No. 260PA22 TENTH JUDICIAL 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

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NEW BRIEF FOR DEFENDANTS-APPELLEES

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NEW BRIEF FOR DEFENDANTS-APPELLEES

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ISSUES PRESENTED

1. Did the trial court lack jurisdiction because plaintiffs failed to exhaust their administrative remedies?

2. Did plaintiffs fail to state a claim that the CON law, as applied, violates the law-of-the-land clause, N.C. Const. art. I, § 19?

3. Did plaintiffs fail to state a claim that the CON law, as applied, violates the exclusive-emoluments and anti-monopoly clauses, N.C. Const. art. I, §§ 32, 34?

INTRODUCTION

Healthcare is one of the most complex, heavily regulated, and politically contested markets in the economy. Whether the healthcare system appropriately balances costs, quality, and access—among many other factors—is a notoriously challenging and critically important policy debate. The legal question here, however, is not whether the State's certificate-of-need law is the best healthcare policy. The question is whether the law passes the deferential review that this Court applies to economic laws. It does.

North Carolinians have debated the CON law for decades. First passed in 1978, the CON law was the product of extensive legislative deliberation over how to stop spiraling healthcare costs and how to improve access to healthcare services. Now as then, these concerns remain particularly acute

for individuals living in the State's rural communities. The General Assembly has since repeatedly amended the CON law in light of ongoing study and analysis. Just last year, for example, the General Assembly made extensive changes to the law, loosening many of its restrictions and exempting certain activities from CON review.

As with all policy debates, some would go further, arguing that the CON law should be repealed in its entirety. They contend that by requiring providers to get state approval before offering certain new health services, CON laws impose unnecessary barriers to entry, limit consumer choice, raise costs, and harm competition. In keeping with these objections, legislation that would repeal the CON law has been introduced in the General Assembly at least six times in the last six years. To date, however, this repeal legislation has not garnered enough support to pass. Plaintiffs here ask the Court to stop this democratic debate about a disputed matter of economics and declare them the winners. But this Court's precedents on judicial review of economic regulations provide the Court with a far more modest role: to determine whether the CON law is reasonable. As shown by the General Assembly's findings in the text of the CON law itself, the CON law easily passes this deferential review.

In addition, plaintiffs ask this Court to weigh in on their constitutional challenges even though they did not first exhaust their administrative remedies. Plaintiffs sidestepped an entire administrative process that could provide them with the relief they seek. That plaintiffs did not exhaust administrative remedies before filing suit in superior court is another independent reason that their claims here fail.

Defendants respectfully request that this Court affirm the judgment of the Court of Appeals.

STATEMENT OF THE CASE

In April 2020, Dr. Jay Singleton and his eye clinic, Singleton Vision Center, filed this lawsuit. (R pp 4-35) Plaintiffs alleged that the CON law, as applied to them, violates three provisions of the state constitution: the law-of-the-land clause, N.C. Const. art. I, § 19; the exclusive-emoluments clause, *id.* art. I, § 32; and the anti-monopoly clause, *id.* art. I, § 34. (R pp 31-34) They sought an injunction preventing defendants from enforcing the CON law against them; a declaration that the CON law is unconstitutional, as applied; and nominal damages. (R p 34)

Defendants moved to dismiss under Rule 12(b)(1) for lack of subject-matter jurisdiction and under Rule 12(b)(6) for failure to state a claim. (R pp

51-56) The trial court denied defendants' motion under Rule 12(b)(1) but granted the motion under Rule 12(b)(6). (R pp 58-59)

Plaintiffs appealed. (R pp 60-62) The Court of Appeals unanimously affirmed the dismissal of the complaint. *Singleton v. N.C. Dep't of Health & Hum. Servs.*, 284 N.C. App. 104, 874 S.E.2d 669 (2022). Plaintiffs then petitioned for discretionary review, which this Court allowed.

STATEMENT OF THE FACTS

A. The General Assembly passes the CON law to protect public health.

For decades, our State's CON law has regulated the cost, quality, and distribution of healthcare services in North Carolina.

By the mid-1960s, healthcare costs were increasing rapidly, straining government budgets. Kenneth R. Wing & Burton Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C. L. Rev. 1165, 1165-66 nn.4-5, 1175-76 (1979). And healthcare services were unevenly distributed, with some areas oversupplied and others facing shortages. James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 Ind. L. Rev. 1025, 1028, 1030-31 & n.25 (1986).

To address these and other problems, state legislatures across the country passed CON laws. Although these laws varied by state, they shared a key feature. The laws required providers to obtain a "certificate of need" from the state before they could offer certain types of new health services. *Id.* at 1028-29. Under these laws, a certificate of need would issue only when the public had an actual need for the proposed service. *Id.* By regulating entry into certain healthcare markets, CON laws sought to control costs, increase quality, and ensure a fair and equitable distribution of health services. *Id.* at 1028-32.

In 1971, our State's General Assembly passed a CON law. *See* Act of July 21, 1971, ch. 1164, § 1, 1971 N.C. Sess. Laws 1715, 1715-17. The law spanned all of three pages. Its stated aim was to encourage the "orderly development" and to avoid the "unnecessary duplication" of medical facilities. *Id.* at 1715. The law sought to achieve this goal by requiring a CON before certain medical facilities were built or expanded. *Id.*

Two years later, this Court struck down the law under our state constitution. *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973). In *Aston Park*, an Asheville hospital was denied a CON to replace its existing 50-bed facility with a new 200-bed facility. *Id.* at

542-43, 193 S.E.2d at 730. The agency that administered the CON program denied the CON on the ground that the additional hospital beds "would be an unnecessary and weakening duplication of services." *Id.* at 543, 193 S.E.2d at 730. "[T]he additional bed capacity to be provided by Aston Park's proposed construction," the agency explained, "would result in the city's having a hospital bed capacity in excess of that which the [agency] concluded is needed." *Id.* at 543, 193 S.E.2d at 731.

The hospital challenged the CON law under various provisions of our state constitution. This Court first held that the law violated the law-of-the-land clause. *Id.* at 551, 193 S.E.2d at 735. The Court asked whether the law had a "reasonable relation" to "the promotion of the public health." *Id.* The Court held that it did not. Specifically, the Court found it "a matter of common knowledge that in many communities hospital costs have spiralled [sic] upward in recent years while patients desiring hospitalization have been unable to find promptly a vacant hospital room." *Id.* at 549, 193 S.E.2d at 734. Although the Court acknowledged that "in many respects a hospital is not comparable to an ordinary business establishment," the Court knew "of no reason to doubt [a hospital's] similarity thereto in its response to the spur of competition." *Id.* The Court stated that healthcare providers, like other

"ordinary businesses," would have an "incentive to lower prices, better service, and more efficient management" in the face of competition—and the record showed "no reason to suppose" otherwise. *Id.* Thus, the Court held that it was unreasonable to deny a hospital the right to expand its services "merely because [doing so would] endanger[ ] the ability of other, established hospitals to keep all their beds occupied." *Id.*

The Court then addressed the hospital's claims under the exclusive-emoluments and anti-monopoly clauses. The Court's analysis of these two claims was one sentence: The "requirement [of the CON law] establishes a monopoly in the existing hospitals contrary to the provisions of article I, section 34 of the Constitution of North Carolina and is a grant to them of exclusive privileges forbidden by article I, section 32." *Id.* at 551, 193 S.E.2d at 736.

Less than a decade after *Aston Park*, the General Assembly passed a new CON law. The General Assembly enacted this new legislation after extensive study and deliberation. In 1977, the General Assembly established the Legislative Commission on Medical Cost Containment. Act of July 1, 1977, ch. 968, §§ 1-7, 1977 N.C. Sess. Laws. 1291-93. The legislature charged the Commission with studying "the present health care system in North

Carolina and the cost trends associated with that system." *Id.* at 1292. The legislature instructed the Commission to hold hearings and make recommendations on how to contain medical costs. *Id.*

The Commission carried out the General Assembly's charge, releasing a report with various policy recommendations. Legislative Comm'n on Med. Cost Containment, *Interim Report to the 1977 General Assembly of North Carolina, Second Session 1978* (1978), https://bit.ly/3FQsgzG. The Commission based its findings and recommendations on evidence and testimony from 65 witnesses. *Id.* at 2.

One of the Commission's central findings was that—contrary to this Court's assumption in *Aston Park*—healthcare markets do not operate under conditions of perfect competition. Unlike "ordinary businesses," the Commission stressed, "the economic structure of the health care industry . . . significantly alters the 'normal' relationship between supply and demand such that competitive forces do not appear." *Id.* at 44.

The Commission's report explained these unusual features of healthcare markets in detail. On the demand side of the market, the Commission found that consumers generally lack necessary information to compare different medical services and providers. *Id.* at 48. Because

"medical knowledge is so complex," consumers generally defer to physician recommendations and have less incentive to "question or seek alternatives" for healthcare than they do for other services. *Id.* at 48-49. In addition, third-party insurers—rather than consumers themselves—typically pay directly for medical care. *Id.* at 48-50. Consumers are less price-sensitive as a result. *Id.* at 50-52. Consumers also make decisions about healthcare services under "the inherent uncertainty of illness or accident." *Id.* at 49. This uncertainty can make consumers less responsive to prices as well. *Id.* at 50-52.

On the supply side of the market, the Commission found that healthcare services were unevenly distributed across the State. The Commission found that third-party payment for most healthcare services "biases health care delivery toward more expensive settings where coverage is more complete." *Id.* at 51. For example, the Commission found that the State as a whole had "an overall excess bed capacity" for hospital services but that most hospitals were located "in urban settings, leaving rural settings underserved." *Id.* at 10. Excess bed capacity in urban areas, by contrast, "led to under-utilization of facilities in those areas." *Id.* at 11. That under-utilization, in turn, raised quality concerns, because "[h]ospital staffs must

perform some procedures fairly often in order to maintain high standards of care." *Id.* The Commission also found that many rural counties had physician shortages as well. *Id.* at 21.

The Commission accompanied these findings with various policy proposals. In the Commission's view, "one of the most important recommendations" that it made was for the General Assembly to pass a CON law. *Id.* at xvi. The Commission believed that a CON law would "both encourage health planning and reduce the number of duplicated services." *Id.* at xv. The Commission estimated that without a CON law, "the citizens of North Carolina could spend between $68 and $84 million each year to maintain empty beds." *Id.*

The General Assembly followed the Commission's recommendation and passed a new CON law. *See* Act of June 16, 1978, ch. 1182, § 2, 1977 N.C. Sess. Laws 71, 71-85. The new law bore little resemblance to the 1971 law that this Court struck down in *Aston Park*. For example, the General Assembly codified findings of fact into the law's text explaining why the CON law would protect public health. Reflecting the Commission's study, the General Assembly specifically found that "forces of free market competition are largely absent" from healthcare services and that a CON law was therefore

"necessary to control the cost, utilization, and distribution of health services." *Id.* at 71. Unlike the old law, the new law also set out detailed criteria for the types of services covered by the CON requirement and the process for obtaining a CON. *Id.* at 79-80, 82-84.

When the General Assembly passed this new law, thirty-seven other states had CON legislation in effect. *See* Wing & Craige, 57 N.C. L. Rev. at 1189.

B. The General Assembly routinely amends the CON law.

Over the ensuing forty-five years, the CON law has formed an integral part of healthcare regulation in our State. *See* N.C. Gen. Stat. § 131E-175 et seq. The law begins by setting out findings of fact that explain why a CON process remains necessary to protect public health. Those findings include:

- That the law is "necessary to control costs, utilization, and distribution of new health service facilities," because "the effect of free market competition" in healthcare markets is "limit[ed]," *id.* § 131E-175(1);

- That the "increasing cost" of healthcare "threatens the health and welfare" of North Carolinians, who "need assurance of economical and readily available health care," *id.* § 131E-175(2);

- That, if left to the free market, the provision of healthcare would suffer from "geographical maldistribution" and that those who "have traditionally been medically underserved" would be "especially" harmed, *id.* § 131E-175(3);

- That access to healthcare is "critical to the welfare of rural North Carolinians," who should be specifically "considered in the certificate of need review process," *id.* § 131E-175(3a);

- That without regulation, "unnecessary health service facilities" would "proliferat[e]," increasing costs, *id.* § 131E-175(4);

- That oversupply of healthcare "places an enormous economic burden on the public," *id.* § 131E-175(6); and

- That "the general welfare and protection of lives, health, and property" requires a CON law to assess the "need, cost of service, accessibility to services, quality of care, feasibility, and other criteria" for proposed health services, *id.* § 131E-175(7).

Over the course of several decades, the General Assembly has routinely changed and updated these findings of fact to explain why the law continues to protect public health.[1]

The General Assembly has carefully studied whether the law continues to protect public health in other ways as well. For example, in 2011, then-

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[1] *See, e.g.*, Act of June 30, 1987, ch. 511, § 1, 1987 N.C. Sess. Laws 795, 795-97 (amending various findings, including that healthcare services would be unevenly distributed "if left to the market place"); Act of Mar. 18, 1993, ch. 7, § 1, 1993 N.C. Sess. Laws 5, 5-6 (additional finding explaining why the CON law is needed to ensure rural access to health services); Act of June 21, 2001, ch. 234, § 1, 2001 N.C. Sess. Laws 607, 607 (additional findings explaining how the CON law helps regulate the development of adult care homes); Act of Aug. 29, 2005, ch. 346, § 5, 2005 N.C. Sess. Laws 1245, 1246 (additional findings about changes to the CON law regarding gastrointestinal endoscopy services).

Speaker Thom Tillis appointed a House Select Committee to evaluate the CON law. Speaker Thom Tillis, *House Select Committee on the Certificate of Need Process and Related Hospital Issues* (Aug. 24, 2011), https://bit.ly/473Eoch. The Select Committee issued a final report with findings and recommendations on ways to reform the CON law. House Select Committee on the Certificate of Need Process and Related Hospital Issues, *Final Report to the 2013 House of Representatives* 11-15 (Dec. 2012), https://bit.ly/3FQy4Jp. The Select Committee did not recommend the law's repeal, but did recommend numerous changes to it. *Id.*

Consistent with this recommendation, the General Assembly has opted to amend various aspects of the CON law instead of repealing the law altogether. In fact, the General Assembly made significant changes to the law as recently as 2023, loosening many of its restrictions and exempting certain activities from CON review. *See* An Act To Provide North Carolina Citizens With Greater Access To Healthcare Options, S.L. 2023-7, Part III, https://bit.ly/3MDXcqy. For example, ambulatory surgical centers in counties with a population greater than 125,000 will no longer be subject to the CON law. *Id.* § 3.2(a). Other changes include removing the CON requirement for MRI scanners in counties with a population greater than

125,000 and increasing the cost thresholds that trigger a CON requirement for replacement equipment and diagnostic centers. *Id.* §§ 3.1(a), 3.3(a).

Over the last six years, at least six bills have been introduced in the General Assembly seeking to repeal the CON law, but none has garnered enough support to pass both chambers.[2] Despite legal challenges like this one, moreover, thirty-four states, including North Carolina, continue to have a CON law of some kind.[3]

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[2] *See* House Bill 640 (2017), bit.ly/41uGGiX; Senate Bill 324 (2017), bit.ly/3RvNGqW; House Bill 410 (2021), bit.ly/3RrNCsu; Senate Bill 309 (2021), bit.ly/47505rP; House Bill 107 (2023), bit.ly/3TreP13; Senate Bill 48 (2023), bit.ly/4aC6QEy.

[3] Ala. Code § 22-21-260 et seq.; Alaska Stat. Ann. § 18.07.031 et seq.; Ark. Code Ann. § 20-8-101 et seq.; Conn. Gen. Stat. Ann. § 19a-630 et seq.; Del. Code Ann. tit. 16, § 9301 et seq.; Fla. Stat. Ann. § 408.031 et seq.; Ga. Code Ann. § 31-6-40 et seq.; Haw. Rev. Stat. Ann. § 323D-42 et seq.; 20 Ill. Comp. Stat. Ann. 3960/1 et seq.; Ind. Code Ann. § 16-29-7-1 et seq.; Iowa Code Ann. § 135.61 et seq.; Ky. Rev. Stat. Ann. § 216B.010 et seq.; La. Stat. Ann. § 40:2116; Me. Rev. Stat. Ann. tit. 22, § 326 et seq.; Md. Code Ann., Health-Gen. § 19-120 et seq.; Mass. Gen. Laws Ann. ch. 111, § 25C et seq.; Mich. Comp. Laws Ann. § 333.22201 et seq.; Miss. Code Ann. § 41-7-171 et seq.; Mo. Ann. Stat. § 197.300 et seq.; Mont. Code Ann. § 50-5-301 et seq.; Neb. Rev. Stat. Ann. § 71-5801 et seq.; Nev. Rev. Stat. Ann. § 439A.100; N.J. Stat. Ann. § 26:2H-5.8; N.Y. Pub. Health Law § 2802; Ohio Rev. Code Ann. § 3702.51 et seq.; Okla. Stat. Ann. tit. 63, § 1-850 et seq.; Or. Rev. Stat. Ann. § 442.310 et seq.; 23 R.I. Gen. Laws Ann. § 23-15-1 et seq.; Tenn. Code Ann. § 68-11-1601 et seq.; Vt. Stat. Ann. tit. 18, § 9431 et seq.; Va. Code Ann. § 32.1-102.1 et seq.; Wash. Rev. Code Ann. § 70.38.015 et seq.; W. Va. Code Ann. § 16-2D-1 et seq.

C. The CON law establishes a process for offering certain new health services.

The CON law provides that no person "shall offer or develop a new institutional health service without first obtaining a certificate of need" from the Department of Health and Human Services. N.C. Gen. Stat. § 131E-178(a). The statute defines the term "new institutional health service" to include specific types of health facilities or services, like building a new hospital or expanding an existing facility. *Id.* § 131E-176(16).

The CON law establishes a process for those seeking to offer new health services. In the first part of the process, health experts project whether a need exists for a new service. In the second part of the process, the Department of Health and Human Services evaluates applications to fulfill any projected need.

1. The Department and the State Health Coordinating Council prepare a plan projecting need for health services.

The CON process begins with health experts who use data on the supply and demand of certain health services to project whether a need exists for those services in a relevant geographic market.

These need determinations are made on an annual basis and set out in a document called the State Medical Facilities Plan. *See, e.g.*, N.C. Dep't of Health & Human Servs., *2023 State Medical Facilities Plan*, https://bit.ly/46lT99l; *accord* R pp 21-22, ¶¶ 66-67 (incorporating the 2020 Plan by reference in the complaint). To receive a CON, an applicant's proposed project must be "consistent with applicable policies and need determinations" in this Plan. N.C. Gen. Stat. § 131E-183(a)(1). The Department of Health and Human Services prepares the Plan together with the State Health Coordinating Council. *Id.* § 131E-176(17), (25). The Council is "an advisory body created by executive order." *Frye Reg'l Med. Ctr., Inc. v. Hunt*, 350 N.C. 39, 44, 510 S.E.2d 159, 163 (1999).

At the start of each year, the Department and the Council begin work on a Plan for the next calendar year that projects the public's need for certain health services in different geographic areas across the State. To make these projections—so-called "need determinations"—the Department and the Council compile data on the supply and demand for various medical facilities, services, and equipment. *2023 Plan* at 7. The Department and the Council then apply mathematical formulas, or "need determination methodologies," to estimate future levels of need. *Id.*

Throughout the year, the public has multiple opportunities to review and comment on the Plan before it becomes final. N.C. Gen. Stat. § 131E-176(25). By the Department's and the Council's first public meeting each March, any person may submit a written petition requesting additions, deletions, or amendments to the Plan's need methodologies or the policies that govern how those methodologies are applied. *2023 Plan* at 7. Each petition is posted online and followed by a two-week public comment period. *Id.* The Plan includes detailed instructions on how to submit a petition of this kind. *Id.* at 10.

The Department and the Council consider these petitions in preparing a proposed Plan for public release by early July. *Id.* at 8. They then hold six public meetings in July following the proposed Plan's release, where they accept oral and written comments. *Id.*; N.C. Gen. Stat. § 131E-176(25). By the final public meeting in July, any person may submit a written petition "requesting an adjustment to the need determination" in the proposed Plan. *2023 Plan* at 8. The individual must show that "special attributes" of a geographic area or healthcare facility "give rise to" a need determination that is different from the need determination estimated in the proposed Plan. *Id.* Each petition is posted online and followed by a two-week public comment

period. *Id.* The Plan includes detailed instructions on how to submit a petition of this kind. *Id.* at 10.

The Department and the Council consider these petitions and prepare a final Plan for submission to the Governor by the end of October. *Id.* at 9. The Governor must approve the final Plan. N.C. Gen. Stat. § 131E-176(25). He may approve the Plan "as submitted," or he may "make any adjustments or amendments deemed appropriate." *2023 Plan* at 9; *see Frye*, 350 N.C. at 44, 510 S.E.2d at 162-63.

With the Governor's approval, the Plan "becomes the official document for health facility and health service planning in North Carolina for the specified calendar year." *2023 Plan* at 7. For example, although work on the 2023 Plan began in January 2022, the Plan included need determinations that providers could apply for during calendar year 2023. *Id.*

This need-determination process is therefore "continuous," because the Plan reopens every year to changes and revisions in light of public comments, along with the Department's, the Council's, and the Governor's review. *Id.* In recent years, moreover, regular changes have been made to

the Plan's methodologies, policies, and need determinations in light of public input through the petition process.[4]

2. The Department evaluates applications to meet projected need.

The CON process then charges the Department with evaluating applications for CONs to meet the Plan's projected healthcare needs.

When a need determination exists, providers may apply for a CON by submitting an application to the Department. N.C. Gen. Stat. § 131E-182; *see id.* § 131E-183(a)(1) (a need determination, where applicable, is "a determinative limitation on the provision of any [CON-regulated service or facility] that may be approved" by the Department). Guided by a list of specific statutory criteria—known as the "review criteria"—the Department evaluates these applications and decides who receives a CON. *Id.* § 131E-

[4] *See, e.g.*, *2023 Plan* at 31 (describing changes to methodology "in response to a petition"); *id.* at 44 (describing an adjusted need determination "in response to a petition"); *id.* at 48 (describing the creation of a multicounty service area "in response to a petition"); *id.* at 79 (describing an adjusted need determination "in response to a petition"); *id.* at 135 (same); *id.* at 309 (same); *id.* at 323 (same); *id.* at 358 (same); *id.* at 359 (same). For other examples, see N.C. Dep't of Health & Human Servs., *2022 State Medical Facilities Plan* at 83, 175, 319, 333, 363, https://bit.ly/3uqnDK3; N.C. Dep't of Health & Human Servs., *2021 State Medical Facilities Plan* at 282, 364, 372, https://bit.ly/3R4eZK7.

177(6) (giving the Department authority to "grant, deny, or withdraw a certificate of need"); *id.* § 131E-183 (review criteria); *id.* § 131E-185 (review process); *id.* § 131E-186 (decision).

The review criteria direct the Department to evaluate CON applications in a way that is consistent with the findings of fact that the General Assembly made when it first enacted the law and that the General Assembly has since amended. *See supra* pp 12-13 & n.1. For example:

- The General Assembly found that "the effect of free market competition" in healthcare markets is "limit[ed]." *Id.* § 131E-175(1). The review criteria therefore require applicants to show "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." *Id.* § 131E-183(18a).

- The General Assembly found that, without a CON law, healthcare services would suffer from "geographical maldistribution" that would harm those who "have traditionally been medically underserved," including North Carolinians who live in rural areas. *Id.* § 131E-175(3), (3a). The review criteria therefore require applicants to show how their proposed project would serve the needs of "low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups." *Id.* § 131E-183(3), (3a), (13).

- The General Assembly found that, without a CON law, the supply of healthcare services could "proliferat[e]," increasing costs for patients and the public at large. *Id.* § 131E-175(4), (6). The review criteria therefore require applicants to show how their proposed

project would avoid the "unnecessary duplication" of existing services. *Id.* § 131E-183(6).

- The General Assembly found that, without a CON law, the "quality of care" could suffer. *Id.* § 131E-175(7). The review criteria therefore require applicants "already involved in the provision of health services" to show "evidence that quality care has been provided in the past" before expanding their offerings. *Id.* § 131E-183(20).

After the Department makes its decision, any "affected person" may petition for a contested case hearing before the Office of Administrative Hearings. *Id.* § 131E-188(a), (c); *accord id.* §§ 150B-22 to -37. An affected person may seek judicial review in the Court of Appeals of an administrative law judge's final decision. *Id.* § 131E-188(b), (c); *id.* §§ 150B-34(a), -51(b); *accord id.* § 7A-29(a).

At each step of this process, the General Assembly has imposed statutory deadlines for the agency and the Office of Administrative Hearings to complete their review. *See, e.g.*, *id.* § 131E-185(a1), (c) (giving the Department 90 days to review applications, which may be extended for a period "not to exceed 60 days"); *id.* § 131E-188(a) (setting out the timeline for a contested case hearing before OAH that requires "a final decision in the case within 270 days after the petition is filed").

D. Instead of following the procedures in the CON law, plaintiffs sue.

Plaintiffs here did not follow any of the well-established procedures in the CON law. Instead, they filed this lawsuit.

Dr. Jay Singleton owns an eye clinic, Singleton Vision Center, in New Bern. (R pp 11-12, ¶¶ 9-10) He wants to offer outpatient eye surgeries—like cataract or glaucoma surgeries—to all of his patients at the Center. (R p 12, ¶ 11; R p 14, ¶ 21) He must receive a CON for an operating room in which to do so. R p 26, ¶ 98; N.C. Gen. Stat. § 131E-176(16)(a), (u). An operating room is "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." N.C. Gen. Stat. § 131E-176(18c).

Dr. Singleton alleges that the Center meets all of the required safety standards for performing outpatient eye surgeries. (R pp 14-15, ¶¶ 24-30) However, when Dr. Singleton filed this lawsuit, the Plan projected no need for an additional operating room in the Craven, Jones, and Pamlico service area, where the Center is located. R p 27, ¶¶ 99-100; *2020 State Medical Facilities Plan* at 72, http://bit.ly/41Idy7P. Dr. Singleton therefore could not apply for a CON. N.C. Gen. Stat. § 131E-183(a)(1) (the Plan's need

determination "constitutes a determinative limitation on the provision of any . . . operating rooms . . . that may be approved").

Dr. Singleton disagrees with the Plan's need determination. He alleges that, despite "consistent population and economic growth" in the New Bern area, only one provider, CarolinaEast, has a CON authorizing it to offer outpatient eye surgeries. (R p 27, ¶¶ 101-03) As a result, Dr. Singleton alleges that he must perform eye surgery services at CarolinaEast, where he maintains surgical privileges. (R p 14, ¶ 20) He alleges that if he could provide these services at the Center instead, he would offer high-quality services at a competitive price to a wide range of patients. (R p 28, ¶ 107)

Yet Dr. Singleton did not allege that he petitioned for an adjustment of the Plan's need determination or its methodology—and indeed, he did not. Dr. Singleton appears to acknowledge, however, that filing a petition could have resulted in a need determination, allowing him to apply for a CON—which, if granted, would have authorized him to provide outpatient surgery services to all of his patients at the Center. (*See* R pp 29-30, ¶¶ 116-20)

Dr. Singleton admits that he chose not to follow this process. He claims that he did not petition to adjust the Plan's methodology or need determinations because the Plan has not projected a need for an additional

operating room in his geographic area "for at least a decade." (R p 27, ¶ 100) And even if Dr. Singleton could apply for a CON, he alleges that it would be "enormously expensive" to do so and may take "several years to resolve." (R p 30, ¶¶ 117-18; *see also* R pp 22-24, ¶¶ 70-87) Dr. Singleton further alleges that CarolinaEast would oppose any CON application that he might file and that he therefore has "virtually no hope" of receiving a CON. (R p 30, ¶¶ 118-19) Filing a lawsuit challenging the CON law's constitutionality, Dr. Singleton claims, is his "only realistic option." (R p 30, ¶ 120)

On this basis, Dr. Singleton and the Center sued. Their complaint alleged that the CON law is unconstitutional, as applied to them, under the law-of-the-land, exclusive-emoluments, and anti-monopoly clauses of our state constitution. (R pp 31-34) The complaint sought declaratory and injunctive relief, as well as nominal damages. (R p 34)

In the trial court, defendants moved to dismiss the complaint for lack of subject-matter jurisdiction under Rule 12(b)(1) and for failure to state a claim under Rule 12(b)(6). (R pp 51-56) The court held a hearing on the motion. (T pp 1-72) The court denied the motion under Rule 12(b)(1) but granted the motion under Rule 12(b)(6). (R pp 58-59) Plaintiffs appealed. (R pp 60-62)

E. The Court of Appeals affirms the trial court's dismissal of plaintiffs' complaint.

The Court of Appeals unanimously affirmed the trial court's dismissal of the complaint.

The Court first held that plaintiffs failed to exhaust their administrative remedies. Specifically, the Court held that when the General Assembly provides an "effective administrative remedy," the remedy "is exclusive and its relief must be exhausted before recourse may be had to the courts." *Singleton*, 284 N.C. App. at 109, 874 S.E.2d at 673 (quoting *Presnell v. Pell*, 298 N.C. 715, 721, 260 S.E.2d 611, 615 (1979)). Applying that rule, the Court concluded that plaintiffs did not exhaust administrative remedies, because they "failed to file an application for a CON or to seek or exhaust any administrative remedy from DHHS prior to filing the action at bar." *Id.* at 109, 874 S.E.2d at 674. Thus, the Court held that it lacked jurisdiction over plaintiffs' exclusive-emoluments and anti-monopoly clause claims. *Id.* at 111, 874 S.E.2d at 675. The Court did not reach the merits of those claims as a result. *Id.*

As for plaintiffs' law-of-the-land claim, the Court reached the merits and affirmed the trial court's dismissal. The Court held that the CON law is

economic legislation that must have a "reasonable" relationship to a "legitimate government purpose." *Id.* at 113, 874 S.E.2d at 676. The Court acknowledged the policy arguments that many advance against CON laws. *See id.* at 115, 874 S.E.2d at 677 (noting that CON laws can be "restrictive, anti-competitive, and create monopolistic policies and powers to the holder"). But the Court addressed the only legal issue relevant here: whether the CON law has a reasonable relationship to the legitimate government interest in protecting public health. *Id.* The Court held that the CON law passed this test. *Id.* The Court stressed that plaintiffs remain free to make their policy arguments about the wisdom of the CON law to the political branches. *Id.* at 115-16, 874 S.E.2d at 677-78.

This appeal followed.

SUMMARY OF THE ARGUMENT

For three reasons, this Court should affirm the judgment below.

First, plaintiffs failed to exhaust administrative remedies before seeking judicial review. The General Assembly has established a comprehensive administrative process for resolving CON-related disputes. Plaintiffs failed to follow that process here. Had they done so, administrative review could have provided plaintiffs with the substantive relief that they

seek—the right to develop a licensed operating room at the Center in which to offer outpatient eye surgeries to all of their patients—thus mooting their as-applied constitutional claims. Under these circumstances, exhaustion was required before plaintiffs sued. To be sure, courts recognize an exception to the exhaustion requirement when administrative remedies are ineffective. But plaintiffs failed to carry their burden to show that they qualify for an exception here.

Second, plaintiffs failed to state a claim under the law-of-the-land clause. Courts review economic legislation deferentially. Under any formulation of this deferential review, the CON law is constitutional. It was a reasonable policy choice for the General Assembly to conclude that a CON law could improve healthcare costs, access, and quality by ensuring that existing providers maintain a sufficient number of patients. The General Assembly supported this reasonable policy choice by codifying detailed findings of fact into the text of the CON law and by implementing those findings through the CON law's review criteria.

Plaintiffs' allegation that the CON law's findings of fact are "false" is beside the point. The legal question here is whether the CON law is debatable—not whether its empirical foundations are true. Plaintiffs also

claim that applying the CON law to their unique circumstances would be irrational. But this Court has long held that when a plaintiff challenges a generally applicable statute on matters of economic policy, it is not enough for the plaintiff to allege that the law might be over- or under-inclusive on a particular set of facts. In addition, neither this Court's decision in *Aston Park* nor its occupational-licensing cases cast doubt on the conclusion that the CON law passes constitutional review under the law-of-the-land clause.

Third, plaintiffs failed to state a claim under the exclusive-emoluments and anti-monopoly clauses. Both clauses require a state-granted "exclusive" privilege. But the CON law regulates entry into certain healthcare markets—it does not create an exclusive privilege by foreclosing all future competition. And because the CON law reasonably promotes the general welfare, it is constitutional under this Court's well-established precedents in any event.

This Court should affirm the judgment of the Court of Appeals.

ARGUMENT

Standard of Review

Whether a plaintiff exhausted administrative remedies is a jurisdictional question that this Court reviews de novo. *Intersal, Inc. v. Hamilton*, 373 N.C. 89, 98, 102, 834 S.E.2d 404, 411, 414 (2019).

This Court also reviews de novo a trial court's dismissal for failure to state a claim. *Id.* at 97, 834 S.E.2d at 411.

Discussion of Law

I. The Trial Court Lacked Jurisdiction Because Plaintiffs Failed To Exhaust Administrative Remedies.

Plaintiffs' claims fail at the threshold because plaintiffs did not exhaust their administrative remedies before they filed this lawsuit. The trial court therefore lacked subject-matter jurisdiction, and plaintiffs' claims should be dismissed.

A. A plaintiff must first exhaust effective administrative remedies before seeking judicial review.

Administrative exhaustion is a well-established jurisdictional requirement. This exhaustion rule "serves the twin purposes of protecting administrative agency authority and promoting judicial efficiency." *State ex rel. Utils. Comm'n v. Carolina Water Serv., Inc.*, 335 N.C. 493, 499, 439 S.E.2d

127, 130 (1994) (quoting *McCarthy v. Madigan*, 503 U.S. 140, 145 (1992)). Administrative review ensures that "the administrative entity most concerned with a particular matter" has "the first chance to discover and rectify" the error that the plaintiff alleges. *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615. It also prevents courts from "untimely and premature intervention" in the administrative process. *Elmore v. Lanier*, 270 N.C. 674, 678, 155 S.E.2d 114, 116 (1967).

When the General Assembly provides an "effective administrative remedy" in a statute, the remedy "is exclusive and its relief must be exhausted before recourse may be had to the courts." *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615. A plaintiff's failure to exhaust administrative remedies thus deprives the trial court of subject-matter jurisdiction. *Abrons Fam. Practice & Urgent Care, P.A. v. N.C. Dep't of Health & Hum. Servs.*, 370 N.C. 443, 447, 810 S.E.2d 224, 228 (2018).

To decide whether parties must first channel their claims through an administrative process before seeking judicial review, courts ask two questions. First, courts ask whether the text and structure of a statute show that the legislature intended to require exhaustion. *See Intersal*, 373 N.C. at 103-04, 834 S.E.2d at 415; *Abrons*, 370 N.C. at 446-47, 810 S.E.2d at 227-28.

The legislature "has expressed an intention" of this kind when a statute establishes "a procedure whereby matters of regulation and control are first addressed by commissions or agencies particularly qualified for [that] purpose." *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615.

Second, courts ask whether this administrative remedy would be "effective." *Id.* at 721-22, 260 S.E.2d at 615. A remedy is effective when the administrative process "is calculated to give relief more or less commensurate" with the substantive relief that the plaintiff seeks. *Jackson ex rel. Jackson v. N.C. Dep't of Hum. Res.*, 131 N.C. App. 179, 186, 505 S.E.2d 899, 904 (1998); *accord Abrons*, 370 N.C. at 452, 810 S.E.2d at 231 (citing favorably to the decision of the Court of Appeals in *Jackson* and finding its reasoning "persuasive").

To be effective, the administrative process need not provide *every* remedy that a plaintiff seeks in her complaint. *Jackson*, 131 N.C. App. at 188-89, 505 S.E.2d at 905. Courts instead focus on the plaintiff's substantive allegations, "notwithstanding" the complaint's prayer for relief. *Id.* at 188, 505 S.E.2d at 905. When the substance of the plaintiff's claim is of the type that "should properly be determined in the first instance by the agencies statutorily charged with administering" a given regulatory scheme, a plaintiff

must first pursue the available administrative remedy. *Id.* at 188-89, 505 S.E.2d at 905. By contrast, a plaintiff need not exhaust administrative remedies that would be "inadequate" or "futile"—in other words, remedies that would be "useless" as a "legal or practical matter." *Abrons*, 370 N.C. at 451-53, 810 S.E.2d at 231.

B. Plaintiffs here failed to exhaust administrative remedies in the CON law.

The rule that a plaintiff must first exhaust administrative remedies before seeking judicial review applies in the CON context and bars plaintiffs' claims here.

The General Assembly has established a comprehensive administrative process in the CON law. As discussed above, in the first part of the process, health experts project whether a need exists for a new health service. *See supra* pp 16-20. In the second part of the process, the Department evaluates applications to fulfill any projected need. *See supra* pp 20-22.

The administrative exhaustion issue here focuses on the first part of this process. It is undisputed that when plaintiffs filed this lawsuit, the State Medical Facilities Plan projected no need for new operating rooms in the geographic area where plaintiffs seek to provide health services. (R p 27,

¶ 99) Plaintiffs disagreed with that no-need finding. The question is whether plaintiffs were first required to raise their disagreement with the Department and the Council—the health experts who administer the Plan—or whether, in the absence of any need determination, plaintiffs could immediately sue in superior court.

The text and structure of the CON law show that plaintiffs here were required to first raise their disagreement with the Plan's no-need finding through the administrative process. The General Assembly has established a framework for resolving disputes about the need determinations in the Plan. Specifically, the CON law provides a mechanism for individuals to seek changes to the Plan before it becomes final.

These procedures are found in section 131E-176(25). Under this provision, the Department and the Council must "accept oral and written comments from the public concerning the Plan." N.C. Gen. Stat. § 131E-176(25). The Department and the Council must also hold at least seven public meetings about the Plan, including at least one meeting before a draft Plan is released and at least six meetings before the Plan becomes final. *Id.*

The Plan itself further implements these statutory requirements. For example, the Plan specifies how individuals may petition the Department

and the Council each spring and summer to change the Plan's need methodologies, policies, or need determinations. *See supra* pp 18-19. The Plan also details the process that the Department and the Council use to rule on these petitions in preparing the final Plan each year. *See supra* pp 18-19. By first channeling disputes about the Plan to the Department and the Council, section 131E-176(25) sets out "a procedure whereby matters of regulation and control are first addressed by commissions or agencies particularly qualified for [that] purpose." *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615. Exhaustion of this administrative process is therefore required before seeking judicial review. *See id.*

Two related statutory provisions reinforce this conclusion. First, the General Assembly has exempted the Plan from the Administrative Procedure Act's rulemaking requirements, but only if the Department follows the procedures in section 131E-176(25). N.C. Gen. Stat. § 150B-2(8a)(k). Second, the General Assembly has provided that, once the procedures in section 131E-176(25) are followed, the Plan's need findings are "a determinative limitation" on many health services that the Department may approve—including on an operating room, the facility that plaintiffs seek to offer here. *Id.* § 131E-183(a)(1). These provisions thus demonstrate that the General Assembly

intended the procedures in section 131E-176(25) to provide the exclusive mechanism for resolving disputes about the Plan through an initial review by health experts.

The way that the agency and regulated parties have understood the CON law provides further support for requiring exhaustion here. For example, parties routinely petition the Department and the Council to change the Plan, and the Plan is amended in light of these petitions. *See supra* p 20 n.4. Given this common practice, the last time regulated parties sought to challenge the constitutionality of the CON law, they expressly alleged in their complaint that they had exhausted their administrative remedies by first petitioning the Department and the Council to adjust the Plan's need determinations. Record on Appeal, *Hope—A Women's Cancer Ctr., P.A. v. State*, 203 N.C. App. 593, 693 S.E.2d 673 (2010), No. COA09-844, at 19-21, ¶¶ 42-46, https://bit.ly/3GyIYUx. The Court of Appeals highlighted these allegations in its opinion in that case. *Hope*, 203 N.C. App. at 595, 693 S.E.2d at 675-76.

By contrast, plaintiffs here concede that they made no effort to exhaust their administrative remedies before seeking judicial review. Instead, plaintiffs ask for an exemption from the exhaustion requirement because,

they claim, the administrative remedies in the CON law are not "effective." (*See, e.g.*, R pp 29-30, ¶¶ 116-20) A plaintiff has the burden to allege that an administrative process is ineffective. *Abrons*, 370 N.C. at 451, 810 S.E.2d at 231. As discussed below, however, plaintiffs have not carried that burden.

C. The administrative remedies in the CON law are effective.

Plaintiffs cannot show that the administrative remedies in the CON law are ineffective. They therefore cannot claim an exemption from the ordinary requirements of administrative exhaustion.

1. The administrative process could provide plaintiffs with the substantive relief that they seek.

The Court of Appeals correctly held that the administrative process could provide plaintiffs in this case with the substantive relief that they seek. *Singleton*, 284 N.C. App. at 109, 874 S.E.2d at 674. Plaintiffs allege that they seek the right to provide "outpatient eye surgeries, full time, to all of [the] patients at the Center." (R p 14, ¶ 21) The administrative process can adequately provide plaintiffs relief "more or less commensurate" with that claim. *See Jackson*, 131 N.C. App. at 189, 505 S.E.2d at 905. Although the Plan does not currently project a need for plaintiffs' proposed services (R p 27,

¶ 99), plaintiffs can petition the Department and the Council to change that decision or the methodology used to reach it. *See supra* pp 18-19.

Plaintiffs themselves have alleged many different reasons why the Department and the Council might adjust the current need determination. For example, plaintiffs allege that the Center will offer "more affordable outpatient eye surgeries than those offered by established providers"; increase healthcare access to the "broader public," including underserved populations; and "promote increased competition." (R p 28, ¶ 107) Plaintiffs could provide information of this kind to the Department and the Council in a petition requesting an adjustment to the need determination. *See 2023 Plan* at 8. In fact, as shown above, the Department and the Council regularly adjust need determinations based on petitions. *See supra* p 20 n.4. And if plaintiffs' petition were successful, they could then apply for a CON. Here, too, plaintiffs have alleged many different reasons why the Department might approve their CON application. (R p 28, ¶ 107)

Thus, the administrative process could allow plaintiffs to receive a CON that would authorize them to perform outpatient eye surgeries for all patients at the Center. By filing this lawsuit instead, however, plaintiffs are short-circuiting the administrative process. This failure to exhaust deprives

the Department and the Council—which have extensive expertise in this complex area—of an opportunity to consider and remedy the harm that plaintiffs allege. *See Presnell*, 298 N.C. at 721, 260 S.E.2d at 615. And, of course, if the Department were to ultimately grant plaintiffs a CON, the constitutional claims that plaintiffs raise here would be moot. Thus, plaintiffs' failure to exhaust also injects our courts into an as-applied constitutional dispute that the administrative decision-making process could avoid. *See id.* at 721-22, 260 S.E.2d at 615. Under these circumstances, requiring exhaustion ensures that the courts do not reach constitutional questions unnecessarily. *Id.* at 722, 260 S.E.2d at 615 (exhaustion is a "policy of judicial restraint").

Moreover, requiring plaintiffs to exhaust administrative remedies would not preclude eventual judicial review. For example, plaintiffs could, like the plaintiffs in *Hope*, raise their constitutional claims in superior court if the Department and the Council were to deny their petition. *See* 203 N.C. App. at 595-96, 693 S.E.2d at 676. And if the petition were granted but plaintiffs were ultimately unsuccessful in applying for a CON, plaintiffs could raise their constitutional claims to the Court of Appeals after going through the administrative process. N.C. Gen. Stat. §§ 7A-29(a), 131E-188(b), 150B-

51(b); *In re Redmond*, 369 N.C. 490, 497, 797 S.E.2d 275, 280 (2017) ("When an appeal lies directly to the Appellate Division from an administrative tribunal, . . . a constitutional challenge may be raised for the first time in the Appellate Division as it is the first destination for the dispute in the General Court of Justice.").

To be sure, plaintiffs are correct that an administrative agency generally does not have the power to declare a law inconsistent with the state constitution. Br. 42; *see Meads v. N.C. Dep't of Agric.*, 349 N.C. 656, 670, 509 S.E.2d 165, 174 (1998). But whether an administrative remedy is adequate turns on the substance of plaintiffs' allegations, "notwithstanding" the prayer for relief. *Jackson*, 131 N.C. App. at 188, 505 S.E.2d at 905.

Here, plaintiffs bring as-applied challenges to the CON law so that they can perform eye surgeries for all patients at the Center. (R pp 31-34) Their claims are therefore based on how the CON law is applied to their specific circumstances, not on the constitutionality of the CON law across the board. *E.g.*, *Cmty. Success Initiative v. Moore*, 384 N.C. 194, 213, 886 S.E.2d 16, 32 (2023) (distinguishing facial from as-applied challenges). Because these fact-specific claims turn on the way the Department and the Council carry out their statutory authority, going through the administrative

process could remedy the alleged constitutional problem—plaintiffs' inability to obtain a CON. And "exhaustion is particularly appropriate when the administrative remedy may eliminate the necessity of deciding constitutional questions." *Thetford Props. IV Ltd. P'ship v. U.S. Dep't of Hous. & Urban Dev.*, 907 F.2d 445, 448 (4th Cir. 1990).

The as-applied nature of plaintiffs' claims here distinguishes this case from others in which this Court has held that plaintiffs did not have to exhaust administrative remedies before asserting constitutional challenges in court. For example, in *Meads*, the plaintiff sought to challenge the facial constitutionality of buffer-zone regulations for aerial pesticides. 349 N.C. at 669-76, 509 S.E.2d at 174-78. This Court held that the plaintiff was not required, before filing suit in superior court, to ask the agency charged with administering the regulations to repeal them or conclude that they were unconstitutional. *Id.* at 669, 509 S.E.2d at 174. Because only the judiciary could decide whether the regulations were constitutional, this Court reasoned, "any effort made by [the plaintiff] to have the constitutionality of the buffer-zone regulations determined by the [agency] would have been in vain." *Id.* at 670, 509 S.E.2d at 174.

Here, by contrast, plaintiffs bring as-applied, rather than facial, constitutional challenges. The administrative process could therefore provide plaintiffs with the substantive relief that they seek while mooting their constitutional claims. By giving the health experts at the Department and the Council the first opportunity to "discover and rectify" the fact-specific error that plaintiffs allege, the CON law establishes an effective administrative remedy that plaintiffs were required to exhaust before seeking judicial review. *Presnell*, 298 N.C. at 721, 260 S.E.2d at 615.

2. The administrative process is not otherwise inadequate or futile.

Plaintiffs' remaining allegations about alleged deficiencies in the CON process fall far short of carrying their burden to show that the administrative remedies here are otherwise inadequate or futile.

First, plaintiffs allege that administrative remedies are inadequate because plaintiffs are "categorically banned" from applying for a CON. Plaintiffs reason that they face this categorical bar because the Plan currently finds no need for new operating rooms in the New Bern area. (R p 27, ¶ 99) But as discussed above, both the CON law itself and the Plan's regulations implementing that law set out a process that allows plaintiffs to petition the

Department and the Council for changes to the need determinations multiple times each year. Nothing about that process imposes a "categorical" bar. To the contrary, the need-determination process is "efficient and effective." *Hope*, 203 N.C. App. at 606, 693 S.E.2d at 682.

Second, plaintiffs allege that administrative remedies are inadequate because plaintiffs want to offer outpatient eye surgeries as soon as possible, and the administrative process takes time. (R pp 29-30, ¶¶ 116-17) But if that were enough to relieve a party from the exhaustion requirement, the exception would swallow the rule: administrative review always takes time.

Plaintiffs' arguments in this respect also misunderstand the administrative process itself. Plaintiffs specifically contend that if the Plan finds no need for a particular health service, a CON will be unavailable "for at least two years." Br. 8. But that is simply incorrect. The Plan *calculates* need determinations by estimating need two years into the future. *E.g.*, *2023 Plan* at 68 (making 2023 need determinations by projecting need in 2025). Once the Plan makes a need determination, however, providers may apply for a CON in that same calendar year. If there is a need determination in the 2023 Plan, for example, providers may apply in 2023 for a CON to fill that need. *E.g.*, *id.* at 79 (2023 timeline in 2023 Plan to apply for CONs in light of

various need determinations). By contrast, if the Plan makes no need determination in a given year, the process merely restarts the next year. Thus, contrary to plaintiffs' claim, nothing in the Plan "sets 'need' two years in advance." Br. 7. For example, if plaintiffs had petitioned the Department and the Council to adjust the need determination in 2020, the year they filed this lawsuit, any need would have been reflected in the 2021 Plan, allowing plaintiffs to apply for a CON in 2021. *See 2021 Plan* at 81.

The statutory deadlines in the CON law further undermine plaintiffs' claim that the administrative process here causes unnecessary delay. The General Assembly has provided a specific timeframe for the agency to review and rule on CON applications. *See supra* p 23. This Court has explained that these deadlines ensure that healthcare markets are "regulated" rather than "encumbered with unnecessary bureaucratic delay." *HCA Crossroads Residential Ctrs., Inc. v. N.C. Dep't of Hum. Res.*, 327 N.C. 573, 579, 398 S.E.2d 466, 470 (1990). As a result, plaintiffs cannot show that the agency process is so lengthy as to render it ineffective.

Third, plaintiffs allege that administrative review is inadequate because it is expensive. (R p 30, ¶ 118) But again, if that were enough to qualify for an exception, then exhaustion would almost never be required,

especially in complex cases. In keeping with this logic, courts have rejected costs associated with the administrative process as a basis for inadequacy. *See, e.g.*, *Volvo GM Heavy Truck Corp. v. U.S. Dep't of Labor*, 118 F.3d 205, 212 n.9, 213 (4th Cir. 1997) (an alleged "lengthy and costly" administrative process did not obviate an exhaustion requirement, and a party's "burden of defending itself in an administrative proceeding" is "wholly insufficient" to excuse exhaustion).

Fourth, plaintiffs claim that it would be pointless to petition the Department and the Council to make adjustments to the Plan because the Plan has not projected a need for an additional operating room in the relevant geographic area "for at least a decade." (R p 27, ¶ 100) Plaintiffs also contend that any CON application that they might submit would be "doomed" because CarolinaEast would oppose it. (R p 30, ¶¶ 118-19) But plaintiffs' arguments again prove too much: if parties could get an exemption from exhaustion requirements merely by alleging that they are unlikely to succeed in the agency process based on past agency decisions, exhaustion would never be required. As the Court of Appeals has rightly held, "futility cannot be established by [a plaintiff's] prediction or anticipation that the [agency] would . . . rule adversely to [its] interests."

Affordable Care, Inc. v. N.C. State Bd. of Dental Exam'rs, 153 N.C. App. 527, 534, 571 S.E.2d 52, 58 (2002). That is the case here as well.

* * *

In sum, plaintiffs had to exhaust their administrative remedies before seeking judicial review. Because they failed to do so, the trial court lacked jurisdiction, and plaintiffs' claims should be dismissed.[5]

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[5] As discussed above, the Court of Appeals below held that plaintiffs failed to exhaust administrative remedies as to their exclusive-emoluments and anti-monopoly claims but not as to their law-of-the-land claim. *Singleton*, 284 N.C. App. at 111, 874 S.E.2d at 675. The Court was right that plaintiffs failed to exhaust administrative remedies. *Id.* But that conclusion applies to *all* of plaintiffs' claims here. In holding that plaintiffs could bring their law-of-the-land claim in superior court without first exhausting administrative remedies, the Court of Appeals cited cases on administrative exhaustion in the context of federal constitutional claims under 42 U.S.C. § 1983. *Id.* at 110, 874 S.E.2d at 674 (citing *Edward Valves, Inc. v. Wake Cnty.*, 343 N.C. 426, 434, 471 S.E.2d 342, 347 (1996)). The "settled rule" under section 1983, however, "is that exhaustion of state remedies is *not* a prerequisite" to bringing a claim. *Knick v. Twp. of Scott*, 139 S. Ct. 2162, 2167 (2019) (emphasis in original) (quoting *Heck v. Humphrey*, 512 U.S. 477, 480 (1994)). Contrary to the Court of Appeals decision below, this Court has never relied on section 1983 case law to decide whether a plaintiff must first exhaust administrative remedies before bringing state constitutional claims of the kind at issue here.

II. Plaintiffs Failed To State A Claim Under The Law-Of-The-Land Clause.

Even if plaintiffs were not required to first exhaust administrative remedies before bringing this lawsuit in superior court, they nonetheless failed to state a law-of-the-land claim. Courts review economic legislation deferentially. Under any formulation of this deferential review, the CON law is constitutional. Plaintiffs' contrary allegations are legally irrelevant. And the cases on which plaintiffs rely support, rather than undermine, the CON law's constitutionality.

A. Courts review economic legislation deferentially.

This Court's deferential review of economic legislation reflects the separation of powers, which prevents one branch from encroaching on the power of another, and which in turn safeguards individual liberty. *Bacon v. Lee*, 353 N.C. 696, 715, 549 S.E.2d 840, 853 (2001). Under our system of separated powers, "whether an act is good or bad law, wise or unwise, is a question for the Legislature and not for the courts." *State v. Warren*, 252 N.C. 690, 696, 114 S.E.2d 660, 666 (1960). "The legislative department is the judge, within reasonable limits, of what the public welfare requires, and the wisdom of its enactments is not the concern of the courts." *Id.* After all,

"unlike the judiciary, the General Assembly is well equipped to weigh all the factors surrounding a particular problem, balance competing interests, provide an appropriate forum for a full and open debate, and address all of the issues at one time." *Rhyne v. K-Mart Corp.*, 358 N.C. 160, 170, 594 S.E.2d 1, 8-9 (2004) (internal citations, quotation marks, and alterations omitted).

Plaintiffs acknowledge that the CON law is economic legislation. *See* Br. 20. When courts review laws of this kind, they apply the rational-basis test. This Court has "consistently interpreted" the law-of-the-land clause "to permit the state, through the exercise of its police power, to regulate economic enterprises provided the regulation is rationally related to a proper governmental purpose." *Poor Richard's, Inc. v. Stone*, 322 N.C. 61, 64, 366 S.E.2d 697, 699 (1988). Under this test, courts ask two questions. First, "is there a proper governmental purpose for the statute?" *Id.* And second, "are the means chosen to effect that purpose reasonable?" *Id.* Legislation that is reasonably related to a proper purpose passes constitutional review. *See id.*

Despite this precedent, plaintiffs argue that the Court "has not always applied the same legal test to economic laws." Br. 20. Specifically, plaintiffs argue that this Court in other cases has applied a heightened "reasonably necessary" test. Br. 22. Under this test, plaintiffs argue that courts should

ask whether a law is "reasonably necessary to promote the public health, morals, order, safety, or general welfare." Br. 22 (quoting *Cheek v. City of Charlotte*, 273 N.C. 293, 296, 160 S.E.2d 18, 21 (1968)). Plaintiffs argue that this test is less deferential to the legislature on matters of economic policy than the rational-basis test and that this Court must therefore "choose" one test over the other. Br. 24.

This Court's precedents are more consistent than plaintiffs claim. Although the cases may use slightly different verbal formulations, they all ask the same substantive question: whether the challenged law is a "rational" or "reasonable" way of effecting a legitimate government purpose. For example, in *Poor Richard's*, this Court used the terms "rational" and "reasonable" interchangeably, as compared to the antonyms "irrational or arbitrary." 322 N.C. at 65-66, 366 S.E.2d at 699-700. Other cases have taken a similar approach. *E.g.*, *State v. Ballance*, 229 N.C. 764, 769-70, 51 S.E.2d 731, 735 (1949) (asking whether a law had "a rational, real, or substantial relation to the public health" or was "reasonably necessary to promote the accomplishment of a public good"); *see also Roller v. Allen*, 245 N.C. 516, 522, 96 S.E.2d 851, 856-57 (1957) (same).

All of the cases, moreover, reflect judicial deference to the political branches on disputed matters of economic policy. For example, even when the Court has held that a law fails the constitutional test for economic legislation, it has nonetheless cautioned that legislative acts are "entitled to great respect" and that the Court has a "duty to sustain an act of the Legislature where its constitutionality may be merely a matter of doubt." *State v. Harris*, 216 N.C. 746, 758, 764, 6 S.E.2d 854, 862, 866 (1940). For this reason, the Court has long recognized that under the deferential standard that applies to economic legislation, laws are valid so long as their wisdom is at least "fairly debatable." *A-S-P Assocs. v. City of Raleigh*, 298 N.C. 207, 214, 258 S.E.2d 444, 449 (1979) (quoting *In Re Appeal of Parker*, 214 N.C. 51, 55, 197 S.E. 706, 709 (1938)); *see Harris*, 216 N.C. at 764, 6 S.E.2d at 866 (striking down a law when upholding its rationality would "embarrass" the Court); *Ballance*, 229 N.C. at 772, 51 S.E.2d at 736 (striking down a law when its irrationality was "plain").

To be sure, this deferential review is not a blank check. It is therefore unsurprising that plaintiffs can cite cases where this Court has held that economic laws failed even this forgiving constitutional standard. Br. 20 n.5. But any difference that might theoretically exist between a rational-basis test

and a reasonably-necessary test is purely academic in the context of this case. As discussed below, under either standard, the CON law is constitutional.

B. The CON law passes any formulation of deferential review.

The CON law is a constitutional economic regulation under the law-of-the-land clause because it is reasonably related to the legitimate government interest in protecting public health.

To begin, the government has a legitimate interest in protecting public health. This Court's cases have confirmed that proposition for more than a century. *State v. Hay*, 126 N.C. 999, 1000, 35 S.E. 459, 460 (1900); *see also, e.g.*, *Meads*, 349 N.C. at 671-72, 509 S.E.2d at 175-76. Understandably then, plaintiffs do not dispute that protecting the public health is a legitimate interest.

The CON law is a reasonable way to achieve this interest. The General Assembly explained why the CON law benefits public health in the law's findings of fact. N.C. Gen. Stat. § 131E-175. Those findings, moreover, trace their roots to a legislative commission that the General Assembly formed to study and issue a report on improvements in our healthcare system. *See supra* pp 8-11. Taken together, the Commission's and the General Assembly's

analysis powerfully demonstrates why the CON law was a reasonable response to widespread concerns about healthcare costs and access—both in 1978, when the law was first passed, and today.

The starting point for the Commission's and the General Assembly's analysis was their finding that healthcare markets do not operate like markets for ordinary goods and services. Specifically, the General Assembly found that healthcare financing "limits the effect of free market competition." N.C. Gen. Stat. § 131E-175(1).

The Commission extensively detailed the reasons for this limited competition. It explained, for example, that most individuals do not pay for healthcare themselves but instead rely on third-party insurers. *See supra* pp 9-10. Because consumers do not directly pay the full cost of many healthcare services, they engage in less price shopping as a result. *See supra* pp 9-10. The Commission explained that consumers are less likely to compare the prices of different healthcare services for other reasons as well. Consumers often make healthcare decisions under conditions of physical or emotional distress, relying on the expertise of medical professionals, rather than their own independent judgment, in choosing which services to buy. *See supra* pp 9-10. The Commission also showed that third-party insurance creates

incentives for providers to concentrate in urban areas, where consumers are more likely to be insured and providers, in turn, are more likely to make a profit. *See supra* p 10.

For these and other reasons, it remains common knowledge today that the "ways of Adam Smith, for good or ill, do not describe the ways of the healthcare market in America." *Tiwari v. Friedlander*, 26 F.4th 355, 366 (6th Cir. 2022) (Sutton, C.J.) (upholding Kentucky's CON law against a rational-basis challenge), *cert. denied* 143 S. Ct. 444 (2022). "Many of the classic features of a free market are simply absent in the health care context." *Colon Health Ctrs. of Am., LLC v. Hazel*, 813 F.3d 145, 158 (4th Cir. 2016) (Wilkinson, J.) (upholding Virginia's CON law against a rational-basis challenge).

A reasonable response to these unique economic conditions is a law requiring an actual need for a new health service in a particular geographic area. Regulating entry into certain healthcare markets, the General Assembly could reasonably believe, would ensure that providers have a sufficient number of patients, thereby lowering costs, increasing quality, and improving access to healthcare services.

As for costs, it is reasonable to think that greater patient volumes would allow providers to spread their fixed costs across more patients,

reducing costs overall. *Tiwari*, 26 F.4th at 364; *Colon Health*, 813 F.3d at 157. Without a CON law, the General Assembly found that "unnecessary health services" could "proliferat[e]," resulting in "costly duplication and underuse of facilities" that could place "an enormous economic burden on the public" and that could otherwise impede public access to affordable care. N.C. Gen. Stat. § 131E-175(4), (6). Indeed, the Commission found that in the absence of regulation, healthcare costs were spiraling, and it estimated that North Carolinians could spend "between $68 and $84 million each year to maintain empty beds." *See supra* p 11. It was reasonable for the General Assembly to "credit its own prior experience with deregulation" in this way. *See Colon Health*, 813 F.3d at 157.

As for quality, it is reasonable to think that greater patient volumes would ensure that providers perform medical services frequently enough to maintain high standards of care. "In other words, practice makes perfect, or at least familiarity with sophisticated medical devices is to be preferred to only infrequent use of them." *Id.* at 156; *see Tiwari*, 26 F.4th at 364. A CON law could therefore reasonably "ensure that new entrants do not overly dilute the market and thereby prevent medical personnel from practicing and performing procedures on a regular basis." *Colon Health*, 813 F.3d at 156.

The Commission, moreover, specifically found that sufficient patient volumes were necessary for maintaining a high quality of care. *See supra* pp 10-11.

As for access, it is reasonable to think that greater patient volumes would ensure that providers in all areas of the State, including in historically underserved rural communities, can operate profitably. The General Assembly found that "if left to the market place," healthcare services could suffer from "geographical maldistribution" that would harm "the welfare of rural North Carolinians" in particular. N.C. Gen. Stat. § 131E-175(3), (3a). "For reasons not difficult to discern, medical services tend to gravitate toward more affluent communities." *Colon Health*, 813 F.3d at 157. CON legislation can "mitigate that trend by incentivizing healthcare providers willing to set up shop in underserved or disadvantaged areas." *Id.* By "reducing competition in highly profitable operations," the CON law "may provide existing hospitals with the revenue they need not only to provide indigents with care, but also to support money-losing but nonetheless important operations like trauma centers and neonatal intensive care units." *Id.*

The CON law implements these concerns about costs, quality, and access through the review criteria. To obtain a CON, a provider must show that its application "is either consistent with or not in conflict with" various statutory requirements. N.C. Gen. Stat. § 131E-183(a); *see Parkway Urology, P.A. v. N.C. Dep't of Health & Hum. Servs.,* 205 N.C. App. 529, 534, 696 S.E.2d 187, 192 (2010) (an application must conform with all statutory review criteria for the applicant to be awarded a CON). These criteria reflect the law's findings of fact by requiring providers seeking to offer new health services to show how they will address the concerns identified by the Commission and the General Assembly if granted a CON. The criteria require a provider to show, for example, how the new health service it proposes to offer will affect competition, provide underserved populations with access to health services, reduce costs, and provide quality care. N.C. Gen. Stat. § 131E-183(a)(3), (3a), (4), (6), (13), (18a), (20); *see supra* pp 21-22.

To be sure, all of these conclusions about the interests that the CON law advances are intensely debatable. As plaintiffs' own complaint recounts in detail, many claim that CON legislation makes for bad policy, arguing that CON laws do not improve—and in fact may harm—competition, costs, quality, and access in healthcare markets. (R pp 15-25, ¶¶ 32-92) The

General Assembly has frequently amended the CON law to account for these concerns, including as recently as last year. *See supra* pp 14-15. But although multiple efforts to repeal the CON law have been introduced in the General Assembly, none has garnered enough support to pass both chambers. *See supra* p 15 n.2. This ongoing conversation among policymakers about whether and to what extent the CON law is needed to maintain a fair and efficient healthcare system confirms that the wisdom of the CON law is at least debatable and therefore constitutional. *See City of Raleigh*, 298 N.C. at 214, 258 S.E.2d at 449.

This conversation is taking place in other states as well. Although some states have chosen to repeal their CON laws, thirty-four states continue to maintain CON legislation of some kind. *See supra* p 15 n.3. The existence of CON legislation in many other states is additional evidence that our State's CON law is a reasonable, if debatable, measure for protecting public health. *See Rhyne*, 358 N.C. at 184, 594 S.E.2d at 17.

C. Plaintiffs' allegations do not establish that the CON law violates the law-of-the-land clause.

Despite all of these realities, plaintiffs nonetheless argue that they have stated a claim under the law-of-the-land clause based on two allegations in

their complaint. First, plaintiffs allege that the CON law's findings of fact are "false." Second, plaintiffs allege that the CON law is irrational as applied to their circumstances. Neither allegation is legally relevant.

1. Plaintiffs' allegations about the CON law's "false" findings are legally irrelevant.

Plaintiffs first allege that the CON law's findings of fact "are false as a matter of fact today," "[w]hatever their truth in 1978" when the CON law was passed. (R p 18, ¶ 49) Plaintiffs argue that taking this allegation as true shows that they have stated a claim under the law-of-the-land clause. Br. 28-29.

Plaintiffs are incorrect that legislative findings must always be assumed "false" whenever a plaintiff makes that allegation at the motion-to-dismiss stage. *See* Br. 29. To be sure, legislative findings of fact are not immune from judicial scrutiny. *Hest Techs., Inc. v. State ex rel. Perdue*, 366 N.C. 289, 294, 749 S.E.2d 429, 433 (2012). But they are still "entitled to weight" when deciding whether a statute is constitutional. *Id.* (quoting *Redevelopment Comm'n of Greensboro v. Sec. Nat'l Bank of Greensboro*, 252 N.C. 595, 611, 114 S.E.2d 688, 700 (1960)). And when "presented with conflicting evidence supporting the legislature's public policy determinations, courts should defer

to the legislature's findings of fact, especially where, like here, that determination is corroborated." *State v. Hilton*, 378 N.C. 692, 703 n.4, 862 S.E.2d 806, 814 n.4 (2021) (Newby, C.J.).

This rule carries particular force in the context of this case. The General Assembly enacted legislative findings in the text of the CON law itself. N.C. Gen. Stat. § 131E-175. It has chosen to maintain those findings in the law's text for forty-five years. *See supra* pp 12-13. The findings set out the benefits of the CON law in great detail and are tied to the extensive study conducted by the General Assembly's Legislative Commission on Medical Cost Containment. *See supra* pp 8-13. The General Assembly has also amended those findings to ensure that they remain valid. *See supra* p 13 n.1. For example, a 1993 amendment specifically found that the CON law is needed to ensure rural access to health services. *See supra* p 13 n.1. And the findings involve a particularly complex, heavily regulated area of the economy. *See Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 196 (1997) (noting that legislative findings have "special significance" when they involve legislative "judgments concerning regulatory schemes of inherent complexity"). If ever a set of legislative findings were to merit deference, this is it.

The legislative findings here, moreover, stand in sharp contrast to the examples that plaintiffs cite, where this Court discounted findings that were threadbare or otherwise unsupported. Br. 29. The findings here do not, for example, purport to make a legal conclusion that the law serves a legitimate government interest. *Town of Atl. Beach v. Young*, 307 N.C. 422, 428, 298 S.E.2d 686, 691 (1983) (legal conclusion that an ordinance served the "public welfare" was not dispositive); *Foster v. N.C. Med. Care Comm'n*, 283 N.C. 110, 125, 195 S.E.2d 517, 527 (1973) (legal conclusion that a law served a "public purpose" was entitled to "great weight" but not dispositive); *Redevelopment Commission*, 252 N.C. at 604-05, 611, 114 S.E.2d at 695, 700 (similar). Instead, the findings provide detailed factual predicates for why the CON law is needed to protect public health—facts that are then implemented through the review criteria. N.C. Gen. Stat. §§ 131E-175, -183.

Nor are the findings here flatly inconsistent with "common knowledge or experience," or otherwise unsupported. *Harris*, 216 N.C. at 758, 6 S.E.2d at 862; *id.* at 752, 6 S.E.2d at 859 (assertion that licensing regime for dry cleaners was required to protect public health was so "meager in its expression of purpose" as to render statute unreasonable); *see also State v. Grady*, 372 N.C. 509, 544, 831 S.E.2d 542, 568 (2019) (State "concede[d] that it

did not present any evidence tending to show the [law's] efficacy in furthering the State's legitimate interests"). To the contrary, the findings in the CON law are amply supported, in the text of the law itself, in the findings of the Commission, and by common experience, as other courts have repeatedly confirmed. *E.g.*, *Tiwari*, 26 F.4th at 366; *Colon Health*, 813 F.3d at 158.

All that contradicts the findings here is plaintiffs' policy disagreement with how the General Assembly has chosen to regulate healthcare. But plaintiffs' allegations on this score—detailed though they may be, (*see* R pp 15-25, ¶¶ 32-92)—are irrelevant under the deferential standard of review that courts apply to economic legislation. Under that standard, the question is not whether the CON law's findings of fact are "true" or "false." Rather, the question is whether the findings are *debatable*. *City of Raleigh*, 298 N.C. at 214, 258 S.E.2d at 449. For all the reasons discussed above, they are. *See supra* Part II.B.

Indeed, if plaintiffs' view of the law were to prevail, parties could survive a motion to dismiss and seek discovery to challenge a state law based on nothing more than a claim that the General Assembly had erred as a matter of policy. A rule of that kind is "bereft of any limiting principle."

Colon Health, 813 F.3d at 159. "Most legislation, after all, relies on assumptions that can be empirically challenged." *Id.* The General Assembly is not required to "submit expert testimony or provide bullet-proof empirical backing for every legislative judgment." *Id.*

Plaintiffs' allegation that the CON law's findings of fact are "false" *today* fails for another reason as well. The question is whether the General Assembly could have been reasonably persuaded by those facts *when it passed* the CON law. *See, e.g.*, *Rhyne*, 358 N.C. at 184, 594 S.E.2d at 17 (asking whether "the perceived need for [the challenged legislation] was at least debatable when the General Assembly chose to enact" the law); *Powe v. Odell*, 312 N.C. 410, 414, 322 S.E.2d 762, 764 (1984) (asking whether there were "reasonable facts on which the legislature could have relied" when it passed the law at issue).

Plaintiffs effectively concede that the CON law was a reasonable regulation when the General Assembly first passed the law in 1978. *See* Br. 10-11. They contend that the CON law has since outlived its usefulness. Br. 10-11. But courts look at the facts known to the legislature at the time of a law's enactment to preserve the separation of powers. After all, updating a statute is a legislative, not a judicial, function. *See* Antonin Scalia & Bryan A.

Garner, *Reading Law: The Interpretation of Legal Texts* 82-83 (2012) ("[C]hanging written law, like adopting written law in the first place, is the function of . . . elected legislators and . . . elected executive officials and their delegates."); *cf. Wis. Cent. Ltd. v. United States*, 138 S. Ct. 2067, 2074 (2018) (only legislatures may "revise statutes in light of new social problems and preferences"). Thus, plaintiffs' allegation that the CON law's findings of fact are now "false" is irrelevant to the constitutional analysis. If conditions have changed since the law's passage that require its further amendment or repeal, as plaintiffs claim, that task is for the political branches. And as shown above, the political branches have taken up that task, regularly updating the law, including its findings of fact. *See supra* pp 13-15 & n.1.

2. Plaintiffs' allegations that the CON law is irrational as applied to them are legally irrelevant.

Plaintiffs also allege that applying the CON law to their particular circumstances would be irrational. Plaintiffs allege, for example, that but for the CON law, Dr. Singleton would offer high-quality and affordable eye surgeries to all patients at the Center. Br. 27; *see, e.g.*, R p 28, ¶ 107. Plaintiffs further allege that barring Dr. Singleton from receiving a CON has no real-world benefit for patient health or safety and instead only serves to

protect Dr. Singleton's potential competitor, CarolinaEast. Br. 27; *see, e.g.*, R pp 10-11, 28, ¶¶ 4, 106. Plaintiffs argue that taking these allegations as true shows that they have stated a claim under the law-of-the-land clause. Br. 27.

As discussed above, these allegations demonstrate that plaintiffs should first exhaust their administrative remedies before seeking judicial review, so that the expert agency charged with administering the CON law can first evaluate their fact-specific claims. *See supra* Part I. But other than by showing that judicial consideration of plaintiffs' claims would be premature, taking these allegations as true does not change the constitutional analysis.

When courts apply deferential review to generally applicable economic legislation, they allow legislatures to pass laws that may be under- or over-inclusive in some circumstances. An economic law is not unconstitutional merely because, as applied to a particular set of facts, the law "results in some inequality" or "is not made with mathematical nicety." *Powe*, 312 N.C. at 413, 322 S.E.2d at 764 (quoting *Dandridge v. Williams*, 397 U.S. 471, 485 (1970)). The General Assembly may pass economic legislation that draws lines, with the consequence that "[o]f necessity some individuals will fall just short of the line while others will just barely cross it." *Duggins v. N.C. State*

Bd. of Certified Pub. Acct. Exam'rs, 294 N.C. 120, 133, 240 S.E.2d 406, 415 (1978). But "incidental individual inequality" created by generally applicable economic laws does not give rise to a constitutional violation. *Id.*; *see also Town of Beech Mountain v. Cnty. of Watauga*, 324 N.C. 409, 414, 378 S.E.2d 780, 784 (1989) (generally applicable tax statute was rational in light of the facts that the General Assembly "could reasonably have determined" in passing the law, even if those facts did not hold as applied to an individual town's unique circumstances).

That approach is consistent with the deferential review that this Court applies to economic laws, and furthers the respect for the separation of powers that such an approach embodies. *See supra* Part. II.A. Thus, in the context of this particular case, plaintiffs' allegations about how the CON law applies to their circumstances do not bear on the constitutional analysis here.

D. The cases on which plaintiffs rely support the CON law's constitutionality.

Plaintiffs ask this Court to reach a contrary conclusion, citing two lines of precedent: this Court's decision in *Aston Park* and this Court's

occupational-licensing cases. But far from supporting plaintiffs' claims, these cases only confirm that the CON law is constitutional.

1. *Aston Park* does not control.

As discussed above, this Court in *Aston Park* struck down a 1971 CON law under the law-of-the-land clause. 282 N.C. at 551, 193 S.E.2d at 735; *see supra* pp 6-8. Plaintiffs contend that the General Assembly "defied" and "overrule[d]" this Court's decision in *Aston Park* by passing a new CON law in 1978. Br. 3. Plaintiffs' argument lacks merit.

Aston Park does not control here because that case concerns a law that no longer exists. The 1971 law that this Court struck down in *Aston Park* was all of three pages, and it did not even purport to show how a CON requirement would promote public health. *See supra* p 6. As a result, this Court saw "no reason to doubt" that healthcare services were "comparable" to any "ordinary business." *Aston Park*, 282 N.C. at 549, 193 S.E.2d at 734. The General Assembly responded to this decision by passing a new CON law. The new law codified findings of fact explaining why a CON requirement would protect public health—findings that the old law lacked. *See supra* pp 11-12. The new law also explained that healthcare markets do not operate under conditions of perfect competition—contrary to the Court's

assumption in *Aston Park*. *See supra* pp 11-12. Thus, as the Court of Appeals has repeatedly held over the course of three decades, these changes to the CON law mean that *Aston Park* does not render the current CON law unconstitutional. *See Hope*, 203 N.C. App. at 607, 693 S.E.2d at 682-83 (holding that "the deficiencies identified by the Court in *Aston Park* are no longer present in the current CON law," rendering *Aston Park* "moot"); *State ex rel. Utils. Comm'n v. Empire Power Co.*, 112 N.C. App. 265, 275, 435 S.E.2d 553, 558 (1993) (similar).

By seeking to tie the current CON law to the deficiencies that this Court earlier identified in the 1971 law, plaintiffs would effectively prevent the General Assembly from ever passing legislation that seeks to respond to court decisions. But this Court has made clear that the legislature has the power to make "statutory changes" that "follow or are reflective of . . . decisions from this Court." *Rosero v. Blake*, 357 N.C. 193, 203, 581 S.E.2d 41, 47 (2003). In exercising that power here, the General Assembly respected, rather than "defied," *Aston Park*.

2. The occupational-licensing cases do not control.

Plaintiffs' reliance on this Court's occupational-licensing cases fares no better. Plaintiffs emphasize a trio of cases that the Court decided in the

middle of the last century: *Roller v. Allen*, 245 N.C. 516, 96 S.E.2d 851 (1957); *State v. Ballance*, 229 N.C. 764, 51 S.E.2d 731 (1949); and *State v. Harris*, 216 N.C. 746, 6 S.E.2d 854 (1940). Br. 17, 22, 28. These cases held unlawful occupational-licensing schemes for tile installers (*Roller*), photographers (*Ballance*), and dry cleaners (*Harris*). But they do not apply in the context of this case, where plaintiffs challenge a law regulating their ability to provide eye surgeries.

To begin, the CON law is not an occupational-licensing regime in the first place. The occupational-licensing cases involve statutory regimes requiring a license as a prerequisite to practicing a given occupation. *Roller*, 245 N.C. at 518, 96 S.E.2d at 853; *Ballance*, 229 N.C. at 766, 51 S.E.2d at 732; *Harris*, 216 N.C. at 754, 6 S.E.2d at 860. Without a license, an individual was entirely excluded from a profession. *Id.* The CON law imposes no such exclusion. Instead, the CON law regulates entry into markets for particular types of new health services, like operating rooms. N.C. Gen. Stat. §§ 131E-176(16), -178(a). The expert agency charged with administering the law revisits those regulations on an annual basis, making adjustments in light of new healthcare data, public input, and written petitions. *See supra* pp 16-20. Most importantly, unlike an occupational-licensing regime, nothing in the

CON law prevents Dr. Singleton from practicing medicine, his chosen occupation. The law merely finds no current need for the new operating room that Dr. Singleton proposes to offer, a determination that may be changed any year. *See supra* pp 16-20. The law regulates *where* the profession may be practiced, not *whether* an individual may practice it.

But even if the CON law resembles an occupational-licensing regime in some respects, the law still has little in common with the laws that this Court has found unconstitutional. The cases require the General Assembly to identify a "distinguishing feature" of the business or occupation that justifies imposing a licensing regime to protect the public welfare. *Harris*, 216 N.C. at 758, 6 S.E.2d at 863. In the trio of cases that plaintiffs emphasize, the Court found it obvious, based on "common knowledge," that licensing requirements for taking photographs, dry cleaning clothes, or installing tile served no possible public-health purpose. *Id.* at 760, 6 S.E.2d at 863; *see Roller*, 245 N.C. at 522-23, 96 S.E.2d at 856-57; *Ballance*, 229 N.C. at 771, 51 S.E.2d at 735-36.

Here, by contrast, healthcare markets have many "distinguishing features" that could reasonably justify the CON law—features that the General Assembly expressly enacted into the law's text. *See supra* Part II.B.

Quite unlike photographers, dry cleaners, or tile layers, members of the medical profession have long been the subject of extensive state regulation to protect public health. *See In re Guess*, 327 N.C. 46, 57, 393 S.E.2d 833, 839 (1990); *State v. Call*, 121 N.C. 643, 645-46, 28 S.E. 517, 517 (1897); *cf. Roller*, 245 N.C. at 526, 96 S.E.2d at 859 (noting a "dividing line between the professions and skilled trades which in the public interest permit of regulation by licensing under the police power, and those ordinary lawful and innocuous occupations and trades which are protected from regulation by constitutional guarantees").

These differences align this case with other occupational-licensing cases where this Court has upheld licensing laws against constitutional challenges. For example, in *Motley v. State Board of Barber Examiners*—decided in 1947, in between *Harris* and *Ballance*—this Court ratified a licensing scheme for barbers. 228 N.C. 337, 45 S.E.2d 550 (1947). The Court held that the law implicated "questions of sanitation, public health and standards of the trade"—"matters of public policy within the control" of the political branches of government. *Id.* at 342, 45 S.E.2d at 553. Similarly, in *State v. Warren*—decided in 1960, just three years after *Roller*—the Court upheld a licensing regime for real-estate brokers. 252 N.C. 690, 114 S.E.2d

660. The Court explained that a regulation of this kind was justified because "the intrinsic nature of the business" brought brokers "into a relation of trust and confidence" with their clients, giving brokers "[c]onstant" "opportunities by concealment and collusion to extract illicit gains." *Id.* at 695, 114 S.E.2d at 665 (quoting *Roman v. Lobe*, 152 N.E. 461, 463 (N.Y. 1926)).

* * *

In sum, under any formulation of the deferential review that applies to economic legislation—and taking all of plaintiffs' allegations as true—plaintiffs have failed to state a claim that the CON law violates the law-of-the-land clause.

III. Plaintiffs Failed To State A Claim Under The Exclusive-Emoluments And Anti-Monopoly Clauses.

Plaintiffs have also failed to state a claim under the exclusive-emoluments and anti-monopoly clauses. Both clauses require plaintiffs to show that the CON law grants an exclusive privilege. But the CON law grants no such exclusivity, because it does not foreclose future entry into the market for health services. And even if the CON law had that effect, the law would still pass constitutional review because it promotes the general welfare.

A. The exclusive-emoluments and anti-monopoly clauses require the grant of an exclusive privilege.

The exclusive-emoluments and anti-monopoly clauses are two related provisions of our state constitution that trace their roots to the founding. The exclusive-emoluments clause provides that "[n]o person or set of persons is entitled to exclusive or separate emoluments or privileges from the community but in consideration of public services." N.C. Const. art. I, § 32; *see also* N.C. Const. of 1776, Declaration of Rights, § III. The anti-monopoly clause provides that "[p]erpetuities and monopolies are contrary to the genius of a free state and shall not be allowed." N.C. Const. art. I, § 34; *see also* N.C. Const. of 1776, Declaration of Rights, § XXIII.

The clauses share a common history and purpose. *See* John V. Orth & Paul Martin Newby, *The North Carolina State Constitution* 91 (2d ed. 2013) (noting that a legal monopoly "is indistinguishable from the 'exclusive privileges' referred to" by the anti-emoluments clause). The clauses were enacted due to the historical experiences of the framers with "English monarchs [who] had used grants of monopolies to reward their political favorites." *Id.* at 90; *see generally* 4 David Hume, *History of England From the Invasion of Julius Caesar to the Revolution of 1688*, at 344-45 (1778)

(describing how the English Crown arbitrarily granted monopoly rights to individuals). As a result, the clauses were designed to "prevent the state government from favoring one person or group over another" and thus "prevent the development of privileged classes." John V. Orth, *Unconstitutional Emoluments: The Emoluments Clauses of the North Carolina Constitution*, 97 N.C. L. Rev. 1727, 1730 (2019).

The clauses also share related language. At the founding, an "emolument" was a "profit" or an "advantage." Samuel Johnson, *A Dictionary of the English Language* (3d ed. 1768); *see also* 1 John Ash, *The New and Complete Dictionary of the English Language* (1775) (same). That profit or advantage, moreover, had to be "exclusive": it had to "debar[ ] [others] from participation." Johnson, *supra*; *see also* 1 Ash, *supra* (defining "exclusive" as "[h]aving the power of exclusion, debarring, excepting"). The word "monopoly" had a similar meaning. Although founding-era definitions of the word varied, a monopoly was understood to be, at a minimum, an "exclusive privilege of selling anything." Johnson, *supra*; *accord* Orth & Newby, *supra* at 91 ("[A] legal monopoly would be the grant of an exclusive right to trade in a certain area or to deal in certain goods.").

The clauses are structurally related as well, with both provisions located in the Declaration of Rights. Like all provisions in the Declaration, the clauses operate against the government, not private actors. *See Bailey v. Flue Cured Tobacco Co-op. Stabilization Corp.*, 158 N.C. App. 449, 456, 581 S.E.2d 811, 816 (2003) (affirming dismissal of anti-monopoly claim for lack of state action). More than a century would pass before Congress enacted the federal antitrust laws, which bar private parties from acquiring or maintaining monopoly power through improper means. *See* Act of July 2, 1890, ch. 647, § 2, 26 Stat. 209 (codified at 15 U.S.C. § 2).

In keeping with this text, history, and structure, this Court has held that, at their historical core, these clauses apply to state-granted "exclusive" privileges. To decide whether state action violates this bar on exclusivity, courts ask whether future competition has been foreclosed in a relevant market. For example, in *Town of Clinton v. Standard Oil Company*, this Court struck down an ordinance that prevented any new gasoline stations from opening a business in a town. 193 N.C. 432, 433, 137 S.E. 183, 183 (1927). The Court held that the ordinance violated the anti-monopoly clause because it ensured that the town's six existing gasoline stations "would be the sole sellers for all time in perpetuity." *Id.* at 435, 137 S.E. at 184. In other

words, the Court explained, the law was "no regulation"—it was "a prohibition." *Id.* at 434, 137 S.E. at 184.

By contrast, this Court has upheld state action that leaves the door open to new market entrants. This Court's decision in *Madison Cablevision, Inc. v. City of Morganton* illustrates this principle. 325 N.C. 634, 386 S.E.2d 200 (1989). There, a city declined to renew a cable-television franchise that it had granted. *Id.* at 640, 386 S.E.2d at 204. The city also rejected franchise applications from two other providers, instead deciding that the city itself would establish a city-owned system. *Id.* at 641, 386 S.E.2d at 204. The city stated that it would revisit the need for additional cable providers in five years. *Id.*

The cable company whose franchise the city declined to renew sued, asserting claims under the exclusive-emoluments and anti-monopoly clauses. *Id.* at 643, 386 S.E.2d at 205. This Court held that the city did not violate either provision. *Id.* at 653, 386 S.E.2d at 211. The Court explained that the city had not made itself an "exclusive" provider of cable-television services within the meaning of the constitution because it had "not foreclosed for any period the possibility that franchises might be granted to other applicants." *Id.* at 654, 386 S.E.2d at 211. To the contrary, the city

"expressly left open the possibility that other cable companies could apply for and obtain a franchise in the future," and the city would revisit that possibility "five years after it issued its decision to operate a municipal system." *Id.* Because the city preserved the possibility of future competition, no "exclusive" privilege was at issue, as required to state a constitutional claim. *Id.*

B. The CON law does not grant an exclusive privilege.

Here, although the CON law regulates entry into certain healthcare markets, it does not prohibit future competition by granting providers "exclusive" rights to a market. Plaintiffs therefore cannot state claims under the exclusive-emoluments and anti-monopoly clauses.

Plaintiffs allege that the CON law excludes them from offering eye surgeries on a full-time basis at their New Bern eye clinic. (R pp 26-30, ¶¶ 93-120) Plaintiffs allege that the CON law instead grants CarolinaEast the "exclusive" right to offer services of that kind. (R p 27, ¶ 101; R p 32, ¶ 137) Plaintiffs claim that the CON law establishes this exclusive right because, for the last ten years, the State Medical Facilities Plan has not found a need for new operating rooms in the relevant geographic area. (R p 27, ¶ 100) As a result, plaintiffs argue that they are "categorically banned" from ever

applying for a CON to offer their own competing services. *See* Br. 40; R p 27, ¶ 99.

These allegations fail as a matter of law. As discussed above, the CON process is flexible in both design and practice, and is responsive to changes based on public, agency, and judicial review. For example, health experts annually update and revise need determinations for certain health services in a given area. *See supra* pp 16-20. Parties may also petition to change these need determinations or the methodologies and policies used to calculate them. *See supra* pp 16-20. Petitions of this kind are granted—and need determinations are amended—with some regularity. *See supra* p 20 n.4. In addition, the CON law sets out a detailed administrative process for parties to challenge CON decisions and gives parties who exhaust those remedies a right to judicial review. *See supra* pp 20-22. Thus, a no-need finding, or a decision denying a CON, does not foreclose the possibility that CONs might be granted to future applicants.

These features of the CON process put this case on all fours with this Court's decision in *Madison Cablevision*. The CON law does "not foreclose[ ] for any period the possibility" that new applicants might be able to enter a given market. *See Madison Cablevision*, 325 N.C. at 654, 386 S.E.2d at 211. To

the contrary, the law "expressly [leaves] open the possibility" that providers may "apply for and obtain" a CON "in the future." *Id.* It does so by establishing a detailed process for agency decision-making, public input, and several layers of review, both within the agency and the judiciary. In other words, the law is a "regulation" rather than a "prohibition"—it does not give any provider the sole right to offer health services "for all time in perpetuity." *Town of Clinton*, 193 N.C. at 435, 137 S.E. at 184.

Plaintiffs appear to argue that, in the alternative, the CON law violates the bar on exclusivity by setting need determinations two years in advance. Br. 7-8. But as discussed above, plaintiffs simply misunderstand how the law operates: Although the CON law *calculates* need determinations by estimating need two years into the future, once a need determination has been made, parties may apply for a CON that same year. *See supra* pp 43-44.

Plaintiffs' argument on this score is also beside the point. The question under the exclusive-emoluments and anti-monopoly clauses is whether state action has left the door open for potential future competition. For example, in *Madison Cablevision*, even though the city declared itself the sole provider of cable-television services, this Court rejected a constitutional challenge because the city would revisit its determination in five years. 325

N.C. at 654, 386 S.E.2d at 211. Thus, even if plaintiffs were correct that the CON law sets need determinations two years in advance, plaintiffs still could not show that the law has eliminated potential future competition, as this Court's cases require.

C. The CON law is otherwise constitutional.

As shown above, plaintiffs' claims fail for a fundamental reason: The CON law does not, as a matter of law, "categorically ban" them from a given market. (R p 27, ¶ 99) This Court therefore need go no further. On the facts alleged in this case, the Court can resolve plaintiffs' exclusive-emoluments and anti-monopoly claims by holding that plaintiffs have not shown that the CON law creates a state-granted "exclusive" privilege.[6]

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[6] Plaintiffs here do not rely on this Court's cases holding that the anti-monopoly clause may apply even in the absence of a showing that "*all* competition has been eliminated." *DiCesare v. Charlotte-Mecklenburg Hosp. Auth.*, 376 N.C. 63, 98, 852 S.E.2d 146, 169 (2020) (emphasis added). When, unlike here, a plaintiff brings an anti-monopoly claim on the theory that competition has been reduced rather than eliminated, this Court has in some cases looked to federal antitrust law to decide whether a plaintiff has alleged "more than a mere adverse effect on competition"—for example, that "competition is stifled," "freedom of commerce is restricted," and prices are "controlled" by a single firm. *Am. Motors Sales Corp. v. Peters*, 311 N.C. 311, 315-17, 317 S.E.2d 351, 355-57 (1984); *see also DiCesare*, 376 N.C. at 98-99, 852 S.E.2d at 169-70 (similar). Here, however, plaintiffs argue that the CON law has eliminated, rather than reduced, competition in the relevant market. Br. 40; *see generally* R pp 26-30, ¶¶ 93-120. In this way, plaintiffs' claim arises

Even if the Court disagrees, however, the CON law is still constitutional because it promotes the general welfare. Under both the exclusive-emoluments and anti-monopoly clauses, this Court has long held that the state may constitutionally grant an exclusive privilege if doing so furthers a public purpose.

1. The CON law does not violate the exclusive-emoluments clause because the law benefits the public interest.

Start with the exclusive-emoluments clause. By its terms, the clause allows the government to provide exclusive emoluments "in consideration of public services." N.C. Const. art. I, § 32.

This Court has long read the term "public services" to include those services that promote the general welfare. For decades, the Court has therefore held that the exclusive-emoluments clause "is not implicated" when a law "is intended for 'the promotion of the general welfare, as distinguished from the benefit of the individual, and if there is reasonable

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only under the historical meaning of the anti-monopoly clause. Br. 30-38. Because plaintiffs have only framed their anti-monopoly claim on an exclusion theory—and because that claim fails on its own terms—this case does not require the Court to address how the anti-monopoly clause might incorporate modern federal antitrust law.

basis for the Legislature to conclude that the granting of the [benefit] would be in the public interest.'" *State ex rel. Utils. Comm'n v. Carolina Util. Customers Ass'n*, 336 N.C. 657, 677, 446 S.E.2d 332, 344 (1994) (quoting *State v. Knight*, 269 N.C. 100, 108, 152 S.E.2d 179, 184 (1967)); *Town of Emerald Isle ex rel. Smith v. State*, 320 N.C. 640, 654, 360 S.E.2d 756, 764 (1987) (same); Orth & Newby, *supra* at 90 (same).

Plaintiffs here, by contrast, argue that the term "public services" is limited to only "*government* services rendered to the people." Br. 32 (emphasis added). They therefore read the clause to permit only those exclusive emoluments in consideration of government-provided, rather than private, services. Br. 36. But plaintiffs cite no case that has ever adopted this formulation. And they ignore decades of this Court's precedents, discussed above, holding that a law promoting the general welfare does not violate the exclusive-emoluments clause. Yet plaintiffs do not ask this Court to overturn these precedents. And plaintiffs fail to explain why the Court should not afford those cases stare decisis effect. Instead, plaintiffs simply announce a new test that they prefer. That is not how the law works.

Plaintiffs' own cases, moreover, are not persuasive support for the distinction they seek to draw between services performed by the government

and services performed by private parties. To be sure, plaintiffs cite cases in which this Court struck down laws under the exclusive-emoluments clause when private parties performed the service at issue. *See* Br. 35. But the Court's reasoning in these cases focused on *why* the service failed to benefit the public rather than on *who* performed the service. *See, e.g.*, *Simonton v. Lanier*, 71 N.C. 498, 504 (1874) (distinguishing "public laws" that are "founded on the gravest considerations of public benefit" from "private statutes" that "are not of common concern, and do not receive the watchful and cautious scrutiny of the legislature"); *Motley v. S. Finishing & Warehouse Co.*, 122 N.C. 347, 351, 30 S.E. 3, 4 (1898) (asking "[w]hat benefit can this privilege be to the public?"); *State v. Fowler*, 193 N.C. 290, 293, 136 S.E. 709, 711 (1927) (finding an exemption from certain criminal laws to be "arbitrary and unreasonable"). If anything, these historical cases therefore confirm—rather than undermine—this Court's well-established test under the exclusive-emoluments clause, which asks whether the law at issue was intended to promote, and reasonably does promote, the general welfare.

Here, the CON law meets both requirements. First, the General Assembly intended the CON law to promote the general welfare. The statute's text shows that the General Assembly's purpose in passing the law

was to protect public health, a legislative aim that this Court has long recognized as legitimate. N.C. Gen. Stat. § 131E-175; *see supra* Part II.B.

Second, the General Assembly had a reasonable basis for concluding that the CON law would serve the public interest. For all the reasons discussed above, the General Assembly could have reasonably concluded that by regulating entry into healthcare markets based on the public's need, a CON law could reduce costs, increase quality, and ensure a fair and equitable distribution of healthcare services. *See supra* Part II.B. These considerations amply satisfy the reasonable-basis requirement under the exclusive-emoluments clause. *See, e.g.*, *Carolina Utility*, 336 N.C. at 677, 446 S.E.2d at 344 (the General Assembly did not confer an exclusive emolument when it passed a law that used utility-supplier refunds to help expand "natural gas facilities into previously unserved areas").

2. The CON law does not violate the anti-monopoly clause because the law does not cause the loss of a common right.

The anti-monopoly clause similarly permits the government to grant an exclusive privilege that furthers a public purpose.

This Court has long endorsed this historical understanding of the word "monopoly." In *State v. Harris*, for example, the Court held that "monopoly,

as originally defined, consisted in a grant by the sovereign of an exclusive privilege to do something which had theretofore been a matter of *common right*." 216 N.C. at 761, 6 S.E.2d at 864 (emphasis added); *see generally* Lord Edward Coke, *The Third Part of The Institutes of The Laws of England: Concerning High Treason, and Other Pleas of the Crown, and Criminal Causes* 181 (1809) (defining a monopoly as a sole "allowance by the king by his grant" that included an element of restraint of "any freedom, or liberty [the public] had before"). A right ceases to be "common" when its "restraint becomes necessary for the public good." *Thrift v. Bd. of Comm'rs*, 122 N.C. 31, 37, 30 S.E. 349, 351 (1898).

As a result, the government may grant an exclusive privilege if that grant does not deprive others of a common right—that is, if granting that privilege serves the public good. This Court's early occupational-licensing cases illustrate this principle. In those cases, this Court held that occupational-licensing regimes violated the anti-monopoly clause for effectively the same reasons that they violated the law-of-the-land clause—the laws did not serve the public good and were otherwise unreasonable. *Ballance*, 229 N.C. at 772, 51 S.E.2d at 736 (holding that because the law was "addressed to the interests of a particular class rather than the good of

society as a whole," it "tends to promote a monopoly in what is essentially a private business"); *see also Harris*, 216 N.C. at 764, 6 S.E.2d at 866; *Roller*, 245 N.C. at 525-26, 96 S.E.2d at 859. By contrast, this Court has upheld against anti-monopoly challenges occupational-licensing laws that did in fact serve the public good and thus did not deprive others of a common right: Indeed, this Court has done so specifically in the healthcare context. *E.g.*, *Call*, 121 N.C. at 646, 28 S.E. at 517 (medical licensing regime was "an exercise of the police power for the protection of the public against incompetents and impost[e]rs, and is in no sense the creation of a monopoly or special privileges").

For all the reasons discussed above, the CON law serves the public good and therefore does not deprive plaintiffs of a "common right." *See supra* Part II.B. This Court has limited common rights to certain "innocuous, ordinary" trades or "legitimate and harmless profession[s]." *Harris*, 216 N.C. at 748, 6 S.E.2d at 856; *American Motors*, 311 N.C. at 321, 317 S.E.2d at 358. But plaintiffs here seek to perform outpatient eye surgeries. They thus seek to engage in the kind of "professions and skilled trades which in the public interest permit of regulation by licensing under the police power." *Roller*, 245 N.C. at 526, 96 S.E.2d at 859; *see also In re Guess*, 327 N.C. at 57, 393

S.E.2d at 839 (holding that "there is no right to practice medicine which is not subordinate to the police power of the state[ ]." (quoting *Lambert v. Yellowley*, 272 U.S. 581, 596 (1926)). Plaintiffs therefore cannot state a claim under the anti-monopoly clause.

D. *Aston Park* does not control plaintiffs' exclusive-emoluments and anti-monopoly claims.

Plaintiffs have one remaining argument: that this Court's decision in *Aston Park* requires holding that the CON law violates the exclusive-emoluments and anti-monopoly clauses. Br. 38.

Plaintiffs are correct that this Court in *Aston Park* stated that the old CON law violated both clauses. 282 N.C. at 551, 193 S.E.2d at 736. But the Court reached that conclusion only in view of its holding that the law lacked a rational or reasonable basis. *Id.*; *see also American Motors*, 311 N.C. at 320, 317 S.E.2d at 358 (stating that the Court's decision on the anti-monopoly clause in *Aston Park* "turned on the absence of a rational relationship between the required certificate of need and any public good or welfare consideration"). In fact, its entire analysis on both clauses consisted of one sentence that echoed its earlier reasoning on the law-of-the-land clause. *Aston Park*, 282 N.C. at 551, 193 S.E.2d at 736. Because the new CON law

solved the earlier deficiencies identified in *Aston Park*, that case does not control here. *See supra* Part II.D.1.

Recognizing that the government may, consistent with the exclusive-emoluments and anti-monopoly clauses, grant an exclusive privilege when doing so serves the public good is not, as plaintiffs claim, to uncritically incorporate the rational-basis test into provisions of our state constitution that have their own distinct text and history. Br. 38-40. To the contrary, plaintiffs' discussion of this issue sells this Court's well-established precedents short. For decades, this Court has preserved a unique and independent role for both clauses. Considering whether a challenged law serves the public, rather than private, good is consistent with that role. It is consistent with the framers' distrust of state action that would allow "the development of privileged classes." Orth, 97 N.C. L. Rev. at 1730.

* * *

In sum, the CON law does not violate the exclusive-emoluments or anti-monopoly clauses because it does not grant an exclusive privilege. In the alternative, the CON law is nonetheless constitutional under these clauses because it promotes the general welfare.

CONCLUSION

The debate over the CON law belongs to the democratic process—to the people, acting through the political branches—not the courts. This Court should affirm the judgment of the Court of Appeals.

Respectfully submitted, this 8th day of January, 2024.

JOSHUA H. STEIN
Attorney General

/s/ Electronically submitted
Nicholas S. Brod
Deputy Solicitor General
N.C. State Bar No. 47598
nbrod@ncdoj.gov

N.C. R. App. P. 33(b) Certification:
I certify that the attorneys listed below have authorized me to list their names on this document as if they had personally signed it.

Ryan Y. Park
Solicitor General
N.C. State Bar No. 52521
rpark@ncdoj.gov

Derek L. Hunter
Special Deputy Attorney General
N.C. State Bar No. 36835
dhunter@ncdoj.gov

John H. Schaeffer
Assistant Attorney General

N.C. State Bar. No. 51965
jschaeffer@ncdoj.gov

North Carolina Department of Justice
P.O. Box 629, Raleigh, NC 27602
(919) 716-6900

Counsel for defendants

CERTIFICATE OF SERVICE

I certify that today, I caused the above document to be served on counsel by e-mail, addressed to:

Joshua A. Windham
Renée D. Flaherty
Institute for Justice
901 N. Glebe Road, Suite 900
Arlington, VA 22203
jwindham@ij.org
rflaherty@ij.org

B. Tyler Brooks
Law Office of B. Tyler Brooks, PLLC
P.O. Box 10767
Greensboro, North Carolina 27404
btb@btylerbrookslawyer.com

Counsel for amici curiae certificate of need scholars

Daniel Gibson
Stam Law Firm
P.O. Box 1600
Apex, NC 27502
dan@stamlawfirm.com

Counsel for plaintiffs

Jonathan D. Guze
John Locke Foundation
4800 Six Forks Road, Suite 220
Raleigh, NC 27609
jguze@lockehq.org

Counsel for amici curiae John Locke Foundation and Professor John V. Orth

Elliot Engstrom
Sellers, Ayers, Dortch & Lyons, P.A.
301 S. McDowell Street, Suite 410
Charlotte, NC 28204
eengstrom@sellersayers.com

Counsel for amicus curiae Goldwater Institute

This 8th day of January, 2024.

/s/ Electronically submitted
Nicholas S. Brod

CONTENTS OF APPENDIX

H. B. 1398

CHAPTER 1164

AN ACT TO PROVIDE FOR ORDERLY AND ADEQUATE DEVELOPMENT OF HEALTH AND MEDICAL FACILITIES BY REQUIRING THE ISSUANCE OF A CERTIFICATE OF NEED.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is hereby amended by inserting a new Article 21 to read as follows:

"Article 21

"Determination of Need for Medical Care Facilities

"§ 90-289. *Orderly Development of Medical Facilities.*—The General Assembly of North Carolina declares that it is the public policy of the State to encourage the necessary and adequate development of health and medical care facilities and that this development shall be accomplished in a manner which is orderly, timely, economical, and without unnecessary duplication of these facilities.

"§ 90-290. *Definitions.*—(1) 'Approved areawide comprehensive health planning council' means a voluntary non-profit or public agency or organization that is recognized and approved by the Division of State Planning to function as a health planning agency.

(2) 'Medical care facility' refers to all of the following facilities licensed by State agencies: hospitals, nursing homes, intermediate care facilities and mental hospitals. The term includes facilities licensed by a State agency for inpatient care services, whether operated for profit or not, and whether private or owned by a local governmental unit. The term does not include physicians' offices, first-aid stations for emergency medical or surgical treatment or similar facilities where no overnight bed care is contemplated or performed.

(3) 'State Licensing Agency' refers to the State agency empowered to license a medical care facility.

"§ 90-291. *Certificate of need.*—(a) Any other provisions of law to the contrary notwithstanding, such State agencies as administer licensing laws applicable to medical care facilities shall, as a precondition to issuing or continuing the license applied for, make a 'determination of need' with respect to any new construction, construction of additional bed capacity or conversion of existing bed capacity for which a license is requested.

(b) Any proposed medical care facility, desiring to be licensed by a State licensing agency, shall make application for a certificate of need, as required by this Article, when such facility proposes new construction. Any existing medical care facility need not apply for a certificate of need except when the facility proposes new construction, construction of additional bed capacity, or the conversion of existing bed capacity to a different license category, except outpatient and emergency services. No certificate of need shall be required as a precondition to issuing or continuing a license to an existing medical care facility in the absence of new construction, construction of additional bed capacity or conversion of existing bed capacity to a different license category for the existing medical care facility.

(c) Certificates of need shall be issued or denied, suspended, revoked or reinstated by such agencies having responsibility for licensing medical care facilities in accordance with law and rules and regulations of the licensing agency. No such certificates shall be denied except with the approval of the board or commission of a State agency licensing medical care facilities; and no decision shall be made contrary

to the recommendations of an areawide health planning council unless such council has been notified by such board of the reason for its determination and has been granted full opportunity for hearing thereon by the board reviewing such a council's findings.

No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide new or additional inpatient facilities in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health services. In making such determinations, there shall be taken into consideration (1) the size, composition and growth of the population of the area to be served; (2) the number of existing and planned facilities of similar types; (3) the extent of utilization of existing facilities; and (4) the availability of facilities or service which may serve as alternatives or substitutes.

(d) Applications for certificates of need shall be made to the State agencies licensing medical care facilities and shall be in such form and contain such information as such State agencies may prescribe. Upon receipt of an application, copies thereof shall be referred by such State licensing agency to the appropriate approved areawide health planning council for review and to the Division of State Planning for information.

The areawide health planning councils shall provide adequate mechanisms for full consideration of such application and for developing recommendations thereon. Such recommendations, whether favorable or unfavorable, shall be forwarded to the State licensing agency within 60 days of the date of referral of the application. A copy of the recommendations of the areawide comprehensive health planning council shall be forwarded to the applicant facility and to the Division of State Planning for information.

Recommendations by areawide comprehensive health planning councils and the State licensing agencies as to issuance of a certificate of need shall be governed by and based upon the principles (1) through (6) set forth in section (c) hereof.

(e) Construction of a new medical care facility or expansion of an existing facility to gain additional bed capacity shall not be instituted or commenced after the effective date of this Article except upon application for and receipt of a certificate of need as provided herein: provided that in any case which, prior to the effective date of this Article, there has been proposed the construction of a new facility or the expansion of bed capacity of an existing facility and preliminary plans have been submitted to a State licensing agency, such proposed projects are exempt to the extent of initial construction or expansion provided for in such preliminary plans from the provisions of this Article.

(f) A certificate of need shall be valid for such period of time, not to exceed two years, as may reasonably be required to complete preparation of detailed construction plans, secure necessary funds and building permits and undertake the construction of a medical facility in question: provided, that, with the advice of an areawide health planning agency or, when appropriate, the other resources utilized by a State licensing agency, the agency may renew the certificate for such further periods as may be reasonable where the applicant has shown that substantial and continuing progress towards commencement of construction has been demonstrated. A certificate of need shall be non-transferable.

(g) The issuance of a certificate of need for a specific project in a medical facility's long-range plan shall not constitute a guarantee that all future proposals contained in that long-range plan will receive a certificate of need; however, the existence of previously certified projects that provide economies and improvement of service that may be derived from operation of joint, cooperative or shared health care resources and reduce the overall cost of future projects shall be taken into account by the areawide health planning council and the licensing agency in reviewing subsequent proposals.

(h) Decisions as to a certificate of need may be made initially by administrative personnel of any board or agency to the extent permitted by law and the rules and regulations of the agency, provided that the rules and regulations shall provide for a final determination by the board or agency upon the written request of any interested party. Decisions concerning a certificate of need shall be appealable to, or subject to judicial review in, the courts as provided by law with regard to licensing decisions of any licensing agency.

(i) The boards or commissions of State licensing agencies shall have authority to adopt policies, rules and regulations in order to effectuate the provisions and purposes of this Article."

Sec. 2. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 21st day of July, 1971.

H. B. 1555 CHAPTER 1165

AN ACT TO AMEND G.S. 24-1.2 RELATING TO THE DEFINITION OF "FIRST SECURITY INSTRUMENT".

The General Assembly of North Carolina enacts:

Section 1. G.S. 24-1.2(b) as amended by Chapter 448 of the 1971 Session Laws is hereby further amended by deleting from the fourth sentence thereof the words "preceding sentence", and inserting in lieu thereof the word "subsection", and by deleting from the fourth sentence thereof the word "ten" and inserting in lieu thereof the word "one", so that the fourth sentence of G.S. 24-1.2(b) shall read as follows:

"Under the provisions of this subsection, a first security instrument is a first mortgage or first deed of trust on real property securing a loan payable in equal installments of principal and interest or equal installments of principal over a period of at least one year, such installments to have been paid at least annually."

Sec. 2. This act shall become effective upon ratification.

In the General Assembly read three times and ratified, this the 21st day of July, 1971.

(4) Records prepared during or as a result of an examination, audit or investigation of any bank or banking practice by an agency of the United States, or jointly by such agency and the Commissioner of Banks, if such records would be confidential under any federal law or regulation.

(5) Any letters, reports, memoranda, recordings, charts, or other documents which would disclose any information set forth in any of the confidential records referred to in subdivisions (1) through (4)."

Sec. 3. (a) There is hereby created a Study Commission on Access to and Confidentiality of Banking Records to be composed of nine members appointed by the Governor, provided that not more than four members nor less than two members of the commission shall be officers, directors or employees of a bank.

(b) The commission shall study the matter of access to and confidentiality of the records of the Commissioner of Banks and the State Banking Commission and shall report its recommendations to the General Assembly not later than March 1, 1979.

(c) The members of the commission shall be paid such per diem and travel expenses as are provided for members of the State boards and commissions generally. Reasonable expenses of the commission shall be paid from the Contingency and Emergency Fund under the procedure in G.S. 143-12.

Sec. 4. This act is effective upon ratification and shall expire on June 30, 1979, unless repealed by the General Assembly prior thereto.

In the General Assembly read three times and ratified, this the 16th day of June, 1978.

S. B. 993 **CHAPTER 1182**

AN ACT TO PROVIDE A CERTIFICATE OF NEED LAW, SO AS TO IMPLEMENT THE RECOMMENDATIONS OF THE LEGISLATIVE COMMISSION ON MEDICAL COST CONTAINMENT.

The General Assembly of North Carolina enacts:

Section 1. This act may be cited as the North Carolina Health Planning and Resource Development Act of 1978.

Sec. 2. Chapter 131 of the General Statutes is amended by adding a new Article 18 to read:

"ARTICLE 18.

"Certificate of Need Law.

"§ 131-170. *Findings of fact.*—The General Assembly of North Carolina makes the following findings:

(1) That, because of the manner in which health care is financed, the forces of free market competition are largely absent and that government regulation is therefore necessary to control the cost, utilization, and distribution of health services.

(2) That the continuously increasing cost of health care services 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 the current system of planning for health care facilities and equipment has led to the proliferation of new inpatient acute care facilities and medical equipment beyond the need of many localities in this State and an inadequate supply of health personnel and of resources for long term, intermediate, and ambulatory care in many localities.

(4) That this trend of proliferation of unnecessary health care facilities and equipment results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of acute care hospital services by physicians.

(5) That a certificate of need law is required by P.L. 93-641 as a condition for receipt of federal funds. If these funds were withdrawn the State of North Carolina would lose in excess of fifty-five million dollars ($55,000,000).

(6) That excess capacity of health 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 type, level, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Human Resources 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.

"§ 131-171. *Definitions.*—As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

(1) 'Ambulatory surgical facility' means a public or private facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization. Such term does not include the offices of private physicians or dentists, whether for individual or group practice.

(2) 'Bed capacity' means 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 regulations of the department except that single beds in single rooms are counted even if the room contains inadequate square footage.

(3) 'Certificate of need' means a written order of the department setting forth the affirmative finding that a proposed project sufficiently satisfies the plans, standards, and criteria prescribed for such projects by this Article and by rules and regulations of the department as provided in G.S. 131-176(a) and which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of such project.

(4) 'Certified cost estimate' means an estimate of the total cost of a project certified by the proponent of the project within 60 days prior to or subsequent to the date of submission of the proposed new institutional health service to the department and which is based on:

a. preliminary plans and specifications,

b. estimates of the cost of equipment certified by the manufacturer or vendor, and

c. estimates of the cost of management and administration of the project.

(5) 'Change of ownership' means the transfer by purchase, lease or comparable arrangements of the controlling interest of a capital asset or capital stock, or voting rights of a corporation, from one person to another. Such transfer is deemed to occur when fifty percent (50%) or more of an existing

capital asset or capital stock or voting rights of a corporation is purchased, leased or acquired by comparable arrangement by one person from another person.

(6) 'Commencement of construction' means that all of the following have been completed with respect to a project:

a. a written contract executed between the applicant and a licensed contractor to construct and complete the project within a designated time schedule in accordance with final architectural plans;

b. required initial permits and approvals for commencing work on the project have been issued by responsible governmental agencies; and

c. actual construction work on the project has started and a progress payment has been made by the applicant to the licensed contractor under terms of the construction contract.

(7) 'Department' means the North Carolina Department of Human Resources.

(8) 'To develop' when used in connection with health services, means to undertake those activities which will result in the offering of institutional health service not provided in the previous 12-month reporting period or the incurring of a financial obligation in relation to the offering of such a service.

(9) 'Final decision' means an approval, a denial, an approval with conditions, or a deferral.

(10) 'Health care facility' means hospitals; psychiatric hospitals; tuberculosis hospitals; skilled nursing facilities; kidney disease treatment centers, including free-standing hemodialysis units; intermediate care facilities; ambulatory surgical facilities; health maintenance organizations; home health agencies; and diagnostic or therapeutic equipment with a value in excess of one hundred fifty thousand dollars ($150,000) purchased or leased by a 'person', as defined in this section. 'Health care facility' does not include a facility operated solely as part of the private medical practice of (i) an independent practitioner, (ii) a partnership, or (iii) a professional medical corporation, except with respect to acquisitions of diagnostic or therapeutic equipment with a value in excess of one hundred fifty thousand dollars ($150,000) if with respect to such acquisition either:

a. the notice required by G.S. 131-173(e) is not filed in accordance with that paragraph with respect to such acquisition, or

b. the department finds, within 30 days after the date it receives a notice in accordance with G.S. 131-173(e) with respect to such acquisition, that the equipment will be used to provide services for inpatients of a hospital.

(11) 'Health Maintenance Organization (HMO)' means a public or private organization which:

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 subdivision a. of this section to enrolled participants on a predetermined periodic rate basis; and

c. provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii)

through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(12) 'Health systems agency' means an agency, as defined by P.L. 93-641, as amended, and rules and regulations implementing that act.

(13) 'Home health agencies' means 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.

'Home health services' means 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 subdivision e. of this subsection, 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 foregoing items and services 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 in his home, or which are furnished at such facility while he is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.

(14) 'Hospital' means 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. Such term does not include psychiatric hospitals, as defined in subdivision (22) of this section, or tuberculosis hospitals, as defined in subdivision (27) of this section.

(15) 'To incur a financial obligation in relation to the offering of a new institutional health service' means that in establishing a new institutional health service a person must fulfill the following performance requirements relative to but not limited to the following types of projects:

a. new construction or renovation project:

1. has acquired title or long-term lease to the appropriate site; and
2. has entered into an enforceable construction contract specifying price and date for commencement of construction within 120 days from the date the contract is entered into; and
3. has filed with the appropriate State agency and received approval on the complete set of schematic drawings for the project; and
4. has obtained a financial commitment, including an enforceable offer and acceptance from a financial institution to provide adequate capital financing for the project.

b. acquisition of equipment: the equipment must either be purchased, the lease agreement must be entered into by the proponent, or if acquired by a comparable arrangement the proponent must have possession of the equipment;

c. change of ownership by lease or purchase or comparable arrangement:

1. the lease must be entered into; or
2. the title to the property or stock must be in the possession of the proponent.

(16) 'Intermediate care facility' means a public or private institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require health-related care and services above the level of room and board.

(17) 'New institutional health services' means:

a. the construction, development, or other establishment of a new health care facility;

b. any expenditure by or on behalf of a health care facility in excess of one hundred fifty thousand dollars ($150,000) which, under generally accepted accounting principles consistently applied, is a capital expenditure; except that this Article shall not apply to expenditures solely for the termination or reduction of beds or of a health service, but shall apply to expenditures for site acquisitions and acquisition of existing health care facilities. Where a person makes an acquisition by or on behalf of a health care facility under lease or comparable arrangement, or through donation, which would have required review if the acquisition had been by purchase, such acquisition shall be deemed a capital expenditure subject to review. The value of the transaction shall be deemed to be the fair market value of the asset and not necessarily the actual dollar amount of the transaction. Donations shall include bequests. A change in a proposed capital expenditure project which in itself meets the criteria set forth herein shall be considered a capital expenditure, as well as a change in ownership of in excess of fifty percent (50%) of an existing health care facility or the acquisition of in excess of fifty percent (50%) of the assets or capital stock of a health care facility.

c. a change in bed capacity of a health care facility which increases the total number of beds, or which distributes beds among various categories, subject to the provisions of subdivision j. of this subdivision, or relocates such beds from one physical facility or site to another. Such bed capacity change is subject to review regardless of whether a capital expenditure is made;

d. health services, including home health services, which are offered in or through a health care facility and which were not offered on a regular basis in or through such health care facility within the 12-month period prior to the time such services would be offered;

e. a formal internal commitment of funds by a facility for a project undertaken by the facility as its own contractor;

f. any expenditure by or on behalf of a health care facility in excess of one hundred fifty thousand dollars ($150,000) made in preparation for the offering or development of a new institutional health service and any

arrangement or commitment made for financing the offering or development of a new institutional health service;

g. any conversion or upgrading of a facility such that it is converted from a type of facility not covered by this Article to any of the types of health care facilities which are covered by this Article as defined in this section;

h. a project which substantially expands a service currently offered or which provides a service not offered in the previous 12-month reporting period by the facility, including a change in type of license of five or more beds, subject to the provisions of subdivision j. of this subdivision. Such substantial change of service is subject to review regardless of whether a capital expenditure is made;

i. the purchase or lease by a person or health care facility of diagnostic or therapeutic equipment, regardless of location, with a value in excess of one hundred fifty thousand dollars ($150,000), except it shall not include purchase or lease of such equipment with a value in excess of one hundred fifty thousand dollars ($150,000) for use in a facility operated solely as part of the private medical practice of (i) an independent practitioner, (ii) a partnership, or (iii) a professional medical corporation unless either,

1. the notice required by G.S. 131-173(e) is not filed in accordance with that subsection, or

2. the department finds, within 30 days after it receives a notice under G.S. 131-173(e), that the equipment will be used to provide services for inpatients of a hospital;

j. The Department of Human Resources is authorized and empowered to adopt rules and regulations, consistent with P.L. 93-641, and federal rules and regulations adopted pursuant to said P.L. 93-641, to permit the interchange of skilled nursing and intermediate care beds within the same health care facility to the maximum degree, extent or number permitted from time to time by said federal rules and regulations without requiring a new certificate of need.

for purposes of this subdivision, the acquisition of one or more items of functionally related diagnostic or therapeutic equipment shall be considered as one project. Purchase or lease shall include purchases, contracts, encumbrances of funds, lease arrangements, conditional sales or a comparable arrangement that purports to be a transfer of ownership in whole or in part. Diagnostic or therapeutic equipment shall include units of equipment and all accessories functionally related and used in the diagnosis and treatment of patients, excluding mechanical and electrical equipment related to basic operation and maintenance of the facility. Functionally related means that pieces of equipment are interdependent to the extent that one piece of equipment is unable to function in the absence of or without the functioning piece, or that one piece of equipment performs the same function as another piece, or that pieces of equipment are normally used together in the provision of a single health care facility service.

(18) 'North Carolina State Health Coordinating Council' means the council as defined by P.L. 93-641, as amended, and rules and regulations implementing that act.

(19) 'To offer', when used in connection with health services, means that the health care facility or health maintenance organization holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(20) 'Person' means 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.

(21) 'Project' or 'capital expenditure project' means a proposal to undertake a capital expenditure that results in the offering of a new institutional health service as defined by this act. 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 care facility.

(22) 'Psychiatric hospital' means a public or private institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(23) 'Skilled nursing facility' means a public or private institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(24) 'State Medical Facilities Plan' means a plan prepared by the Department of Human Resources and the North Carolina State Health Coordinating Council, as required by P.L. 93-641, as amended, and rules and regulations implementing that act.

(25) 'State Health Plan' means the plan required by P.L. 93-641, as amended, and rules and regulations implementing that act.

(26) 'State Mental Health Plan' means the plan prepared by the Department of Human Resources under P.L. 94-63 for the purposes of providing an inventory of existing mental health and mental retardation services, and of establishing priorities for the development of new services to adequately meet the identified needs.

(27) 'Tuberculosis hospital' means a public or private institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis.

(28) 'Undertake', with reference to a project or capital expenditure project, means:

a. constructing, remodeling, installing, or proceeding with a project or any part of a project which exceeds one hundred fifty thousand dollars ($150,000) in the current fiscal year or can exceed a total of one hundred fifty thousand dollars ($150,000) in three consecutive fiscal years;

b. the expenditure or commitment of funds, which exceeds one hundred fifty thousand dollars ($150,000) in the current fiscal year or can exceed a total of one hundred fifty thousand dollars ($150,000) in three

subsequent fiscal years, for a project which shall include but not be limited to:

1. construction and financing of the project;
2. equipment orders, purchases, leases or acquisition through other comparable arrangements or donations;
3. development of studies, surveys, reports, working drawings, plans and specifications;
4. acquisitions, purchases, leases, or contracts for necessary developmental services respecting an existing or proposed health facility;
5. promotion, sponsorship, solicitation or representation or holding out to the public for donations or a fund raising drive for a specified project;
6. obtaining or securing bonds for a specified project;
7. executing contracts for the project;
8. cost of legal fees.

c. The expenditure or commitment of funds to develop applications, studies, reports, schematics, long-range planning or preliminary plans and specifications certified to cost one hundred fifty thousand dollars ($150,000) or less shall not be considered to be the undertaking of a project.

"§ 131-172. *Department of Human Resources is designated State Health Planning and Development Agency; powers and duties.*—The Department of Human Resources is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to fulfill responsibilities defined in P.L. 93-641.

The department shall 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 and regulations pursuant to G.S. Chapter 150A;

(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 care 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 regulation, procedures for submission of periodic reports by persons or health facilities subject to agency review under this Article;

(4) develop policy, criteria, and standards for health care facilities planning, conduct statewide inventories of and make determinations of need for health care facilities, and develop a State plan coordinated with other plans of health systems agencies with other pertinent plans and with the State health plan of the department;

(5) implement, by regulation, criteria for project review;

(6) have the power to grant, deny, suspend, or revoke a certificate of need;

(7) solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or property to the department for use by the department or health systems agencies in the administration of this Article;

(8) develop procedures for appeals of decisions to approve or deny a certificate of need, as provided by G.S. 131-180;

(9) the Secretary of Human Resources shall have final decision-making authority with regard to all functions described in this section.

"§ 131-173. *Services and facilities requiring certificates of need.*—(a) No person shall undertake new institutional health services or health care facilities without first having obtained a certificate of need as provided by this Article.

(b) Projects subject to certificate of need review shall include 'new institutional health services' as defined by this Article.

(c) Where the estimated cost of a proposed project is certified by a licensed architect or engineer to be one hundred fifty thousand dollars ($150,000) or less, such expenditure shall be deemed not to exceed one hundred fifty thousand dollars ($150,000) and shall not require review as a capital expenditure regardless of the actual cost of the project, provided that the following conditions are met:

(1) The estimated cost is certified to the department within 60 days of the date of submission of the project upon which the obligation for such expenditure is incurred. Such 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 such expenditure exceeded one hundred fifty thousand dollars ($150,000). Such notice shall include a copy of a certified cost estimate.

(d) The department may grant a certificate of need which permits expenditures only for predevelopment activities, but does not authorize the offering or development of a new institutional health service with respect to which such predevelopment activities are proposed. Expenditures in preparation for the offering of a new institutional health service shall include expenditures for architectural designs, plans, working drawings, and specifications. Such expenditures shall also include those for site acquisition and preliminary plans, studies, and surveys.

(e) Before any person enters into a contractual arrangement to acquire diagnostic or therapeutic equipment with a value in excess of one hundred fifty thousand dollars ($150,000), which will not be owned by or located in a health care facility, such person shall notify the department of such person's intent to acquire such equipment. Such notice shall be made in writing on such form as the department shall prescribe and shall be made at least 30 days before contractual arrangements are entered into to acquire the equipment with respect to which the notice is given. For the purposes of this subsection, health care facility does not include a facility operated solely as part of the private medical practice of (i) an independent practitioner, (ii) a partnership, or (iii) a professional medical corporation.

(f) Any local health department under Article 3 of Chapter 130 of the General Statutes which provides a new institutional health service as defined in G.S. 131-171(17) is subject to the provisions of this Article.

"§ 131-174. *Nature of certificate of need.*—(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 transferable or assignable nor shall a project or capital expenditure project be transferred from one person to

another. A certificate of need shall be valid for the period of time specified therein.

(b) A certificate of need shall be issued for a 12-month period, or such other lesser period as specified by the department, effective on the date of the department's action. Within the effective period, the legal proponent of the proposed project must perform on the project by fulfilling the specific performance requirements set forth by this act for incurring a financial obligation in relation to the offering of a new institutional health service.

(c) By regulation, the department may define the extent, not to exceed six months, for which a certificate of need may be renewed, provided the applicant by petition makes a good faith showing that, within a reasonable time, he will complete the establishment, construction, or modification of the health care facility, and that he will incur the financial obligation within the extended approval period.

(d) The department shall adopt rules pertaining to the requirement of filing for a certificate of need based on a change of ownership of a health care facility. Any substantial change as to the person who or the partnership which is the operator of a health care facility shall be subject to approval by the department, provided, this provision will not interfere with the authority of the owner of a health care facility to make any change in employment of any administrator who holds a valid license issued by the North Carolina Department of Human Resources. The department shall adopt rules which shall state, at a minimum, that any transfer, assignment or other disposition or change of ownership or control of fifty percent (50%) or more of the capital stock or voting rights thereunder of a corporation which is the operator of a health care facility in the State, or any transfer, assignment, or other disposition of the stock or voting rights thereunder of such corporation which results in the ownership or control of more than fifty percent (50%) of the stock or voting rights thereunder of such corporation by any person shall be subject to approval by the department in accordance with procedures for filing a certificate of need application. In the absence of such approval, the enforcement provisions of G.S. 131-182 may be invoked.

"§ 131-175. *Application.*—All persons or health care facilities subject to review, as defined in G.S. 131-171 must file an application for a certificate of need with the department. An application for a certificate of need shall be made on the forms provided by the department. This application shall contain such information as the department, by regulation, deems necessary to conduct the review. Such application shall include affirmative evidence on which the department shall make the findings required under this Article, and upon which the department shall make its final decision on the application.

"§ 131-176. *Review criteria.*—(a) The department shall promulgate rules implementing criteria outlined in this subsection to determine whether an applicant is to be issued a certificate for the proposed project. Criteria so implemented are to be consistent with federal law and regulations and shall cover:

(1) The relationship of the proposed project to the State Medical Facilities Plan, the State Health Plan, and the State Mental Health Plan.

(2) The relationship of services reviewed to the long-range development plan of the persons providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of less costly or more effective alternative methods of providing such services.

(5) The immediate and long-term financial feasibility of the proposal, as well as the probable impact of the proposal on the costs of and charges for providing health services.

(6) The relationship of the services proposed to be provided to the existing health care system of the area in which such services are proposed to be provided.

(7) The availability of resources, including health manpower, management personnel, and funds for capital and operating needs, for the provision of the services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services.

(8) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

(9) Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics and specialty centers.

(10) The special needs and circumstances of health maintenance organizations for which assistance may be provided under Title XIII of the Public Health Service Act. Such needs and circumstances include the needs of and costs to members and projected members of the health maintenance organization in obtaining health services and the potential for a reduction in the use of inpatient care in the community through an extension of preventive health services and the provision of more systematic and comprehensive health services. The consideration of a new institutional health service proposed by a health maintenance organization shall also address the availability and cost of obtaining the proposed new institutional health service from the existing providers in the area that are not health maintenance organizations.

(11) The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

(12) In the case of a construction project, the costs and methods of the proposed construction, including the costs and methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project.

(13) The need that the medically underserved portion of the population, especially those people located in rural or economically depressed areas, has for such services, and the extent to which the project under review proposes to meet that need.

(b) Criteria adopted for reviews in accordance with subsection (a) of this section may vary according to the purpose for which a particular review is being conducted or the type of health service reviewed.

"§ 131-177. *Review process.*—(a) Except as provided in subsection (c) of this section there shall be a time limit of 90 days for review of the project beginning on the day the department declares the application 'complete for review', as established by departmental regulations.

(1) The appropriate Health Systems Agency shall review each application for a certificate of need in accord with its adopted plans, standards, criteria, and procedures, and shall submit its comments thereon to the department within 60 days after receipt of a complete application by the department. The comments may include a recommendation to approve the application, to approve the application with conditions, to defer the application, or to deny the application. Suggested modifications, if any, shall relate directly to the project under review.

(2) The appropriate Health Systems Agency shall, during the course of its review, provide an opportunity for a public meeting at which interested persons may introduce testimony and exhibits.

(3) Any person may file written comments and exhibits concerning a proposal under review with the appropriate Health Systems Agency and the department.

(b) The department shall issue as provided in this Article a certificate of need with or without conditions or reject the application within the review period. If the department fails to act within such period, the failure to act shall constitute denial of the application.

(c) The department shall promulgate rules establishing criteria for determining when it would not be practicable to complete a review within 90 days from receipt of a completed application. If the department finds that these criteria are met for a particular project, it may extend the review period for a period not to exceed 60 days and provide notice of such extension to all affected persons.

"§ 131-178. *Final decision.*—The department shall send its decision along with written findings to the person proposing the new institutional health service and to the Health Systems Agency for the health service area in which the new service is proposed to be offered or developed. In the case of a final decision to 'approve' or 'approve with conditions' a proposal for a new institutional health service, the department shall issue a certificate of need to the person proposing the new institutional health service.

"§ 131-179. *Written notice of decision.*—The department shall, within 15 days after it makes a final decision on an application, provide in writing to the applicant, to the appropriate Health Systems Agency and, upon request to affected persons, the findings and conclusions on which it based its decision, including but not limited to the criteria used by the department in making such decision.

"§ 131-180. *Rights of appeal and judicial review.*—(a) In fulfilling the functions and duties of this Article the department shall comply with the North Carolina Administrative Procedures Act, G.S. Chapter 150A.

(b) Any proponent of a new institutional health service or capital expenditure project or any person who qualifies as a 'party' or 'person aggrieved' under G.S. 150A-2 shall have all the rights of appeal and judicial review available under Articles 3 and 4 of G.S. Chapter 150A.

(c) In the instance that the department makes a recommendation on review of a project which is inconsistent with a recommendation made by a particular

Health Systems Agency, the department shall submit a written, detailed statement of the reasons for the inconsistency. The Health Systems Agency may request an appeal under the North Carolina Administrative Procedures Act, G.S. Chapter 150A.

"§ 131-181. *Forfeiture of certificate of need.*—The department may revoke a certificate of need, for failure to perform on the certificate of need, based on rules adopted by the department. The department may revoke a certificate of need for, including but not necessarily limited to, the following reasons:

(1) For failure to satisfy within 180 days following issuance of the certificate of need any performance requirements that may be set forth by the department.

(2) After review, upon 12 months' duration of approval, for failure to incur the financial obligation for a capital expenditure as defined in this Article.

(3) After notice and a fair hearing on proof that a person who has been awarded a certificate of need, and who before completion of the project and operation of the facility, has attempted to or has transferred or conveyed more than five percent (5%) ownership or control in a facility without prior written approval of the department. Transfers resulting from personal illness or other good cause, as determined by the department, may be exempt from this provision based on rules adopted by the department. Transfers resulting from death shall be exempt from this provision.

"§ 131-182. *Enforcement and sanctions.*—(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 expenditures in excess of one hundred fifty thousand dollars ($150,000) in preparation for 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, except as otherwise provided in G.S. 131-173.

(c) 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.

(d) Nothing in this Article shall be construed as terminating the P.L. 92-603, Section 1122 capital expenditure program or the contract between the State of North Carolina and the United States under that program. The sanctions available under that program and contract, with regard to the determination of whether the amounts attributable to an applicable project or capital expenditure project should be included or excluded in determining payments to the proponent under Titles V, XVIII, and XIX of the Social Security Act, shall remain available to the State.

(e) If any health care facility 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 and regulations hereunder is 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.

(f) If any health care facility proceeds to offer or develop a new institutional health service without having first obtained a certificate of need for such services, the licensure for such facility may be revoked or suspended by the

Medical Care Commission, or the Commission for Health Services, as appropriate.

(g) A civil penalty of not more than twenty thousand dollars ($20,000) may be assessed by the department 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 and regulations pertaining thereto, or in violation of the terms of such a certificate. 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. The department may assess the penalties provided for in this subsection. Any person assessed shall be notified of the assessment by registered or certified mail, and the notice shall specify the reasons for the assessment. If the person assessed fails to pay the amount of the assessment to the department within 30 days after receipt of notice, or such longer period, not to exceed 180 days, as the department may specify, the department may institute a civil action in the superior court of the county in which the violation occurred or, in the discretion of the department, in the superior court of the county in which the person assessed has its principal place of business, to recover the amount of the assessment. In any such civil action, the scope of the court's review of the department's action (which shall include a review of the amount of the assessment), shall be as provided in Chapter 150A of the General Statutes. 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.

(h) 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.

(i) If any health care facility proceeds to offer or develop a new institutional health service without having first obtained a certificate of need for such services, the Secretary of Human Resources or any person aggrieved, as defined by G.S. 150A-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.

"§ 131-183. *Venue.*—(a) Any action brought by a 'person aggrieved', as defined by G.S. 150A-2(6), to enforce the provisions of this Article against any health care facility, as defined in G.S. 131-171(10) or its agents or employees, may be brought in the superior court of any county in which the cause of action arose or in the county in which the health care facility is located, or in Wake County.

(b) An action brought by a 'party', as defined by G.S. 150A-2(5), who has exhausted all administrative remedies made available to that party by statute or rules and regulations, may be brought in the Superior Court of Wake County at any time after a final decision by the department. Such action must be filed not later than 30 days after a written copy of the final decision by the department is given by personal service or registered or certified mail to the person seeking judicial review."

Sec. 3. The provisions of this act are severable, and if any of its provisions shall be held unconstitutional by any court of competent jurisdiction, the decision of such court shall not affect or impair the remaining provisions.

Sec. 4. This act shall become effective January 1, 1979.

This act shall not apply to any project which has received approval under the Section 1122, P.L. 92-603 program prior to January 1, 1979, as long as construction has commenced before January 1, 1980.

This act shall not apply to any project for which application is made under the Section 1122, P.L. 92-603 program between July 1, 1978, and January 1, 1979, if such application is approved, and construction has commenced before January 1, 1980.

Rules and Regulations under this act may be issued at any time after the date of ratification of this act, but shall not become effective prior to January 1, 1979.

In the General Assembly read three times and ratified, this the 16th day of June, 1978.

S. B. 1023 **CHAPTER 1183**

AN ACT TO ESTABLISH REQUIREMENTS FOR LICENSES FOR COMMERCIAL FISHING VESSELS OWNED BY NONRESIDENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 113-161 is hereby rewritten to read as follows:

"§ 113-161. *Nonresidents reciprocal agreements.*—Persons who are not residents of North Carolina are not entitled to obtain licenses under the provisions of G.S. 113-152 except as hereinafter provided. Residents of jurisdictions which sell commercial fishing licenses to North Carolina residents are entitled to North Carolina commercial fishing licenses under the provisions of G.S. 113-152. Such licenses may be restricted in terms of area, gear and fishery by the commission so that the nonresidents are licensed to engage in North Carolina fisheries on the same or similar terms that North Carolina residents can be licensed to engage in the fisheries of such other jurisdiction. The secretary may enter into such reciprocal agreements with other jurisdictions as are necessary to allow nonresidents to obtain commercial fishing licenses in North Carolina subject to the foregoing provisions."

Sec. 2. This act is effective upon ratification.

In the General Assembly read three times and ratified, this the 16th day of June, 1978.

S. B. 931 **CHAPTER 1184**

AN ACT TO REQUIRE HOME HEALTH SERVICES IN EVERY COUNTY, SO AS TO IMPLEMENT THE RECOMMENDATIONS OF THE LEGISLATIVE RESEARCH COMMISSION'S COMMITTEE ON AGING.

The General Assembly of North Carolina enacts:

Section 1. General Statutes Chapter 130 is amended by adding a new section to read as follows:

"§ 130-170.2. *Home health services to be provided in all counties.*—(a) Every county shall provide home health services as defined in G.S. 130-170.1(a).

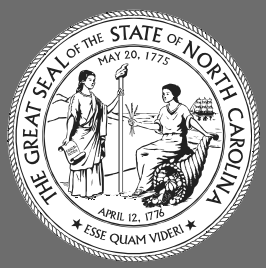
(b) For the purpose of this section, home health services shall be as defined in G.S. 130-170.1(a), except that such services may be provided by any organization listed in subsection (c) of this section.

(c) Home health services may be provided by a county health department, by a district health department, by a home health agency licensed under G.S.

STATE HEALTH COORDINATING COUNCIL

2020

State Medical Facilities Plan



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Service Regulation

common resources such as shared health databases, purchasing cooperatives, and shared information management, and by promoting coordinated services that reduce duplicative and conflicting care. The SHCC also recognizes the importance of balanced competition and market advantage in order to encourage innovation, insofar as those innovations improve safety, quality, access, and value in health care delivery.

The State Health Planning Process

Throughout the development of the North Carolina State Medical Facilities Plan there are opportunities for public review and comment. Sections of the Plan, including the policies and methods for projecting need, are developed with the assistance of committees of the North Carolina State Health Coordinating Council. The committees submit their recommendations to the Council for approval. A Proposed Plan is assembled and made available to the public. Public hearings on the Proposed Plan are held throughout the State during the summer. Comments and petitions received during this period are considered by the Council and, upon incorporation of all changes approved by the Council, a final draft of the Plan is presented to the Governor for review and approval. With the Governor's approval, the State Medical Facilities Plan becomes the official document for health facility and health service planning in North Carolina for the specified calendar year.

Other Publications

Information concerning publications or the availability of other data related to the health planning process may be obtained by contacting the:

North Carolina Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

Telephone Number: (919) 855-3865

NOTE

Determinations of need for services and facilities in this Plan do not imply an intent on the part of the North Carolina Department of Health and Human Services, Division of Health Benefits to participate in the reimbursement of the cost of care of patients using services and facilities developed in response to these needs.

North Carolina State Health Coordinating Council Members

Member:	Representing:	From:
Christopher G. Ullrich, MD, Chairman	At-Large	Charlotte
Representative Gale Adcock	NC House of Representatives	Cary
Christina Apperson	At-Large	Raleigh
Robert Bashford, MD	At-Large	Chapel Hill
Glendora Brothers	Hospice	Elizabeth City
Kelli Collins	Business and Industry (Large)	Summerfield
Stephen L. DeBiasi, FACHE, CMPE	At-Large	Wilmington
Allen Feezor	At-Large	Bolivia
William (Brian) Floyd	Hospitals	Greenville
Sandra Greene, DrPH	Academic Medical Centers	Chapel Hill
Charul G. Haugan, MD, FACEP	At-Large	Raleigh
Valarie Jarvis, RN, BSN	At-Large	Durham
Lyndon Jordan, III, MD	At-Large	Raleigh
Patricia Leonard	At-Large	Carolina Beach
Kenneth J. Lewis	Health Insurance Industry	Pinehurst
James Martin, Jr.	Nursing Homes	Hickory
Robert B. McBride, Jr., MD	At-Large	Charlotte
Commissioner Tonya McDaniel	County Government (Urban)	Winston-Salem
Commissioner Barbara McKoy	County Government (Rural)	Lillington
Denise M. Michaud	At-Large	Morganton
Vincent Morgus	Business and Industry (Small)	Raleigh
Dwight Perry, MD	At-Large	Durham
Senator Gladys A. Robinson	NC Senate	Greensboro
Timothy Rogers	Home Care Facilities	Raleigh
Quintana Stewart	Public Health Director	Hillsborough

CHAPTER 2
AMENDMENTS AND REVISIONS TO THE STATE MEDICAL FACILITIES PLAN

Amendment of Approved Plans
After the North Carolina State Medical Facilities Plan has been signed by the Governor, it will be amended only as necessary to correct errors or to respond to statutory changes, amounts of legislative appropriations or judicial decisions. The North Carolina State Health Coordinating Council will conduct a public hearing on proposed amendments and will recommend changes it deems appropriate for the Governor's approval.

NOTE: Need determinations as shown in this document may be increased or decreased during the year pursuant to Policy GEN-2 *(See Chapter 4).*

Petitions to Revise the Next State Medical Facilities Plan
Anyone who finds that the North Carolina State Medical Facilities Plan policies or methodologies, or the results of their application, are inappropriate may petition for changes or revisions. Such petitions are of two general types: those requesting changes in basic policies and methodologies, and those requesting adjustments to the need projections.

Petitions for Changes in Policies and Methodologies
People who wish to recommend changes that may have a statewide effect are asked to contact Healthcare Planning and Certificate of Need Section staff as early in the year as possible, and to submit petitions no later than March 4, 2020. Changes with the potential for a statewide effect are the addition, deletion, and revision of policies or projection methodologies. These types of changes will need to be considered in the first four months of the calendar year as the Proposed North Carolina State Medical Facilities Plan (explained below) is being developed for the following year.

Instructions for Writing Petitions for Changes in Policies and Methodologies
At a minimum, each written petition requesting a change in policies and methodologies used in the North Carolina State Medical Facilities Plan should contain:

1. Name, address, email address and phone number of petitioner.

2. Statement of the requested change, citing the policy or planning methodology in the North Carolina State Medical Facilities Plan for which the change is proposed.

3. Reasons for the proposed change to include:

    a. A statement of the adverse effects on the providers or consumers of health services that are likely to ensue if the change is not made, and

    b. A statement of alternatives to the proposed change that were considered and found not feasible.

4. Evidence that the proposed change would not result in unnecessary duplication of health resources in the area.

5. Evidence that the requested change is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: safety and quality, access, and value.

Each written petition must be clearly labeled "Petition" and one copy of each petition must be received by the North Carolina Division of Health Service Regulation, Healthcare Planning by 5:00 p.m. on March 4, 2020. Petitions must be submitted by e-mail, mail or hand delivery.

E-Mail: DHSR.SMFP.Petitions-Comments@dhhs.nc.gov

Mail: North Carolina Division of Health Service Regulation
Healthcare Planning
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

The office location and address for hand delivery and use of delivery services is:

809 Ruggles Drive
Raleigh, North Carolina 27603

Response to Petitions for Changes in Policies and Methodologies
The process for response to such petitions is as follows:

1. The Division will prepare an agency report. Staff may request additional information from the petitioner or any other people or organizations who may be affected by the proposed change.

2. The petition will be considered by the appropriate committee of the North Carolina State Health Coordinating Council and the committee will make recommendations to the North Carolina State Health Coordinating Council regarding disposition of the petition.

3. The North Carolina State Health Coordinating Council will consider the committee's recommendations and make decisions regarding whether to incorporate the changes into the Proposed North Carolina State Medical Facilities Plan for the following year.

Petitioners will receive written notification of times and places of meetings at which their petitions will be discussed. Disposition of all petitions for changes in basic policies and methodologies in the North Carolina State Medical Facilities Plan will be made no later than the final State Health Coordinating Council meeting of the calendar year.

Petitions for Adjustments to Need Determinations
On or about July 1 of each year, the North Carolina State Health Coordinating Council adopts a North Carolina Proposed State Medical Facilities Plan for the following year. A Public Review and Comment Period follows, during which regional public hearings are held to receive oral/written comments and written petitions. The Public Review and Comment Period dates are available from Healthcare Planning and appear below.

People who believe that unique or special attributes of a particular geographic area or institution give rise to resource requirements that differ from those provided by application of the standard planning procedures and policies may submit a written petition requesting an adjustment to the need determination given in the North Carolina Proposed State Medical Facilities Plan. These petitions should be delivered to Healthcare Planning as early in the Public Review and Comment Period as possible, but no later than the deadline for receipt of petitions. Requirements for petitions to change need determinations in the North Carolina Proposed State Medical Facilities Plan are given below.

Instructions for Writing Petitions for Adjustments to Need Determinations
At a minimum, each written petition requesting an adjustment to a need determination in the Proposed State Medical Facilities Plan should contain:

1. Name, address, email address and phone number of petitioner.

2. A statement of the requested adjustment, citing the provision or need determination within the Proposed State Medical Facilities Plan for which the adjustment is proposed.

3. Reasons for the proposed adjustment, including:

    a. Statement of the adverse effects on the population of the affected area that are likely to ensue if the adjustment is not made, and

    b. A statement of alternatives to the proposed adjustment that were considered and found not feasible.

4. Evidence that health service development permitted by the proposed adjustment would not result in unnecessary duplication of health resources in the area.

5. Evidence that the requested adjustment is consistent with the three Basic Principles governing the development of the North Carolina State Medical Facilities Plan: safety and quality, access and value.

Petitioners should use the same service area definitions as provided in the relevant program chapter(s) of the North Carolina Proposed State Medical Facilities Plan.

Petitioners should also be aware that Healthcare Planning staff, in reviewing the proposed adjustment, may request additional information and opinions from the petitioner or any other people and organizations who may be affected by the proposed adjustment.

Each written petition must be clearly labeled "Petition" and one copy of each petition must be received by Healthcare Planning by 5:00 p.m. on July 29, 2020. Petitions must be submitted by e-mail, mail or hand delivery.

E-Mail: DHSR.SMFP.Petitions-Comments@dhhs.nc.gov

Mail: North Carolina Division of Health Service Regulation
Healthcare Planning
2704 Mail Service Center
Raleigh, North Carolina 27699-2704

The office location and address for hand delivery and use of delivery services:

809 Ruggles Drive
Raleigh, North Carolina 27603

Response to Petitions for Adjustments to Need Determinations
The process for response to these petitions by the North Carolina Division of Health Service Regulation and the North Carolina State Health Coordinating Council is as follows:

1. The Division will prepare an agency report. Staff may request additional information from the petitioner, or other people or organizations who may be affected by the proposed change.

2. The relevant committee submits its recommendations to the North Carolina State Health Coordinating Council and the committee will make recommendations to the North Carolina State Health Coordinating Council regarding disposition of the petition.

3. The North Carolina State Health Coordinating Council considers the committee recommendations and decides whether to incorporate the recommended adjustments in the final draft of the North Carolina State Medical Facilities Plan to be forwarded to the Governor.

Petitioners will receive written notification of times and places of meetings at which their petitions will be discussed. Disposition of all petitions for adjustments to need determinations in the North Carolina State Medical Facilities Plan will be made no later than the date of the final Council meeting of the calendar year.

Scheduled State Health Coordinating Council Meetings and Committee Meetings
Any changes to Council, Committee, workgroup, and public hearing meeting dates, times, and locations will be posted on the meeting information web page at:

https://info.ncdhhs.gov/dhsr/mfp/meetings.html

All meetings are scheduled from 10:00 a.m. until noon in Room 104 of the Brown Building on the Dorothea Dix Campus, 801 Biggs Drive, Raleigh NC. Directions to the Brown Building can be found at:

https://info.ncdhhs.gov/dhsr/brown.html

North Carolina State Health Coordinating Council

March 4, 2020

June 10, 2020

August 26, 2020 (conference call meeting)

October 7, 2020

The Council will conduct a public hearing on statewide issues related to development of the North Carolina Proposed 2021 State Medical Facilities Plan immediately following the business meeting on March 4, 2020.

Committee Meetings for 2020

Acute Care Services Committee

April 7

May 19

September 15

Long-Term and Behavioral Health Committee

April 9

May 14

September 17

Technology and Equipment Committee

April 15

May 20

September 9

Deadlines for Spring Petitions and Comments, and Public Hearing Schedule

March 4, 2020	The Council will conduct a Public Hearing on statewide issues related to the development of the North Carolina Proposed 2021 State Medical Facilities Plan (SMFP) immediately following the business meeting. Electronic media may not be used in presentations at the public hearing.
March 4, 2020 5:00 p.m.	Deadline for receipt by Healthcare Planning of petitions on statewide issues.
March 18, 2020 5:00 p.m.	Deadline for receipt by Healthcare Planning of all written comments regarding petitions submitted by the March 4 deadline and all other comments related to development of the North Carolina Proposed 2021 SMFP.

2020 Schedule of Summer Public Hearings on the N.C. Proposed 2021 SMFP

(All hearings begin at 1:30 p.m.)

Wednesday July 8	Greensboro	Cone Health Administrative Services Building 721 Green Valley Road, Board Room
Friday July 10	Wilmington	New Hanover Public Library 201 Chestnut Street, Harnett Room
Tuesday July 14	Concord	Atrium Health Cabarrus 920 Church Street, Media Arts Classroom 1, 2 & 3
Friday July 17	Asheville	Mission Health System - Health Education Center 1 Hospital Drive, Conference Room 5205-5207
Tuesday July 21	Greenville	Pitt County Office Building 1717 West 5th Street, Eugene James Auditorium
Wednesday July 29	Raleigh	Dorothea Dix Campus Brown Building, 801 Biggs Dr., Room 104

Electronic media may not be used in presentations at any public hearings.

Deadlines for Summer Petitions and Comments

July 29, 2020 5:00 p.m.	Deadline for receipt by Healthcare Planning of petitions for adjustments to need determinations and comments regarding other issues related to the Proposed 2021 SMFP.
August 12, 2020 5:00 p.m.	Deadline for receipt by Healthcare Planning of any written comments on petitions submitted by the July 29 deadline and all comments regarding other issues related to the Proposed 2021 SMFP.