https://tinyurl.com/2ypth4ku (securing property means securing "citizens that free use of their faculties, and free choice of their occupations, which not only constitute their property in the general sense of the word; but are the means of acquiring property"); T. Jefferson, *Thoughts on Lotteries* (Jan. 1826), https://tinyurl.com/2c5dc868 ("every one has a natural right to choose for his pursuit such [work] as he thinks most likely to furnish him subsistence").

Early North Carolinians cherished their economic freedom. As the war raged, farmers looked toward a "peace" when people could "follow an honest occupation for their livelihood" and "open trade will occasion a plenty of goods, and many will be competitors for the planters' custom." *The North-Carolina Weekly Gazette* (Mar. 13, 1778), https://tinyurl.com/yc65k36a. When peace came, a local paper reprinted a national article celebrating how, at last, a people whose "industry and labour found a constant occupation . . . enjoy[ed], every man, without molestation or the least governmental interference, the fruits of our labours." *The Wilmington Gazette* (Jul. 17, 1804) (reprinted from *The National Intelligencer* (Jul. 4, 1804)), https://tinyurl.com/cm3z6fpn.

But it wasn't quite "every man"—not yet. The Constitution originally protected only "freem[e]n." N.C. Const. (1776), Decl. of Rts. § 12. Which left out a huge part of North Carolina's population: slaves. People like Lunsford Lane, a Raleigh-born slave whose secret "plans for money-making" and "great economy and industry" earned him enough to buy his freedom. *The Narrative of Lunsford Lane*, 8–10, 15–16, 22, 29 (1842), https://tinyurl.com/3hwsphsf. Or like Moses Grandy, a Camden-born slave who had "to buy his freedom *three times over!*," and whose tireless labor earned him the means to do it. *Narrative of the Life of Moses Grandy*, iv, 17, 22, 30, 34 (1843), https://tinyurl.com/22mw5kux. They deserved economic freedom as much as anybody else.

The Constitution of 1868 secured it. A post-Civil War coalition driven in part by former slaves elected delegates who promised to seek "[e]qual civil and political rights [for] the negroes." Robert N. Hunter, Jr., *The Past As Prologue: Albion Tourgée and the North Carolina Constitution*, 5 Elon L. Rev. 89, 97 & n.57 (2013). And the delegates made good on their promise. They replaced "freeman" with "person," added an "equal protection" clause, and declared that "all persons" have "inalienable rights . . . [to] life, liberty, the enjoyment of the fruits of their own labor, and the pursuit of happiness." N.C. Const. (1868), art. I, §§ 1, 17. This "Lockean" text ensured that *all* North Carolinians would have "the right to work and the right to own what that labor produces." Richard Dietz, *Factories of Generic Constitutionalism*, 14 Elon L. Rev. 1, 21 (2022).

Heeding text and history, this Court has repeatedly affirmed the right to earn a living. The Court has avowed "the right to earn [our] daily bread." *State v. Warren*, 211 N.C. 75, 189 S.E.2d 108, 110 (1937) (cite omitted). That "the right to earn a living must be regarded as inalienable." *State v. Harris*, 216 N.C. 746, 6 S.E.2d 854, 863 (1940). That "liberty . . . includes the right of the citizen . . . to earn his livelihood by any lawful calling." *State v. Ballance*, 229 N.C. 764, 769, 51 S.E.2d 731, 734 (1949) (cleaned up). That the "right to conduct a lawful business or earn a livelihood is regarded as fundamental." *Roller v. Allen*, 245 N.C. 516, 518–19, 96 S.E.2d 851, 854 (1957) (cleaned up). And recently—if doubts remained—

that we have a "fundamental right to earn a livelihood." *King v. Town of Chapel Hill*, 367 N.C. 400, 408, 758 S.E.2d 364, 371 (2014) (cleaned up).

B. The law of the land forbids statutes that exceed the police power.

Since the right to earn a living is a "libert[y]," the legislature can't restrict it "but by the law of the land." Art. I, § 19. The key point here is that not every statute is a law of the land in the original sense. Start with text and history. Law of the land is an "ancient" phrase that stems from Magna Carta. John Orth & Paul Newby, *The North Carolina State Constitution* 68 (2d ed. 2013). Over time, it came to mean the government must follow "the norms of the common law." *Id.* at 67–70; Randy Barnett & Evan Bernick, *No Arbitrary Power: An Originalist Theory of the Due Process of Law*, 60 Wm. & Mary L. Rev. 1599, 1608 (2019). North Carolinians declared independence precisely because the English government violated those norms. *See* N.C. Const. (1776), pmbl.

They formed a new state to promote "their happiness and prosperity" and to "preserve the blessings of liberty." *Id.* & Decl. of Rts. § XXI. But they knew it wouldn't work if the legislature held too much power. *See* S. Johnston, *Letter to James Iredell* (Apr. 20, 1776), https://tinyurl.com/ye2yv43k (noting the framers sought to "prevent [the legislature from] assuming more power than would be consistent with the liberties of the people"); J. Iredell, *To the Public* (1786), https://tinyurl.com/mspjwnuk (noting the framers rejected "the principle of unbounded legislative power" because they "knew the value of liberty too well, to

suffer it to depend on the capricious voice of popular favor").[4] So they adopted a Declaration of Rights to constrain legislative power.

The law of the land clause subordinates statutes to the "the common law, and . . . the constitution." *Trs. of UNC v. Foy*, 5 N.C. 58, 88 (1805). That means (among other things) that laws must serve a valid purpose—a purpose rooted in the legitimate functions of government. *See Hoke v. Henderson*, 15 N.C. 1, 11 (1833) ("The purpose of the ordinary laws instituted by society, is to protect the things appropriated to one individual, from the acts and wrongs of other individuals."), *overruled on other grounds by Mial v. Ellington*, 134 N.C. 131, 46 S.E. 961 (1903). Put another way: Laws must fall within the scope of the police power. *See* Barnett & Bernick, 60 Wm. & Mary L. Rev. at 1643–47, 1662–67 (describing police power's historical roots and limits). Otherwise, they are not really "laws" at all.

This Court gave its classic statement on the scope of the police power in *State v. Williams*, 146 N.C. 618, 61 S.E. 61 (1908). There, the defendant argued that a law against moving liquor was not a "law of the land" because it exceeded the police power. *Id.*, 61 S.E.2d at 62. The Court held that the power includes only laws "*appropriate and needful*, for the protection of public morals, the public health, or the public safety." *Id.*, 61 S.E.2d at 64 (emphasis added). Thus, if "a statute

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[4] Iredell's letter "undoubtedly influenced the court's decision" in *Bayard v. Singleton*, 1 N.C. 5 (1787), America's first case declaring a statute unconstitutional. Scott Gerber, *The Origins of an Independent Judiciary in North Carolina, 1663–1787*, 87 N.C. L. Rev. 1771, 1817 (2009).

purporting to have been enacted to protect the public health, the public morals, or the public safety *has no real or substantial relation to those objects* . . . it is the duty of the courts so to adjudge." *Id.* (quoting *Mugler v. Kansas*, 123 U.S. 623 (1887) (emphasis added)). The liquor law failed because liquor was legal to drink and merely moving it did not harm anybody. *Williams*, 61 S.E. at 62, 66–67.

C. Economic laws must be reasonably necessary to protect the public.

To sum up: The right to earn a living is a "liberty" and economic laws are not "law[s] of the land" unless they fall within the police power. This Court has applied these basic concepts for over a century, striking down a host of economic laws because they did not really protect the public.[5] The rub is that the Court has not always applied the same legal test to economic laws. *See* Pls.' PDR 14–19.

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[5] *See, e.g.*, *State v. Biggs*, 133 N.C. 729, 46 S.E. 401 (1903) (medical license for nutritionists); *State v. Warren*, 211 N.C. 75, 189 S.E. 108 (1937) (extra license requirements for real-estate brokers); *State v. Harris*, 216 N.C. 746, 6 S.E.2d 854 (1940) (drycleaner license); *Palmer v. Smith*, 229 N.C. 612, 51 S.E.2d 8 (1948) (ban on opticians replacing lenses); *State v. Ballance*, 229 N.C. 764, 51 S.E.2d 731 (1949) (photographer license); *Roller v. Allen*, 245 N.C. 516, 96 S.E.2d 851 (1957) (tiler license); *City of Winston-Salem v. S. Ry. Co.*, 248 N.C. 637, 105 S.E.2d 37 (1958) (law requiring railroad to build bridge); *State ex rel. Util. Comm'n v. Atl. Greyhound Corp.*, 252 N.C. 18, 113 S.E.2d 57 (1960) (ban on bus franchising); *Cheek v. City of Charlotte*, 273 N.C. 293, 160 S.E.2d 18 (1968) (massage regulations); *State v. Smith*, 265 N.C. 173, 143 S.E.2d 293 (1965) (Sunday law for nightclubs); *State v. Greenwood*, 280 N.C. 651, 187 S.E.2d 8 (1972) (Sunday law for pool halls); *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973) (prior version of CON law); *Bulova Watch Co. v. Brand Distribs. of N. Wilkesboro, Inc.*, 285 N.C. 467, 206 S.E.2d 141 (1974) (cap on watch prices); *King v. Town of Chapel Hill*, 367 N.C. 400, 758 S.E.2d 364 (2014) (fee schedule for towing).

Sometimes, the Court uses a hyper-deferential test rooted in federal due process law. Under this test, economic laws need only be "rationally related to a legitimate state interest." *Meads v. N.C. Dep't of Agric.*, 349 N.C. 656, 671, 509 S.E.2d 165, 175 (1998) (citing *Ferguson v. Skrupa*, 372 U.S. 726 (1963)). While that sounds like a burden a plaintiff might meet by building a strong factual record, this line of cases says no. Plaintiffs can't use "evidence" to prove irrationality. *Rhyne v. K-Mart Corp.*, 358 N.C. 160, 182, 594 S.E.2d 1, 16 (2004). If the law "could have" some "conceivable" relation to a valid purpose, it must be upheld. *Id.* at 180–83, 594 S.E.2d at 15–16 (citing *Texfi Indus., Inc. v. City of Fayetteville*, 301 N.C. 1, 11, 269 S.E.2d 142, 149 (1980)). And that means the state can do anything—even forcibly sterilize you—if it "may be" benign. *In re Moore's Sterilization*, 289 N.C. 95, 103, 221 S.E.2d 307, 312 (1976) (citing *Buck v. Bell*, 274 U.S. 200 (1927)).[6]

[6] In truth, the federal rational basis test is not as tepid as these cases claim. Plaintiffs *can* introduce evidence of irrationality under the federal test. *See United States v. Carolene Prods. Co.*, 304 U.S. 144, 153 (1938) (holding that "[w]here the existence of a rational basis for legislation . . . depends upon facts beyond the sphere of judicial notice, such facts may properly be made the subject of judicial inquiry," and that "the constitutionality of a statute predicated upon the existence of a particular state of facts may be challenged by showing to the court that those facts have ceased to exist"). And when that evidence is strong enough, federal courts *do* strike down economic laws. *See, e.g.*, *St. Joseph Abbey v. Castille*, 712 F.3d 215, 223–27 (5th Cir. 2013) (striking down protectionist restriction on casket sales after trial); *Craigmiles v. Giles*, 312 F.3d 220, 224–26, 229 (6th Cir. 2002) (same); *Catherine H. Barber Mem'l Shelter, Inc. v. Town of N. Wilkesboro Bd. of Adjustment*, 576 F. Supp. 3d 318, 340–43 (W.D.N.C. 2021) (striking down disparate treatment of homeless shelter and similar facilities based on summary judgment evidence).

Other times, though, the Court applies a more engaged test based on *Williams*'s holding that police regulations must be "appropriate and needful," or have a "real or substantial relation," to the public health or welfare. 146 N.C. 618, 61 S.E. at 64 (cleaned up). Under this line of cases,

> [t]he rule is that a statute or ordinance which curtails the right of any person to engage in any occupation can be sustained as a valid exercise of the police power *only if it is reasonably necessary to promote the public health, morals, order, safety, or general welfare*.

Cheek v. City of Charlotte, 273 N.C. 293, 296, 160 S.E.2d 18, 21 (1968) (emphasis added); *accord Aston Park*, 282 N.C. at 551, 193 S.E.2d at 735 (quoting *Ballance*, 229 N.C. 764, 51 S.E.2d at 735). Moreover, because "the validity of [a] police regulation primarily depends on . . . all the surrounding circumstances and particular facts of the case," plaintiffs can use "evidence" to prove that a law exceeds the police power. *City of Winston-Salem v. S. Ry. Co.*, 248 N.C. 637, 639–55, 105 S.E.2d 37, 38–50 (1958).

This Court has held, for example, that it was unconstitutional to require a license to lay tile because "[n]othing in the record" showed that tiling was a threat to the public. *Roller*, 245 N.C. at 521–24, 96 S.E.2d at 856–58. That an ordinance forcing a railroad to build a bridge was "unreasonable and oppressive" because the railroad gave "voluminous evidence" at trial that "changed economic conditions" made the bridge unnecessary. *S. Ry. Co.*, 248 N.C. at 639–55, 105 S.E.2d at 38–50. And that a law capping watch prices exceeded the police power because there was

"no persuasive evidence" that the cap was "necessary to protect [watchmakers]." *Bulova Watch Co. v. Brand Distribs. of N. Wilkesboro, Inc.*, 285 N.C. 467, 479–81, 206 S.E.2d 141, 149–51 (1974)

The Court has also relied on evidence when deciding whether supposed health measures exceeded the police power. For example, seven years before the U.S. Supreme Court's leading rational basis decision in *Williamson v. Lee Optical*, 348 U.S. 483 (1955), this Court struck down a similar law that banned opticians from replacing lenses because "the plaintiffs' evidence" showed it was a simple "mechanical" task that opticians could perform "with accuracy and exactness." *Palmer v. Smith*, 229 N.C. 612, 615–16, 51 S.E.2d 8, 11–12 (1948). Before that, the Court held that forcing a nutritionist to get a medical license was not a valid police regulation because "it is not found here that the defendant is deceiving and injuring the public, or is ignorant and incompetent, to the detriment of the public, in the application of the methods he uses." *State v. Biggs*, 133 N.C. 729, 46 S.E. 401, 404 (1903).

In *Aston Park*, likewise, the Court repeatedly relied on a lack of evidence that banning a new hospital would promote public health when striking down the prior CON law. *See, e.g.*, 282 N.C. at 547, 193 S.E.2d at 733 ("Nothing whatever in this record suggests that the hospital Aston Park proposes to construct will not be adequate in design, structure or equipment or that it will not be maintained in accordance with the highest standards of sanitation and patient care."); *id.* at 549,

193 S.E.2d at 734 ("The record discloses no reason to suppose that [competition will not lower prices and increase quality] in the practice of the healing arts and in the operation of institutions for that purpose.").

These two lines of cases—one using a fact-free "rational basis" test and the other using a fact-based "reasonably necessary" test—can't coexist. So this Court must choose. And here, the choice is clear: The right to earn a living deserves real, fact-based review.

First, as discussed above, the right to earn a living is "fundamental" in North Carolina. *King*, 367 N.C. at 408, 758 S.E.2d at 371 (citing *Roller*, 245 N.C. at 518–19, 96 S.E.2d at 854). The Court has said so again and again. In every other context, laws that restrict fundamental rights trigger strict scrutiny, meaning the law must be "narrowly tailored to advance a compelling governmental interest." *Stephenson v. Bartlett*, 355 N.C. 354, 377 (2002). Even "quasi-fundamental" rights get intermediate scrutiny, meaning the law must "advance important government interests" through means not "substantially more [burdensome] than necessary to further those interests." *Blankenship v. Bartlett*, 363 N.C. 518, 526–27, 681 S.E.2d 759, 765–66 (2009). These are both fact-based tests. The right to earn a living deserves no less protection.

Second, fact-free rational basis review is "tantamount to no review at all." *FCC v. Beach Commc'ns*, 508 U.S. 307, 323 n.3 (1993) (Stevens, J., concurring). And that's a problem. Plaintiffs, shackled by arbitrary laws but unable to prove it

with evidence, will either lose in court or never try. Courts, which have a duty "to protect . . . state constitutional rights," *Corum*, 330 N.C. at 783, 413 S.E.2d at 290, will have no way to assess whether economic laws are "appropriate and needful, for the protection of the public[.]" *Williams*, 146 N.C. 618, 61 S.E.2d at 64. And the legislature, confident that courts won't check its work, will restrict the right to earn a living however it pleases—often at the expense of those who lack political clout. *See* Joshua Newberg, *In Defense of* Aston Park*: The Case for State Substantive Due Process Review of Health Care Regulation*, 68 N.C. L. Rev. 253, 268–72 (1990) (showing the CON law struck down in *Aston Park* was the product of "industry capture" that set up a "cartel at the expense of the public interest").

The Court recently made similar points about another state constitutional right: "the privilege of education." Art. I, § 15. When a student challenged his suspension, the Court held that "[r]ational basis review . . . does not adequately protect student access to [education]." *King ex rel. Harvey-Barrow v. Beaufort Cnty. Bd. of Educ.*, 364 N.C. 368, 377, 704 S.E.2d 259, 264 (2010). The Court explained that fact-free review wouldn't "guard against arbitrary decisions or inadvertent errors." *Id*. State constitutional rights, the Court held, deserve "more exacting review." *Id.*, 704 S.E.2d at 265. That principle applies with equal force here.

Third, while the Court's "reasonably necessary" test for economic laws is rooted in text, history, and state precedent, the rational basis test is not. "North Carolina's courts never used rational basis language until after the federal courts

began using that test for substantive due process claims." Dietz, 14 Elon L. Rev. at 29. So it's hard to see how that test—invented for the textually distinct federal due process clause 150 years after our Constitution was adopted—could possibly reflect the original meaning of Article I, § 19.

Fourth, of all the tests the Court could use to secure the fundamental right to earn a living, "the rational basis test is the lowest tier of review." *Rhyne*, 358 N.C. at 181, 594 S.E.2d at 16. It's the only test that ignores the plaintiff's evidence, lets the government make facts up, and lets courts imagine bases for the law. *But see supra* p 21 n.6. All other constitutional standards—including the "reasonably necessary" test—focus on how a law works in the real world. When push comes to shove, the Court must give "our Constitution a liberal interpretation in favor of its citizens." *Corum*, 330 N.C. at 783, 413 S.E.2d at 290. The very fact that other tests would better protect the right to earn a living is, alone, enough to reject the rational basis test.

This Court would be far from the first to do so. Within just the last decade, the Georgia, Pennsylvania, and Texas high courts have rejected the rational basis test in favor of state tests—all of them fact-based—that better protect economic liberty. *See, e.g.*, *Raffensperger v. Jackson*, 888 S.E.2d 483, 493–95 (Ga. 2023) (more protective "reasonably necessary" test under Georgia's "due process of law" clause); *Ladd v. Real Estate Comm'n*, 230 A.3d 1096, 1109 (Pa. 2020) (similar test under Pennsylvania's "inherent rights" clause); *Patel v. Tex. Dep't of Licensing &*

Regul., 469 S.W.3d 69, 87 (Tex. 2015) (similar test under Texas's "law of the land" clause). North Carolina should join them.

D. Dr. Singleton stated a claim when he alleged the CON law does not protect the public.

Because facts matter, Dr. Singleton made detailed allegations about how the CON law affects him and the public. Those allegations go directly to whether the law, as applied to him, is "appropriate and needful, for the protection of the public morals, the public health, or the public safety." *Williams*, 146 N.C. 618, 61 S.E. at 64. And they show—unambiguously—that the law does not protect the public.

Dr. Singleton alleged his surgeries would be safe. (R pp 12, 14–15, 28, ¶¶ 11, 24–30, 107). He alleged his patients need more affordable eye surgeries and that he can provide them at his clinic for a fraction of the price CarolinaEast charges. (R pp 22, 27, 29–30, ¶¶ 69, 104, 112–13, 123). He alleged that banning him from the market is "without any real-world benefits to patient health or safety." (R pp 10–11, ¶¶ 3–4). He alleged there's no evidence that the CON law "increases access to safe, affordable surgeries in the Craven/Jones/Pamlico area" or "serves any other legitimate governmental purpose." (R pp 28, 33–34, ¶¶ 106, 148–49). And he alleged that, in the real world, the law reduces access to care so that CarolinaEast can profit. (R pp 10–11, 29, 34, ¶¶ 4, 113, 150).

A law that does not protect—and worse, harms—the public is not a valid use of the police power. That's what this Court has held in case after case striking

down economic laws. *Supra* p 20 n.5. It's what the Court held about the first CON law. *See Aston Park*, 282 N.C. at 551, 193 S.E.2d at 735. And it's what the Court of Appeals should have held here—but didn't.

The Court of Appeals didn't discuss Dr. Singleton's factual allegations at all. Instead, the court relied on its prior holding that the CON law's "findings of fact" "show how the CON law affects the public welfare." *Singleton v. DHHS*, 284 N.C. App. 104, 114–15, 874 S.E.2d 669, 676–77 (2022) (citing, in part, *Hope—A Women's Cancer Ctr, P.A. v. State*, 203 N.C. App. 593, 603–04, 693 S.E.2d 673, 680–81 (2010)). Of course, Dr. Singleton alleged that the "'findings of fact' are false as a matter of fact today," both generally and as applied to him. (R pp 18, 28, 33, ¶¶ 49, 106, 148–48). But the Court of Appeals never mentioned that either. It simply treated the law's findings as absolute and dismissed Dr. Singleton's claim.

That was error. *Courts*, not the legislature, have the final say on whether laws exceed the police power. *Williams*, 146 N.C. 618, 61 S.E. at 64; *King*, 367 N.C. at 406–07, 413, 758 S.E.2d at 370, 374. So "[t]he Legislature cannot, by preamble or fact finding declaration, attribute to a business or occupation a character which it does not have according to common knowledge or experience and thus withdraw the legislation from judicial review." *Harris*, 216 N.C 746, 6 S.E.2d at 862. Rather, whatever the legislature claims about its law, the Court must still decide whether "the facts . . . laid bare to the Court" show "those circumstances upon which . . . the police power must depend." *Id.*, 6 S.E.2d at 866.

It's no different in any other constitutional setting. Zoning? A "mere assertion within the [law] that it is for the public welfare is not enough in and of itself to bring the [law] within a valid exercise of the police power." *Town of Atlantic Beach v. Young*, 307 N.C. 422, 428, 298 S.E.2d 686, 691 (1983). Taxes? A "declar[ation] in the Act" that funds are being spent for "a public purpose" is "not conclusive." *Foster v. N.C. Med. Care Comm'n*, 283 N.C. 110, 125, 195 S.E.2d 517, 527 (1973). Takings? "[L]egislative findings and declaration of policy" have weight, but they "have no magical quality to make valid that which is invalid, and are subject to judicial review." *Redev. Comm'n of Greensboro v. Sec. Nat. Bank of Greensboro*, 252 N.C. 595, 611, 114 S.E.2d 688, 700 (1960). Searches? Legislative findings are not presumed true if "the only evidence contained in the record fails to support [them]." *State v. Grady*, 372 N.C. 509, 541, 831 S.E.2d 542, 566 (2019).

The point is, legislative findings are not gospel. They can't shield a law from constitutional review. If they could, the fundamental right to earn a living—and every other right—would be subject to the legislature's "arbitrary will" and Article I, § 19 would be a "dead letter." *Foy*, 5 N.C. at 88–89. That is not the law. At the pleadings stage, the Court of Appeals should have credited Dr. Singleton's allegations that the CON law doesn't protect the public, deprives real patients of access to affordable surgeries, and that its findings are false. Those allegations put the CON law well beyond the police power, and Dr. Singleton's claim well within the pleading standard. The Court should reverse.

II. Dr. Singleton stated claims that the CON law violates the exclusive privileges and anti-monopoly clauses.

Article I, §§ 32 and 34 forbid the legislature from granting "exclusive or separate emoluments or privileges from the community but in consideration of public services," and declare that "[p]erpetuities and monopolies are contrary to the genius of a free state and shall not be allowed." Using the same text-history-precedent framework from above, Dr. Singleton stated claims that the CON law violates these clauses. Both ban *exclusive rights* to provide *private services* (Part A)—which leaves no room for the rational basis test that started infecting this Court's cases in the late 20th century. (Part B). Accordingly, Dr. Singleton stated claims when he alleged that the CON law grants a private hospital—CarolinaEast—an exclusive right to provide surgeries in the Craven/Jones/Pamlico area. (Part C). The Court of Appeals, oddly, dismissed Dr. Singleton's exclusive privileges and anti-monopoly claims as "procedural due process" claims that require exhaustion under Rule 12(b)(1). But that was wrong. Both claims are substantive challenges to the CON law that, under blackletter law, do not require exhaustion. (Part D). The Court of Appeals' decision should be reversed.

A. The legislature can't grant exclusive rights to provide private services.

The exclusive privileges and anti-monopoly clauses date to the founding. N.C. Const. (1776), Decl. of Rts. §§ 3, 23. They have no federal counterparts, which "suggests that the people of North Carolina intended to provide a distinct

set of protections . . . than those provided to them by the federal Constitution." *State v. Kelliher*, 381 N.C. 558, 579–80, 873 S.E.2d 366, 382 (2022). Text, history, and precedent point one way: These clauses, as originally understood, bar *exclusive rights* to provide *private services*.

Text first. Article I, § 32 forbids the legislature from granting "exclusive or separate emoluments or privileges from the community but in consideration of public services." Article I, § 34 says that "monopolies . . . shall not be allowed." Both clauses are phrased as "categorical prohibition[s]." Dietz, 14 Elon L. Rev. at 7–19. No exclusive emoluments or privileges except for public services—period. No monopolies—period. Neither calls out for a special test or judicial interest-balancing. They prohibit specific conduct, using specific words, without exception. *See Kelliher*, 381 N.C. at 579, 873 S.E.2d at 382 ("we presume that the words of a statute or constitutional provision mean what they say"). The Court just has to decide what those words mean.

In 1776, there was no confusion about what they meant. An "emolument" was a profit or advantage. 1 S. Johnson, *A Dictionary of the English Language* (4th ed. 1773), https://tinyurl.com/4mm79893. A "privilege" was any advantage or right not open to others. 2 Johnson, *Dictionary*, https://tinyurl.com/58u3erhz. And a "monopoly" was an exclusive right or privilege to sell anything (whether a good or a service). *Id.*, https://tinyurl.com/bdzcx38e. These terms work together. By banning exclusive emoluments, privileges, and monopolies, the framers hoped

to secure a right to "compete equally for political and economic advantage." John Orth, *Unconstitutional Emoluments: The Emoluments Clauses of the North Carolina Constitution*, 97 N.C. L. Rev. 1727, 1729–30 (2019).

There is one exception—just one—baked into the text. The legislature can grant exclusive rights in exchange for "public services." Art. I, § 32. Those words had diverse meanings in 1776. But history, discussed below, brings a few of those meanings to the fore. "Public" often meant owned by the polity or not for private interest. 2 Johnson, *Dictionary*, https://tinyurl.com/s842w52n. "Service" often meant acts performed at the command of a superior, the duties of public office, or employment. *Id.*, https://tinyurl.com/ms5zdbhn.

So, even before turning to history, "public services" could sensibly mean government services rendered to the people. *See* Dietz, 14 Elon L. Rev. at 10 (endorsing similar reading); Orth, 97 N.C. L. Rev. at 1734 (same). On this reading, the government could pay its officers, provide its own services, or set up utilities with corresponding public duties, without violating the exclusive privileges or anti-monopoly clauses. The government could not, however, grant a private entity an exclusive right to compete in a market—like declaring: "There shall be only one BBQ restaurant in Raleigh." (Thank goodness.)

History confirms that both clauses ban exclusive rights to provide private services. For centuries, the Crown granted "royal monopolies" to fill its coffers and hand out political favors. Calabresi & Leibowitz, 36 Harv. J.L. Pub. Pol'y at

989–1008. These were "exclusive grant[s] of power from the government—in the form of a 'license' or 'patent'—to work in a particular trade or to sell a specific good." *Id.* at 984. Monopoly holders were thus "insulated from competition by a special legal privilege which barred others from competing, and thereby earning a living." Sandefur, 6 Chap. L. Rev. at 218–19.

Monopolies outraged the English people. *See* Calabresi & Leibowitz, 36 Harv. J.L. & Pub. Pol'y at 990–91. In the courts, they successfully challenged monopolies on everything from wine (1377), to upholstering (1614), to tailoring (1614), to plastering (1624), to, in the famed *Case of Monopolies*, trading cards (1603). *Id.* at 991–93; Sandefur, 6 Chap. L. Rev. at 209–16. In 1610, the King's Bench even held that the Royal College of Physicians couldn't wield absolute power to deny licenses and punish unlicensed doctors. Bernard Siegan, *Protecting Economic Liberties*, 6 Chap. L. Rev. 43, 49–50 (2003) (citing *Dr. Bonham's Case*, 77 Eng. Rep. 646 (K.B. 1610)). On the heels of these wins, Parliament got involved too, passing a Statute of Monopolies (1624) that banned most privileges "for the sole buying, selling, making, working or using of any thing within this realm." Calabresi & Leibowitz, 36 Harv. J.L. & Pub. Pol'y at 997–99.

The American colonists were well-aware of the English people's disdain for monopolies. Sandefur, 6 Chap. L. Rev. at 218. Indeed, they lived it. In 1773, Parliament passed the Tea Act, which gave the East India Company an exclusive right to sell tea in the colonies. *Id.* That monopoly, imposed when tensions with

the English government were already high, "pushed" the colonists to Revolution. *Id.*; *see also* J. Adams, *The American Commissioners: Memorandum for the Dutch* (Mar. 31, 1778), https://tinyurl.com/5pfk7k38 (explaining that "[t]he English . . . monopoly of the American commerce . . . compel'd the Americans to reclaim their ancient, unalienable rights"). And even after the Revolution, the nation's leading political minds continued to write about the evils of state-granted monopolies.[7]

North Carolina took immediate action by banning monopolies and special economic privileges. N.C. Const. (1776), Decl. of Rts. §§ 3, 23. That approach appealed to anti-federalists during the federal ratification debates. George Mason, notably, worried that without a bill of rights "Congress may grant monopolies in trade and commerce." G. Mason, *Objections to This Constitution of Government* (Sept. 1787), https://tinyurl.com/4fbbvkxu. North Carolinians must have shared that concern, because they refused to ratify the federal Constitution without a bill of rights—and even demanded that it include a provision mirroring their own ban on exclusive privileges. *Proceedings and Debates of the Convention of North-Carolina* (Aug. 1, 1788), *270–71, https://tinyurl.com/v9973fvv. They wanted to be sure that England's struggle with monopolies would not repeat itself in North Carolina.

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[7] *See, e.g.*, J. Madison, *Letter to Thomas Jefferson* (Oct. 17, 1788), https://tinyurl.com/4pbzepat ("Monopolies . . . are justly classed among the greatest nuisances in Government."); J. Madison, *Property* (Mar. 29, 1792), https://tinyurl.com/2ypth4ku ("That is not a just government, nor is property secure under it, where . . . monopolies deny to part of its citizens . . . free use of their faculties, and free choice of occupations").

In turn, this Court has often held that exclusive economic rights violated the exclusive privileges and anti-monopoly clauses. The cases most consistent with text and history haven't applied the federal rational basis test that started infecting the Court's cases in the late 20th century. *See* Part B *infra* (explaining why the rational basis test should not apply). Instead, the Court has simply asked whether the plain text forbids the privilege. Article I, § 32: Did the law grant an exclusive privilege for private services? *Leete v. County of Warren*, 341 N.C. 116, 118, 462 S.E.2d 476, 477–78 (1995). Article I, § 34: Did the law grant a monopoly? *Town of Clinton v. Standard Oil Co.*, 193 N.C. 432, 137 S.E. 183, 184 (1927). If the Court answers yes to either question, the privilege is unconstitutional—no matter how badly the legislature wants to grant it.

Consider a few examples, starting with Article I, § 32. The Court has struck down exclusive rights to charge special interest rates, *Simonton v. Lanier*, 71 N.C. 498, 503 (1874), to run a warehouse free from tort liability, *Motley v. S. Finishing & Warehouse Co.*, 122 N.C. 347, 30 S.E. 3, 4 (1898), to make and sell alcohol, *State v. Fowler*, 193 N.C. 290, 136 S.E. 709, 711 (1927), to provide taxi services, *State v. Sasseen*, 206 N.C. 644, 175 S.E. 142, 144 (1934), to provide real-estate services, *State v. Warren*, 211 N.C. 75, 189 S.E. 108, 111 (1937), and to conduct a gambling business, *State ex .rel. Taylor v. Carolina Racing Ass'n*, 241 N.C. 80, 94, 84 S.E. 390, 400 (1954).

By the same token, the Court has upheld privileges under Article I, § 32 when they were granted "in consideration of public services," like paying public school teachers and military veterans, *Hinton v. Lacy*, 193 N.C. 496, 173 S.E.2d 669, 674 (1927); *Harrill v. Tchrs.' & State Emps.' Ret. Sys.*, 271 N.C. 357, 360–61, 156 S.E.2d 702, 706 (1967), granting a franchise to provide cable services on a city's behalf, *Madison Cablevision, Inc. v. City of Morganton*, 325 N.C. 634, 654, 386 S.E.2d 200, 212 (1989), and granting a franchise to a public ferry, *In re Spease Ferry*, 138 N.C. 219, 50 S.E. 625, 626 (1905). Taken together, these cases establish a clear rule: The government is free to provide its own services or to contract them out—but it can't target a market, kick everybody out, and then crown one private business king of that market.

Article I, § 34 works the same way. It forbids "monopolies," "originally defined . . . [as] a grant by the sovereign of an exclusive privilege to do something which had theretofore been a matter of common right," like the right to trade goods and services "to earn a livelihood." *Harris*, 216 N.C. 746, 6 S.E.2d at 864. Applying that definition, the Court has struck down laws that granted exclusive rights to build waterworks, *Thrift v. Bd. of Comm'rs of Elizabeth City*, 122 N.C. 31, 30 S.E. 349, 351 (1898), to run gas stations, *Town of Clinton*, 193 N.C. 432, 137 S.E. at 184; *Shuford v. Town of Waynesville*, 214 N.C. 135, 198 S.E. 585, 588 (1938), and to provide taxi services, *Sasseen*, 206 N.C. 644, 175 S.E. at 144.

Town of Clinton offers a particularly clean statement of the law. There, the Court struck down an ordinance that capped the number of gas stations that could operate in a district. The ordinance was invalid because it

> does not regulate, but keeps alive, the six gasoline places inside the [district] where gasoline is sold, and prohibits defendant from carrying on a like legitimate business in the same limits. It discriminates against defendant, and gives a monopoly to those now carrying on the business in the district. It is no regulation; it is a prohibition.

193 N.C. 432, 137 S.E. at 184; *see also State v. Pendegrass*, 106 N.C. 664, 10 S.E. 1002, 1003 (1890) (shorter statement of same rule). Thus, the government can regulate private services to protect the public—but it can't exclude people from the market entirely.

That's why licensing laws typically don't create monopolies. Anybody can enter the market and compete if they can meet a set of objective criteria. *See, e.g.*, *State v. Call*, 121 N.C. 643, 28 S.E. 517, 517 (1897) (medical licensing law didn't grant monopoly because "[t]he door stands open to all who possess the requisite age and good character, and can stand the examination"); *State v. Warren*, 252 N.C. 690, 697, 114 S.E.2d 660, 666–67 (1960) (real-estate licensing law didn't grant monopoly because "[t]he door is open to all who possess the requisite competency, good character and can pass the examination which is exacted of all applicants alike"). Legitimate police regulations are fine; shutting people out of the market because others got there first is not.

Aston Park followed that rule to a tee. The first CON law banned new hospitals from opening whenever a state agency found there were a "sufficient" number of hospitals in the market. *Aston Park*, 282 N.C. at 551, 554, 193 S.E.2d at 733, 736. The existing hospitals were not state facilities or utilities. *Id.* at 550, 193 S.E.2d at 734–35. They were private entities providing private services. *See Foster*, 283 N.C. at 125–27, 195 S.E.2d at 527–29 (holding, just three months later, that "privately operated, managed, and controlled" hospitals don't provide "public" services). Thus, banning new hospitals from competing "establishe[d] a monopoly in the existing hospitals contrary to . . . Article I, § 34 . . . and [was] a grant to them of exclusive privileges forbidden by Article I, § 32." *Aston Park*, 282 N.C. at 551, 193 S.E.2d at 736. Today's CON law suffers the same defect.

B. There is no textual or historical basis for applying the rational basis test.

Around the time *Aston Park* was decided, the Court started applying the rational basis test under the exclusive privileges and anti-monopoly clauses. *See* Pls.' PDR 27–29, 33–34 (describing the shift); Dietz, 14 Elon L. Rev. at 10–11, 17–18 (same). But why? Nothing in the text of either clause implies that the legislature can create monopolies or grant exclusive privileges just because it thinks they're "rational." To the contrary, the point of the Declaration of Rights is to put certain "rights . . . beyond the control of the Legislature." *Foy*, 5 N.C. at 83. Giving the

legislature extreme deference to grant monopolies and other exclusive privileges defeats the point.

What's more, this Court only started using the rational basis test after the U.S. Supreme Court invented it for due process cases in the 1930s. Dietz, 14 Elon L. Rev. at 29; *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 (1938). But Article I, §§ 32 and 34 aren't due process clauses. They're distinct state clauses adopted over 150 years before the rational basis test was ever conceived. And, as the historical context shows, they were adopted because the framers did not trust the government to dictate, as centuries of monarchs had, when competition should be allowed. Applying the rational basis test flouts that history. *See* Dietz, 14 Elon L. Rev. at 18 ("There is little to support the notion that the framers contemplated this sort of rationality standard.").

Worse, the Court has never explained why the rational basis test suits the text or history of either clause. *Id.* at 13, 19. Nor has the Court explained why its pre-*Aston Park* cases taking a more text-driven approach were somehow off base. Instead, the rational basis test "seeped" in without explanation. *Id.* at 19. That's hard to square with the Court's role as the "interpreter of *our State Constitution*." *Corum*, 330 N.C. at 783, 413 S.E.2d at 290 (emphasis added). Surely "the framers of these [two] clauses wanted them to mean *something*" more than "federal due process doctrine." Dietz, 14 Elon L. Rev. at 35. This Court, armed with a renewed

focus on text and history, should reject the rational basis test and decide what Article I, §§ 32 and 34 truly mean.

C. Dr. Singleton stated claims when he alleged the CON law grants an exclusive right to run a private operating room.

With all that said, Dr. Singleton's exclusive privileges and anti-monopoly claims are not complex. To state a claim under either clause, he had to allege that the CON law, as applied, grants an *exclusive right* to provide *private services*—here, operating room services. He checked both boxes.

First, Dr. Singleton alleged that the CON law grants CarolinaEast an exclusive right to run an operating room in the Craven/Jones/Pamlico area. (R pp 31–32, ¶¶ 131, 137). As he explained in his complaint, the law is "fundamentally anticompetitive: Established providers are insulated from competition in their service areas; aspiring providers are prevented from participating in the healthcare market solely because other providers got there first." (R p 25, ¶ 92). Indeed, since Dr. Singleton opened his clinic in 2004, the state has never declared a "need" for a new operating room in his area. (R p 27, ¶ 99). The only entity that holds—or has ever held—a CON in his area is CarolinaEast. (R p 27, ¶¶ 101, 103). That's an exclusive right.

Second, Dr. Singleton alleged that CarolinaEast provides private services. As he put it in the complaint, "CarolinaEast, the only entity with a CON to run a surgical facility in the Craven/Jones/Pamlico area, is a private healthcare provider

that provides private services." (R p 32, ¶ 141). Thus, CarolinaEast does not hold its privilege "in consideration of public services." Art. I, § 32.

Dr. Singleton's allegations put this case on all fours with *Aston Park*. The CON law, like its predecessor, bars Dr. Singleton from the Craven/Jones/Pamlico market "to protect [CarolinaEast] from competition otherwise legitimate." *Aston Park*, 282 N.C. at 552, 193 S.E.2d at 736. It therefore "establishes a monopoly in [CarolinaEast] contrary to . . . Article I, § 34" and grants "exclusive privileges forbidden by Article I, § 32." *Id.* at 551, 193 S.E.2d at 736. Because Dr. Singleton alleged that the CON law grants CarolinaEast precisely the same monopoly and exclusive privilege struck down in *Aston Park*, (R pp 31–33, ¶¶ 130–43), he stated valid claims.

D. Dr. Singleton was not required to exhaust administrative remedies.

Last, the Court of Appeals mistakenly dismissed Dr. Singleton's exclusive privileges and anti-monopoly claims for failure to exhaust administrative remedies. *Singleton*, 284 N.C. App. at 111, 874 S.E.2d at 675. For starters, *there is no remedy* for Dr. Singleton to exhaust. Since opening his clinic in 2004, the State Medical Facilities Plan has never declared a need for a new operating room in his area. That was true when he filed this case, and it remains true today. The Plan "constitutes a determinative limitation on . . . operating rooms . . . that may be approved." N.C. Gen. Stat. § 131E-183(a)(1). Thus, Dr. Singleton has no way—and never had any

way—to apply for a CON. Moreover, because the Plan declares "need" two years in advance, no CON will be available through at least 2025. *Supra* pp 7–9.

But even if Dr. Singleton *could* apply for a CON, a plaintiff does not need to exhaust administrative remedies before he can challenge the constitutionality of a statute. *Meads v. N.C. Dep't of Agric.*, 349 N.C. 656, 670, 509 S.E.2d 165, 174 (1998). That's because plaintiffs don't have to exhaust "inadequate" remedies, and state agencies lack the power to say whether statutes—like the CON law—violate the Constitution. *Id.* In *Meads*, for example, forcing the plaintiff to ask the Pesticide Board whether a law violated substantive due process or equal protection would have been "in vain." *Id.* All three of Dr. Singleton's claims fall squarely within the *Meads* rule.

The Court of Appeals had no trouble applying that rule when it held Dr. Singleton was not required to exhaust administrative remedies before challenging the CON law under Article I, § 19. *Singleton*, 284 N.C. App. at 111, 874 S.E.2d at 675. Dr. Singleton's claims under Article I, §§ 32 and 34—at least for exhaustion purposes—are no different. They assert the CON law is unconstitutional, just on different grounds. So why did the Court of Appeals reach a different result?

Because it misread Dr. Singleton's claims entirely. The court treated his exclusive privileges and anti-monopoly claims as "procedural due process" claims that require exhaustion. *Singleton*, 284 N.C. App. at 111, 874 S.E.2d at 675. That was wrong. Dr. Singleton did not bring a procedural due process claim. (R pp 31–

34, ¶¶ 130–52). In fact, he distinguished all of his claims from a procedural claim multiple times. (Oral Arg., https://tinyurl.com/2ube2s3r, at 2:55–3:02 ("This isn't a challenge to the administrative process itself."); App p 74 (same point in briefing)). Had the Court of Appeals recognized Dr. Singleton's claims for what they were—the same substantive claims that prevailed in *Aston Park*—it would have affirmed the trial court's denial of the Rule 12(b)(1) motion.

Beyond failing to apply blackletter exhaustion law, the Court of Appeals' analysis exposes a bigger problem: the exclusive privileges and anti-monopoly clauses are under-litigated. This Court has not decided any similar claims since *Aston Park*—50 years ago. As Justice Dietz recently explained, that's in part due to this Court's more recent cases applying the federal rational basis test under both clauses:

> When . . . courts and litigants focus on federal due process and ignore more particularized state provisions, the wording, the history, and the precedent of those state clauses all fade away. Litigants may stop asserting them and the courts' ability and willingness to analyze them will wither. The result is that the language carefully chosen by the framers is lost.

Dietz, 14 Elon L. Rev. at 33–34. That's what happened below. Now, this Court has an opportunity to remind North Carolinians—parties and judges alike—how these foundational clauses really work.

CONCLUSION

Dr. Singleton stated claims that the CON law, as applied to him, violates Article I, §§ 19, 32, and 34. The Court of Appeals' decision should be reversed.

Respectfully submitted this 1st day of November, 2023.

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CONTENTS OF APPENDIX

10A NCAC 13C.0202

.0202 REQUIREMENTS FOR ISSUANCE OF LICENSE

Currentness

(a) Upon application for a license from a facility never before licensed, a representative of the Department shall make an inspection of that facility. Every building, institution, or establishment that has been issued a license shall be inspected for compliance with the rules found in this Subchapter. An ambulatory surgery facility shall be deemed to meet licensure requirements if the ambulatory surgery facility is accredited by The Joint Commission, AAAHC, or AAAASF. Accreditation shall not exempt a facility from statutory or rule requirements for licensure nor shall it prohibit the Department from conducting inspections as provided in this Rule to determine compliance with all requirements.

(b) If the applicant has been issued a Certificate of Need and is found to be in compliance with the rules found in this Subchapter, then the Department shall issue a license to expire on December 31 of each year.

(c) The Department shall be notified at the time of:

(1) any change of the owner or operator;

(2) any change of location;

(3) any change as to a lease; and

(4) any transfer, assignment, or other disposition or change of ownership or control of 20 percent or more of the capital stock or voting rights thereunder of a corporation that is the operator or owner of an ambulatory surgical facility, or any transfer, assignment, or other disposition of the stock or voting rights thereunder of such corporation that results in the ownership or control of more than 20 percent of the stock or voting rights thereunder of such corporation by any person.

A new application shall be submitted to the Department in the event of such a change or changes.

(d) The Department shall not grant a license until the plans and specifications that are stated in Section .1400 of this Subchapter, covering the construction of new buildings, additions, or material alterations to existing buildings are approved by the Department.

(e) The facility design and construction shall be in accordance with the licensure rules for ambulatory surgical facilities found in this Subchapter, the North Carolina State Building Code, and local municipal codes.

(f) Submission of Plans.

(1) When construction or remodeling of a facility is planned, one copy of construction documents and specifications shall be submitted by the owner or owner's appointed representative to the Department for review and approval. Schematic design drawings and design development drawings may be submitted for approval prior to the required submission of construction documents.

(2) Approval of construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

(3) The plans shall include a plot plan showing the size and shape of the entire site and the location of all existing and proposed facilities.

(g) To qualify for licensure or license renewal, each facility shall provide to the Division, with its application, an attestation statement in a form provided by the Division verifying compliance with the requirements defined in Rule .0301(d) of this Subchapter.

Current with amendments received through September 11, 2023. Some sections may be more current; see credits for details.

10A NCAC 13C.0202, 10A NC ADC 13C.0202

End of Document

West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-175

§ 131E-175. Findings of fact

Currentness

The General Assembly of North Carolina makes the following findings:

(1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed complements of these health service facilities.

(2) That the increasing cost of health care services offered through health service facilities threatens the health and welfare of the citizens of this State in that citizens need assurance of economical and readily available health care.

(3) That, if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.

(3a) That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process.

(4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.

(5) Repealed by Laws 1987, c. 511, § 1.

(6) That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.

(7) That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services

being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served.

(8) That because persons who have received exemptions under Section 11.9(a) of S.L. 2000-67, as amended, and under Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as amended by Section 1 of S.L. 1999-135, have had sufficient time to complete development plans and initiate construction of beds in adult care homes.

(9) That because with the enactment of this legislation, beds allowed under the exemptions noted above and pending development will count in the inventory of adult care home beds available to provide care to residents in the State Medical Facilities Plan.

(10) That because State and county expenditures provide support for nearly three-quarters of the residents in adult care homes through the State County Special Assistance program, and excess bed capacity increases costs per resident day, it is in the public interest to promote efficiencies in delivering care in those facilities by controlling and directing their growth in an effort to prevent underutilization and higher costs and provide appropriate geographical distribution.

(11) That physicians providing gastrointestinal endoscopy services in unlicensed settings should be given an opportunity to obtain a license to provide those services to ensure the safety of patients and the provision of quality care.

(12) That demand for gastrointestinal endoscopy services is increasing at a substantially faster rate than the general population given the procedure is recognized as a highly effective means to diagnose and prevent cancer.

Credits

Added by Laws 1977, (2nd Sess.), c. 1182, § 2. Amended by Laws 1983, c. 775, § 1; Laws 1987, c. 511, § 1; Laws 1993, c. 7, § 1, March 18, 1993; S.L. 1997-443, § 11A.118(a), eff. July 1, 1997; S.L. 2001-234, § 1, eff. Jan. 1, 2002; S.L. 2005-346, § 5, eff. Aug. 31, 2005.

Notes of Decisions (30)

N.C.G.S.A. § 131E-175, NC ST § 131E-175

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

End of Document

West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-176

§ 131E-176. Definitions

Effective: March 27, 2023
Currentness

The following definitions apply in this Article:

(1) Adult care home.--A facility with seven or more beds licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes or under this Chapter that provides residential care for aged individuals or individuals with disabilities whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.

(1a) Air ambulance.--Aircraft used to provide air transport of sick or injured persons between destinations within the State.

(1b) Ambulatory surgical facility.--A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.

(1c) Ambulatory surgical program.--A formal program for providing on a same-day basis those surgical procedures which require local, regional, or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery or gastrointestinal endoscopy, to be medically unnecessary.

(2) Bed capacity.--Space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. The term “bed capacity” also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(2a) Bone marrow transplantation services.--The process of infusing bone marrow into persons with diseases to stimulate the production of blood cells.

(2b) Burn intensive care services.--Services provided in a unit designed to care for patients who have been severely burned.

(2c) Campus.--The adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities.

(2d) Capital expenditure.--An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.

(2e) Repealed by S.L. 2005-325, § 1, eff. Dec. 31, 2005.

(2f) Cardiac catheterization equipment.--The equipment used to provide cardiac catheterization services.

(2g) Cardiac catheterization services.--Those procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart.

(3) Certificate of need.--A written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of the project.

(4) Repealed by Laws 1993, c. 7, § 2.

(5) Change in bed capacity.--Any of the following:

a. Any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another.

b. Any redistribution of health service facility bed capacity among the categories of health service facility bed.

c. Any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.

(5a) Chemical dependency treatment facility.--A public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or a substance use disorder. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of individuals with chemical dependence or substance use disorders, and related services. The facility or unit may be any of the following:

a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5 of this Chapter.

b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes.

c. A freestanding facility specializing in treatment of individuals with chemical dependence or substance use disorders that is licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes. The facility may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance use disorder, alcoholism or drug abuse facilities," or by other names if the purpose is to provide treatment of individuals with chemical dependence or substance use disorders. The term, however, does not include social setting detoxification facilities, medical detoxification facilities, halfway houses, or recovery farms.

(5b) Chemical dependency treatment beds.--Beds that are licensed for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance use disorder are chemical dependency treatment beds. Chemical dependency treatment beds do not include beds licensed for detoxification.

(6) Department.--The North Carolina Department of Health and Human Services.

(7) Develop.--When used in connection with health services, means to undertake those activities which will result in the offering of institutional health service or the incurring of a financial obligation in relation to the offering of such a service.

<Text of (7a), as amended by S.L. 2023-7, § 3.1(a), eff. March 27, 2023, and eff. until contingency. See notes below.>

(7a) Diagnostic center.--"Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

<Text of (7a), as amended by S.L. 2023-7, § 3.3(a), eff. upon contingency. See notes below.>

(7a) Diagnostic center.--"Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds three million dollars ($3,000,000). No facility, program, or provider, including, but not limited to, physicians'

offices, clinical laboratories, radiology centers, or mobile diagnostic programs, shall be deemed a diagnostic center solely by virtue of having a magnetic resonance imaging scanner in a county with a population of greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census. In determining whether the medical diagnostic equipment in a diagnostic center costs more than three million dollars ($3,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

(7b) Expedited review.--The status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.

b. The proposed capital expenditure is less than five million dollars ($5,000,000).

c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.

d. The agency has not determined that a public hearing is in the public interest.

(7c) Gamma knife.--Equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.

(7d) Gastrointestinal endoscopy room.--A room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

(8), (9) Repealed by Laws 1987, c. 511, § 1.

(9a) Health service.--An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. “Health service” does not include administrative and other activities that are not integral to clinical management.

<Text of (9b), as amended by S.L. 2023-7, § 3.1(a), eff. March 27, 2023, and eff. until contingency. See notes below.>

(9b) Health service facility.--A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

<Text of (9b), as amended by S.L. 2023-7, § 3.2(a), eff. upon contingency. See notes below.>

(9b) Health service facility.--A hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term “health service facility” does not include a qualified urban ambulatory surgical facility.

<Text of (9c), as amended by S.L. 2023-7, § 3.1(a), eff. March 27, 2023.>

(9c) Health service facility bed.--A bed licensed for use in a health service facility in the categories of (i) acute care beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.

(10) Health maintenance organization (HMO).--A public or private organization which has received its certificate of authority under Article 67 of Chapter 58 of the General Statutes and which either is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act or satisfies all of the following:

a. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage.

b. Is compensated, except for copayments, for the provision of the basic health care services listed in sub-subdivision a. of this subdivision to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided.

c. Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organizations, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(10a) Heart-lung bypass machine.--The equipment used to perform extra-corporeal circulation and oxygenation during surgical procedures.

(11) Repealed by Laws 1991, c. 692, § 1.

(12) Home health agency.--A private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.

(12a) Home health services.--Items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for sub-subdivision e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:

a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse.

b. Physical, occupational, or speech therapy.

c. Medical social services, home health aid services, and other therapeutic services.

d. Medical supplies, other than drugs and biologicals and the use of medical appliances.

e. Any of the items and services listed in this subdivision which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual at home, or which are furnished at the facility while the individual is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(13) Hospital.--A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except long-term care hospitals.

(13a) Hospice.--Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(13b) Hospice inpatient facility.--A freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting. For purposes of this Article only, a hospital which has a contractual agreement with a licensed hospice to provide inpatient services to a hospice patient as defined in G.S. 131E-201(4) and provides those services in a licensed acute care bed is not a hospice inpatient facility and is not subject to the requirements in sub-subdivision (5)b. of this section for hospice inpatient beds.

(13c) Hospice residential care facility.--A freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.

(14) Repealed by Laws 1987, c. 511, § 1.

(14a) Intermediate care facility for individuals with intellectual disabilities.--Facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

(14b) Repealed by Laws 1991, c. 692, § 1.

(14c) Reserved.

(14d) Repealed by S.L. 2001-234, § 2, eff. Jan. 1, 2002.

(14e) Kidney disease treatment center.--A facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 405.

(14f) "Legacy Medical Care Facility" means a facility that meets all of the following requirements:

a. Is not presently operating.

b. Has not continuously operated for at least the past six months.

c. Within the last 24 months:

1. Was operated by a person holding a license under G.S. 131E-77; and

2. Was primarily engaged in providing to inpatients or outpatients, by or under supervision of physicians, (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(14g) Linear accelerator.--A machine used to produce ionizing radiation in excess of 1,000,000 electron volts in the form of a beam of electrons or photons to treat cancer patients.

(14h) Reserved.

(14i) Lithotriptor.--Extra-corporeal shock wave technology used to treat persons with kidney stones and gallstones.

(14j) Reserved.

(14k) Long-term care hospital.--A hospital that has been classified and designated as a long-term care hospital by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 412.

(14*l*) Reserved.

(14m) Magnetic resonance imaging scanner.--Medical imaging equipment that uses nuclear magnetic resonance.

(14n) Main campus.--All of the following for the purposes of G.S. 131E-184(f) and (g) only:

a. The site of the main building from which a licensed health service facility provides clinical patient services and exercises financial and administrative control over the entire facility, including the buildings and grounds adjacent to that main building.

b. Other areas and structures that are not strictly contiguous to the main building but are located within 250 yards of the main building.

<Text of (14***o***) eff. until contingency. See notes below.>

(14***o***) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than two million dollars ($2,000,000). In determining whether the major medical equipment costs more than two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

<Text of (14***o***), as amended by S.L. 2023-7, § 3.3(a), eff. upon contingency. See notes below.>

(14***o***) Major medical equipment.--"Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than two million dollars ($2,000,000). In determining whether the major medical equipment costs more than two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment as defined in this section or magnetic resonance imaging scanners in counties with a population greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using

the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

(15) Repealed by Laws 1987, c. 511, § 1.

(15a) Multispecialty ambulatory surgical program.--A formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.

(15b) Neonatal intensive care services.--Those services provided by a health service facility to high-risk newborn infants who require constant nursing care, including but not limited to continuous cardiopulmonary and other supportive care.

(16) New institutional health services.--Any of the following:

a. The construction, development, or other establishment of a new health service facility.

<Text of (16)b. eff. until contingency. See notes below.>

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding four million dollars ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds four million dollars ($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

<Text of (16)b., as amended by S.L. 2023-7, § 3.2(a), eff. upon contingency. See notes below.>

b. Except with respect to qualified urban ambulatory surgical facilities and except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding four million dollars ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds four million dollars ($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

c. Any change in bed capacity.

d. The offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.

f. The development or offering of a health service as listed in this subdivision by or on behalf of any person:

1. Bone marrow transplantation services.

2. Burn intensive care services.

2a. Cardiac catheterization services, except cardiac catheterization services provided on equipment furnished by a person authorized to operate the equipment in North Carolina pursuant to either a certificate of need issued for mobile cardiac catheterization equipment or a settlement agreement executed by the Department for provision of cardiac catheterization services.

3. Neonatal intensive care services.

4. Open-heart surgery services.

5. Solid organ transplantation services.

f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:

1. Air ambulance.

2. Repealed by S.L. 2005-325, § 1, eff. Dec. 31, 2005.

3. Cardiac catheterization equipment.

4. Gamma knife.

5. Heart-lung bypass machine.

5a. Linear accelerator.

6. Lithotriptor.

<Text of (16)f1.7. eff. until contingency. See notes below.>

7. Magnetic resonance imaging scanner.

<Text of (16)f1.7., as amended by S.L. 2023-7, § 3.3(a), eff. upon contingency. See notes below.>

7. Magnetic resonance imaging scanner. This sub-sub-subdivision applies only to counties with a population of 125,000 or less according to the 2020 federal decennial census or any subsequent federal decennial census.

8. Positron emission tomography scanner.

9. Simulator.

g. to k. Repealed by Laws 1987, c. 511, § 1.

l. The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E-180.

m. Any conversion of nonhealth service facility beds to health service facility beds.

n. The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility;

o. The opening of an additional office by an existing home health agency or hospice within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency or hospice outside its service area as defined by rules adopted by the Department.

p. The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.

q. The relocation of a health service facility from one service area to another.

r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.

s. The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if the equipment would otherwise be subject to review in accordance with sub-subdivision f1. of this subdivision or sub-subdivision p. of this subdivision if it had been acquired in North Carolina.

t. Repealed by S.L. 2001-242, § 4, eff. June 23, 2001.

u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.

v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.

(17) North Carolina State Health Coordinating Council.--The Council that prepares, with the Department of Health and Human Services, the State Medical Facilities Plan.

(17a) Nursing care.--Any of the following:

a. Skilled nursing care and related services for residents who require medical or nursing care.

b. Rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.

These are services which are not primarily for the care and treatment of mental diseases.

(17b) Nursing home facility.--A health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.

(18) Offer.--In connection with health services, the act by a person of holding out as capable of providing, or as having the means to provide, specified health services.

(18a) Repealed by S.L. 2005-325, § 1, eff. Dec. 31, 2005.

(18b) Open-heart surgery services.--The provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects.

(18c) Operating room.--A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.

(19) Person.--An individual; a trust or estate; a partnership; a corporation, including associations, joint stock companies, and insurance companies; the State; or a political subdivision or agency or instrumentality of the State.

(19a) Positron emission tomography scanner.--Equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures.

(20) Project or capital expenditure project.--A proposal to undertake a capital expenditure that results in the offering of a new institutional health service. A project, or capital expenditure project, or proposed project may refer to the project from its earliest planning stages up through the point at which the specified new institutional health service may be offered. In the case of facility construction, the point at which the new institutional health service may be offered must take place after the facility is capable of being fully licensed and operated for its intended use, and at that time it shall be considered a health service facility.

(21) Psychiatric facility.--A public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of individuals with mental illnesses.

<Text of (21a), as enacted by S.L. 2023-7, § 3.2(a), eff. upon contingency. See notes below.>

(21a) Qualified urban ambulatory surgical facility.--An ambulatory surgical facility that meets all of the following criteria:

a. Is licensed by the Department to operate as an ambulatory surgical facility.

b. Has a single specialty or multispecialty ambulatory surgical program.

c. Is located in a county with a population greater than 125,000 according to the 2020 federal decennial census or any subsequent federal decennial census.

(22) Rehabilitation facility.--A public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of individuals with disabilities through an integrated program of medical and other services which are provided under competent, professional supervision.

<Text of (22a), as amended by S.L. 2023-7, § 3.1(a), eff. March 27, 2023.>

(22a) Replacement equipment.--Equipment that costs less than three million dollars ($3,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than three million dollars ($3,000,000) the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2023, and on September 30 each year thereafter, the cost threshold amount in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

(23) Repealed by Laws 1991, c. 692, § 1.

(24) Repealed by Laws 1993, c. 7, § 2.

(24a) Service area.--The area of the State, as defined in the State Medical Facilities Plan or in rules adopted by the Department, which receives services from a health service facility.

(24b) Simulator.--A machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient.

(24c) Reserved.

(24d) Solid organ transplantation services.--The provision of surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor.

(24e) Reserved.

<Text of (24f) eff. until contingency. See notes below.>

(24f) Specialty ambulatory surgical program.--A formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and authorized by its certificate of need.

<Text of (24f), as amended by S.L. 2023-7, § 3.2(a), eff. upon contingency. See notes below.>

(24f) Specialty ambulatory surgical program.--A formal program for providing on a same-day basis surgical procedures of the same surgical specialty and authorized by its certificate of need, if a certificate of need is required.

(25) State Medical Facilities Plan.--The plan prepared by the Department of Health and Human Services and the North Carolina State Health Coordinating Council, and approved by the Governor. In preparing the Plan, the Department and the State Health Coordinating Council shall maintain a mailing list of persons who have requested notice of public hearings regarding the Plan. Not less than 15 days prior to a scheduled public hearing, the Department shall notify persons on its mailing list of the date, time, and location of the hearing. The Department shall hold at least one public hearing prior to the adoption of the proposed Plan and at least six public hearings after the adoption of the proposed Plan by the State Health Coordinating Council. The Council shall accept oral and written comments from the public concerning the Plan.

(26) Repealed by Laws 1983 (Reg. Sess., 1984), c. 1002, § 9.

(27) Repealed by Laws 1987, c. 511, § 1.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1983 (Reg. Sess., 1984), c. 1002, §§ 1 to 9; Laws 1983 (Reg. Sess., 1984), c. 1022, §§ 2, 3; Laws 1983 (Reg. Sess., 1984), c. 1064, § 1; Laws 1983 (Reg. Sess., 1984), c. 1110, §§ 1, 2; Laws 1985, c. 589, §§ 42, 43(a); Laws 1985, c. 740, §§ 1, 2, 6; Laws 1985 (Reg. Sess., 1986), c. 1001, § 2; Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 1; Laws 1991, c. 701, § 1; Laws 1993, c. 7, § 2, eff. March 18, 1993; Laws 1993, c. 376, §§ 1 to 4, eff. July 17, 1998; S.L. 1997-443, § 11A.118(a), eff. July 1, 1997; S.L. 2000-135, § 1, eff. July 14, 2000; S.L. 2001-234, § 2, eff. Jan. 1, 2002; S.L. 2001-242, §§ 2, 4, eff. June 23, 2001; S.L. 2003-229, § 13, eff. July 1, 2003; S.L. 2003-390, §§ 1, 2, eff. Aug. 7, 2003; S.L. 2005-325, § 1, eff. Aug. 26, 2005; S.L. 2005-346, §§ 6(a) to 6(d), eff. Aug. 31, 2005; S.L. 2009-145, § 2, eff. June 19, 2009; S.L. 2009-462, § 4(k), eff. Oct. 1, 2009; S.L. 2013-360, § 12G.3(a), eff. July 1, 2013; S.L. 2015-288, § 1, eff. Oct. 29, 2015; S.L. 2018-81, § 3(a), eff. June 25, 2018; S.L. 2019-76, § 19, eff. Oct. 1, 2019; S.L. 2021-129, § 1, eff. Oct. 1, 2021; S.L. 2023-7, § 3.1(a), eff. March 27, 2023; S.L. 2023-7, §§ 3.2(a), 3.3(a), eff. conting.

Editors' Notes

CONTINGENT EFFECTIVE DATES AND EXPIRATIONS

<Text of section as amended by S.L. 2023-7, § 3.2(a), is effective two years from the date the Department of Health and Human Services (DHHS) issues the first direct payment in accordance with the Healthcare Access and Stabilization Program (HASP) under G.S. 108A-148.1, and expires if no payments are directed by June 30, 2025, pursuant to § 3.2(d) of that act. See Historical and Statutory notes.>

<Text of section as amended by S.L. 2023-7, § 3.3(a), is effective three years from the date the Department of Health and Human Services (DHHS) issues the first direct payment in accordance with the Healthcare Access and Stabilization Program (HASP) under G.S. 108A-148.1, and expires if no payments are directed by June 30, 2025, pursuant to § 3.3(b) of that act. See Historical and Statutory notes.>

Notes of Decisions (46)

N.C.G.S.A. § 131E-176, NC ST § 131E-176

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

End of Document

West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-177

§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties

Effective: June 24, 2011
Currentness

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this Article;

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such grants-in-aid;

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this Article;

(4) Develop policy, criteria, and standards for health service facilities planning; shall conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and services; and develop a State Medical Facilities Plan;

(5) Implement, by rule, criteria for project review;

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this Article;

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this Article; and

(8) Repealed by Laws 1987, c. 511, § 1.

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section.

Credits

Added by Laws 1983, c. 713, § 96. Amended by Laws 1983, c. 775, § 1; Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 2; Laws 1993, c. 7, § 3, eff. March 18, 1993; Laws 1993, c. 383, § 2, eff. July 18, 1993; Laws 1993, c. 383, § 3, eff. July 1, 1993; S.L. 1997-443, § 11A.118(a), eff. July 1, 1997; S.L. 2007-323, § 30.4(a), eff. Oct. 1, 2007; S.L. 2011-284, § 90, eff. June 24, 2011.

Notes of Decisions (10)

N.C.G.S.A. § 131E-177, NC ST § 131E-177

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

End of Document

West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-178

§ 131E-178. Activities requiring certificate of need

Effective: July 5, 2007
Currentness

(a) No person shall offer or develop a new institutional health service without first obtaining a certificate of need from the Department; provided, however, no person who provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:

(1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;

(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;

(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and

(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.

(b) No person shall make an acquisition by donation, lease, transfer, or comparable arrangement without first obtaining a certificate of need from the Department, if the acquisition would have been a new institutional health service if it had been made by purchase. In determining whether an acquisition would have been a new institutional health service, the capital expenditure for the asset shall be deemed to be the fair market value of the asset or the cost of the asset, whichever is greater.

(c) No person shall incur an obligation for a capital expenditure which is a new institutional health service without first obtaining a certificate of need from the Department. An obligation for a capital expenditure is incurred when:

(1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the construction, acquisition, lease or financing of a capital asset;

(2) A person takes formal action to commit funds for a construction project undertaken as his own contractor; or

(3) In the case of donated property, the date on which the gift is completed.

(d) Where the estimated cost of a proposed capital expenditure, including the fair market value of equipment acquired by purchase, lease, transfer, or other comparable arrangement, is certified by a licensed architect or engineer to be equal to or less than the expenditure minimum for capital expenditure for new institutional health services, such expenditure shall be deemed not to exceed the amount for new institutional health services regardless of the actual amount expended, provided that the following conditions are met:

(1) The certified estimated cost is prepared in writing 60 days or more before the obligation for the capital expenditure is incurred. Certified cost estimates shall be available for inspection at the facility and sent to the Department upon its request.

(2) The facility on whose behalf the expenditure was made notifies the Department in writing within 30 days of the date on which such expenditure is made if the expenditure exceeds the expenditure minimum for capital expenditures. The notice shall include a copy of the certified cost estimate.

(e) The Department may grant certificates of need which permit capital expenditures only for predevelopment activities. Predevelopment activities include the preparation of architectural designs, plans, working drawings, or specifications, the preparation of studies and surveys, and the acquisition of a potential site.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1983 (Reg. Sess., 1984), c. 1110, § 3; Laws 1985, c. 740, § 3; Laws 1985 (Reg. Sess., 1986), c. 1001, § 1; Laws 1987, c. 511, § 1; Laws 1987, c. 768; Laws 1991, c. 692, § 3; Laws 1993, c. 7, § 4, eff. March 18, 1993; S.L. 2005-346, § 7, eff. Aug. 31, 2005; S.L. 2007-182, § 1, eff. July 5, 2007.

Notes of Decisions (19)

N.C.G.S.A. § 131E-178, NC ST § 131E-178

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
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N.C.G.S.A. § 131E-179

§ 131E-179. Research activities

Currentness

(a) Notwithstanding any other provisions of this Article, a health service facility may offer new institutional health services to be used solely for research, or incur the obligation of a capital expenditure solely for research, without a certificate of need, if the Department grants an exemption. The Department shall grant an exemption if the health service facility files a notice of intent with the Department in accordance with rules promulgated by the Department and if the Department finds that the offering or obligation will not:

(1) Affect the charges of the health service facility for the provision of medical or other patient care services other than services which are included in the research;

(2) Substantially change the bed capacity of the facility; or

(3) Substantially change the medical or other patient care services of the facility.

(b) After a health service facility has received an exemption pursuant to subsection (a) of this section, it shall not offer the new institutional health services, or use a facility acquired through the capital expenditure, in a manner which affects the charges of the facility for the provision of medical or other patient care services, other than the services which are included in the research and shall not charge patients for the use of the service for which an exemption has been granted, without first obtaining a certificate of need from the Department; provided, however, that any facility or service acquired or developed under the exemption provided by this section shall not be subject to the foregoing restrictions on its use if the facility or service could otherwise be offered or developed without a certificate of need.

(c) Any of the activities described in subsection (a) of this section shall be deemed to be solely for research even if they include patient care provided on an occasional and irregular basis and not as a part of the research program.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 4.

N.C.G.S.A. § 131E-179, NC ST § 131E-179

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N.C.G.S.A. § 131E-181

§ 131E-181. Nature of certificate of need

Currentness

(a) A certificate of need shall be valid only for the defined scope, physical location, and person named in the application. A certificate of need shall not be transferred or assigned except as provided in G.S. 131E-189(c).

(b) A recipient of a certificate of need, or any person who may subsequently acquire, in any manner whatsoever permitted by law, the service for which that certificate of need was issued, is required to materially comply with the representations made in its application for that certificate of need. The Department shall require any recipient of a certificate of need, or its successor, whose service is in operation to submit to the Department evidence that the recipient, or its successor, is in material compliance with the representations made in its application for the certificate of need which granted the recipient the right to operate that service. In determining whether the recipient of a certificate of need, or its successor, is operating a service which materially differs from the representations made in its application for that certificate of need, the Department shall consider cost increases to the recipient, or its successor, including, but not limited to, the following:

(1) Any increase in the consumer price index;

(2) Any increased cost incurred because of Government requirements, including federal, State, or any political subdivision thereof; and

(3) Any increase in cost due to professional fees or the purchase of services and supplies.

(c) Whenever a certificate of need is issued more than 12 months after the application for the certificate of need began review, the Department shall adjust the capital expenditure amount proposed by increasing it to reflect any inflation in the Department of Commerce's Construction Cost Index that has occurred since the date when the application began review; and the Department shall use this recalculated capital expenditure amount in the certificate of need issued for the project.

(d) A project authorized by a certificate of need is complete when the health service or the health service facility for which the certificate of need was issued is licensed and certified and is in material compliance with the representations made in the certificate of need application.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1985, c. 521, § 1; Laws 1985 (Reg. Sess., 1986), c. 968, § 1; Laws 1987, c. 511, § 1; Laws 1989, c. 233; Laws 1991, c. 692, § 5; Laws 1991 (Reg. Sess., 1992), c. 959, § 85; Laws 1993, c. 7, § 5, eff. March 18, 1993.

Notes of Decisions (4)

N.C.G.S.A. § 131E-181, NC ST § 131E-181

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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N.C.G.S.A. § 131E-182

§ 131E-182. Application

Effective: October 1, 2007
Currentness

(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that applications for similar proposals in the same service area will be reviewed together.

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require such information as the Department, by its rules deems necessary to conduct the review. An applicant shall be required to furnish only that information necessary to determine whether the proposed new institutional health service is consistent with the review criteria implemented under G.S. 131E-183 and with duly adopted standards, plans and criteria.

(c) An application fee is imposed on an applicant for a certificate of need. An applicant must submit the fee with the application. The fee is not refundable, regardless of whether a certificate of need is issued. Fees collected under this section shall be credited to the General Fund as nontax revenue. The application fee is five thousand dollars ($5,000) plus an amount equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in the application that exceeds one million dollars ($1,000,000). In no event may the fee exceed fifty thousand dollars ($50,000).

Credits
Added by Laws 1983, c. 713, § 97. Amended by Laws 1983, c. 775, § 1; Laws 1987, c. 511, § 1; S.L. 2005-325, § 3, eff. Aug. 26, 2005; S.L. 2005-346, § 8, eff. Aug. 31, 2005; S.L. 2007-323, § 30.4(b), eff. Oct. 1, 2007.

Notes of Decisions (3)

N.C.G.S.A. § 131E-182, NC ST § 131E-182
The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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N.C.G.S.A. § 131E-183

§ 131E-183. Review criteria

Currentness

(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

(2) Repealed by Laws 1987, c. 511, § 1.

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

(4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.

(5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

(7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.

(8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.

(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.

(10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:

a. The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and

b. The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:

1. Would be available under a contract of at least five years' duration;

2. Would be available and conveniently accessible through physicians and other health professionals associated with the HMO;

3. Would cost no more than if the services were provided by the HMO; and

4. Would be available in a manner which is administratively feasible to the HMO.

(11) Repealed by Laws 1987, c. 511, § 1.

(12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally

experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;

b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.

(14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.

(15) to (18) Repealed by Laws 1987, c. 511, § 1.

(18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

(19) Repealed by Laws 1987, c. 511, § 1.

(20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.

(21) Repealed by Laws 1987, c. 511, § 1.

(b) The Department is authorized to adopt rules for the review of particular types of applications that will be used in addition to those criteria outlined in subsection (a) of this section and may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed. No such rule adopted by the Department shall require an academic medical center teaching hospital, as defined by the State Medical Facilities Plan, to demonstrate that any facility or service at another hospital is being appropriately utilized in order for that academic medical center teaching hospital to be approved for the issuance of a certificate of need to develop any similar facility or service.

(c) Repealed by Laws 1987, c. 511, § 1.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1983, c. 920, § 2; Laws 1983 (Reg. Sess., 1984), c. 1002, § 10; Laws 1985, c. 445, § 1; Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 6; Laws 1991, c. 701, § 2; Laws 1993, c. 7, § 6, eff. March 18, 1993; S.L. 2001-242, § 3, eff. June 23, 2001.

Notes of Decisions (116)

N.C.G.S.A. § 131E-183, NC ST § 131E-183

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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N.C.G.S.A. § 131E-184

§ 131E-184. Exemptions from review

Effective: March 27, 2023
Currentness

(a) Except as provided in subsection (b) of this section, the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

(1) To eliminate or prevent imminent safety hazards as defined in federal, State, or local fire, building, or life safety codes or regulations.

(1a) To comply with State licensure standards.

(1b) To comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that act.

(2) Repealed by Laws 1987, c. 511, § 1.

(3) To provide data processing equipment.

(4) To provide parking, heating or cooling systems, elevators, or other basic plant or mechanical improvements, unless these activities are integral portions of a project that involves the construction of a new health service facility or portion thereof and that is subject to certificate of need review.

(5) To replace or repair facilities destroyed or damaged by accident or natural disaster.

(6) To provide any nonhealth service facility or service.

(7) To provide replacement equipment.

(8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of this subdivision.

(9) To develop or acquire a physician office building regardless of cost, unless a new institutional health service other than defined in G.S. 131E-176(16)b. is offered or developed in the building.

(10) To allow a licensed home care agency, as defined in G.S. 131E-136, to provide Early and Periodic Screening, Diagnosis, and Treatment services to children up to 21 years of age, in compliance with federal Medicaid requirements under 42 U.S.C. § 1396d. This exemption applies to all home care agencies licensed under Article 6 of this Chapter, whether or not they are Medicare-certified.

(b) Those portions of a proposed project which are not proposed for one or more of the purposes under subsection (a) of this section are subject to certificate of need review, if these non-exempt portions of the project are new institutional health services under G.S. 131E-176(16).

(c), (d) Repealed by S.L. 2023-7, § 3.1(b), eff. March 27, 2023.

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would meet all of the following requirements:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding any of the following existing facilities:

1. Nursing home facility.

2. Adult care home facility.

3. Intermediate care facility for individuals with intellectual disabilities.

b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.

b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.

c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents.

(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the monetary threshold set forth in G.S. 131E-176(22a) if all of the following conditions are met:

(1) The equipment being replaced is located on the main campus.

(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.

(3) The licensed health service facility proposing to purchase the replacement equipment shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus.

(2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

(h) The Department must exempt from certificate of need review the acquisition or reopening of a Legacy Medical Care Facility. The person seeking to operate a Legacy Medical Care Facility shall give the Department written notice of all of the following:

(1) Its intention to acquire or reopen a Legacy Medical Care Facility within the same county and the same service area as the facility that ceased continuous operations. If the Legacy Medical Care Facility will become operational in a new location within the same county and the same service area as the facility that ceased continuous operations, then the person responsible for giving the written notice required by this section shall notify the Department, as soon as reasonably practicable and prior to becoming operational, of the new location of the Legacy Medical Care Facility. For purposes of this subdivision, “service area” means the service area identified in the North Carolina State Medical Facilities Plan in effect at the time the written notice required by this section is given to the Department.

(2) That the facility will be operational within 36 months of the notice.

The Department shall extend the time by which a facility must be operational in order to be exempt from certificate of need review under this subsection by one additional 36-month period if the person seeking to reopen or acquire the Legacy Medical Care Facility gives the Department written notice of extension within 36 months of the original notice of intent to acquire or reopen the Legacy Medical Care Facility. The written notice of extension must notify the Department (i) that the person has undertaken all reasonable efforts to make the facility operational within 36 months of the notice of intent, (ii) that, despite these reasonable efforts, the person does not anticipate the facility will be operational within that time, and (iii) of its intention that the facility will be operational within 36 months of the notice of extension.

A person seeking to operate a Legacy Medical Care Facility located in a development tier one or tier two area, as defined in G.S. 143B-437.08, may request an additional extension of time by which the facility must be operational in order to be exempt from certificate of need review under this subsection by providing an additional written notice of extension to the Department, delivered prior to the conclusion of the original 36-month extension period, affirming that the person has entered into a contract for the acquisition or reopening of the Legacy Medical Care Facility and that, pursuant to the terms of the contract, the facility will commence operations within 36 months of the conclusion of the original notice of extension. Upon receipt of this notice, the Department shall grant an extension of the time by which the facility must be operational that is sufficient to permit the acquisition or reopening of the Legacy Medical Care Facility as provided in the contract.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; Laws 1991 (Reg. Sess., 1992), c. 1030, § 37; Laws 1993, c. 7, § 7, eff. March 18, 1993; S.L. 2001-424, § 25.19(c), eff. July 1, 2001; S.L. 2002-159, § 41, eff. Oct. 11, 2002; S.L. 2009-145, § 1, eff. June 19, 2009; S.L. 2009-487, § 3, eff. Aug. 26, 2009; S.L. 2011-145, § 19.1(h), eff. Jan. 1, 2012; S.L. 2013-360, § 12G.3(b), eff. July 1, 2013; S.L. 2013-363, § 4.6, eff. July 1, 2013; S.L. 2014-100, § 12G.1(a), eff. Aug. 7, 2014; S.L. 2015-288, § 2, eff. Oct. 29, 2015; S.L. 2017-184, § 7(a), eff. July 25, 2017; S.L. 2017-186, § 2(xxxxx), eff. Dec. 1, 2017; S.L. 2018-81, § 3(b), eff. June 25, 2018; S.L. 2018-145, § 15, eff. Dec. 27, 2018; S.L. 2019-76, § 20, eff. Oct. 1, 2019; S.L. 2021-180, § 9E.4, eff. July 1, 2021; S.L. 2021-180, § 19C.9(sss), eff. Jan. 1, 2023; S.L. 2023-7, § 3.1(b), eff. March 27, 2023.

Notes of Decisions (12)

N.C.G.S.A. § 131E-184, NC ST § 131E-184

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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N.C.G.S.A. § 131E-185

§ 131E-185. Review process

Currentness

(a) Repealed by Laws 1987, c. 511, § 1.

(a1) Except as provided in subsection (c) of this section, there shall be a time limit of 90 days for review of the applications, beginning on the day established by rule as the day on which applications for the particular service in the service area shall begin review.

(1) Any person may file written comments and exhibits concerning a proposal under review with the Department, not later than 30 days after the date on which the application begins review. These written comments may include:

a. Facts relating to the service area proposed in the application;

b. Facts relating to the representations made by the applicant in its application, and its ability to perform or fulfill the representations made;

c. Discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with relevant review criteria, plans, and standards.

(2) No more than 20 days from the conclusion of the written comment period, the Department shall ensure that a public hearing is conducted at a place within the appropriate service area if one or more of the following circumstances apply; the review to be conducted is competitive; the proponent proposes to spend five million dollars ($5,000,000) or more; a written request for a public hearing is received before the end of the written comment period from an affected party as defined in G.S. 131E-188(c); or the agency determines that a hearing is in the public interest. At such public hearing oral arguments may be made regarding the application or applications under review; and this public hearing shall include the following:

a. An opportunity for the proponent of each application under review to respond to the written comments submitted to the Department about its application;

b. An opportunity for any person, except one of the proponents, to comment on the applications under review;

c. An opportunity for a representative of the Department, or such other person or persons who are designated by the Department to conduct the hearing, to question each proponent of applications under review with regard to the contents of the application;

The Department shall maintain a recording of any required public hearing on an application until such time as the Department's final decision is issued, or until a final agency decision is issued pursuant to a contested case hearing, whichever is later; and any person may submit a written synopsis or verbatim statement that contains the oral presentation made at the hearing.

(3) The Department may contract or make arrangements with a person or persons located within each service area for the conduct of such public hearings as may be necessary. The Department shall publish, in each service area, notice of the contracts that it executes for the conduct of those hearings.

(4) Within 15 days from the beginning of the review of an application or applications proposing the same service within the same service area, the Department shall publish notice of the deadline for receipt of written comments, of the time and place scheduled for the public hearing regarding the application or applications under review, and of the name and address of the person or agency that will preside.

(5) The Department shall maintain all written comments submitted to it during the written comment stage and any written submissions received at the public hearing as part of the Department's file respecting each application or group of applications under review by it. The application, written comments, and public hearing comments, together with all documents that the Department used in arriving at its decision, from whatever source, and any documents that reflect or set out the Department's final analysis of the application or applications under review, shall constitute the Department's record for the application or applications under review.

(a2) When an expedited review has been approved by the Department, no public hearing shall be held. The Department may contact the applicant and request additional or clarifying information, amendments to, or substitutions for portions of the application. The Department may negotiate conditions to be imposed on the certificate of need with the applicant.

(b) Repealed by Laws 1991 (Reg. Sess., 1992), c. 900, § 137(a), eff. July 8, 1992.

(c) The Department may extend the review period for a period not to exceed 60 days and provide notice of such extension to all applicants. For expedited reviews, the Department may extend the review period only if it has requested additional substantive information from the applicant.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 7; Laws 1991 (Reg. Sess., 1992), c. 900, § 137(a), (b); Laws 1993, c. 7, § 8, eff. March 18, 1993; S.L. 2005-325, § 4, eff. Aug. 26, 2005.

Notes of Decisions (9)

N.C.G.S.A. § 131E-185, NC ST § 131E-185

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N.C.G.S.A. § 131E-186

§ 131E-186. Decision

Effective: October 1, 2019
Currentness

(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. Approvals involving new or expanded bed capacity for nursing care or intermediate care for individuals with intellectual disabilities shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected.

(b) Within five business days after it makes a decision on an application, the Department shall provide written notice of all the findings and conclusions upon which it based its decision, including the criteria used by the Department in making its decision, to the applicant.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; Laws 1991 (Reg. Sess., 1992), c. 900, § 137(c); S.L. 2019-76, § 21, eff. Oct. 1, 2019.

Notes of Decisions (15)

N.C.G.S.A. § 131E-186, NC ST § 131E-186
The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-187

§ 131E-187. Issuance of a certificate of need

Effective: July 31, 2009
Currentness

(a), (b) Repealed by S.L. 2009-373, § 1, eff. July 31, 2009.

(c) The Department shall issue a certificate of need in accordance with the time line requirements of this section but only after all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met. The Department shall issue a certificate of need within:

(1) Thirty-five days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188.

(2) Five business days after it receives a file-stamped copy of the notice of voluntary dismissal, unless the voluntary dismissal is a stipulation of dismissal without prejudice.

(3) Thirty-five days of the date of the written notice of the final agency decision affirming or approving the issuance, unless a notice of appeal to the North Carolina Court of Appeals is timely filed.

(4) Twenty days after a mandate is issued by the North Carolina Court of Appeals affirming the issuance of a certificate of need, unless a notice of appeal or petition for discretionary review to the North Carolina Supreme Court is timely filed.

(5) Five business days after the North Carolina Supreme Court issues a mandate affirming the issuance of a certificate of need or an order declining to certify the case for discretionary review if the order declining to certify the case disposes of the appeal in its entirety.

Credits
Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; S.L. 2009-373, § 1, eff. July 31, 2009.

Notes of Decisions (4)

N.C.G.S.A. § 131E-187, NC ST § 131E-187
The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-188

§ 131E-188. Administrative and judicial review

Effective: January 1, 2012
Currentness

(a) After a decision of the Department to issue, deny or withdraw a certificate of need or exemption or to issue a certificate of need pursuant to a settlement agreement with an applicant to the extent permitted by law, any affected person, as defined in subsection (c) of this section, shall be entitled to a contested case hearing under Article 3 of Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department makes its decision. When a petition is filed, the Department shall send notification of the petition to the proponent of each application that was reviewed with the application for a certificate of need that is the subject of the petition. Any affected person shall be entitled to intervene in a contested case.

A contested case shall be conducted in accordance with the following timetable:

(1) An administrative law judge or a hearing officer, as appropriate, shall be assigned within 15 days after a petition is filed.

(2) The parties shall complete discovery within 90 days after the assignment of the administrative law judge or hearing officer.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.

(4) The administrative law judge or hearing officer shall make a final decision within 75 days after the hearing.

(5) Repealed by S.L. 2011-398, § 46, eff. Jan. 1, 2012.

The administrative law judge or hearing officer assigned to a case may extend the deadlines in subdivisions (2) through (4) so long as the administrative law judge or hearing officer makes a final decision in the case within 270 days after the petition is filed.

(a1) On or before the date of filing a petition for a contested case hearing on the approval of an applicant for a certificate of need, the petitioner shall deposit a bond with the clerk of superior court where the new institutional health service that is the subject of the petition is proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the petition, but may not be less than five thousand dollars ($5,000) and may not exceed fifty thousand dollars ($50,000). A petitioner who received approval for a certificate of need and is contesting only a condition in the certificate is not required to file a bond under this subsection.

The applicant who received approval for the new institutional health service that is the subject of the petition may bring an action against a bond filed under this subsection in the superior court of the county where the bond was filed. Upon finding that the petition for a contested case was frivolous or filed to delay the applicant, the court may award the applicant part or all of the bond filed under this subsection. At the conclusion of the contested case, if the court does not find that the petition for a contested case was frivolous or filed to delay the applicant, the petitioner shall be entitled to the return of the bond deposited with the superior court upon demonstrating to the clerk of superior court where the bond was filed that the contested case hearing is concluded.

(b) Any affected person who was a party in a contested case hearing shall be entitled to judicial review of all or any portion of any final decision in the following manner. The appeal shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal shall be as provided by the rules of appellate procedure. The appeal of the final decision shall be taken within 30 days of the receipt of the written notice of final decision, and notice of appeal shall be filed with the Office of Administrative Hearings and served on the Department and all other affected persons who were parties to the contested hearing.

(b1) Before filing an appeal of a final decision granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of this subsection shall not apply to any appeal filed by the Department.

(1) The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the appeal, but may not be less than five thousand dollars ($5,000) and may not exceed fifty thousand dollars ($50,000); provided that the applicant who received approval of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its discretion, not to exceed three hundred thousand dollars ($300,000). A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of Appeals. If the Court of Appeals does not find that the appeal was frivolous or filed to delay the applicant and does not remand the case to superior court for a possible award of all or part of the bond to the holder of the certificate of need, the person originally filing the bond shall be entitled to a return of the bond.

(c) The term “affected persons” includes: the applicant; any individual residing within the service area or the geographic area served or to be served by the applicant; any individual who regularly uses health service facilities within that geographic area or the service area; any person who provides services, similar to the services under review, to individuals residing within the service area or the geographic area proposed to be served by the applicant; any person who, prior to receipt by the agency of the proposal being reviewed, has provided written notice to the agency of an intention to provide similar services in the future to individuals residing within the service area or the geographic area to be served by the applicant; third party payers who reimburse health service facilities for services in the service area in which the project is proposed to be located; and any agency which establishes rates for health service facilities or HMOs located in the service area in which the project is proposed to be located.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1983 (Reg. Sess., 1984), c. 1000, § 1; Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 8; Laws 1991, c. 701, § 3; Laws 1993, c. 7, § 9, eff. March 18, 1993; S.L. 1997-443, § 11A.118(a), eff. July 1,

1997; S.L. 2005-325, § 5, eff. Aug. 26, 2005; S.L. 2007-182, § 1, eff. July 5, 2007; S.L. 2009-373, § 2, eff. July 31, 2009; S.L. 2011-326, § 23, eff. June 27, 2011; S.L. 2011-398, § 46, eff. Jan. 1, 2012.

Notes of Decisions (21)

N.C.G.S.A. § 131E-188, NC ST § 131E-188

The statutes and Constitution are current through S.L. 2023-125 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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West's North Carolina General Statutes Annotated
Chapter 131E. Health Care Facilities and Services (Refs & Annos)
Article 9. Certificate of Need

N.C.G.S.A. § 131E-189

§ 131E-189. Withdrawal of a certificate of need

Effective: October 1, 2021
Currentness

(a) The Department shall specify in each certificate of need the time the holder has to make the service or equipment available or to complete the project and the timetable to be followed. The timetable shall be the one proposed by the holder of the certificate of need unless the Department specifies a different timetable in its decision letter. The holder of the certificate shall submit such periodic reports on his progress in meeting the timetable as may be required by the Department. If no progress report is provided or, after reviewing the progress, the Department determines that the holder of the certificate is not meeting the timetable and the holder cannot demonstrate that it is making good faith efforts to meet the timetable, the Department may withdraw the certificate. If the Department determines that the holder of the certificate is making a good faith effort to meet the timetable, the Department may, at the request of the holder, extend the timetable for a specified period.

(b) The Department may withdraw any certificate of need, if the holder of the certificate fails to develop the service in a manner consistent with the representations made in the application or with any condition or conditions the Department placed on the certificate of need.

(c) The Department may immediately withdraw any certificate of need if the holder of the certificate, before completion of the project or operation of the facility, transfers ownership or control of the facility, the project, or the certificate of need. Any transfer after that time will be subject to the requirement that the service be provided consistent with the representations made in the application and any applicable conditions the Department placed on the certificate of need. Transfers resulting from death or personal illness or other good cause, as determined by the Department, shall not result in withdrawal if the Department receives prior written notice of the transfer and finds good cause. Transfers resulting from death shall not result in withdrawal.

(d) Notwithstanding subsections (a), (b), or (c) of this section, a certificate of need issued by the Department for the construction of a health service facility on or after October 1, 2021, expires if the holder of the certificate of need fails to execute or commit to a contract for design services for the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall execute or commit to a contract for design services for the project authorized by the certificate of need within four years after the date the Department's decision to approve the certificate of need for that project becomes final.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall execute or commit to a contract for design services for the project authorized by the certificate of need within two years after the date the Department's decision to approve the certificate of need for that project becomes final.

(e) Notwithstanding subsections (a), (b), or (c) of this section, a certificate of need issued by the Department for the construction of a health service facility prior to October 1, 2021, expires if the holder of the certificate of need fails to execute or commit to a contract for design services for the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall execute or commit to a contract for design services for the project authorized by the certificate of need by October 1, 2025.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall execute or commit to a contract for design services for the project authorized by the certificate of need by October 1, 2023.

(f) Notwithstanding subsections (d) and (e) of this section, certificates of need that (i) are issued for the construction of a health service facility prior to October 1, 2021, and (ii) have a specific deadline to execute or commit to a contract for design services for the project authorized by the certificate of need will not expire unless the holder fails to execute or commit to a contract for design services by the deadline specified in the certificate of need.

(g) In the event the holder of a certificate of need is unable to execute or commit to a contract for design services for the project due to developments beyond the control of the holder of the certificate of need or for other good cause, the time for performance shall be extended by a period equal to the period during which performance of the obligation has been delayed or failed to be performed.

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1987, c. 511, § 1; Laws 1993, c. 7, § 10, eff. March 18, 1993; S.L. 2021-129, § 2, eff. Oct. 1, 2021.

Notes of Decisions (1)

N.C.G.S.A. § 131E-189, NC ST § 131E-189

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N.C.G.S.A. § 131E-190

§ 131E-190. Enforcement and sanctions

Currentness

(a) Only those new institutional health services which are found by the Department to be needed as provided in this Article and granted certificates of need shall be offered or developed within the State.

(b) No formal commitments made for financing, construction, or acquisition regarding the offering or development of a new institutional health service shall be made by any person unless a certificate of need for such service or activities has been granted.

(c) Repealed by Laws 1993, c. 7, § 11, eff. March 18, 1993.

(d) If any person proceeds to offer or develop a new institutional health service without having first obtained a certificate of need for such services, the penalty for such violation of this Article and rules hereunder may include the withholding of federal and State funds under Titles V, XVIII, and XIX of the Social Security Act for reimbursement of capital and operating expenses related to the provision of the new institutional health service.

(e) The Department may revoke or suspend the license of any person who proceeds to offer or develop a new institutional health service without having first obtained a certificate of need for such services.

(f) The Department may assess a civil penalty of not more than twenty thousand dollars ($20,000) against any person who knowingly offers or develops any new institutional health service within the meaning of this Article without a certificate of need issued under this Article and the rules pertaining thereto, or in violation of the terms or conditions of such a certificate, whenever it determines a violation has occurred and each time the service is provided in violation of this provision. In determining the amount of the penalty the Department shall consider the degree and extent of harm caused by the violation and the cost of rectifying the damage. A person who is assessed a penalty shall be notified of the penalty by registered or certified mail. The notice shall state the reasons for the penalty. If a person fails to pay a penalty, the Department shall refer the matter to the Attorney General for collection. For the purpose of this subsection, the word “person” shall not include an individual in his capacity as an officer, director, or employee of a person as otherwise defined in this Article.

The clear proceeds of penalties provided for in this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2.

(g) No agency of the State or any of its political subdivisions may appropriate or grant funds or financially assist in any way a person, applicant, or facility which is or whose project is in violation of this Article.

(h) If any person proceeds to offer or develop a new institutional health service without having first obtained a certificate of need for such services, the Secretary of Health and Human Services or any person aggrieved, as defined by G.S. 150B-2(6), may bring a civil action for injunctive relief, temporary or permanent, against the person offering, developing or operating any new institutional health service. The action may be brought in the superior court of any county in which the health service facility is located or in the superior court of Wake County.

(i) If the Department determines that the recipient of a certificate of need, or its successor, is operating a service which materially differs from the representations made in its application for that certificate of need, the Department may bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b).

Credits

Added by Laws 1983, c. 775, § 1. Amended by Laws 1985 (Reg. Sess., 1986), c. 968, § 2; Laws 1987, c. 511, § 1; Laws 1991, c. 692, § 9; Laws 1993, c. 7, § 11, eff. March 18, 1993; S.L. 1997-443, § 11A.118(a), eff. July 1, 1997; S.L. 1998-215, § 80, eff. Oct. 31, 1998.

Notes of Decisions (1)

N.C.G.S.A. § 131E-190, NC ST § 131E-190

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N.C.G.S.A. § 131E-191.1

§ 131E-191.1. Lobbyists prohibited from serving on the North Carolina State Health Coordinating Council

Effective: August 26, 2009
Currentness

No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the North Carolina State Health Coordinating Council. No person previously registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the North Carolina State Health Coordinating Council within 120 days after the expiration of the lobbyist's registration.

Credits
Added by S.L. 2009-477, § 2, eff. Aug. 26, 2009.

N.C.G.S.A. § 131E-191.1, NC ST § 131E-191.1
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