

Chapter 131E.
Health Care Facilities and Services.

Article 1.

General Provisions.

§ 131E-1. Definitions.

As used in this Chapter, unless the context clearly indicates otherwise:

- (1) "Department" means the Department of Health and Human Services.
- (2) "Person" means an individual, trust, estate, partnership, or corporation including associations, joint-stock companies, and insurance companies. (1983, c. 775, s. 1; 1997-443, s. 11A.118(a).)

§ 131E-2. Contested case hearing petition time limit.

Except as otherwise provided in this Chapter, a petition for a contested case that is authorized by this Chapter shall be filed in the Office of Administrative Hearings within 30 days after the Department mails written notice of an agency decision to the person filing the petition. This section shall not be construed to create any right to file a petition for a contested case that is not otherwise granted in this Chapter. (1991, c. 143, s. 1, c. 761, s. 23.)

§ 131E-3. Coordination of rules on pathological materials.

The Division of Health Service Regulation, Department of Health and Human Services (Department), shall adopt rules governing the procedures regarding the request for and release of pathological materials made to clinical laboratories within the jurisdiction of the Department. These rules shall be consistent with the North Carolina Hospital Association Best Practices Principles and the College of American Pathologists 2003 Professional Relations Manual and shall be developed in consultation with the North Carolina Medical Board to ensure consistency in procedures governing pathological materials. (2013-43, s. 1.)

§ 131E-4. Reserved for future codification purposes.

Article 2.

Public Hospitals.

Part 1. Municipal Hospitals.

§ 131E-5. Title and purpose.

- (a) This Part shall be known and may be cited as the "Municipal Hospital Act."
- (b) The purpose of this Part is to authorize municipalities to construct, operate and maintain hospitals and other facilities which furnish hospital, clinical and similar services to the people of this State. It is also the purpose of this Part to authorize municipalities to cooperate with other public and private agencies and with each other. Additionally, it is the purpose of this Part to authorize municipalities to accept assistance from State and federal agencies and from other sources.

(c) This Part provides an additional and alternative method for municipalities to establish facilities that furnish hospital, clinical and similar services. This Part shall not be regarded as repealing any powers now existing under any other law, either general, special or local.

(d) This Part shall be construed liberally to effect its purposes. (1983, c. 775, s. 1.)

§ 131E-6. Definitions.

As used in this Part, unless otherwise specified:

- (1) "City", as defined in G.S. 160A-1(2), means a municipal corporation organized under the laws of this State for the better government of the people within its jurisdiction and having the powers, duties, privileges, and immunities conferred by law on cities, towns, and villages. The term "city" does not include counties or municipal corporations organized for a special purpose under any statute or law. The word "city" is interchangeable with the words "town" and "village" and shall mean any city as defined in this subdivision without regard to the terminology employed in charters, local acts, other portions of the General Statutes, or local customary usage.
- (2) "Community general hospital" means a short-term nonfederal hospital that provides diagnostic and therapeutic services to patients for a variety of medical conditions, both surgical and nonsurgical, such services being available for use primarily by residents of the community in which it is located.
- (3) "Corporation, foreign or domestic, authorized to do business in North Carolina" means any of the following:
 - a. A corporation for profit or having a capital stock which is created and organized under Chapter 55 of the General Statutes or any other general or special act of this State.
 - b. A foreign corporation which has procured a certificate of authority to transact business in this State pursuant to Article 10 of Chapter 55 of the General Statutes.
 - c. A limited liability company formed under Chapter 57D of the General Statutes.
 - d. A foreign limited liability company that has procured a certificate of authority to transact business in this State pursuant to Article 7 of Chapter 57D of the General Statutes.
- (4) "Hospital facility" means any one or more buildings, structures, additions, extensions, improvements or other facilities, whether or not located on the same site or sites, machinery, equipment, furnishings or other real or personal property suitable for health care or medical care; and includes, without limitation, general hospitals; chronic disease, maternity, mental, tuberculosis and other specialized hospitals; nursing homes, including skilled nursing facilities and intermediate care facilities; adult care homes for the aged and disabled; public health center facilities; housing or quarters for local public health departments; facilities for

intensive care and self-care; clinics and outpatient facilities; clinical, pathological and other laboratories; health care research facilities; laundries; residences and training facilities for nurses, interns, physicians and other staff members; food preparation and food service facilities; administrative buildings, central service and other administrative facilities; communication, computer and other electronic facilities; fire-fighting facilities; pharmaceutical and recreational facilities; storage space; X ray, laser, radiotherapy and other apparatus and equipment; dispensaries; utilities; vehicular parking lots and garages; office facilities for hospital staff members and physicians; and such other health and hospital facilities customarily under the jurisdiction of or provided by hospitals, or any combination of the foregoing, with all necessary, convenient or related interests in land, machinery, apparatus, appliances, equipment, furnishings, appurtenances, site preparation, landscaping, and physical amenities.

- (4a) "Hospital land" means air and ground rights to real property held either in fee or by lease by a municipality, with all easements, rights-of-way, appurtenances, landscaping, and physical amenities such as utilities, parking lots, and garages, but excluding other improvements to land described in subsection (4) of this section and G.S. 131E-16(15).
- (5) "Municipality" means any county, city, or other political subdivision of this State, or any hospital district created under Part C of this Article.
- (6) "Nonprofit association" or "nonprofit corporation" means any association or corporation from which no part of the net earnings inures or may lawfully inure to the benefit of a private shareholder or individual. (1983, c. 775, s. 1; 1997-233, s. 1; 2014-115, s. 56(a).)

§ 131E-7. General powers.

(a) A municipality shall have all the powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to the powers granted elsewhere in this Part:

- (1) To construct, equip, operate, and maintain hospital facilities;
- (2) To levy property taxes pursuant to G.S. 153A-149 or G.S. 160A-209 and to allocate those and other revenues whose use is not otherwise restricted by law to fund hospital facilities; a hospital district may levy annually a tax on property having a situs in the district under the rules and according to the procedures prescribed in the Machinery Act, Chapter 105 of the General Statutes, Subchapter II, and a hospital district may allocate those and other revenues whose use is not otherwise restricted by law to fund hospital facilities;
- (3) To issue bonds and notes pursuant to the Local Government Finance Act, Chapter 159 of the General Statutes, for the financing of hospital facilities;

- (4) To use property owned or controlled by the municipality;
- (5) To acquire real or personal property, including existing hospital facilities, by purchase, grant, gift, devise, lease, condemnation, or otherwise;
- (6) To establish a fee schedule for services received from hospital facilities and to make services available regardless of ability to pay.

(b) A municipality or a public hospital may contract with or enter into any arrangement with other public hospitals or municipalities of this or other states, the State of North Carolina, federal, or public agencies, or with any person, private organization, or nonprofit corporation or association for the provision of health care. The municipality or public hospital may pay for or contribute its share of the cost of any such contract or arrangement from revenues available for these purposes, including revenues rising from the provision of health care.

(c) Any two or more municipalities may enter into agreements to jointly exercise the powers, privileges, and authorities granted by this Part. These agreements may provide for:

- (1) The appointment of a board, composed of representatives of the parties to the agreement, to supervise and manage a hospital facility;
- (2) The authority and duties of the board and the compensation of its members;
- (3) The proportional share of the costs of acquisition, construction, improvement, maintenance, or operation of hospital facilities;
- (4) The duration, amendment, and termination of the agreement and the disposition of property on termination of the agreement; and
- (5) Any other matters as necessary.

(d) A municipality may lease any hospital facility, or part, to a nonprofit association on terms and conditions consistent with the purposes of this Part. The municipality will determine the length of the lease. No lease executed under this subsection shall be deemed to convey a freehold interest.

(e) A municipality shall not sell nor convey any rights of ownership the municipality has in any hospital facility, including the buildings, land and equipment associated with the hospital, to any corporation or other business entity operated for profit, except that nothing herein shall prohibit the sale of surplus buildings, surplus land or surplus equipment by a municipality to any corporation or other business entity operated for profit.

A municipality may lease any hospital facility, or part, to any corporation, foreign or domestic, authorized to do business in North Carolina on terms and conditions consistent with the purposes of this Part and with G.S. 160A-272. The municipality shall determine the length of the lease; however, no lease under this subsection shall be longer than 10 years, including options to renew or extend the original term of the lease, except that leases of surplus buildings, surplus land or surplus equipment may be for any length of time determined by the municipality. The lease shall provide that the hospital facility will be operated as a community general hospital open to the general public and that the lessee will accept Medicare and Medicaid patients. No lease executed under this subsection shall be deemed to convey a freehold interest. No bonds, notes nor other evidences of indebtedness shall be issued by a municipality to finance equipment for or the acquisition, extension, construction, reconstruction, improvement, enlargement, or betterment of any hospital facility when the facility is leased to a corporation, foreign or domestic, authorized to do business in North Carolina.

For purposes of this subsection, "surplus" means any building, land or equipment which is not required for use in the delivery of necessary health care services by a hospital facility at the time of the sale, conveyance of ownership rights, or lease.

This subsection shall not be construed to affect any pending litigation nor to reflect any legislative intent as to any prior authorized or executed agreements. This subsection shall be effective from January 1, 1984 until June 30, 1984.

(f) In addition to the general and special powers conferred by this Part, a municipality is authorized to exercise powers necessary to implement the powers under this Part. (1983, c. 775, s. 1; 1993, c. 529, s. 5.3; 1995, c. 509, s. 71.)

§ 131E-7.1. Public hospitals' managed care development authorized.

A public hospital as defined in G.S. 159-39(a) may acquire an ownership interest, in whole or in part, in a nonprofit or for-profit managed care company, including a health maintenance organization, physician hospital organization, physician organization, management services organization, or preferred provider organization with which the public hospital is also directly or indirectly a contracting provider. Ownership interest may be evidenced by the ownership or acquired by the purchase of stock. This ownership or acquisition of stock is the exercise of a health care function and is not the investment of idle funds within the meaning of G.S. 159-30 and G.S.159-39(g). (1995 (Reg. Sess., 1996), c. 713, s. 1.)

§ 131E-8. Sale of hospital facilities to nonprofit corporations.

(a) A municipality as defined in G.S. 131E-6(5) or hospital authority as defined in G.S. 131E-16(14), upon such terms and conditions as it deems wise, with or without monetary consideration, may sell or convey to a nonprofit corporation organized under Chapter 55A of the General Statutes any rights of ownership the municipality or hospital authority has in a hospital facility including the building, land and equipment associated with the hospital, if the nonprofit corporation is legally committed to continue to operate the facility as a community general hospital open to the general public, free of discrimination based upon race, creed, color, sex or national origin. The nonprofit corporation shall also agree, as a condition of the municipality or hospital authority's conveying ownership, to provide such services to indigent patients as the municipality or hospital authority and the nonprofit corporation shall agree. The nonprofit corporation shall further agree that should it fail to operate the facility as a community general hospital open to the general public or should the nonprofit corporation dissolve without a successor nonprofit corporation to carry out the terms and conditions of the agreement of conveyance, all ownership rights in the hospital facility, including the building, land and equipment associated with the hospital, shall revert to the municipality or hospital authority or successor entity originally conveying the hospital.

(b) When either general obligation bonds or revenue bonds issued for the benefit of the hospital to be conveyed are outstanding at the time of sale or conveyance, then the nonprofit corporation must agree to the following:

By the effective date of sale or conveyance, the nonprofit corporation shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds then

outstanding to the maturity date or dates of such bonds or to the date or dates specified for the redemption thereof. The nonprofit corporation shall furnish to the Local Government Commission such evidence as the Commission may require that the securities purchased will satisfy the requirements of this section. A hospital which has placed funds in escrow to retire outstanding general obligation or revenue bonds, as provided in this section, shall not be considered a public hospital, and G.S. 159-39(a)(3) shall be inapplicable to such hospitals.

(c) Any sale or conveyance under this section must be approved by the municipality or hospital authority by a resolution adopted at a regular meeting of the governing body on 10 days' public notice. Notice shall be given by publication describing the hospital facility to be conveyed, the proposed monetary consideration or lack thereof, and the governing body's intent to authorize the sale or conveyance.

(d) Neither G.S. 153A-176 nor Article 12 of Chapter 160A of the General Statutes shall apply to sales or conveyances pursuant to this section.

(e) A sale or conveyance of substantially all the equipment is a sale or conveyance of hospital facility. (1983, c. 775, s. 1; 1989, c. 444.)

§ 131E-8.1. Maintenance of Health Education Facilities.

(a) This section shall apply to all sales and leases of a hospital facility by a municipality or hospital authority where any portion of the facility was constructed with a capital grant from the Area Health Education Centers Program (AHEC).

(b) The municipality or hospital authority shall give specific notice of intent to sell or lease and of any public hearing to the Director of the local AHEC program and the Director of the AHEC Program at the University of North Carolina School of Medicine at Chapel Hill.

(c) The municipality or hospital authority may provide continued access to the identical or equivalent facilities suitable for continuation of AHEC activities, including all services being provided under the existing operating contract. The municipality or hospital authority may convey all ownership rights in the hospital facility, or any part thereof, to the local AHEC Program without monetary consideration. Further, the municipality or hospital authority may reimburse the local AHEC Program for any funds used for the original construction of any office for AHEC provided by AHEC to establish or continue the hospital facility.

(d) No portion of this section shall be construed to alter rights or obligations of the operating contracts between the hospital facility and AHEC. (1983 (Reg. Sess., 1984), c. 1056, s. 1; 1985 (Reg. Sess., 1986), c. 995.)

§ 131E-9. Governing authority of hospital facilities.

(a) The governing body of a municipality may establish by resolution an office, board, or other municipal agency to plan, establish, construct, maintain, or operate a hospital facility. The resolution shall prescribe the powers, duties, compensation, and tenure of the members of the governing authority. The municipality shall remain responsible for the expenses of planning, establishment, construction, maintenance and operation of the hospital facilities.

(b) (1) The county board of commissioners of a county may establish by resolution a county hospital authority to plan, establish, construct, maintain, or operate a hospital facility. The authority shall be referred to as "_____ County Hospital Authority."

(2) The county hospital authority shall consist of six appointed members and one ex officio member.

- (3) The appointed members of the authority shall be appointed by the county board of commissioners. All appointed members shall be residents of the county. Three of the members shall be residents of a city in the county and the remaining three members shall not be residents of the same city or cities in which the other three members appointed under this subdivision reside.
- (4) For the initial appointments to the county hospital authority, two of the members shall be appointed for a term of three years, two for a term of four years, and two for a term of five years to achieve staggered terms. All subsequent appointments shall be for five-year terms.
- (5) The ex officio member of the county hospital authority shall be a member of the county board of commissioners. The ex officio member's term on the hospital authority shall be commensurate with his or her term as a member of the county board of commissioners.
- (6) When any member of the county hospital authority resigns or is removed from office before the expiration of the member's term, the county board of commissioners shall appoint a person to serve the unexpired portion of the term.

(c) Any authority vested in a county under this Part or any authority or power that may be exercised by a hospital authority under the Hospital Authorities Act, Chapter 131E, Article 2, Part B, may be vested by resolution of the county board of commissioners in a county hospital authority established under this section. However, a county hospital authority shall exercise only the powers and duties prescribed in the county board of commissioners' resolution. The county board of commissioners shall determine in the resolution the compensation, traveling and any other expenses which shall be paid to each member of the county hospital authority. However, the expenses to plan, establish, construct and operate the hospital facility shall remain the responsibility of the county. (1983, c. 775, s. 1.)

§ 131E-10. Condemnation.

Every municipality is authorized to condemn property to carry out the purposes of this Part. In condemning property, a municipality shall proceed in the manner provided in Chapter 40A of the General Statutes or in the charter of the municipality. A municipality or its agents is authorized to enter upon land, provided no unnecessary damage is done, to make surveys and examinations relative to any condemnation proceeding. Notwithstanding the provisions of any other statute or of any applicable municipal charter, the municipality may take possession of property to be condemned at any time after the commencement of the condemnation proceeding. The municipality shall not be precluded from abandonment of the condemnation of property in any case where possession has not taken place. (1983, c. 775, s. 1.)

§ 131E-11. Federal and State aid.

Every municipality or nonprofit association is authorized to accept and disburse federal and State moneys, whether made available by grant, loan, gift or devise, to carry out the purposes of this Part. All federal moneys shall be accepted and disbursed upon the terms and conditions prescribed by the United States, if the terms and conditions are consistent with State law. All State moneys shall be accepted and disbursed upon the terms and conditions prescribed by either or both

the State and the North Carolina Medical Care Commission. Unless the terms and conditions provide otherwise, the chief financial officer of the municipality shall deposit all moneys received under this section and keep them in separate trust funds. (1983, c. 775, s. 1.)

§ 131E-12. Public purposes.

The exercise of the powers, privileges, and authorities conferred on municipalities by this Part are public and government functions, exercised for a public purpose and matters of public necessity. In the case of a county, the exercise of the powers, privileges and authorities conferred by this Part is a county function and purpose, as well as a public and governmental function. In the case of any municipality other than a county, the exercise of the powers, privileges, and authorities conferred by this Part is a municipal function and purpose, as well as a public and governmental function. (1983, c. 775, s. 1.)

§ 131E-13. Lease or sale of hospital facilities to or from for-profit or nonprofit corporations or other business entities by municipalities and hospital authorities.

(a) A municipality or hospital authority as defined in G.S. 131E-16(14), may lease, sell, or convey any hospital facility, or part, to a corporation, foreign or domestic, authorized to do business in North Carolina, subject to these conditions, which shall be included in the lease, agreement of sale, or agreement of conveyance:

- (1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable, by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services.
- (2) The corporation shall ensure that indigent care is available to the population of the municipality or area served by the hospital authority at levels related to need, as previously demonstrated and determined mutually by the municipality or hospital authority and the corporation.
- (3) The corporation shall not enact financial admission policies that have the effect of denying essential medical services or treatment solely because of a patient's immediate inability to pay for the services or treatment.
- (4) The corporation shall ensure that admission to and services of the facility are available to beneficiaries of governmental reimbursement programs (Medicaid/Medicare) without discrimination or preference because they are beneficiaries of those programs.
- (5) The corporation shall prepare an annual report that shows compliance with the requirements of the lease, sale, or conveyance.

The corporation shall further agree that if it fails to substantially comply with these conditions, or if it fails to operate the facility as a community general hospital open to the general public and free of discrimination based on race, creed, color, sex, or national origin unless relieved of this responsibility by operation of law, or if the corporation dissolves without a successor corporation to carry out the terms and conditions of the lease, agreement of sale, or agreement of conveyance, all ownership or other rights in the hospital facility, including the building, land and equipment associated with the hospital, shall revert to the municipality or hospital authority or successor entity originally conveying the hospital; provided that any building, land, or equipment associated with the hospital facility that the corporation has constructed or acquired since the sale may revert only upon payment to the corporation of a sum equal to the cost less depreciation of the building, land, or equipment.

This section shall not apply to leases, sales, or conveyances of nonmedical services or commercial activities, including the gift shop, cafeteria, the flower shop, or to surplus hospital property that is not required in the delivery of necessary hospital services at the time of the lease, sale, or conveyance.

(b) In the case of a sale or conveyance, if either general obligation bonds or revenue bonds issued for the benefit of the hospital to be conveyed are outstanding at the time of sale or conveyance, then the corporation shall agree to the following:

By the effective date of sale or conveyance, the corporation shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds then outstanding to the maturity date or dates of such bonds or to the date or dates specified for the redemption thereof. The corporation shall furnish to the Local Government Commission such evidence as the Commission may require that the securities purchased will satisfy the requirements of this section. A hospital which has placed funds in escrow to retire outstanding general obligation or revenue bonds, as provided in this section, shall not be considered a public hospital, and G.S. 159-39(a)(3) shall be inapplicable to such hospitals.

No bonds, notes or other evidences of indebtedness shall be issued by a municipality or hospital authority to finance equipment for or the acquisition, extension, construction, reconstruction, improvement, enlargement, or betterment of any hospital facility if the facility has been sold or conveyed to a corporation, foreign or domestic, authorized to do business in North Carolina.

(c) In the case of a lease, the municipality or hospital authority shall determine the length of the lease. No lease executed under this section shall be deemed to convey a freehold interest. Any sublease or assignment of the lease shall be subject to the conditions prescribed by this section. If the term of the lease is more than 10 years, and either general obligation bonds or revenue bonds issued for the benefit of the hospital to be leased are outstanding at the time of the lease, then the corporation shall agree to the following:

By the effective date of the lease, the corporation shall place into an escrow fund money or direct obligations of, or obligations the principal of and interest on which, are unconditionally guaranteed by the United States of America (as approved by the Local Government Commission), the principal of and interest on which, when due and payable, will provide sufficient money to pay the principal of and the interest and redemption premium, if any, on all bonds then outstanding to the maturity date or dates of such bonds or to the date or dates specified for the redemption thereof. The corporation shall furnish to the Local Government Commission such evidence as the Commission may require that the securities purchased will satisfy the requirements of this section.

No bonds, notes or other evidences of indebtedness shall be issued by a municipality or hospital authority to finance equipment for or the acquisition, extension, construction, reconstruction, improvement, enlargement, or betterment of any hospital facility when the facility is leased to a corporation, foreign or domestic, authorized to do business in North Carolina.

(d) The municipality or hospital authority shall comply with the following procedures before leasing, selling, or conveying a hospital facility, or part thereof:

- (1) The municipality or hospital authority shall first adopt a resolution declaring its intent to sell, lease, or convey the hospital facility at a regular meeting on 10 days' public notice. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, sell, or convey the hospital facility involved, known potential buyers or lessees, a solicitation of additional interested buyers or lessees and intent to negotiate the terms of the lease or sale. Specific notice, given by certified mail, shall be given to the local office of each state-supported program that has made a capital expenditure in the hospital facility, to the Department of Health and Human Services, and to the Office of State Budget and Management.
- (2) At the meeting to adopt a resolution of intent, the municipality or hospital authority shall request proposals for lease or purchase by direct solicitation of at least five prospective lessees or buyers. The solicitation shall include a copy of G.S. 131E-13.
- (3) The municipality or hospital authority shall conduct a public hearing on the resolution of intent not less than 15 days after its adoption. Notice of the public hearing shall be given by publication at least 15 days before the hearing. All interested persons shall be heard at the public hearing.
- (4) Before considering any proposal to lease or purchase, the municipality or hospital authority shall require information on charges, services, and indigent care at similar facilities owned or operated by the proposed lessee or buyer.
- (5) Not less than 45 days after adopting a resolution of intent and not less than 30 days after conducting a public hearing on the resolution of intent, the municipality or hospital authority shall conduct a public hearing on proposals for lease or purchase that have been made. Notice of the public

hearings shall be given by publication at least 10 days before the hearing. The notice shall state that copies of proposals for lease or purchase are available to the public.

- (6) The municipality or hospital authority shall make copies of the proposals to lease or purchase available to the public at least 10 days before the public hearing on the proposals.
- (7) Not less than 60 days after adopting a resolution of intent, the municipality or hospital authority at a regular meeting shall approve any lease, sale, or conveyance by a resolution. The municipality or hospital authority shall adopt this resolution only upon a finding that the lease, sale, or conveyance is in the public interest after considering whether the proposed lease, sale, or conveyance will meet the health-related needs of medically underserved groups, such as low income persons, racial and ethnic minorities, and handicapped persons. Notice of the regular meeting shall be given at least 10 days before the meeting and shall state that copies of the lease, sale, or conveyance proposed for approval are available.
- (8) At least 10 days before the regular meeting at which any lease, sale, or conveyance is approved, the municipality or hospital authority shall make copies of the proposed contract available to the public.

(e) Notwithstanding the provisions of subsections (c) and (d) of this section or G.S. 131E-23, a hospital authority as defined in G.S. 131E-16(14) or a municipality may lease or sublease hospital land to a corporation or other business entity, whether for profit or not for profit, and may participate as an owner, joint venturer, or other equity participant with a corporation or other business entity for the development, construction, and operation of medical office buildings and other health care or hospital facilities, so long as the municipality, hospital authority, or other entity continues to maintain its primary community general hospital facilities as required by subsection (a) of this section.

(f) A municipality or hospital authority may permit or consent to the pledge of hospital land or leasehold estates in hospital land to facilitate the development, construction, and operation of medical office buildings and other health care or hospital facilities. A municipality or hospital authority also may, as lessee, enter into master leases or agreements to fund for temporary vacancies relating to hospital land or hospital facilities for use in the provision of health care.

(g) Neither G.S. 153A-176 nor Article 12 of Chapter 160A of the General Statutes shall apply to leases, subleases, sales, or conveyances under this Chapter.

(h) A municipality or hospital authority that has complied with the requirements of subdivisions (1) through (6) of subsection (d) of this section but has not, following good-faith negotiations, approved any lease, sale, or conveyance as required by subdivisions (7) and (8) of subsection (d) of this section may, not less than 120 days following the public hearing required by subdivision (5) of subsection (d) of this section, solicit additional prospective lessees or buyers not previously solicited as required by subdivision (2) of subsection (d) of this section and may approve any lease, sale, or

conveyance without the necessity to repeat compliance with the requirements of subdivisions (1) through (6) of subsection (d) of this section, except for the following:

- (1) Before considering any proposal to lease or purchase the hospital facility or part thereof, the municipality or hospital authority shall require information on charges, services, and indigent care at similar facilities leased, owned, or operated by the proposed lessee or buyer.
- (2) The municipality or hospital authority shall declare its intent to approve any lease or sale in the manner authorized by this subsection at a regular or special meeting held on 10 days' public notice. Such notice shall state that copies of the lease, sale, or conveyance proposed for approval will be available 10 days prior to the regular or special meeting required by subdivision (3) of this subsection and that the lease, sale, or conveyance shall be considered for approval at a regular or special meeting not less than 10 days following the regular or special meeting required by this subsection. Notice shall be given by publication in one or more papers of general circulation in the affected area describing the intent to lease, sell, or convey the hospital facility involved and the potential buyer or lessee.
- (3) Not less than 10 days following the regular or special meeting required by subdivision (2) of this subsection, the municipality or hospital authority shall approve any lease, sale, or conveyance by a resolution at a regular or special meeting.
- (4) At least 10 days before the regular or special meeting at which any lease, sale, or conveyance is approved, the municipality or hospital authority shall make copies of the proposed contract available to the public. (1983 (Reg. Sess., 1984), c. 1066, s. 1; 1997-233, s. 2; 1997-443, s. 11A.118(a); 2000-140, s. 93.1(a); 2001-424, s. 12.2(b); 2015-288, s. 3.)

§ 131E-14. Lease or sale of hospital facilities to certain nonprofit corporations.

If a municipality or hospital authority leases, sells, or conveys a hospital facility, or part, to a nonprofit corporation of which a majority of voting members of its governing body is not appointed or controlled by the municipality or hospital authority, the procedural requirements set forth in G.S. 131E-13(d) shall apply. (1983 (Reg. Sess., 1984), c. 1066, s. 2.)

§ 131E-14.1. Branch facilities.

Notwithstanding anything in this Article, any municipality owning and operating a hospital organized under the provisions of this Part or Part 3 or any nonprofit corporation which leases or operates a hospital facility pursuant to an agreement with the municipality may erect, remodel, enlarge, purchase, finance, and operate branches and related facilities within this State but outside the boundaries of the county subject to the following limitations:

- (1) No moneys derived from the exercise by the owning municipality of its power of taxation shall be expended on facilities located outside its boundaries;

- (2) No moneys derived from the issuance by the owning municipality of its bonds or notes shall be expended on facilities located outside its boundaries;
- (3) The owning municipality shall not possess the power of eminent domain or have the right of condemnation with respect to hospital facilities located outside its boundaries; and
- (4) The power conferred on counties by G.S. 153A-169 and G.S. 153A-170 to adopt ordinances regulating the use of county-owned property and parking on county-owned property shall not extend to hospital facilities located outside its boundaries unless the board of commissioners of the county in which the facility is located shall by resolution permit any such ordinance to be applicable within its jurisdiction.
- (5), (6) Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 676, s. 1. (1983, c. 578, s. 1; 1993 (Reg. Sess., 1994), c. 676, s. 1.)

§ 131E-14.2. Conflict of interest.

(a) No member of the board of directors or employee of a public hospital, as defined in G.S. 159-39(a), or that person's spouse shall do either of the following:

- (1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.
- (2) Have any direct interest in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. This restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business provided that the contract, undertaking, or other transaction shall be authorized by the board by specific resolution on which no director having direct interest shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have a "direct interest" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the contract, undertaking, or other transaction shall be authorized by the board of directors by specific resolution on which no director or employee having an interest, direct or indirect, shall vote.

(c) If a member of the board of directors or an employee of a public hospital or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the member of the board of directors or the employee shall immediately disclose the same in writing to the board and the disclosure shall be entered upon the minutes of the board. Failure to disclose shall constitute misconduct in office and shall be grounds for removal.

(c1) Subsection (a) of this section shall not apply if the director or employee is not involved in making or administering the contract. A director or employee is involved in administering a contract if the director or employee oversees the performance of or interprets the contract. A

director or employee is involved in making a contract if the director or employee participates in the development of specifications or terms or in the preparation or award of the contract. A director or employee is not involved in making or administering a contract solely because of the performance of ministerial duties related to the contract. A director is also involved in making a contract if the board of directors takes action on the contract, whether or not the director actually participates in that action, unless the contract is approved under an exception to this section under which the director is allowed to benefit and is prohibited from voting.

(d) Subsection (a) of this section shall not apply to any member of the board of directors of a public hospital if (i) the undertaking or contract or series of undertakings or contracts between the public hospital and one of its officials is approved by specific resolution of the board adopted in an open and public meeting and recorded in its minutes; (ii) the official entering into the contract or undertaking with the public hospital does not in an official capacity participate in any way or vote; and (iii) the amount does not exceed twelve thousand five hundred dollars (\$12,500) for medically related services and twenty-five thousand dollars (\$25,000) for other goods or services within a 12-month period, or the contract is for medically related or administrative services that are provided by a director who serves on the board as an ex officio representative of the hospital medical staff pursuant to a hospital bylaw adopted prior to January 1, 2005, or that are provided by the spouse of that director.

(e) Subsection (a) of this section shall not apply to any employment relationship between a public hospital and the spouse of a member of the board of directors of the public hospital.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A public hospital that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare. (2001-409, s. 6; 2005-70, s. 1; 2006-264, s. 64(b).)

Part 2. Hospital Authority.

§ 131E-15. Title and purpose.

(a) This Part shall be known as the "Hospital Authorities Act."

(b) The General Assembly finds and declares that in order to protect the public health, safety, and welfare, including that of low income persons, it is necessary that counties and cities be authorized to provide adequate hospital, medical, and health care and that the provision of such care is a public purpose. Therefore, the purpose of this Part is to provide an alternate method for counties and cities to provide hospital, medical, and health care. (1943, c. 780, ss. 1, 2; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-16. Definitions.

As used in this Part, unless otherwise specified:

(1) "Board of county commissioners" means the legislative body charged with governing the county.

- (2) "Bonds" means any bonds or notes issued by the hospital authority pursuant to this Part and the Local Government Finance Act, Chapter 159 of the General Statutes.
- (3) "City" means any city or town which is, or is about to be, included in the territorial boundaries of a hospital authority when created hereunder.
- (4) "City clerk" and "mayor" means the clerk and mayor, respectively, of the city, or the officers thereof charged with the duties customarily imposed on the clerk and mayor, respectively.
- (5) "City council" means the legislative body, council, board of commissioners, board of trustees, or other body charged with governing the city or town.
- (6) "Commissioner" means one of the members of a hospital authority appointed in accordance with the provisions of this Part.
- (7) "Community general hospital" means a short-term nonfederal hospital that provides diagnostic and therapeutic services to patients for a variety of medical conditions, both surgical and nonsurgical, such services being available for use primarily by residents of the community in which it is located.
- (8) "Contract" means any agreement of a hospital authority with or for the benefit of an obligee whether contained in a resolution, trust indenture, mortgage, lease, bond or other instrument.
- (9) "Corporation, foreign or domestic, authorized to do business in North Carolina" means a corporation for profit or having a capital stock which is created and organized under Chapter 55 of the General Statutes or any other general or special act of this State, or a foreign corporation which has procured a certificate of authority to transact business in this State pursuant to Article 10 of Chapter 55 of the General Statutes.
- (10) "County" means the county which is, or is about to be, included in the territorial boundaries of a hospital authority when created hereunder.
- (11) "County clerk" and "chairman of the board of county commissioners" means the clerk and chairman, respectively, of the county or the officers thereof charged with the duties customarily imposed on the clerk and chairman, respectively.
- (12) "Federal government" means the United States of America, or any agency, instrumentality, corporate or otherwise, of the United States of America.
- (13) "Government" means the State and federal governments and any subdivision, agency or instrumentality, corporate or otherwise, of either of them.
- (14) "Hospital authority" means a public body and a body corporate and politic organized under the provisions of this Part.
- (15) "Hospital facilities" means any one or more buildings, structures, additions, extensions, improvements or other facilities, whether or not

located on the same site or sites, machinery, equipment, furnishings or other real or personal property suitable for health care or medical care; and includes, without limitation, general hospitals; chronic disease, maternity, mental, tuberculosis and other specialized hospitals; nursing homes, including skilled nursing facilities and intermediate care facilities; adult care homes for the aged and disabled; public health center facilities; housing or quarters for local public health departments; facilities for intensive care and self-care; clinics and outpatient facilities; clinical, pathological and other laboratories; health care research facilities; laundries; residences and training facilities for nurses, interns, physicians and other staff members; food preparation and food service facilities; administrative buildings, central service and other administrative facilities; communication, computer and other electronic facilities; fire-fighting facilities; pharmaceutical and recreational facilities; storage space; X ray, laser, radiotherapy and other apparatus and equipment; dispensaries; utilities; vehicular parking lots and garages; office facilities for hospital staff members and physicians; and such other health and hospital facilities customarily under the jurisdiction of or provided by hospitals, or any combination of the foregoing, with all necessary, convenient or related interests in land, machinery, apparatus, appliances, equipment, furnishings, appurtenances, site preparation, landscaping and physical amenities.

- (15a) "Hospital land" means air and ground rights to real property held either in fee or by lease by a hospital authority, with all easements, rights-of-way, appurtenances, landscaping, and physical amenities such as utilities, parking lots, and garages, but excluding other improvements to land described in G.S. 131E-6(4) and subsection (15) of this section.
- (16) "Municipality" means any county, city, town or incorporated village, other than a city as defined above, which is located within or partially within the territorial boundaries of an authority.
- (17) "Real property" means lands, lands under water, structures, and any and all easements, franchises and incorporeal hereditaments and every estate and right therein, legal and equitable, including terms for years and liens by way of judgment, mortgage or otherwise.
- (18) "State" means the State of North Carolina. (1943, c. 780, s. 3; 1971, c. 780, s. 22; c. 799; 1983, c. 775, s. 1; 1995, c. 535, s. 19; 1997-233, s. 3.)

§ 131E-17. Creation of a hospital authority.

(a) A hospital authority may be created whenever a city council or a county board of commissioners finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a hospital authority.

(b) After the adoption of a resolution creating a hospital authority, the mayor or the chairman of the county board of commissioners shall appoint commissioners in accordance with G.S. 131E-18.

(c) The commissioners shall be a public body and a body corporate and politic upon the completion of the procedures described in G.S. 131E-19. (1943, c. 780, s. 4; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-18. Commissioners.

(a) The mayor or the chairman of the county board shall appoint the commissioners of the authority. There shall be not less than six and not more than 30 commissioners. Upon a finding that it is in the public interest, the commissioners may adopt a resolution increasing or decreasing the number of commissioners by a fixed number; Provided that no decrease in the number of commissioners shall shorten a commissioner's term. A certified copy of the resolution and a list of nominees shall be submitted to the mayor or the chairman of the county board of commissioners for appointments in accordance with the procedures set forth in subsection (d) of this section.

(b) For the initial appointments of commissioners, one-third of the commissioners shall be appointed for a term of one year, one-third for a term of two years, and one-third for a term of three years to achieve staggered terms. All subsequent appointments shall be for three-year terms. A commissioner shall hold office until a successor has been appointed and qualified. Vacancies from resignation or removal from office shall be filled for the unexpired portion of the term.

(c) The mayor or the chairman of the county board of commissioners shall name the first chair of the authority. Thereafter, the commissioners shall elect each subsequent chair from their members. The commissioners shall elect from their members the first vice-chair and all subsequent vice-chairs.

(d) When a commissioner resigns, is removed from office, completes a term of office, or when there is an increase in the number of commissioners, the remaining commissioners shall submit to the mayor or the chairman of the county board of commissioners a list of nominees for appointment to the commission. The mayor or the chairman of the county board of commissioners shall appoint, only from the nominees, the number of commissioners necessary to fill all vacancies. However, the mayor or the chairman of the county board of commissioners may require the commissioners to submit as many additional lists of nominees as he or she may desire.

(e) The mayor shall file with the city clerk, or the chairman of the county board of commissioners shall file with the county clerk, a certificate of appointment or reappointment of a commissioner. The certificate shall be conclusive evidence of the due and proper appointment of the commissioner.

(f) Commissioners shall receive no compensation for their services, but they shall be entitled to reimbursement for necessary expenses, including travel expenses, incurred in the discharge of their duties.

(g) For a county with a population of less than 75,000, according to the most recent decennial federal census, the following exceptions to the provisions of this section shall apply:

- (1) The commissioners shall be appointed by the county board of commissioners rather than the chairman of the county board of commissioners;
- (2) In making appointments under subsection (d) of this section, the county board of commissioners shall consider the nominations of the commissioners of the authority, but the county board of the

commissioners is not bound by the nominations and may choose any qualified person.

The foregoing exceptions shall not apply when a county with a population of less than 75,000 jointly establishes a hospital authority with a city.

(h) A majority of the commissioners shall constitute a quorum. (1943, c. 780, s. 5; 1971, c. 799; 1973, c. 792; 1981, c. 525, s. 1; 1983, c. 775, s. 1.)

§ 131E-19. Incorporation of a hospital authority.

(a) After the commissioners are appointed, they shall present to the Secretary of State an application for incorporation as a hospital authority. The application shall be signed by each of the commissioners and shall set forth:

- (1) That the city council or the county board of commissioners has found that it is in the interest of the public health and welfare to create a hospital authority;
- (2) That the mayor or the chairman of the county board of commissioners has appointed them as commissioners;
- (3) The name and official residence of each of the commissioners;
- (4) A certified copy of the appointment evidencing the commissioners' right to office, and the date and place of induction into and taking of office;
- (5) That they desire the hospital authority to become a public body and a body corporate and politic under this Part;
- (6) The term of office of each of the commissioners;
- (7) The name which is proposed for the corporation; and
- (8) The location and principal office of the corporation.

The application shall be subscribed and sworn to by each of the commissioners before an officer authorized by the laws of this State to take and certify oaths. This officer shall certify upon the application that he or she personally knows the commissioners and knows them to be the officers as asserted in the application, and that each subscribed to the application and took the oath in the officer's presence.

(b) The Secretary of State shall examine the application. If he or she finds that the name proposed for the corporation is not identical with that of a person or of any other corporation in this State or so nearly similar so as to lead to confusion and uncertainty, the application shall be filed and recorded in the appropriate book of record in the Secretary of State's office. The Secretary of State shall then make and issue to the commissioners a certificate of incorporation pursuant to this Part, under the Seal of the State, and shall record the certificate with the application.

(c) A hospital authority's name or the location or principal office of the corporation may be changed by the adoption of a resolution by the majority of the authority's commissioners. A copy of the resolution, duly verified by the chair and secretary of the commission before an officer authorized by the laws of this State to take and certify oaths, shall be delivered to the Secretary of State, along with a conformed copy. If the Secretary of State finds that the proposed name is not identical with that of a person or any corporation of this State, or so nearly similar as to lead to confusion and uncertainty, the resolution shall be filed and recorded in the appropriate book of record in the Secretary of State's office. A resolution changing the location or principal office of the hospital authority shall be filed and recorded in the appropriate book of record in the Secretary of State's office. The Secretary of State shall then return to the authority the conformed copy,

together with a certificate stating that the attached copy is a true copy of the document in the Secretary of State's office, that shows the date of filing.

(d) In any legal proceeding, a copy of the certificate of incorporation, certified by the Secretary of State, shall be admissible in evidence and shall be conclusive proof of its filing and contents and the incorporation of the hospital authority in accordance with this Part. (1943, c. 780, s. 4; 1966, c. 988, s. 1; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-20. Boundaries of the authority.

(a) The territorial boundaries of a hospital authority shall include the city or county creating the authority and the area within 10 miles from the territorial boundaries of that city or county. However, a hospital authority may engage in health care activities in a county outside its territorial boundaries pursuant to:

- (1) An agreement with a hospital facility if only one hospital currently exists in that county;
- (2) An agreement with any hospital if more than one hospital currently exists in that county; or
- (3) An agreement with any health care agency if no hospital currently exists in that county.

In no event shall the territorial boundaries of a hospital authority include, in whole or in part, the area of any previously existing hospital authority. All priorities shall be determined on the basis of the time of issuance of the certificates of incorporation by the Secretary of State.

(b) After the creation of an authority, the subsequent existence within its territorial boundaries of more than one city or county shall in no way affect the territorial boundaries of the authority. (1943, c. 780, s. 4; 1971, c. 799; 1983, c. 775, s. 1; 1993, c. 529, s. 6.1.)

§ 131E-21. Conflict of interest.

(a) No commissioner or employee of the hospital authority or that person's spouse shall do either of the following:

- (1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.
- (2) Have any interest, direct or indirect, in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. The foregoing restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business; Provided that any such contract, undertaking, or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner having an interest, direct or indirect, shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have an "interest, direct or indirect" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the contract, undertaking or other transaction shall be authorized by the

commissioners by specific resolution on which no commissioner or employee having an interest, direct or indirect, shall vote.

(c) If a commissioner or employee of an authority or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the commissioner or employee shall immediately disclose the same in writing to the authority and the disclosure shall be entered upon the minutes of the authority. Failure to disclose shall constitute misconduct in office and shall be grounds for a commissioner's removal from office under G.S. 131E-22.

(d) Subsection (a) of this section shall not apply to any commissioner of a hospital authority if (i) the undertaking or contract or series of undertakings or contracts between the hospital authority and one of its officials is approved by specific resolution of the governing body adopted in an open and public meeting and recorded in its minutes and the amount does not exceed twelve thousand five hundred dollars (\$12,500) for medically related services and twenty-five thousand dollars (\$25,000) for other goods or services within a 12-month period; and (ii) the official entering into the contract or undertaking with the hospital authority does not in an official capacity participate in any way or vote.

(e) Subsection (a) of this section shall not apply to any employment relationship between a hospital authority and the spouse of a commissioner of the hospital authority.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A hospital authority that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare. (1943, c. 780, s. 7; 1971, c. 749; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1058, s. 1; 2001-409, s. 7.)

§ 131E-22. Removal of commissioners.

(a) The appointing authority, as stated in G.S. 131E-18, may remove a commissioner for inefficiency, neglect of duty, or misconduct in office. A commissioner may be removed only after he or she has been given a copy of the charges and provided the opportunity to be heard in person or by counsel. A commissioner is entitled to at least 10 days after receipt of the notice to prepare for a hearing before the mayor or the chairman of the county.

(b) An obligee of the authority may file with the mayor or the chairman of the county board of commissioners written charges that the authority is willfully violating the laws of the State or a term, provision, or covenant to any contract to which the authority is a party. The mayor or the chairman of the county board of commissioners shall give each of the commissioners a copy of the charges at least 10 days prior to the hearing on the charges. The commissioners shall be provided an opportunity to be heard in person or by counsel. The mayor or the chairman of the county board of commissioners shall, within 15 days after receipt of the charges, remove any commissioners of the authority who are found to have acquiesced in any willful violation. If a commissioner has not filed a written statement before the hearing with the authority stating his or her objections to or lack of participation in the violation, the commissioner shall be deemed to have acquiesced in a willful violation.

(c) If, after due and diligent search, a commissioner to whom charges are required to be delivered cannot be found within the county where the authority is located, the charges shall be

deemed to be served upon the commissioner when it is mailed to the commissioner at the commissioner's last known address as the same appears on the records of the authority.

(d) In the event of the removal of any commissioner, the mayor shall file in the office of the city clerk, or the chairman of the county board of commissioners shall file with the county clerk, a record of the proceedings together with the charges against the commissioner and the findings. (1943, c. 780, s. 8; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-23. Powers of the authority.

(a) An authority shall have all powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to those powers granted elsewhere in this Part:

- (1) To investigate hospital, medical, and health conditions and the means of improving those conditions;
- (2) To determine where inadequate hospital and medical facilities exist;
- (3) To accept donations or money, personal property, or real estate for the benefit of the authority and to take title to the same from any person, firm, corporation or society;
- (4) To acquire by purchase, gift, devise, lease, condemnation, or otherwise any existing hospital facilities;
- (5) To purchase, lease, obtain options upon, or otherwise acquire any real or personal property or any interest therein from any person, firm, corporation, city, county, or government;
- (6) To sell, exchange, transfer, assign, or pledge any real or personal property or any interest therein to any person, firm, corporation, city, county or government;
- (7) To own, hold, clear and improve property;
- (8) To borrow money upon its bonds, notes, debentures, or evidences of indebtedness, as provided for in G.S. 131E-26 and G.S. 131E-27;
- (9) To purchase real or personal property pursuant to G.S. 131E-32;
- (10) To appoint an administrator of a hospital facility and necessary assistants, and any and all other employees necessary or advisable, to fix their compensation, to adopt necessary rules governing their employment, and to remove employees;
- (11) To delegate to its agents or employees any powers or duties as it may deem appropriate;
- (12) To employ its own counsel and legal staff;
- (13) To adopt, amend and repeal bylaws for the conduct of its business;
- (14) To enter into contracts for necessary supplies, equipment, or services for the operation of its business;
- (15) To appoint committees or subcommittees as it shall deem advisable, to fix their duties and responsibilities, and to do all things necessary in connection with the construction, repair, reconstruction, management, supervision, control and operation of the authority's business;

- (16) To establish procedures for health care providers to secure the privilege of practicing within any hospital operated by the authority pursuant to Part 3 of Article 5 of this Chapter;
- (17) To establish reasonable rules governing the conduct of health care providers while on duty in any hospital operated by the facility pursuant to Part 3 of Article 5 of this Chapter;
- (18) To provide for the construction, reconstruction, improvement, alteration or repair of any hospital facility, or any part of a facility;
- (19) To enter into any contracts or other arrangements with any municipality, other public agency of this or any other State or of the United States, or with any individual, private organization, or nonprofit association for the provision of hospital, clinical, or similar services;
- (20) To lease any hospital facilities to or from any municipality, other public agency of this or any other state or of the United States, or to any individual, corporation, or association upon any terms and subject to any conditions as may carry out the purposes of this Part. The authority may provide for the lessee to use, operate, manage and control the hospital facilities, and to exercise designated powers, in the same manner as the authority itself might do;
- (21) To act as an agent for the federal, State or local government in connection with the acquisition, construction, operation or management of a hospital facility, or any part thereof;
- (22) To arrange with the State, its subdivisions and agencies, and any county or city, to the extent it is within the scope of their respective functions,
 - a. To cause the services customarily provided by each to be rendered for the benefit of the hospital authority,
 - b. To furnish, plan, replan, install, open or close streets, roads, alleys, sidewalks or similar facilities and to acquire property, options or property rights for the furnishing of property or services for a hospital facility, and
 - c. To provide and maintain parks and sewage, water and other facilities for hospital facilities and to lease and rent any of the dwellings or other accommodations or any of the lands, buildings, structures or facilities embraced in any hospital facility and to establish and revise the rents and charges;
- (23) To insure the property or the operations of the authority against risks as the authority may deem advisable;
- (24) To invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, in property or securities in which trustees, guardians, executors, administrators, and others acting in a fiduciary capacity may legally invest funds under their control;
- (25) To sue and be sued;
- (26) To have a seal and to alter it at pleasure;
- (27) To have perpetual succession;

- (28) To make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the authority;
- (29) To remove vehicles parked on land owned or leased by the hospital authority in areas clearly designated as no parking or restricted parking zones. An owner of a removed vehicle as a condition of regaining possession of the vehicle, shall reimburse the hospital authority for all reasonable costs, not to exceed fifty dollars (\$50.00), incidental to the removal and storage of the vehicle provided that the designation of the area as a no parking or restricted parking zone clearly indicates that the owner may be subject to these costs;
- (30) To plan and operate hospital facilities;
- (31) To provide teaching and instruction programs and schools for medical students, interns, physicians, nurses, technicians and other health care professionals;
- (32) To provide and maintain continuous resident physician and intern medical services;
- (33) To adopt, amend and repeal rules and regulations governing the admission of patients and the care, conduct, and treatment of patients;
- (34) To establish a fee schedule for services received from hospital facilities and make the services available regardless of ability to pay;
- (35) To maintain and operate isolation wards for the care and treatment of mental, contagious, or other similar diseases;
- (36) To sell a hospital facility pursuant to G.S. 131E-8 or G.S. 131E-13; and
- (37) To agree to limitations upon the exercise of any powers conferred upon the hospital authority by this Part in connection with any loan by a government.
- (38) To engage in health care activities outside the State.

(b) A hospital authority may exercise any or all of the powers conferred upon it by this Part, either generally or with respect to any specific hospital facility or facilities, through or by designated agents, including any corporation or corporations which are or shall be formed under the laws of this State.

(c) Expired pursuant to Session Laws 1983, c. 775, s. 1.

(d) No provisions with respect to the acquisition, operation or disposition of property by other public bodies shall be applicable to a hospital authority unless otherwise specified by the General Assembly. (1913, c. 42, s. 15; 1917, c. 268; C.S., s. 7273; 1983, c. 775, s. 1; 1995, c. 509, s. 135.1(1); 1997-456, s. 27; 1999-456, s. 6; 2015-288, s. 5.)

§ 131E-24. Eminent domain.

(a) A hospital authority may acquire by eminent domain any real property, including fixtures and improvements, which it deems necessary to carry out the purposes of this Part. The hospital authority may exercise the power of eminent domain under the provisions of Chapter 40A of the General Statutes or any other statute now in force or subsequently enacted for the exercise of the power of eminent domain.

(b) No property belonging to any city, town, or county, any government, religious or charitable organization, or to any existing hospital or clinic may be acquired without its consent. No property belonging to a public utility corporation may be acquired without the approval of the commission or other officer or agency, if any, having regulatory power over the corporation.

(c) The right of eminent domain shall not be exercised unless and until a certificate of public convenience and necessity for the facility has been issued by the North Carolina Utilities Commission. The proceedings leading up to issuing of the certificate of public convenience and necessity, and the right of appeal from the proceedings shall be governed by the Public Utilities Act, Chapter 62 of the General Statutes, and the rights under that act are hereby expressly reserved to all interested parties in the proceedings. In addition to the powers now granted by law to the North Carolina Utilities Commission, the Utilities Commission is authorized to investigate and examine all facilities set up or attempted to be set up under this Part and to determine the question of public convenience and necessity for the facility. (1943, s. 780, s. 10; 1971, c. 799; 1981, c. 919, s. 18; 1983, c. 775, s. 1.)

§ 131E-25. Zoning and building laws.

All hospital facilities of the authority shall be subject to the planning, zoning, sanitary and building laws, ordinances and regulations applicable to the locality in which the hospital facility is situated. (1943, c. 780, s. 11; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-26. Revenue bonds and notes.

(a) A hospital authority shall have the power to issue revenue bonds under the Local Government Revenue Bond Act, Chapter 159 of the General Statutes, Article 5, or the bond and revenue anticipation provisions of Chapter 159 of the General Statutes, Article 9, for the purpose of acquiring, constructing, reconstructing, improving, enlarging, bettering, equipping, extending or operating hospital facilities.

(b) A hospital authority shall have the power to borrow for the purposes above enumerated upon its notes or other evidences of indebtedness, subject to the approval of the Local Government Commission as provided in G.S. 131E-32(c). Such approval shall be required regardless of the amount of any such borrowing. Any borrowing by a hospital authority before the date of ratification of Part 2 of Article 2 of this Chapter, whether or not approved by the Local Government Commission, is valid, ratified and confirmed. (1983, c. 775, s. 1.)

§ 131E-27. Contracts with federal government.

A hospital authority is authorized:

- (1) To borrow money and accept grants from the federal government for or to aid in the construction of a hospital facility;
- (2) To acquire any land acquired by the federal government for the construction of a hospital facility; and
- (3) To acquire, lease or manage any hospital facility constructed or owned by the federal government.

To these ends, a hospital authority is authorized to enter into contracts, mortgages, trust indentures, leases or other agreements giving the federal government the right to supervise and approve the construction, maintenance and operation of the hospital facility. It is the purpose and intent of this Part to authorize every hospital authority to do any and all things necessary to secure

the financial aid and cooperation of the federal government in the construction, maintenance, and operation of hospital facilities. (1943, c. 780, s. 19; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-28: Repealed by Session Laws 2016-5, s. 5.3(a), effective May 11, 2016.

§ 131E-29. Audits and recommendations.

Each hospital authority shall file with the mayor of the city or the chairman of the county board of commissioners at least annually an audit report by a certified public accountant of its activities for the preceding year, and shall make any recommendations necessary to carry out the purposes of this Part. (1943, c. 780, s. 22; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-30. Appropriations.

Each year the governing body of a city or county in which the hospital authority is located may appropriate and transfer funds to the authority. The appropriations shall be from the General Fund and may not exceed five percent (5%) of the General Fund. Money appropriated and paid to the hospital authority by a city or county shall be deemed a necessary expense of the city or county. However, the appropriations shall not be deemed to be a revenue of the authority for the purpose of bonds of the hospital authority issued under the Local Government Revenue Bond Act, Chapter 159 of the General Statutes, Article 5. (1943, c. 780, s. 25; 1971, c. 780, s. 23; c. 799; 1983, c. 775, s. 1.)

§ 131E-31. Transfers of property by a city or county to a hospital authority.

(a) A city or county may lease, sell, convey, or otherwise transfer, with or without consideration or with nominal consideration, any property, whether real or personal or mixed, to a hospital authority whose territorial boundaries include at least part of the city or county. A hospital authority is authorized to accept such lease, transfer, assignment or conveyance and to bind itself to the performance and observation of any agreements and conditions required by the city or county.

(b) If a city or county sells, conveys, or otherwise irrevocably transfers to a hospital authority property with a market value in excess of two hundred fifty thousand dollars (\$250,000), and if the hospital authority accepts this property, the mayor of the city or the chairman of the county board of commissioners shall have the right to name additional commissioners to serve on the authority. The number of additional commissioners shall be such that the proportion of additional commissioners to existing commissioners is approximately equal to the proportion of the total value being transferred to the hospital authority to the total value of property already held by the authority. The determination of the ratios will be made solely by the governing body of the city or county transferring the property to the hospital authority; however, in no event shall fewer than two nor more than nine commissioners be added to the hospital authority. The total number of commissioners shall be increased by the number of commissioners added under this subsection. The times of commencement and expiration of the initial terms of the commissioners being added shall be determined by agreement between the hospital authority and the governing body of the city or county. After the expiration of the initial terms, subsequent terms will be three years. Copies of the agreement setting out the number of persons being added and the terms of each shall be filed with the clerk of the city or the clerk of the county board of commissioners making the transfer and, thereafter, copies of the reports referred to in G.S. 131E-29 shall be filed with the clerk of the

city or the clerk of the county board of commissioners. (1943, c. 780, s. 26; 1961, c. 988, s. 2; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-32. Purchase money security interests.

(a) An authority shall have the power and authority to purchase real or personal property under installment contracts, purchase money mortgages or deeds of trust, or other instruments, which create in the property purchased a security interest to secure payment of the purchase price and interest thereon. No deficiency judgment may be rendered against any authority for breach of an obligation authorized by this section. Any contract made or entered into by an authority before the date of ratification of Part 2 of Article 2 of this Chapter which would have been valid hereunder is valid, ratified and confirmed.

(b) A hospital authority may contract pursuant to this section in an amount of less than seven hundred fifty thousand dollars (\$750,000), adjusted, as hereinafter provided, in any single transaction without the approval of the Local Government Commission: Provided, however, that the approval of the Local Government Commission shall be required for any single contract pursuant to this section if the aggregate dollar amount of all such contracts outstanding after any such single transaction, exclusive of revenue bonds issued pursuant to G.S. 131E-26 and federal contracts entered pursuant to G.S. 131E-27, would exceed ten percent (10%) of the total operating revenues, as hereinafter defined, of the hospital authority for its most recently completed fiscal year as set forth in the audited financial statements of such authority for such fiscal year. The approval of the Local Government Commission shall be required with respect to any single contract pursuant to this section in an amount of seven hundred fifty thousand dollars (\$750,000) or more, adjusted as hereinafter provided.

(c) Approval of the Local Government Commission under this section or as required by G.S. 131E-26(b) shall be obtained in accordance with such rules and regulations as the Local Government Commission may prescribe and shall be evidenced by the secretary's certificate on the contract or note or other evidence of indebtedness. In determining whether to approve any such contract or borrowing, the Local Government Commission shall consider whether the hospital authority can demonstrate the financial responsibility and capability of the hospital authority to fulfill its obligations with respect to such contract or borrowing. The Local Government Commission may approve the application without other findings, if it finds that (i) the proposed project or the purpose of the borrowing is necessary and expedient, (ii) the contract or the borrowing, under the circumstances, is preferable to a bond issue for the same purpose, (iii) the sums to fall due under the contract or borrowing are adequate and not excessive for the proposed purpose, (iv) the authority's debt management procedures are good, or that reasonable assurances have been given that its debt will henceforth be managed in strict compliance with law and (v) the authority is not in default on any of its debt service obligations. Any contract or borrowing subject to this subsection requiring the approval of the Local Government Commission that does not bear the secretary's certificate thereon shall be void, and it shall be unlawful for any officer, employee or agent of a hospital authority to make any payments of money thereunder. An order of the Local Government Commission approving any such contract or borrowing shall not be regarded as an approval of the legality of the contract or borrowing in any respect.

(d) The seven hundred fifty thousand dollars (\$750,000) amount referred to in G.S. 131E-32(b) shall be in effect from July 15, 1983 through September 30, 1984. For each twelve-month period thereafter, the seven hundred fifty thousand dollar (\$750,000) amount shall be the figure in effect for the preceding twelve-month period, adjusted to reflect the change in the

preceding twelve-month period in the Department of Commerce Composite Construction Cost Index.

(e) For purposes of G.S. 131E-32(b), the "total operating revenues" of a hospital authority for a fiscal year means patient revenue, less provisions for contractual adjustments, uncompensated care and bad debts, plus other operating revenues, all as determined in accordance with generally accepted accounting principles. (1983, c. 775, s. 1.)

§ 131E-33. Part controlling.

Insofar as the provisions of this Part are inconsistent with the provisions of any other law, the provisions of this Part shall be controlling; however this Part shall not be construed as preventing a city, town, or county from establishing and operating a hospital under the authority of any other law now or hereafter in effect. (1943, c. 780, s. 28; 1971, c. 799; 1983, c. 775, s. 1.)

§ 131E-34: Repealed by Session Laws 2011-326, s. 17, effective June 27, 2011.

§§ 131E-35 through 131E-39. Reserved for future codification purposes.

Part 3. Hospital District Act.

§ 131E-40. Title and purpose.

- (a) This Part shall be known as the "Hospital District Act."
- (b) It is the purpose of this Part to authorize the creation of hospital districts to furnish hospital, clinical and similar services to the people of this State.
- (c) This Part provides an additional and alternative method for the provision of hospital, clinical and similar services.
- (d) This Part shall be construed liberally to effect its purposes. (1983, c. 775, s. 1.)

§ 131E-41. Methods of creation of a hospital district.

(a) The voters of an area may petition their county board of commissioners and the North Carolina Medical Care Commission for the creation of a hospital district. All of the area proposed to be included within a hospital district must be located within one county. The petition shall be signed by at least 500 voters of the area described in the petition. However, if the area has less than 1,100 voters, then the minimum number of petitioners shall be 250 voters. The petition shall set forth:

- (1) A description of the area to be included within the proposed hospital district;
- (2) The names of all municipalities located in whole or in part in the proposed hospital district;
- (3) The names of all publicly owned hospitals in the proposed hospital district;
- (4) The purpose or purposes sought to be accomplished by the creation of the hospital district; and
- (5) The proposed name of the hospital district.

The petition shall be delivered to the county board of commissioners of the county in which the proposed hospital district would be located. If the county board of commissioners approves the

creation of the hospital district, they shall have the petition delivered to the North Carolina Medical Care Commission for review under G.S. 131E-42.

(b) In the alternative, the county board of commissioners, in its discretion, may create a hospital district by resolution. This authority exists only when one hospital district already exists in the county, or when a special tax levy for hospital purposes has been authorized or is now authorized with respect to a portion of the county. This power is limited to establishing a hospital district in the area lying outside the existing hospital district or outside the portion of the county in which a hospital tax levy has been or is now authorized. When a county board of commissioners exercises its power under this subsection, all other provisions of this Part shall be applicable, except as modified by this subsection. (1949, c. 766, s. 5; 1953, c. 1045, s. 1; 1959, cc. 877, 1074; 1971, c. 780, s. 37.4; 1973, c. 476, s. 152; c. 494, s. 45; c. 1090, s. 1; 1983, c. 775, s. 1.)

§ 131E-42. Hearing and determination.

(a) After receipt of a petition for the creation of a hospital district that meets the requirements of G.S. 131E-41(a) and that has been approved by the county board of commissioners, the North Carolina Medical Care Commission shall give notice of a hearing on the creation of a hospital district. The notice of hearing shall be posted at the county courthouse door and at three public places within the proposed district. In addition, notice of hearing shall be published at least once for three successive weeks in a newspaper circulating in the proposed district. The notice of hearing shall specify:

- (1) The date of hearing which shall not be earlier than 20 days after the first posting and publication of notice;
- (2) The location of the hearing, which shall be within the county in which the proposed district would be located; and
- (3) That any interested person may appear and be heard at the hearing.

(b) At the time and place specified in the notice of hearing, the North Carolina Medical Care Commission, or its designee, shall hear all interested persons, and, if necessary, adjourn and reconvene at a later time.

(c) After the hearing, the North Carolina Medical Care Commission shall determine if it is in the public interest and beneficial to the residents of the area to create a hospital district, and, if it is, shall adopt a resolution creating the hospital district. The resolution shall define the area to be included in the hospital district. The area shall either be the one described in the petition or a part of that area. However, no municipality, in whole or in part, shall be included in a hospital district unless the governing body of the municipality shall have approved by resolution the inclusion and shall have filed a certified copy of the resolution with the North Carolina Medical Care Commission.

(d) Each hospital district shall be designated by the North Carolina Medical Care Commission as the "_____ Hospital District of _____ County," inserting in the blank spaces a name identifying the locality and the name of the county.

(e) The North Carolina Medical Care Commission shall give notice of the creation of a hospital district. The notice shall be published at least once for two successive weeks in the newspaper in which the notice of hearing required by G.S. 131E-42(a) was published. A notice substantially in the following form, the blanks first being properly filled in, with the printed or written signature of the executive secretary of the North Carolina Medical Care Commission appended, shall be published with the resolution:

The foregoing resolution was passed by the North Carolina Medical Care Commission on the _____ day of _____, ____; it was first published on the _____ day of _____, ____.

Any action or proceeding questioning the validity of the resolution or creation of the _____ Hospital District of _____ County or the inclusion in the district of any of the areas described in the resolution must be commenced within thirty days after the first publication of this resolution.

Secretary
North Carolina Medical
Care Commission.

(1943, c. 766, s. 5; 1951, c. 805; 1953, c. 1045, ss. 1, 2; 1959, c. 877; 1973, c. 476, s. 152; c. 1090, s. 1; 1983, c. 775, s. 1; 1999, c. 456, s. 59.)

§ 131E-43. Limitation of actions.

Any action or proceeding in any court to set aside a resolution of the North Carolina Medical Care Commission creating any hospital district, or questioning the validity of the resolution, or the creation of any hospital district, or the inclusion in the district of any of the territory described in the resolution creating the district, must be commenced within 30 days after the first publication of the resolution and notice required by G.S. 131E-42(e). Thereafter, no right of action or defense founded upon the invalidity of a resolution or the creation of a district or the inclusion of any territory in the district shall be asserted, nor shall the validity of the resolution or the creation of the district or the inclusion of any territory be open to question in any court upon any ground, except in any action or proceeding commenced within the 30-day period. (1949, c. 766, s. 5; 1951, c. 805; 1953, c. 1045, s. 2; 1973, c. 476, s. 152; c. 1090, s. 1; 1983, c. 775, s. 1.)

§ 131E-44. General powers.

(a) The inhabitants of a hospital district are a body corporate and politic by the name specified by the North Carolina Medical Care Commission. Under that name they:

- (1) Are vested with all the property and rights of property belonging to any corporation;
- (2) Have perpetual succession;
- (3) May sue or be sued;
- (4) May contract;
- (5) May acquire any real or personal property;
- (6) May hold, invest, sell or dispose of property;
- (7) May have a seal and alter and renew it; and
- (8) May exercise the powers conferred upon them by this Part.

(b) A hospital district is vested with all the powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to the powers granted elsewhere:

- (1) Those powers granted under the Municipal Hospital Act, Chapter 131E of the General Statutes, Article 2, Part A;

- (2) To issue general obligation and revenue bonds and bond anticipation notes pursuant to the Local Government Finance Act, Chapter 159 of the General Statutes;
- (3) To issue tax and revenue anticipation notes pursuant to Chapter 159 of the General Statutes, Article 9, Part 2; and
- (4) All other powers as are necessary and incidental to the exercise of the powers of this Part. (1971, c. 780, s. 37.4; 1973, c. 476, s. 152; c. 494, s. 45; 1983, c. 775, s. 1.)

§ 131E-45. County taxes.

The county board of commissioners may levy a tax for the financing of the operation, equipment, and maintenance of any hospital operated by the district, including any public or nonprofit hospital, if the tax is approved by a majority of the qualified voters of the hospital district who shall vote on the question of levying the tax. The county board of commissioners shall determine the rate or amount of taxes that will be levied if approved by the voters of the district. The election on the question of levying the tax may be held at any time fixed by the county board of commissioners and shall be conducted in the same manner as bond elections held under G.S. 159-61. (1949, c. 766, s. 5; 1953, c. 1045, s. 6; 1983, c. 775, s. 1.)

§ 131E-46. Referendum on repeal of tax levy.

(a) The board of commissioners of the county in which a hospital district was created under the provisions of this Part may, if a tax levy was authorized by referendum under G.S. 131E-45, call a referendum on the repeal of the authority to levy a tax. Such referendum may be called only if there are no outstanding general obligation bonds of the district.

(b) The question on the ballot shall be:

"[] FOR removal of the right of the board of county commissioners to levy and collect a tax in _____ Hospital District of _____ County,

"[] AGAINST removal of the right of the board of county commissioners to levy and collect a tax in _____ Hospital District of _____ County."

(c) The referendum shall be conducted in the same manner as bond elections held under G.S. 159-61. No new registration of voters shall be required.

(d) If a majority of the votes cast are in favor of the question, then beginning on the first day of the fiscal year following the date of the referendum, the board of county commissioners shall have no authority to levy a tax in the hospital district unless the voters approve under G.S. 131E-45. No referendum may be held within one year of the date of a referendum under this section. (1983, c. 775, s. 1.)

§ 131E-47. Governing body.

The board of county commissioners of the county in which a hospital district is located shall be the governing body of the district. All of the provisions of the Municipal Hospital Act, Chapter 131E, Article 2, Part 1, shall apply to the hospital district and to the county board of commissioners as the governing body. (1953, c. 1045, s. 7; 1983, c. 775, s. 1.)

Part 4. Limited Liability.

§ 131E-47.1. Limited liability.

(a) A person serving as a director, trustee, or officer of a public hospital as defined in G.S. 159-39, or as a commissioner, member, or officer of a hospital authority established under Part 1 or 2 of this Article, or as a director, trustee, or officer of North Carolina Memorial Hospital, shall be immune individually from civil liability for monetary damages, except to the extent covered by insurance, for any act or failure to act arising out of this service, except where the person:

- (1) Is compensated for his services beyond reimbursement for expenses,
- (2) Was not acting within the scope of his official duties,
- (3) Was not acting in good faith,
- (4) Committed gross negligence or willful or wanton misconduct that resulted in the damage or injury,
- (5) Derived an improper personal financial benefit from the transaction,
- (6) Incurred the liability from the operation of a motor vehicle, or
- (7) Is defendant in an action brought under G.S. 55A-28.1 or 55A-28.2.

(b) The immunity in subsection (a) is personal to the directors, trustees, officers, commissioners, and members, and does not immunize the hospital or hospital authority for liability for the acts or omissions of the directors, trustees, or officers. (1987 (Reg. Sess., 1988), c. 1057, s. 1; c. 1100, s. 39.2.)

Article 2A.

Garnishment for Debts Owed Public Hospitals.

§§ 131E-48 through 131E-51: Repealed by Session Laws 2013-382, s. 13.2, effective October 1, 2013, and applicable to hospital and ambulatory surgical facility billings and collections practices occurring on or after that date.

§ 131E-52: Reserved for future codification purposes.

§ 131E-53: Reserved for future codification purposes.

§ 131E-54: Reserved for future codification purposes.

Article 3.

North Carolina Specialty Hospitals.

Part 1. Lenox Baker Children's Hospital.

§§ 131E-55 through 131E-58: Repealed by Session Laws 1987, c. 856, s. 13.

§ 131E-59: Reserved for future codification purposes.

§ 131E-60: Reserved for future codification purposes.

§ 131E-61: Reserved for future codification purposes.

§ 131E-62: Reserved for future codification purposes.

§ 131E-63: Reserved for future codification purposes.

§ 131E-64: Reserved for future codification purposes.

Part 2. Other Programs Controlled by the Department.

§ 131E-65. Alcohol Detoxification Program.

There shall be no reduction of services offered, no contracting of primary services, nor removal of this facility from Buncombe County without prior approval of the General Assembly. (1983, c. 775, s. 1.)

§ 131E-66: Repealed by Session Laws 1985, c. 589, s. 40.

§ 131E-67. Specialty hospitals.

All functions, powers, duties, and obligations heretofore vested in the Board of Directors of the North Carolina Specialty Hospitals and Eastern North Carolina Hospital are hereby transferred to and vested in the Department. All appropriations heretofore made to such Board of Directors or to any of the hospitals are hereby transferred to the Department. The Secretary of the Department shall have the power and duty to adopt rules for the operation of these facilities. (1979, c. 838, s. 46; 1983, c. 775, s. 1.)

§ 131E-68. Reserved for future codification purposes.

§ 131E-69. Reserved for future codification purposes.

Article 4.

Construction and Enlargement of Hospitals.

§ 131E-70. Construction and enlargement of local hospitals.

(a) The Department is authorized to continue surveys of all counties in the State to determine:

- (1) The hospital needs of the county;
- (2) The economic ability of various areas to support adequate hospital service;
- (3) What assistance by the State, if any, is necessary to supplement other available funds; to finance the construction of new hospitals and health centers, additions to existing hospitals and health centers; and to finance equipment necessary to provide adequate hospital service for the citizens of the county;

and to periodically report this information, together with its recommendations, to the Governor, who shall transmit the reports to the General Assembly for any legislative action necessary to ensure an adequate statewide hospital program.

(b) The Department is authorized to act as the agency of the State to develop and administer a statewide plan in accordance with rules adopted by the Medical Care Commission for the

construction and maintenance of hospitals, public health centers and related facilities and to receive and administer funds which may be provided by the General Assembly and by the federal government.

(c) The Department is authorized to develop statewide plans for the construction and maintenance of hospitals, medical centers and related facilities, or other plans necessary in order to meet the requirements and receive the benefits of applicable federal legislation.

(d) The Department is authorized to adopt rules to carry out the intent and purposes of this Article.

(e) The Department shall be responsible for doing all acts necessary to authorize the State to receive the full benefits of any federal statutes enacted for the construction and maintenance of hospitals, health centers or allied facilities.

(f) The Medical Care Commission shall make grants-in-aid to counties, cities, towns and subdivisions of government to acquire real estate and construct hospital facilities, including the reconstruction, remodeling or addition to any hospital facilities acquired by municipalities or subdivisions of government for use as community hospitals. These appropriations and funds made available by the State shall be allocated, apportioned and granted for the purposes of this Article and for other purposes in accordance with the rules adopted by the Medical Care Commission. The Medical Care Commission may furnish financial and other types of aid and assistance to any nonprofit hospital owned and operated by a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual, upon the same terms and conditions as this aid and financial assistance is granted to municipalities and subdivisions of government.

(g) The Department may make available to any eligible hospital, clinic, or other medical facility operated by the State any unallocated federal sums or balances remaining after all grants-in-aid for local approvable projects made by the Department have been completed, disbursed or encumbered. (1945, c. 1096; 1947, c. 933, ss. 3, 5; 1949, c. 592; 1951, c. 1183, s. 1; 1971, c. 134; 1973, c. 476, s. 152; c. 1090, s. 1; 1979, c. 504, ss. 8, 14; 1983, c. 775, s. 1.)

§§ 131E-71 through 131E-74. Reserved for future codification purposes.

Article 5.

Hospital Licensure Act.

Part 1. Article Title and Definitions.

§ 131E-75. Title; purpose.

(a) This Article shall be known as the "Hospital Licensure Act."

(b) The purpose of this article is to establish hospital licensing requirements which promote public health, safety and welfare and to provide for the development, establishment and enforcement of basic standards for the care and treatment of patients in hospitals. (1947, c. 933, s. 6; 1983, c. 775, s. 1.)

§ 131E-76. Definitions.

As used in this article, unless otherwise specified:

(1) "Commission" means the North Carolina Medical Care Commission.

- (1a) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the North Carolina Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development. To be designated as a critical access hospital under this subdivision, the hospital must be certified as a critical access hospital pursuant to 42 CFR Part 485 Subpart F. The North Carolina Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development may designate a hospital located in a Metropolitan Statistical Area as a rural hospital for the purposes of the critical access hospital program if the hospital is located in a county with twenty-five percent (25%) or more rural residents as defined by the most recent United States decennial census.
- (1b) through (1d) Reserved for future codification purposes.
- (1e) "Gastrointestinal endoscopy room" means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.
- (2) "Governing body" means the Board of Trustees, Board of Directors, partnership, corporation, association, person or group of persons who maintain and control the hospital. The governing body may or may not be the owner of the properties in which the hospital services are provided.
- (3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, adult care homes licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes, and any outpatient department including a portion of a hospital operated as an outpatient department, on or off of the hospital's main campus, that is operated under the hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 C.F.R. § 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within 30 feet of any hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the hospital shall provide plans and specifications to the Department for review and approval as required for hospital construction or renovations in a manner described by the Department.
- (4) "Infirmary" means a unit of a school, or similar educational institution, which has the primary purpose to provide limited short-term health and nursing services to its students.

- (5) "Medical review committee" means any of the following committees formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing:
 - a. A committee of a state or local professional society.
 - b. A committee of a medical staff of a hospital.
 - c. A committee of a hospital or hospital system, if created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital or system.
 - d. A committee of a peer review corporation or organization.
- (6) Renumbered.
- (6a) "Operating room" means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.
- (7) "Rural hospital network" means an alliance of members that shall include at least one critical access hospital and one other hospital. To qualify as a rural hospital network, the critical access hospital must submit a comprehensive, written memorandum of understanding to the Department of Health and Human Services, Office of Research, Demonstrations and Rural Health Development, for the Department's approval. The memorandum of understanding must include provisions for patient referral and transfer, a plan for network-wide emergency services, and a plan for sharing patient information and services between hospital members including medical staff credentialing, risk management, quality assurance, and peer review. (1947, c. 933, s. 6; 1949, c. 920, s. 1; 1955, c. 369; 1961, c. 51, s. 1; 1973, c. 476, s. 152; 1983, c. 775, s. 1; 1985, c. 589, s. 41; 1993, c. 321, s. 245; 1995, c. 535, s. 20; 1997-443, s. 11A.118(a); 2004-149, ss. 1.1, 2.4; 2004-199, s. 49; 2005-346, ss. 1, 2; 2009-462, s. 4(j); 2009-487, s. 4(a).)

Part 2. Hospital Licensure.

§ 131E-77. Licensure requirement.

(a) No person or governmental unit shall establish or operate a hospital in this state without a license. An infirmary is not required to obtain a license under this Part.

(b) The Commission shall prescribe by rule that any licensee or prospective applicant seeking to make specified types of alteration or addition to its facilities or to construct new facilities shall submit plans and specifications before commencement to the Department for preliminary inspection and approval or recommendations with respect to compliance with the applicable rules under this Part.

(c) An applicant for licensing under this Part shall provide information related to hospital operations as requested by the Department. The required information shall be submitted by the applicant on forms provided by the Department and established by rule.

(d) Upon receipt of an application for a license, the Department shall issue a license if it finds that the applicant complies with the provisions of this Article and the rules of the Commission. The Department shall renew each license in accordance with the rules of the

Commission. The Department shall charge the applicant a nonrefundable annual base license fee plus a nonrefundable annual per-bed fee as follows:

Facility Type	Number of Beds	Base Fee	Per-Bed Fee
General Acute Hospitals:	1-49 beds	\$250.00	\$17.50
	50-99 beds	\$350.00	\$17.50
	100-199 beds	\$450.00	\$17.50
	200-399 beds	\$550.00	\$17.50
	400-699 beds	\$750.00	\$17.50
	700+ beds	\$950.00	\$17.50
Other Hospitals:		\$500.00	\$17.50

(e) The Department shall issue the license to the operator of the hospital who shall not transfer or assign it except with the written approval of the Department. The license shall designate the number and types of inpatient beds, the number of operating rooms, and the number of gastrointestinal endoscopy rooms.

(e1) Any license issued by the Department shall include only facilities (i) operated by the hospital within a single county and (ii) operated by the hospital in an immediately adjoining county; provided, however, that facilities operated by a hospital in an immediately adjoining county shall only be included within the same hospital license if the applicant hospital demonstrates all of the following to the satisfaction of the Department:

- (1) There was previously only one hospital licensed by the Department providing inpatient services in the immediately adjoining county.
- (2) The licensed hospital in the immediately adjoining county described in subdivision (1) of this subsection closed or otherwise ceased providing hospital services to patients no more than three years prior to the date the applicant hospital first applied to license a facility in such immediately adjoining county.

If the Department approves a hospital's initial request to include within its hospital license a facility in an immediately adjoining county, then any other hospital services thereafter developed and operated by the applicant in such immediately adjoining county in accordance with applicable law may also be included within and covered by the license issued to the applicant by the Department.

(f) The operator shall post the license on the licensed premises in an area accessible to the public. (1947, c. 933, s. 6; 1949, c. 920, ss. 3, 4; 1963, c. 66; 1973, c. 476, s. 152; c. 1090, s. 1; 1975, c. 718, s. 2; 1983, c. 775, s. 1; 2003-284, s. 34.2(a); 2005-276, s. 41.2(b); 2005-346, s. 3; 2009-451, s. 10.76(e); 2011-145, s. 18.10(c); 2011-391, s. 42.1; 2016-94, s. 12G.3(a); 2017-57, s. 11G.2(a).)

§ 131E-78. Adverse action on a license.

(a) The Department shall have the authority to deny, suspend, revoke, annul, withdraw, recall, cancel, or amend a license in any case when it finds a substantial failure to comply with the provisions of this Part or any rule promulgated under this Part.

(b) Repealed by Session Laws 2007-444, s. 1, effective August 23, 2007.

(b1) The Secretary may suspend the admission of any new patients to specific areas of a hospital or suspend specific services of a hospital licensed under this Article where the conditions of the hospital constitute a substantial failure to comply with the provisions of this Part or any rule adopted under this Part and are dangerous to the health or safety of the patients. When the Secretary suspends admissions or specific services, the suspension shall be limited to the smallest possible components of the hospital. The Department shall provide consultation to assist the hospital in correcting the conditions that led to the suspension in order that the suspension can be lifted at the earliest possible time after the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In determining whether to suspend admissions or services under this subsection, the Secretary shall consider the following factors:

- (1) The character and degree of impact of the conditions at the hospital on the health and safety of its patients.
- (2) The character and degree of impact that the proposed suspension of admissions or services would have on the functionality of the hospital and the availability of services necessary to the community or to current patients of the hospital.
- (3) Whether all other reasonable means for correcting the problem have been exhausted and no less restrictive alternative to suspension of admissions or service exists.

(c) Repealed by Session Laws 2007-444, s. 1, effective August 23, 2007.

(c1) A hospital may contest any adverse action on its license under this section in accordance with Chapter 150B of the General Statutes. (1947, c. 933, s. 6; 1973, c. 476, s. 152; c. 1090, s. 1; 1981, c. 614, ss. 16, 17; 1983, c. 775, s. 1; 1987, c. 827, s. 1; 2007-444, s. 1.)

§ 131E-78.1: Reserved for future codification purposes.

§ 131E-78.2: Reserved for future codification purposes.

§ 131E-78.3: Reserved for future codification purposes.

§ 131E-78.4: Reserved for future codification purposes.

§ 131E-78.5. Designation as primary stroke center.

(a) The Department shall designate as a primary stroke center any hospital licensed under this Article that demonstrates to the Department that the hospital is certified by the Joint Commission or other nationally recognized accrediting body that requires conformance to best practices for stroke care in order to be identified as a primary stroke center. A hospital that is certified by the Joint Commission or other nationally recognized accrediting body that requires conformance to best practices for stroke care in order to be identified as a primary stroke center shall report the certification to the Department within 90 days of receiving that certification. A hospital shall inform the Department of any changes to its certification status within 30 days of any change.

(b) Each hospital designated as a primary stroke center pursuant to this section shall make efforts to coordinate the provision of appropriate acute stroke care with other hospitals licensed in this State through a formal written agreement. The agreement shall, at a minimum, address (i) transportation of acute stroke patients to hospitals designated as

primary stroke centers and (ii) acceptance by hospitals designated as primary stroke centers of acute stroke patients initially treated at hospitals that are not capable of providing appropriate stroke care.

(c) The Department shall maintain within the Division of Health Service Regulation, Office of Emergency Services, a list of the hospitals designated as primary stroke centers in accordance with this section and post the list on the Department's Internet Web site. Annually on June 1, the Department shall transmit this list to the medical director of each licensed emergency medical services provider in this State.

(d) A hospital licensed under this Article shall not advertise or hold itself out to the public as a primary stroke center unless certified as a primary stroke center by the Joint Commission or other nationally recognized accrediting body that requires conformance to best practices for stroke care in order to be identified as a primary stroke center.

(e) Nothing in this section shall be construed to do any of the following:

(1) Establish a standard of medical practice for stroke patients.

(2) Restrict in any way the authority of any hospital to provide services authorized under its hospital license.

(f) The Department may adopt rules to implement the provisions of this section. (2013-44, s. 1.)

§ 131E-79. Rules and enforcement.

(a) The Commission shall promulgate rules necessary to implement this Article.

(b) The Department shall enforce this Article and the rules of the Commission. (1947, c. 933, s. 6; 1973, c. 476, s. 152; 1983, c. 775, s. 1.)

§ 131E-79.1. Counseling patients regarding prescriptions.

(a) Any hospital or other health care facility licensed pursuant to this Chapter or Chapter 122C of the General Statutes, health maintenance organization, local health department, community health center, medical office, or facility operated by a health care provider licensed under Chapter 90 of the General Statutes, providing patient counseling by a physician, a registered nurse, or any other appropriately trained health care professional shall be deemed in compliance with the rules adopted by the North Carolina Board of Pharmacy regarding patient counseling.

(b) As used in this section, "patient counseling" means the effective communication of information to the patient or representative in order to improve therapeutic outcomes by maximizing proper use of prescription medications and devices. (1993, c. 529, s. 7.7.)

§ 131E-79.2. Educating parents of newborns regarding pertussis disease.

(a) Each hospital licensed under this Article shall provide to the parents of newborns delivered at the hospital free, medically accurate educational information about pertussis disease and the availability of the tetanus-diphtheria and pertussis (Tdap) vaccine to protect against pertussis disease. The hospital shall provide this educational information to parents during the postpartum period and prior to the mother's discharge from the hospital. As used in this section, "postpartum period" means the period of time between the mother's admittance to the hospital for delivery of the newborn child through the first few hours after childbirth.

(b) The educational information provided to parents pursuant to this section shall include, at a minimum, the most current recommendations of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices regarding the use of tetanus-toxoid-diphtheria-acellular pertussis (Tdap) vaccine to reduce the burden of pertussis in infants.

(c) Nothing in this section shall be construed to require a hospital to provide or pay for any vaccination against pertussis disease. (2013-161, s. 1.)

§ 131E-80. Inspections.

(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the hospital's initial licensing, any location included or added to the hospital's accreditation through an accrediting body approved pursuant to section 1865(a) of the Social Security Act, shall be deemed to be part of the hospital's license; provided, however, that all locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part.

(b) The Department may delegate to any state officer or agency the authority to inspect hospitals. The Department may revoke this delegated authority at its discretion and make its own inspections.

(c) Authorized representatives of the Department shall have at all times the right of proper entry upon any and all parts of the premises of any place in which entry is necessary to carry out the provisions of this Part or the rules adopted by the Commission; and it shall be unlawful for any person to resist a proper entry by such authorized representative upon any premises other than a private dwelling. However, no representative shall, by this entry onto the premises, endanger the health or well being of any patient being treated in the hospital.

(d) To enable the Department to determine compliance with this Part and the rules promulgated under the authority of this Part and to investigate complaints made against a hospital licensed under this Part, while maintaining the confidentiality of the complainant, the Department shall have the authority to review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been patients of the hospital licensed under this Part and the personnel records of those individuals employed by the licensed hospital. The examinations of these records is permitted notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient. Proceedings of medical review committees are exempt from the provisions of this section. The hospital, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews shall be kept confidential by the Department and not disclosed without written authorization of the patient, employee or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning a hospital without the consent of that person. Any officer, administrator, or employee of the Department who willfully discloses confidential or privileged information without

appropriate authorization or court order shall be guilty of a Class 3 misdemeanor and upon conviction shall only be fined in the discretion of the court but not in excess of five hundred dollars (\$500.00). Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "Public Records" defined.

(e) Information received by the Commission and the Department through filed reports, license applications, or inspections that are required or authorized by the provisions of this Part, may be disclosed publicly except where this disclosure would violate the confidential relationship existing between physician and patient. However, no such public disclosure shall identify the patient involved without permission of the patient or court order. (1947, c. 933, s. 6; 1973, c. 476, s. 152; c. 1090, s. 1; 1981, c. 586, s. 3; 1983, c. 775, s. 1; 1993, c. 539, s. 957; 1994, Ex. Sess., c. 24, s. 14(c); 2009-487, s. 4(b).)

§ 131E-81. Penalties.

(a) Any person establishing, conducting, managing, or operating any hospital without a license shall be guilty of a Class 3 misdemeanor, and upon conviction shall only be liable for a fine of not more than fifty dollars (\$50.00) for the first offense and not more than five hundred dollars (\$500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) Except as otherwise provided in this Part, any person who willfully violates any provision of this Part or who willfully fails to perform any act required, or who willfully performs any act prohibited by this Part, shall be guilty of a Class 1 misdemeanor. However, any person who willfully violates any rule adopted by the Commission under this Part or who willfully fails to perform any act required by, or who willfully does any act prohibited by, these rules shall be guilty of a Class 3 misdemeanor. (1947, c. 933, s. 6; 1983, c. 775, s. 1; 1993, c. 539, s. 958; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-82. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of a hospital without a license.

(b) If any person shall hinder the proper performance of duty of the Secretary or a representative in carrying out the provisions of this Part, the Secretary may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes, and Rule 65 of the Rules of Civil Procedure. (1947, c. 933, s. 6; 1973, c. 476, s. 152; 1983, c. 775, s. 1.)

§ 131E-83. Temporary change of hospital bed capacity.

A hospital may temporarily increase its bed capacity by up to ten percent (10%) over its licensed bed capacity by utilizing observation beds for hospital inpatients if the hospital notifies and obtains the approval of the Division of Health Service Regulation. For purposes of this section, "temporarily" means not longer than 60 consecutive days. (2001-410, s. 1; 2007-182, s. 1.)

§ 131E-84. Waiver of rules for hospitals that provide temporary shelter or temporary services during a disaster or emergency.

(a) The Division of Health Service Regulation may temporarily waive, during disasters or emergencies declared in accordance with Article 1A of Chapter 166A of the General Statutes, any rules of the Commission pertaining to a hospital to the extent necessary to allow the hospital to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify, in advance of a declared disaster or emergency, rules that may be waived, and the extent to which the rules may be waived, upon a declaration of disaster or emergency in accordance with Article 1A of Chapter 166A of the General Statutes. The Division may also waive rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health, safety, or welfare of any of the persons occupying the hospital. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72 hours of the time the preapproved waivers are deemed by the emergency management agency to apply.

(b) As used in this section, "emergency management agency" is as defined in G.S. 166A-19.3. (2007-444, s. 2; 2012-12, s. 2(t).)

§ 131E-84.1. Human trafficking public awareness sign.

Each hospital licensed under this Article shall prominently display in its emergency room or emergency department in a place that is clearly conspicuous and visible to employees and the public a public awareness sign created and provided by the North Carolina Human Trafficking Commission that contains the National Human Trafficking Resource hotline information. (2017-57, s. 17.4(d); 2017-197, s. 5.8.)

Part 3. Hospital Privileges.

§ 131E-85. Hospital privileges and procedures.

(a) The granting or denial of privileges to practice in hospitals to physicians licensed under Chapter 90 of the General Statutes, Article 1, dentists, optometrists, and podiatrists and the scope and delineation of such privileges shall be determined by the governing body of the hospital on a non-discriminatory basis. Such determinations shall be based upon the applicant's education, training, experience, demonstrated competence and ability, and judgment and character of the applicant, and the reasonable objectives and regulations of the hospital, including, but not limited to appropriate utilization of hospital facilities, in which privileges are sought. Nothing in this Part shall be deemed to mandate hospitals to grant or deny to any such individuals or others privileges to practice in hospitals, or to offer or provide any type of care.

(b) The procedures to be followed by a licensed hospital in considering applications of dentists, optometrists, and podiatrists for privileges to practice in such hospitals shall be similar to those applicable to applications of physicians licensed under Chapter 90 of the General Statutes, Article 1. Such procedures shall be available upon request.

(c) In addition to the granting or denial of privileges, the governing body of each hospital may suspend, revoke, or modify privileges.

(d) All applicants or individuals who have privileges shall comply with all applicable medical staff bylaws, rules and regulations, including the policies and procedures governing the qualifications of applicants and the scope and delineation of privileges.

(e) The Department shall not issue or renew a license under this Article unless the applicant has demonstrated that the procedures followed in determining hospital privileges are in accordance with this Part and rules of the Department. (1981, c. 659, s. 10; 1983, c. 775, s. 1; 1987, c. 859, s. 18; 1989, c. 446; 1997-75, s. 2.)

§ 131E-86. Limited privileges.

(a) It shall be unlawful for an individual who is not licensed under Chapter 90 of the General Statutes, Article 1, to admit a patient to a hospital without written proof in accordance with the policy of the governing body of the hospital that a physician licensed under Chapter 90 of the General Statutes, Article 1, who is a member of the medical staff will be responsible for the performance of a basic medical appraisal and for the medical needs of the patient. The governing body of a hospital may waive this requirement for a dentist licensed under Chapter 90 of the General Statutes, Article 2, to the extent authorized by this statute, who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Dental Association.

(b) The governing body of each hospital shall not grant privileges that exceed the scope of a license. (1983, c. 775, s. 1.)

§ 131E-87. Reports of disciplinary action; immunity from liability.

The chief administrative officer of each licensed hospital in the State shall report to the appropriate occupational licensing board the details, as prescribed by the board, of any revocation, suspension, limitation, or voluntary reduction of privileges of a health care provider to practice in that hospital. Each hospital shall also report to the board its medical staff resignations. Reports concerning physician privileges and resignations shall be made in accordance with G.S. 90-14.13. Any person making a report required by this section shall be immune from any resulting criminal prosecution or civil liability unless the person knew the report was false or acted in reckless disregard of whether the report was false. (1983, c. 775, s. 1; 1987, c. 859, s. 16; 2006-144, s. 9.)

§ 131E-88. Reserved for future codification purposes.

§ 131E-89. Reserved for future codification purposes.

Part 4. Discharge from Hospital.

§ 131E-90. Authority of administrator; refusal to leave after discharge.

The case of a patient who refuses or fails to leave the hospital upon discharge by the attending physician shall be reviewed by two physicians licensed to practice medicine in this State, one of whom may be the attending physician. If in the opinion of the physicians, the patient should be discharged as cured or as no longer needing treatment or for the reason that treatment cannot benefit the patient's case or for other good and sufficient reasons, the patient's refusal to leave shall constitute a trespass. The patient shall be guilty of a Class 3 misdemeanor. (1965, c. 258; 1983, c. 775, s. 1; 1993, c. 539, s. 959; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-91. Fair billing and collections practices for hospitals and ambulatory surgical facilities.

(a) All hospitals and ambulatory surgical facilities licensed pursuant to this Chapter shall, upon request of the patient, present an itemized list of charges to all discharged patients detailing in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient. Patient bills that are not itemized shall include notification to the patient of the right to request, free of charge, an itemized bill. A patient may request an itemized list of charges at any time within three years after the date of discharge or so long as the hospital or ambulatory surgical facility, a collections agency, or another assignee of the hospital or ambulatory surgical facility asserts the patient has an obligation to pay the bill. Each hospital and ambulatory surgical facility shall establish a method for patients to inquire about or dispute a bill.

(b) If a patient has overpaid the amount due to the hospital or ambulatory surgical facility, whether as the result of insurance coverage, patient error, health care facility billing error, or other cause, and the overpayment is not in dispute or on appeal, the hospital or ambulatory surgical facility shall provide the patient with a refund within 45 days of receiving notice of the overpayment.

(c) A hospital or ambulatory surgical facility shall not bill insured patients for charges that would have been covered by their insurance had the hospital or ambulatory surgical facility submitted the claim or other information required to process the claim within the allotted time requirements of the insurer.

(d) Hospitals and ambulatory surgical facilities shall abide by the following reasonable collections practices:

- (1) A hospital or ambulatory surgical facility shall not refer a patient's unpaid bill to a collections agency, entity, or other assignee during the pendency of a patient's application for charity care or financial assistance under the hospital's or ambulatory surgical facility's charity care or financial assistance policies.
- (2) A hospital or ambulatory surgical facility shall provide a patient with a written notice that the patient's bill will be subject to collections activity at least 30 days prior to the referral being made.
- (3) A hospital or ambulatory surgical facility that contracts with a collections agency, entity, or other assignee shall require the collections agency, entity, or other assignee to inform the patient of the hospital's or ambulatory surgical facility's charity care and financial assistance policies when engaging in collections activity.
- (4) A hospital or ambulatory surgical facility shall require a collections agency, entity, or other assignee to obtain the written consent of the hospital or ambulatory surgical facility prior to the collections agency, entity, or other assignee filing a lawsuit to collect the debt.
- (5) For debts arising from the provision of care by a hospital or ambulatory surgical center, the doctrine of necessities as it existed at common law shall apply equally to both spouses, except where they are permanently

living separate and apart, but shall in no event create any liability between the spouses as to each other. No lien arising out of a judgment for a debt owed a hospital or ambulatory surgical facility under this section shall attach to the judgment debtors' principal residence, or, if the land upon which the principal residence is located is greater than five acres, then no lien shall attach to the judgment debtors' principal residence and the surrounding five acres, held by them as tenants by the entireties or that was held by them as tenants by the entireties prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse.

- (6) For debts arising from the provision of care by a hospital or ambulatory surgical center to a minor, there shall be no execution on or otherwise forced sale of the principal residence of the custodial parent or parents for a judgment obtained for the outstanding debt until such time as the minor is either no longer residing with the custodial parent or parents or until the minor reaches the age of majority, whichever occurs first.

(e) The Commission shall adopt rules to ensure that this section is properly implemented. The Department shall not issue or renew a license under this Article unless the applicant has demonstrated that the requirements of this subsection are being met. (1991, c. 310, s. 1; 2013-382, s. 13.1; 2013-393, s. 2.)

§ 131E-92. Reserved for future codification purposes.

§ 131E-93. Reserved for future codification purposes.

§ 131E-94. Reserved for future codification purposes.

Part 5. Medical Review Committee.

§ 131E-95. Medical review committee.

(a) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(b) The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined", and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility licensed under Chapter 131E of the General Statutes, or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during

proceedings of the committee. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings.

(c) Information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that performs any accreditation or certification including the Joint Commission on Accreditation of Healthcare Organizations, or to a patient safety organization or its designated contractors. Information released under this subsection shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification, or the patient safety organization's or its contractors' analysis of patient safety and health care quality. Information released under this subsection retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this section, and the standards review or patient safety organization shall keep the information confidential subject to this section, except as necessary to carry out the organization's patient safety, accreditation, or certification activities. For the purposes of this section, "patient safety organization" means an entity that collects and analyzes patient safety or health care quality data of providers for the purpose of improving patient safety and the quality of health care delivery and includes, but is not limited to, an entity formed pursuant to Public Law No. 109-41. (1973, c. 1111; 1981, c. 725; 1983, c. 775, s. 1; 1999-222, s. 2; 2002-179, s. 19; 2004-149, s. 2.5; 2006-144, s. 3.2.)

Part 6. Risk Management.

§ 131E-96. Risk management programs.

(a) Each hospital shall develop and maintain a risk management program which is designed to identify, analyze, evaluate, and manage risks of injury to patients, visitors, employees, and property through loss reduction and prevention techniques and quality assurance activities, as prescribed in rules promulgated by the Commission.

(b) The Department shall not issue or renew a license under this Article unless the applicant is in compliance with this section. (1987, c. 859, s. 17.)

Part 7. Confidential Information.

§ 131E-97. Confidentiality of patient information.

(a) Medical records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes.

(b) Charges, accounts, credit histories, and other personal financial records compiled and maintained by health care facilities in connection with the admission, treatment, and discharge of individual patients are not public records as defined by Chapter 132 of the General Statutes. (1993 (Reg. Sess., 1994), c. 570, s. 10.)

§ 131E-97.1. Confidentiality of personnel information.

(a) Except as provided in subsection (b) of this section, the personnel files of employees or former employees, and the files of applicants for employment maintained by a public hospital

as defined in G.S. 159-39 or maintained by a hospital that has been sold or conveyed pursuant to G.S. 131E-8 are not public records as defined by Chapter 132 of the General Statutes.

(b) Repealed by Session Laws, 1997-517, s. 3.

(c) Information regarding the qualifications, competence, performance, character, fitness, or conditions of appointment of an independent contractor who provides health care services under a contract with a public hospital as defined in G.S. 159-39, or with a hospital which has been sold or conveyed pursuant to G.S. 131E-8, is not a public record as defined by Chapter 132 of the General Statutes. Information regarding a hearing or investigation of a complaint, charge, or grievance by or against an independent contractor who provides health care services under a contract with a public hospital as defined in G.S. 159-39 or with a hospital which has been sold or conveyed pursuant to G.S. 131E-8, is not a public record as defined by Chapter 132 of the General Statutes. Final action making an appointment or discharge or removal by a public hospital having final authority for the appointment or discharge or removal shall be taken in an open meeting, unless otherwise exempted by law. The following information with respect to each independent contractor of health care services of a public hospital, as defined by G.S. 159-39, is a matter of public record: name; age; date of original contract; beginning and ending dates; position title; position descriptions; and total compensation of current and former positions; and the date of the most recent promotion, demotion, transfer, suspension, separation, or other change in position classification. (1993 (Reg. Sess., 1994), c. 570, s. 10; 1995, c. 99, s. 1; c. 509, s. 135.2(q); 1997-517, s. 3.)

§ 131E-97.2. Confidentiality of credentialing information.

Information acquired by a public hospital, as defined in G.S. 159-39, a hospital that has been sold or conveyed pursuant to G.S. 131E-8, a State-owned or State-operated hospital, or by persons acting for or on behalf of a hospital, in connection with the credentialing and peer review of persons having or applying for privileges to practice in the hospital is confidential and is not a public record under Chapter 132 of the General Statutes; provided that information otherwise available to the public shall not become confidential merely because it was acquired by the hospital or by persons acting for or on behalf of the hospital. (1993 (Reg. Sess., 1994), c. 570, s. 10; 1995, c. 509, s. 135.2(r).)

§ 131E-97.3. Confidentiality of competitive health care information.

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of hospitals and public hospital authorities. Competitive health care information does not include any of the information hospitals and ambulatory surgical facilities are required to report under G.S. 131E-214.12. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of a public hospital or public hospital authority, as defined in G.S. 159-39, shall be a public record unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If a public hospital or public hospital authority is requested to disclose any contract which the hospital or hospital authority believes in good faith contains or constitutes competitive health care information, the hospital or hospital authority may

either redact the portions of the contract believed to constitute competitive health care information prior to disclosure, or if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. For the purposes of this section, competitive health care information includes, but is not limited to, contracts entered into by or on behalf of a public hospital or public hospital authority to purchase a medical practice. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent an elected public body, in closed session, which has responsibility for the hospital, the Attorney General, or the State Auditor from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information. (1993 (Reg. Sess., 1994), c. 570, s. 10; 2001-516, s. 5; 2007-508, s. 8.5; 2013-382, s. 10.4.)

§ 131E-98. Inmate medical records.

Notwithstanding any other provision of law, a hospital does not breach patient confidentiality by providing the Division of Adult Correction and Juvenile Justice of the Department of Public Safety with the medical records of inmates who receive medical treatment at the hospital while in the custody of the Division. A hospital complying with a request from the Division of Adult Correction and Juvenile Justice of the Department of Public Safety or its agent for a copy of the medical records of an inmate who received medical services while in custody shall be immune from liability in any civil action for the release of the inmate's medical record. (1993, c. 321, s. 178(b); 2011-145, s. 19.1(h); 2017-186, s. 2(www).)

§ 131E-99. Confidentiality of health care contracts.

Except for the information a hospital or an ambulatory surgical facility is required to report under G.S. 131E-214.12, the financial terms and other competitive health care information directly related to the financial terms in a health care services contract between a hospital or a medical school and a managed care organization, insurance company, employer, or other payer is confidential and not a public record under Chapter 132 of the General Statutes. Nothing in this section shall prevent an elected public body which has responsibility for the hospital or medical school from having access to this confidential information in a closed session. The disclosure to a public body does not affect the

confidentiality of the information. Members of the public body shall have a duty not to further disclose the confidential information. (1995 (Reg. Sess., 1996), c. 713, s. 2; 1997-123, ss. 1, 2; 2013-382, s. 10.5.)

Article 6.

Health Care Facility Licensure Act.

Part 1. Nursing Home Licensure Act.

§ 131E-100. Title; purpose.

- (a) This Part shall be known as the "Nursing Home Licensure Act."
- (b) The purpose of the Nursing Home Licensure Act is to establish authority and duty for the Department to inspect and license private nursing homes. (1983, c. 775, s. 1.)

§ 131E-101. Definitions.

As used in this Part, unless otherwise specified:

- (1) "Adult care home", as distinguished from a nursing home, means a facility operated as a part of a nursing home and which provides residential care for aged or disabled persons whose principal need is a home with the shelter or personal care their age or disability requires. Medical care in an adult care home is usually occasional or incidental, such as may be required in the home of any individual or family, but the administration of medication is supervised. Continuing planned medical and nursing care to meet the resident's needs may be provided under the direct supervision of a physician, nurse, or home health agency. Adult care homes are to be distinguished from nursing homes subject to licensure under this Part.
- (1a) "Combination home" means a nursing home offering one or more levels of care, including any combination of skilled nursing, intermediate care, and adult care home.
- (2) "Commission" means the North Carolina Medical Care Commission.
- (3) "Community advisory committee" means a nursing home advisory committee established for the statutory purpose of working to carry out the intent of the Nursing Home Patients' Bill of Rights (Chapter 131E, Article 6, Part 2) in accordance with G.S. 143B-181.1.
- (4) Repealed by Session Laws 1995, c. 535, s. 21.
- (5) "Medical review committee" means a committee of a State or local professional society, of a medical staff of a licensed hospital, of physicians having privileges within the nursing home or of a peer review corporation or organization which is formed for the purpose of evaluating the quality, cost of or necessity for health care services under applicable federal statutes.
- (6) "Nursing home" means a facility, however named, which is advertised, announced, or maintained for the express or implied purpose of providing nursing or convalescent care for three or more persons unrelated to the licensee. A "nursing home" is a home for chronic or convalescent patients, who, on admission, are not as a rule, acutely ill and who do not usually require special facilities such as an operating room, X-ray facilities, laboratory facilities, and

obstetrical facilities. A "nursing home" provides care for persons who have remedial ailments or other ailments, for which medical and nursing care are indicated; who, however, are not sick enough to require general hospital care. Nursing care is their primary need, but they will require continuing medical supervision.

- (7) "Peer review committee" means any committee appointed in accordance with G.S. 131E-108, "Peer review."
- (8) "Quality assurance committee" means a committee, agency, or department of a state or local professional organization, of a medical staff of a licensed hospital, nursing home, of nurses or aides on the staff of a nursing home, or adult care home, of physicians having privileges within the nursing home, or adult care home, or of a peer review corporation or organization that is formed for the purpose of evaluating the quality, cost of, or necessity for health care services under applicable federal and State statutes, regulations, and rules. (1961, c. 51, s. 3; 1981, c. 833; 1983, c. 775, s. 1; 1995, c. 535, s. 21; 2004-149, s. 2.1.)

§ 131E-102. Licensure requirements.

(a) No person shall operate a nursing home without a license obtained from the Department. Any person may operate a nursing home or a combination home, as defined in this Part, in the same building or in two or more buildings adjoining or next to each other on the same site. Both a nursing home and a combination home must be licensed by the Department under this Part.

(b) Applications shall be available from the Department, and each application filed with the Department shall contain all necessary and reasonable information that the Department may by rule require. A license shall be granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of this Part and the rules promulgated under this Part. The Department shall charge the applicant a nonrefundable annual license fee in the amount of four hundred twenty dollars (\$420.00) plus a nonrefundable annual per-bed fee of seventeen dollars and fifty cents (\$17.50).

(c) A license to operate a nursing home shall be annually renewed upon the filing and the Department's approval of the renewal application. A license shall not be renewed if outstanding fees and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall be available from the Department and shall contain all necessary and reasonable information that the Department may by rule require.

(d) Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the written approval of the Department.

(e) In order for a nursing home to maintain its license it shall not intentionally impede the proper performance of the duties of a lawfully appointed community advisory committee as set forth in G.S. 131E-128(h). (1961, c. 51, s. 3; 1963, c. 859; 1983, c. 775, s. 1; 1993, c. 530, s. 1; 2003-284, s. 34.3(a); 2005-276, s. 41.2(c); 2009-451, s. 10.76(g).)

§ 131E-103. Adverse action on a license.

(a) Subject to subsection (b), the Department shall have the authority to deny a new or renewal application for a license, and to amend, recall, suspend or revoke an existing license upon

a determination that there has been a substantial failure to comply with the provisions of this Part or the rules promulgated under this Part.

(b) The provisions of Chapter 150B of the General Statutes, the Administrative Procedure Act, shall govern all administrative action and judicial review in cases where the Department has taken the action described in subsection (a). A petition for a contested case shall be filed within 20 days after the Department mails the licensee a notice of its decision to deny a renewal application, or to recall, suspend, or revoke an existing license. (1961, c. 51, s. 3; 1983, c. 775, s. 1; 1987, c. 827, s. 1; 1991, c. 143, s. 2, c. 761, s. 24.)

§ 131E-104. Rules and enforcement.

(a) The Commission is authorized to adopt, amend, and repeal all rules necessary for the implementation of this Part.

(b) The Commission shall adopt rules for the operation of the adult care portion of a combination home. The rules shall provide that for each requirement applicable to freestanding adult care homes or freestanding nursing homes, the combination home may choose to operate the adult care portion of the home in compliance with either the requirement applicable to freestanding adult care homes or the higher standard applicable to freestanding nursing homes.

(c) The Department shall enforce the rules adopted or amended by the Commission with respect to nursing homes. (1961, c. 51, s. 3; 1973, c. 476, s. 128; 1981, c. 614, s. 1; 1983, c. 775, s. 1; 1995, c. 535, s. 22; 2000-154, s. 6.1.)

§ 131E-105. Inspections.

(a) The Department shall inspect any nursing home and any adult care home operated as a part of a nursing home in accordance with rules adopted by the Commission.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department, when necessary for investigating compliance with this Part or rules promulgated by the Commission, may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been patients of the facility being inspected unless that patient objects in writing to review of that patient's records. Physicians, psychologists, psychiatrists, nurses, and anyone else interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communications between physician and patient," or any other rules of law, if the patient has not made written objection to this disclosure. The facility, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information which is provided without malice or fraud to the Department. Any confidential or privileged information received from review of records or interviews shall be kept confidential by the Department and not disclosed without written authorization of the patient or legal representative or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning a facility without consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of

G.S. 132-1, "'Public records' defined." Prior to releasing any information or allowing any inspections referred to in this subsection, the patient must upon admission be advised in writing by the facility that the patient has the right to object in writing to the release of information or review of the records and that by an objection in writing the patient may prohibit the inspection or release of the records.

(c) Authorized representatives of the Department with identification to this effect shall have at all times the right of proper entry upon any and all parts of the premises of any place in which entry is necessary to carry out the provisions of this Part or the rules adopted by the Commission. It shall be unlawful for any person to resist a proper entry by an authorized representative upon any premises other than a private dwelling. (1981, c. 586, s. 1; c. 614, s. 1; 1983, c. 775, s. 1; 1995, c. 535, s. 23.)

§ 131E-106. Evaluation of residents in adult care homes.

The Department shall prescribe the method of evaluation of residents in the adult care portion of a combination home in order to determine when any of these residents is in need of professional medical and nursing care as provided in licensed nursing homes. (1963, c. 859; 1981, c. 833; 1983, c. 775, s. 1; 1995, c. 535, s. 24.)

§ 131E-107. Quality assurance, medical, or peer review committees.

(a) A member of a duly appointed quality assurance, medical or peer review committee shall not be subject to liability for damages in any civil action on account of any act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee, if the committee member acts without malice or fraud, and if such peer review committee is approved and operates in accordance with G.S. 131E-108.

(b) The proceedings of a quality assurance, medical, or peer review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined", and shall not be subject to discovery or introduction into evidence in any civil action against a nursing home or a provider of professional health services that results from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about the person's testimony before the committee or any opinions formed as a result of the committee hearings. (1983, c. 775, s. 1; 2004-149, s. 2.2.)

§ 131E-108. Peer review.

It is not a violation of G.S. 131E-117(5) for medical records to be disclosed to a private peer review committee if:

- (1) The peer review committee has been approved by the Department;
- (2) The purposes of the peer review committee are to:

- a. Survey facilities to verify a high level of quality care through evaluation and peer assistance;
 - b. Resolve written complaints in a responsible and professional manner; and
 - c. Develop a basic core of knowledge and standards useful in establishing a means of measuring quality of care; and
- (3) The peer review committee keeps such records confidential. (1979, c. 707; 1983, c. 775, s. 1; 1997-456, s. 27.)

§ 131E-109. Penalties.

(a) Any person establishing, conducting, managing or operating any nursing home without a license shall be guilty of a Class 3 misdemeanor, and upon conviction shall only be liable for a fine of not more than five hundred dollars (\$500.00) for the first offense and not more than five hundred dollars (\$500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) Any person acting under the authority of the Department who gives advance notice to an operator of a nursing home of the date or time that the nursing home is to be inspected shall be guilty of a Class 3 misdemeanor. The inspection of a nursing home for initial licensure shall be exempt from the prohibition of prior notice. All subsequent inspections must comply with the provisions of this subsection.

(c) The Secretary or a designee may suspend the admission of any new patients or residents at any nursing home or domiciliary home where the conditions of the nursing home or domiciliary home are detrimental to the health or safety of the patient or resident. This suspension shall remain in effect until the Secretary is satisfied that conditions or circumstances merit the removal of the suspension. This subsection shall be in addition to authority to suspend or revoke the license of the home. Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. The petition for a contested case shall be filed in the Office of Administrative Hearings within 20 days after the Department mails a written notice of suspension of admissions to the facility.

(d) Except as otherwise provided in this Part, any person who violates any provision of this Part or who willfully fails to perform any act required, or who willfully performs any act prohibited by this Part, shall be guilty of a Class 1 misdemeanor: Provided, however, that any person who willfully violates any rule adopted by the Commission under this Part or who willfully fails to perform any act required by, or who willfully performs any act prohibited by, these rules shall be guilty of a Class 3 misdemeanor.

(e) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. (1977, c. 656, ss. 1, 2; 1981, c. 667, ss. 1, 2; 1983, c. 775, s. 1; 1991, c. 143, s. 3; c. 761, s. 25; 1993, c. 539, s. 960; 1994, Ex. Sess., c. 24, s. 14(c); 1998-215, s. 78(c).)

§131E-110. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management or operation of a nursing home without a license.

(b) If any person shall hinder the proper performance of duty of the Secretary or a representative in carrying out the provisions of this Part, the Secretary may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure. (1983, c. 775, s. 1.)

§ 131E-111: Recodified as § 131E-255 by Session Laws 1995 (Reg. Sess., 1996), c. 713, s. 3(a), as amended by Session Laws 1995 (Reg. Sess., 1996), c. 713, s. 3(b).

§ 131E-112. Waiver of rules for health care facilities that provide temporary shelter or temporary services during a disaster or emergency.

(a) The Division of Health Service Regulation may temporarily waive, during disasters or emergencies declared in accordance with Article 1A of Chapter 166A of the General Statutes, any rules of the Commission pertaining to facilities or home care agencies to the extent necessary to allow the facility or home care agency to provide temporary shelter and temporary services requested by the emergency management agency. The Division may identify, in advance of a declared disaster or emergency, rules that may be waived, and the extent the rules may be waived, upon a disaster or emergency being declared in accordance with Article 1A of Chapter 166A of the General Statutes. The Division may also waive rules under this subsection during a declared disaster or emergency upon the request of an emergency management agency and may rescind the waiver if, after investigation, the Division determines the waiver poses an unreasonable risk to the health, safety, or welfare of any of the persons occupying the facility. The emergency management agency requesting temporary shelter or temporary services shall notify the Division within 72 hours of the time the preapproved waivers are deemed by the emergency management agency to apply.

(b) As used in this section, "emergency management agency" is as defined in G.S. 166A-19.3. (1999-307, s. 1; 2007-182, s. 1; 2012-12, s. 2(u).)

§ 131E-113. Immunization of employees and residents.

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) A nursing home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(c) A nursing home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the nursing home is unable to verify that the individual has received the required immunization, the nursing home shall

provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the immunizations required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Commission for Public Health shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, "employee" means an individual who is a part-time or full-time employee of the nursing home. (2000-112, ss. 3, 4; 2007-182, s. 1.3.)

§ 131E-114. Special care units; disclosure of information required.

(a) A nursing home or combination home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

- (1) The Department, as part of its licensing procedures.
- (2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

- (1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.
- (2) The process and criteria for placement, transfer, or discharge to or from the special care unit.
- (3) The process used for assessment and establishment of the plan of care and its implementation, as required under State and federal law.
- (4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.
- (5) Dementia-specific staff training.
- (6) Physical environment features designed specifically for the special care unit.
- (7) Alzheimer's disease and other dementia-specific programming.
- (8) Opportunities for family involvement.
- (9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each licensed facility subject to this section.

(d) Nothing in this section shall be construed as prohibiting a nursing home or combination home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to a nursing home or

combination home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term "special care unit" means a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities. (2000-154, s. 6.)

§ 131E-114.1. Posting of information indicating number of staff on duty.

Every nursing home subject to licensure under this Part shall post in a conspicuous place in the nursing home information about required staffing that enables residents and their families to readily ascertain each day the number of direct care staff and supervisors that are required by law to be on duty for that day. (2001-85, s. 2; 2001-487, s. 85(b).)

§ 131E-114.2. Use of medication aides to perform technical aspects of medication administration.

(a) Facilities licensed and medication administration services provided under this Part may utilize medication aides to perform the technical aspects of medication administration consistent with G.S. 90-171.20(7) and (8), and G.S. 90-171.43.

- (1) A medication aide who is employed in a facility licensed under Article 5 and Article 6, Part 1 of this Chapter shall be listed as a Nurse Aide I on the Nurse Aide I Registry in addition to being listed on the Medication Aide Registry.
- (2) Medication administration as used in Article 5 and Article 6, Part 1 of this Chapter shall not include intravenous or injectable medication services.

(b) The Commission shall adopt rules to implement this section. Rules adopted by the Commission shall include:

- (1) Training and competency evaluation of medication aides as provided for under this section.
- (2) Requirements for listing under the Medication Aide Registry as provided for under G.S. 131E-270.
- (3) Requirements for supervision of medication aides by licensed health professionals or appropriately qualified supervisory personnel consistent with this Part. (2005-276, s. 10.40C(a); 2007-444, s. 4(a).)

§ 131E-114.3. Smoking prohibited inside long-term care facilities; penalty.

(a) Except to the extent otherwise provided by federal law, smoking is prohibited inside long-term care facilities. As used in this section:

- (1) "Long-term care facilities" include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, and other licensed facilities that provide long-term care services.
- (2) "Smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.
- (3) "Inside" means a fully enclosed area.

(b) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:

- (1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.
- (2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.
- (3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c) The Department may impose an administrative penalty not to exceed two hundred dollars (\$200.00) for each violation on any person who owns, manages, operates, or otherwise controls the long-term care facility and fails to comply with subsection (b) of this section. A violation of this section constitutes a civil offense only and is not a crime. (2007-459, s. 2.)

§ 131E-114.4. Examination and screening for the presence of controlled substances required for applicants for employment in nursing homes.

(a) An offer of employment by a nursing home licensed under this Part to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the nursing home shall not employ the applicant unless and until the applicant provides to the nursing home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the nursing home may require a second examination and screening to verify the results of the prior examination and screening.

(b) A nursing home may require random examination and screening for controlled substances as a condition of continued employment. If the nursing home has reasonable grounds to believe that an employee is an abuser of a controlled substance, the nursing home may require that employee to undergo examination and screening for controlled substances as a condition of continued employment.

(c) A nursing home and an officer or employee of a nursing home that, in good faith, comply with this section are not liable for the failure of the nursing home to employ or continue the employment of an individual on the basis of the results of an examination and screening of the applicant or employee for controlled substances.

(d) An entity and officers and employees of an entity that perform controlled substance examination and screening in accordance with Article 20 of Chapter 95 of the General Statutes shall be immune from civil liability for conducting or failing to conduct

the examination and screening if the examination and screening are requested and received in compliance with this section and with Article 20 of Chapter 95 of the General Statutes.

(e) The results of an examination and screening conducted at the request of a nursing home in accordance with this section are confidential and not a public record under Chapter 132 of the General Statutes. The nursing home shall maintain the confidentiality of all information related to the examination and screening of an applicant for employment or an individual currently employed by the nursing home.

(f) The nursing home shall pay expenses related to controlled substance examination and screening pursuant to this section, except examinee-requested retests. The examinee shall pay all reasonable expenses for retests of confirmed positive results. (2013-167, s. 2.)

Part 2. Nursing Home Patients' Bill of Rights.

§ 131E-115. Legislative intent.

It is the intent of the General Assembly to promote the interests and well-being of the patients in nursing homes and adult care homes licensed pursuant to G.S. 131E-102, and patients in a nursing home operated by a hospital which is licensed under Article 5 of Chapter 131E of the General Statutes. It is the intent of the General Assembly that every patient's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist the patient in the fullest possible exercise of these rights. (1977, c. 897, s. 1; 1983, c. 143, s. 2; c. 775, s. 1; 1995, c. 509, s. 72; c. 535, s. 25.)

§ 131E-116. Definitions.

As used in this Part, unless otherwise specified:

- (1) "Administrator" means an administrator of a facility.
- (1a) "Commission" means the North Carolina Medical Care Commission.
- (2) "Facility" means a nursing home and a home for the aged or disabled licensed pursuant to G.S. 131E-102, and also means a nursing home operated by a hospital which is licensed under Article 5 of G.S. Chapter 131E.
- (3) "Patient" means a person who has been admitted to a facility.
- (4) "Representative payee" means a person certified by the federal government to receive and disburse benefits for a recipient of governmental assistance. (1977, c. 897, s. 1; 1983, c. 143, s. 1, c. 775, s. 1; 1993, c. 499, s. 1.)

§ 131E-117. Declaration of patient's rights.

All facilities shall treat their patients in accordance with the provisions of this Part. Every patient shall have the following rights:

- (1) To be treated with consideration, respect, and full recognition of personal dignity and individuality;
- (2) To receive care, treatment and services which are adequate, appropriate, and in compliance with relevant federal and State statutes and rules;
- (3) To receive at the time of admission and during the stay, a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and of related charges. Charges for services not covered

under Medicare or Medicaid shall be specified. Upon receiving this statement, the patient shall sign a written receipt which must be on file in the facility and available for inspection;

- (4) To have on file in the patient's record a written or verbal order of the attending physician containing any information as the attending physician deems appropriate or necessary, together with the proposed schedule of medical treatment. The patient shall give prior informed consent to participation in experimental research. Written evidence of compliance with this subdivision, including signed acknowledgements by the patient, shall be retained by the facility in the patient's file;
- (5) To receive respect and privacy in the patient's medical care program. Case discussion, consultation, examination, and treatment shall remain confidential and shall be conducted discreetly. Personal and medical records shall be confidential and the written consent of the patient shall be obtained for their release to any individual, other than family members, except as needed in case of the patient's transfer to another health care institution or as required by law or third party payment contract;
- (6) To be free from mental and physical abuse and, except in emergencies, to be free from chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need;
- (7) To receive from the administrator or staff of the facility a reasonable response to all requests;
- (8) To associate and communicate privately and without restriction with persons and groups of the patient's choice on the patient's initiative or that of the persons or groups at any reasonable hour; to send and receive mail promptly and unopened, unless the patient is unable to open and read personal mail; to have access at any reasonable hour to a telephone where the patient may speak privately; and to have access to writing instruments, stationery, and postage;
- (9) To manage the patient's financial affairs unless authority has been delegated to another pursuant to a power of attorney, or written agreement, or some other person or agency has been appointed for this purpose pursuant to law. Nothing shall prevent the patient and facility from entering a written agreement for the facility to manage the patient's financial affairs. In the event that the facility manages the patient's financial affairs, it shall have an accounting available for inspection and shall furnish the patient with a quarterly statement of the patient's account. The patient shall have reasonable access to this account at reasonable hours; the patient or facility may terminate the agreement for the facility to manage the patient's financial affairs at any time upon five days' notice.
- (10) To enjoy privacy in visits by the patient's spouse, and, if both are inpatients of the facility, they shall be afforded the opportunity where feasible to share a room;
- (11) To enjoy privacy in the patient's room;
- (12) To present grievances and recommend changes in policies and services, personally or through other persons or in combination with others, on the patient's personal behalf or that of others to the facility's staff, the community advisory committee, the administrator, the Department, or other persons or

- groups without fear of reprisal, restraint, interference, coercion, or discrimination;
- (13) To not be required to perform services for the facility without personal consent and the written approval of the attending physician;
 - (14) To retain, to secure storage for, and to use personal clothing and possessions, where reasonable;
 - (15) To not be transferred or discharged from a facility except for medical reasons, the patient's own or other patients' welfare, nonpayment for the stay, or when the transfer or discharge is mandated under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. The patient shall be given at least five days' advance notice to ensure orderly transfer or discharge, unless the attending physician orders immediate transfer, and these actions, and the reasons for them, shall be documented in the patient's medical record;
 - (16) To be notified within 10 days after the facility has been issued a provisional license because of violation of licensure regulations or received notice of revocation of license by the North Carolina Department of Health and Human Services and the basis on which the provisional license or notice of revocation of license was issued. The patient's responsible family member or guardian shall also be notified. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1989, c. 75; 1997-443, s. 11A.118(a).)

§ 131E-118. Transfer of management responsibilities.

The patient's representative who has been given the power in writing by the patient to manage the patient's financial affairs or the patient's legal guardian as appointed by a court or the patient's attorney-in-fact as specified in the power of attorney agreement may sign any documents required by the provisions of this Part, may perform any other act, and may receive or furnish any information required by this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-119. No waiver of rights.

No facility may require a patient to waive the rights specified in this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-120. Notice to patient.

(a) A copy of G.S. 131E-115 through G.S. 131E-127 shall be posted conspicuously in a public place in all facilities. Copies of G.S. 131E-115 through G.S. 131E-127 shall be furnished to the patient upon admittance to the facility, to all patients currently residing in the facility, to the sponsoring agency, to a representative payee of the patient, or to any person designated in G.S. 131E-118, and to the patient's next of kin, if requested. Receipts for the statement signed by these persons shall be retained in the facility's files.

(b) The address and telephone number of the section in the Department responsible for the enforcement of the provisions of this Part shall be posted and distributed with copies of the Part. The address and telephone number of the county social services department shall also be posted and distributed. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-121. Responsibility of administrator.

Responsibility for implementing the provisions of this Part shall rest on the administrator of the facility. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-122. Staff training.

Each facility shall provide appropriate staff training to implement each patient's rights included in this Part. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-123. Civil action.

Every patient shall have the right to institute a civil action for injunctive relief to enforce the provisions of this Part. The Department, a general guardian, or any person appointed as guardian ad litem pursuant to law, may institute an action pursuant to this section on behalf of the patient or patients. Any agency or person named above may enforce the rights of the patient specified in this Part which the patient is unable to personally enforce. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-124. Enforcement and investigation; confidentiality.

(a) The Department shall be responsible for the enforcement of the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable time, not to exceed 60 days, upon receipt of a complaint.

(a1) When the Department receives a complaint alleging a violation of the provisions of this Part pertaining to patient care or patient safety, the Department shall initiate an investigation as follows:

- (1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.
- (2) Within 24 hours if the complaint alleges abuse of a resident as defined by G.S. 131D-20(1).
- (3) Within 48 hours if the complaint alleges neglect of a resident as defined by G.S. 131D-20(8).
- (4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory requirements for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) The Department is authorized to inspect patients' medical records maintained at the facility when necessary to investigate any alleged violation of this Part.

(c) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific resident if written authorization is obtained from the resident, legal representative, or responsible party. The designation of the responsible party shall be maintained by the nursing facility in the resident's medical record.

(d) Pursuant to 42 U.S.C. § 1395 and G.S. 131E-127, a nursing home as defined in G.S. 131E-101(6), is not in violation of any applicable statute, rule, or regulation for any action taken pursuant to a physician's order when the physician has determined that the action is medically necessary. (1977, c. 897, s. 1; 1983, c. 775, s. 1; 1999-113, s. 3; 1999-334, s. 1.9.)

§ 131E-125. Revocation of a license.

(a) The Department shall have the authority to revoke a license issued pursuant to G.S. 131E-102 in any case where it finds that there has been a substantial failure to comply with the provisions of this Part or any failure that endangers the health, safety or welfare of patients.

A revocation shall be effected by mailing to the licensee by registered mail, or by personal service of, a notice setting forth the particular reasons for such action. Such revocation shall become effective 20 days after the mailing or service of the notice, unless the applicant or licensee, within such 20-day period, files a petition for a contested case, in which case the notice shall be deemed to be suspended. At any time at or prior to the hearing, the Department may rescind the notice of revocation upon being satisfied that the reasons for the revocation have been or will be removed.

(b) In the case of a nursing home operated by a hospital which is licensed under Article 5 of G.S. Chapter 131E, when the Department of Health and Human Services finds that there has been a substantial failure to comply with the provisions of this Part, it may issue an order preventing the continued operation of the home.

Such order shall be effected by mailing to the hospital by registered or certified mail, or by personal service of, a notice setting forth the particular reasons for such action. Such order shall become effective 20 days after the mailing of the notice, unless the hospital, within such 20-day period, files a petition for a contested case, in which case the order shall be deemed to be suspended. At any time at or prior to the hearing, the Department of Health and Human Services may rescind the order upon being satisfied that the reasons for the order have been or will be removed. (1977, c. 897, s. 1; 1983, c. 143, s. 3; c. 775, s. 1; 1987, c. 827, s. 251; 1997-443, s. 11A.118(a).)

§ 131E-126: Repealed by Session Laws 1987, c. 600, s. 1.

§ 131E-127. No interference with practice of medicine or physician-patient relationship.

Nothing in this Part shall be construed to interfere with the practice of medicine or the physician-patient relationship. (1977, c. 897, s. 1; 1983, c. 775, s. 1.)

§ 131E-128. Nursing home advisory committees.

(a) It is the purpose of the General Assembly that community advisory committee members function as representatives of the Office of the State Long-Term Care Ombudsman and through their designation work to maintain the intent of the Nursing Home Resident's Bill of Rights within the nursing homes in this State, including nursing homes operated by hospitals licensed under Article 5 of G.S. Chapter 131E. It is the further purpose of the General Assembly that the committees promote community involvement and cooperation with nursing homes and an integration of these homes into a system of care for the elderly.

(b) (1) A community advisory committee shall be established in each county which has a nursing home, including a nursing home operated by a hospital licensed under Article 5 of G.S. Chapter 131E, shall serve all the homes in the county, and shall work with each home in the best interest of the persons residing in each home. In a county which has one, two, or three nursing homes, the committee shall have five members. In a county with four or more nursing homes, the committee shall have one additional

member for each nursing home in excess of three, and may have up to five additional members per committee at the discretion of the county commissioners.

- (2) In each county with four or more nursing homes, the committee shall establish a subcommittee of no more than five members and no fewer than three members from the committee for each nursing home in the county. Each member must serve on at least one subcommittee.
- (3) Boards of county commissioners are encouraged to appoint the Nursing Home Community Advisory Committees. Of the members, a minority (not less than one-third, but as close to one-third as possible) must be chosen from among persons nominated by a majority of the chief administrators of nursing homes in the county and of the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes. If the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to make a nomination within 45 days after written notification has been sent to them by the board of county commissioners requesting a nomination, these appointments may be made by the board of county commissioners without nominations.
- (4) Notwithstanding any other provision of this Article, appointment to a nursing home community advisory committee is contingent upon designation of the appointee by the Office of the State Long-Term Care Ombudsman in accordance with G.S. 143B-181.18. A designated appointee is directly accountable to the State Long-Term Care Ombudsman Program in order to perform the duties as a representative of the Office of the State Long-Term Care Ombudsman. Removal of the appointee's designation by the Office of the State Long-Term Care Ombudsman automatically rescinds the appointment to the nursing home community advisory committee.
- (5) Any individual who serves as a community advisory committee member must go through the Office of the State Long-Term Care Ombudsman's certification and designation process and meet the certification and designation requirements in accordance with the State Long-Term Care Ombudsman Program Policies and Procedures.

(c) Each committee member shall serve an initial term of one year. Any person reappointed to a second or subsequent term in the same county shall serve a three-year term. Persons who were originally nominees of nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, or who were appointed by the board of county commissioners when the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make nominations, may not be reappointed without the consent of a majority of the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of

G.S. Chapter 131E, which operate nursing homes within the county. If the nursing home chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes fail to approve or reject the reappointment within 45 days of being requested by the board of county commissioners, the commissioners may reappoint the member if they so choose.

(d) Any vacancy shall be filled by appointment of a person for a one-year term. Any person replacing a member nominated by the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes or a person appointed when the chief administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes failed to make a nomination shall be selected from among persons nominated by the administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes, as provided in subsection (b). If the county commissioners fail to appoint members to a committee, or fail to fill a vacancy, the appointment shall be made or vacancy filled by the Office of the State Long-Term Care Ombudsman no sooner than 45 days after the commissioners have been notified of the appointment or vacancy if nomination or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is not required. If nominations or approval of the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes is required, the appointment shall be made or vacancy filled by the Office of the State Long-Term Care Ombudsman no sooner than 45 days after the commissioners have received the nomination or approval, or no sooner than 45 days after the 45-day period for action by the nursing home administrators and the governing bodies of the hospitals licensed under Article 5 of G.S. Chapter 131E, which operate nursing homes.

(e) The committee shall elect from its members a chair, to serve a one-year term.

(f) Each member must be a resident of the county which the committee serves. No person or immediate family member of a person with a financial interest in a home served by a committee, or employee or governing board member or immediate family member of an employee or governing board member of a home served by a committee, or immediate family member of a patient in a home served by a committee may be a member of a committee. Membership on a committee shall not be considered an office as defined in G.S. 128-1 or G.S. 128-1.1. Any county commissioner who is appointed to the committee shall be deemed to be serving on the committee in an ex officio capacity. Members of the committee shall serve without compensation, but may be reimbursed for the amount of actual expenses incurred by them in the performance of their duties. The names of the committee members and the date of expiration of their terms shall be filed with the Office of the State Long-Term Care Ombudsman, which shall supply a copy to the Division of Health Service Regulation.

(g) The Office of the State Long-Term Care Ombudsman shall develop training requirements for certification and designation in accordance with 45 C.F.R. § 1324.13(c)(2). Each committee member must receive certification training as specified by

the State Long-Term Care Ombudsman Program Policies and Procedures and be designated as representatives of the State Long-Term Care Ombudsman Program prior to exercising any power under subsection (h) of this section. The State Long-Term Care Ombudsman Program shall provide the committees with information, guidelines, training, and consultation to direct them in the performance of their duties.

- (h) (1) Each committee shall apprise itself of the general conditions under which the persons are residing in the homes, and shall work for the best interests of the persons in the homes. This may include assisting persons who have grievances with the home and facilitating the resolution of grievances at the local level.
- (2) Each committee shall quarterly visit the nursing home it serves. For each official quarterly visit, a majority of the committee members shall be present. In addition, each committee may visit the nursing home it serves whenever it deems it necessary to carry out its duties. In counties with four or more nursing homes, the subcommittee assigned to a home shall perform the duties of the committee under this subdivision, and a majority of the subcommittee members must be present for any visit.
- (3) Each member of a committee shall have the right to enter into the facility the committee serves in order to carry out the members' responsibilities. In a county where subcommittees have been established, this right of access shall be limited to homes served by those subcommittees to which the member has been appointed.
- (4) The committee or subcommittee may communicate through its chair with the Department or any other agency in relation to the interest of any patient. The identity of any complainant or resident involved in a complaint shall not be disclosed except as permitted under the Older Americans Act of 1965, as amended, 42 U.S.C. § 3001 et seq.
- (5) Each home shall cooperate with the committee as it carries out its duties.
- (6) Before entering into any nursing home, the committee, subcommittee, or member shall identify itself to the person present at the facility who is in charge of the facility at that time.

(i) Any written communication made by a member of a nursing home advisory committee within the course and scope of the member's duties, as specified in G.S. 131E-128, shall be privileged to the extent provided in this subsection. All communication shall be considered the property of the Office of the State Long-Term Care Ombudsman and subject to the Office's disclosure policies. This privilege shall be a defense in a cause of action for libel if the member was acting in good faith and the statements or communications do not amount to intentional wrongdoing.

To the extent that any nursing home advisory committee or any member thereof is covered by liability insurance, that committee or member shall be deemed to have waived the qualified immunity herein to the extent of indemnification by insurance. (1977, c. 897, s. 2; 1977, 2nd Sess., c. 1192, s. 1; 1983, c. 143, ss. 4-9; c. 775, ss. 1, 6; 1987, c. 682, s. 1;

1995, c. 254, s. 7; 1997-176, s. 1; 1997-443, s. 11A.118(a); 2007-182, s. 1; 2017-103, s. 1(b).)

§ 131E-128.1. Nursing home medication management advisory committee.

(a) Definitions. – As used in this section, unless the context requires otherwise, the term:

- (1) "Advisory committee" means a medication management committee established under this section to advise the quality assurance committee.
- (2) "Medication-related error" means any preventable medication-related event that adversely affects a patient in a nursing home and that is related to professional practice, or health care products, procedures, and systems, including prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.
- (3) "Nursing home" means a nursing home licensed under this Chapter and includes an adult care home operated as part of a nursing home.
- (4) "Potential medication-related error" means a medication-related error that has not yet adversely affected a patient in a nursing home, but that has the potential to if not anticipated or prevented or if left unnoticed.
- (5) "Quality assurance committee" means a committee established in a nursing home in accordance with federal and State regulations to identify circumstances requiring quality assessment and assurance activities and to develop and implement appropriate plans of action to correct deficiencies in quality of care.

(b) Purpose. – It is the purpose of the General Assembly to enhance compliance with this Part through the establishment of medication management advisory committees in nursing homes. The purpose of these committees is to assist nursing homes to identify medication-related errors, evaluate the causes of those errors, and take appropriate actions to ensure the safe prescribing, dispensing, and administration of medications to nursing home patients.

(c) Advisory Committee Established; Membership. – Every nursing home shall establish a medication management advisory committee to advise the quality assurance committee on quality of care issues related to pharmaceutical and medication management and use in the nursing home. The nursing home shall maintain the advisory committee as part of its administrative duties. The advisory committee shall be interdisciplinary and consist of the nursing home administrator and at least the following members appointed by the nursing home administrator:

- (1) The director of nursing.
- (2) The consultant pharmacist.
- (3) A physician designated by the nursing home administrator.
- (4) At least three other members of the nursing home staff.

(d) Meetings. – The advisory committee shall meet as needed but not less frequently than quarterly. The Director of Nursing or Staff Development Coordinator shall chair the

advisory committee. The nursing home administrator shall ensure that a record is maintained of each meeting.

(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces, and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not be considered public records within the meaning of G.S. 132-1. The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home or a provider of professional health services resulting from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

- (1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be immune from discovery or use in a civil action merely because they were presented during meetings or proceedings of the advisory committee. A member of the advisory committee or a person who testifies before the committee may testify in a civil action but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.
- (2) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to information reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection. The standards review organization shall keep the information confidential subject to this subsection.
- (3) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to information reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this

subsection. The Department shall keep the information confidential subject to this subsection.

- (4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to information reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection. The occupational licensing board shall keep the information confidential subject to this subsection.
- (f) Duties. – The advisory committee shall do the following:
 - (1) Assess the nursing home's pharmaceutical management system, including its prescribing, distribution, administration policies, procedures, and practices and identify areas at high risk for medication-related errors.
 - (2) Review the nursing home's pharmaceutical management goals and respond accordingly to ensure that these goals are being met.
 - (3) Review, investigate, and respond to nursing home incident reports, deficiencies cited by licensing or credentialing agencies, and resident grievances that involve actual or potential medication-related errors.
 - (4) Identify goals and recommendations to implement best practices and procedures, including risk reduction technology, to improve patient safety by reducing the risk of medication-related errors.
 - (5) Develop recommendations to establish a mandatory, nonpunitive, confidential reporting system within the nursing home of actual and potential medication-related errors.
 - (6) Develop specifications for drug dispensing and administration documentation procedures to ensure compliance with federal and State law, including the North Carolina Nursing Practice Act.
 - (7) Develop specifications for self-administration of drugs by qualified patients in accordance with law, including recommendations for assessment procedures that identify patients who may be qualified to self-administer their medications.

(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, or 131E-128.4. (2003-393, s. 1; 2013-360, s. 12G.2(a), (b).)

§ 131E-128.2. Nursing home quality assurance committee; duties related to medication error prevention.

Every nursing home administrator shall ensure that the nursing home quality assurance committee develops and implements appropriate measures to minimize the risk of actual and potential medication-related errors, including the measures listed in this section. The design and implementation of the measures shall be based upon recommendations of the medication management advisory committee and shall:

- (1) Increase awareness and education of the patient and family members about all medications that the patient is using, both prescription and over-the-counter, including dietary supplements.
- (2) Increase prescription legibility.
- (3) Minimize confusion in prescription drug labeling and packaging, including unit dose packaging.
- (4) Develop a confidential and nonpunitive process for internal reporting of actual and potential medication-related errors.
- (5) To the extent practicable, implement proven medication safety practices, including the use of automated drug ordering and dispensing systems.
- (6) Educate facility staff engaged in medication administration activities on similar-sounding drug names.
- (7) Implement a system to accurately identify recipients before any drug is administered.
- (8) Implement policies and procedures designed to improve accuracy in medication administration and in documentation by properly authorized individuals, in accordance with prescribed orders and stop order policies.
- (9) Implement policies and procedures for patient self-administration of medication.
- (10) Investigate and analyze the frequency and root causes of general categories and specific types of actual or potential medication-related errors.
- (11) Develop recommendations for plans of action to correct identified deficiencies in the facility's pharmaceutical management practices. (2003-393, s. 1.)

§ 131E-128.3. Staff orientation on medication error prevention.

The nursing home administrator shall ensure that the nursing home provide a minimum of one hour of education and training in the prevention of actual or potential medication-related errors. This training shall be provided upon orientation and annually thereafter to all nonphysician personnel involved in direct patient care. The content of the training shall include at least the following:

- (1) General information relevant to the administration of medications including terminology, procedures, routes of medication administration, potential side effects, and adverse reactions.
- (2) Additional instruction on categories of medication pertaining to the specific needs of the patient receiving the medication.
- (3) The facility's policy and procedures regarding its medication administration system.
- (4) How to assist patients with safe and accurate self-administration of medication, where appropriate.
- (5) Identifying and reporting actual and potential medication-related errors. (2003-393, s. 1.)

§ 131E-128.4. Nursing home pharmacy reports; duties of consultant pharmacist.

(a) The consultant pharmacist for a nursing home shall conduct a drug regimen review for actual and potential drug therapy problems in the nursing home and make remedial or preventive clinical recommendations into the medical record of every patient receiving medication. The consultant pharmacist shall conduct the review at least monthly in accordance with the nursing home's policies and procedures.

(b) The consultant pharmacist shall report and document any drug irregularities and clinical recommendations promptly to the attending physician or nurse-in-charge and the nursing home administrator. The reports shall include problems identified and recommendations concerning:

- (1) Drug therapy that may be affected by biological agents, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medication to the same recipient.
- (2) Monitoring for potential adverse effects.
- (3) Allergies.
- (4) Drug interactions, including interactions between prescription drugs and over-the-counter drugs, drugs and disease, and interactions between drugs and nutrients.
- (5) Contraindications and precautions.
- (6) Potential therapeutic duplication.
- (7) Overextended length of treatment of certain drugs typically prescribed for a short period of time.
- (8) Beer's listed drugs that are potentially inappropriate for use by elderly persons.
- (9) Undertreatment or medical conditions that are suboptimally treated or not treated at all that warrant additional drug therapy to ensure quality of care.
- (10) Other identified problems and recommendations.

(c) The consultant pharmacist shall report drug product defects and adverse drug reactions in accordance with the ASHSP-USP-FDA Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System. The term "ASHSP-USP-FDA" means American Society of Health System Pharmacists-United States Pharmacopoeia-Food and Drug Administration. Information released to the ASHSP-USP-FDA retains its confidentiality and is not subject to discovery or use in any civil action as provided under G.S. 131E-128.1.

(d) The consultant pharmacist shall ensure that all known allergies and adverse effects are documented in plain view in the patient's medical record, including the medication administration records, and communicated to the dispensing pharmacy. The specific medications and the type of allergy or adverse reaction shall be specified in the documentation.

(e) The consultant pharmacist shall ensure that drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The consultant pharmacist shall further ensure that the prescribing provider is notified of the automatic stop order prior to the dispensing of the last dose so that the provider may decide whether to continue to use the drug.

(f) The consultant pharmacist shall, on a quarterly basis, submit a summary of the reports submitted under subsections (a) and (b) of this section to the medication management advisory committee established under G.S. 131E-128.1. The summary shall not include any information that would identify a patient, a family member, or an employee of the nursing home. The purpose

of the summary shall be to facilitate the identification and analysis of weaknesses in the nursing home's pharmaceutical care system that have an adverse impact on patient safety. (2003-393, s. 1.)

§ 131E-128.5: Repealed by Session Laws 2013-360, s. 12G.2(c), effective July 1, 2013.

§ 131E-129. Penalties; remedies.

(a) Violation Classification and Penalties. – The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility which is found to be in violation of the requirements of G.S. 131E-117 or applicable State and federal laws and regulations. Citations for violations shall be classified and penalties assessed according to the nature of the violation as follows:

- (1) "Type A1 Violation" means a violation by a facility of the regulations and requirements set forth in G.S. 131E-117, or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm. The person making the findings shall do the following:
 - a. Orally and immediately inform the facility of the Type A1 Violation and the specific findings.
 - b., c. Repealed by Session Laws 2011-249, s. 3, effective June 23, 2011.
 - d. Require a written, credible allegation regarding how the facility will immediately remove the Type A1 Violation in order to protect residents from further risk or additional harm.
 - e. Within 15 working days of the investigation, send a report of the findings to the facility.
 - f. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance by the date specified by the Department.

The Department shall impose a civil penalty in an amount not less than one thousand dollars (\$1,000) nor more than twenty thousand dollars (\$20,000) for each Type A1 Violation. Where a facility has failed to correct a Type A1 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the violation continues beyond the date specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

- (1a) "Type A2 Violation" means a violation by a facility of the regulations, standards, and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in substantial risk that death or serious physical harm will occur. The person making the findings shall do the following:
 - a. Orally and immediately inform the facility of the Type A2 Violation and the specific findings.

- b. Require a credible allegation regarding how the facility will immediately remove the Type A2 Violation in order to protect residents from further risk or additional harm.
- c. Within 10 working days of the investigation, send a report of the findings to the facility.
- d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance by the date specified by the Department.

The violation or violations shall be corrected within the time specified for correction by the Department or its authorized representative. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Where a facility has failed to correct a Type A2 Violation, the Department shall assess the facility a civil penalty in the amount of up to one thousand dollars (\$1,000) for each day that the deficiency continues beyond the time specified for correction by the Department or its authorized representative. The Department or its authorized representative shall determine whether the violation has been corrected.

- (1b) "Past Corrected Type A1 or Type A2 Violation" means either (i) the violation was not previously identified by the Department or its authorized representative or (ii) the violation was discovered by the facility and was self reported, but in either case the violation has been corrected. In determining whether a penalty should be assessed under this section, the Department shall consider the following factors:
 - a. Preventive systems in place prior to the violation.
 - b. Whether the violation or violations were abated immediately.
 - c. Whether the facility implemented corrective measures to achieve and maintain compliance.
 - d. Whether the facility's system to ensure compliance is maintained and continues to be implemented.
 - e. Whether the regulatory area remains in compliance.
- (2) "Type B Violation" means a violation by a facility's licensee of the regulations, standards and requirements set forth in G.S. 131E-117 or applicable State or federal laws and regulations governing the licensure or certification of a facility which is detrimental to the health, safety, or welfare of any resident, but which does not result in substantial risk that death or serious physical harm will occur. The person making the findings shall do the following:
 - a. Orally and immediately inform the facility of the Type B Violation and the specific findings.

- b. Require a written plan regarding how the facility will immediately remove the Type B Violation in order to protect residents from further risk or additional harm.
- c. Within 10 working days of the investigation, send a report of the findings to the facility.
- d. Require a plan of correction to be submitted to the Department, based on the written report of the findings, that describes steps the facility will take to achieve and maintain compliance by the date specified by the Department.

Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars (\$400.00) for each day that the violation continues beyond the date specified for correction without just reason for such failure. The Department or its authorized representative shall ensure that the violation has been corrected.

- (3) Repeat Violations. – The Department shall impose a civil penalty which is treble the amount assessed under subsection (a) of this section when a facility under the same management or ownership has received a citation during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred, and the current violation is for the same specific provision of a statute or regulation for which it received a violation during the previous 12 months. The counting of the 12-month period shall be tolled during any time when the facility is being operated by a court-appointed temporary manager pursuant to law.

(b) Repealed by Session Laws 2011-249, s. 3, effective June 23, 2011.

(c) Factors to be considered in determining amount of initial penalty. In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

- (1) There is substantial risk that serious physical harm, abuse, neglect, or exploitation will occur.
- (2) Serious physical harm, abuse, neglect, or exploitation, without substantial risk for resident death, did occur.
- (3) Serious physical harm, abuse, neglect, or exploitation, with substantial risk for resident death, did occur.
- (4) A resident died.
- (5) A resident died and there is substantial risk to others for serious physical harm, abuse, neglect, or exploitation.
- (6) A resident died and there is substantial risk for further resident death.
- (7) Reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and G.S. 131E-265 did occur.
- (8) Efforts by the licensee to correct violations.

- (9) The number and type of previous violations committed by the licensee within the past 36 months.
 - (10) The number of residents put at risk by the violations.
 - (c1) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Secretary shall document the findings in written record and shall make the written record available to all affected parties including:
 - (1) The penalty review committee;
 - (2) The local department of social services who is responsible for oversight of the facility involved;
 - (3) The licensee involved;
 - (4) The residents affected; and
 - (5) The family member who serves as a responsible party or those who have legal authority on behalf of the affected resident.
 - (c2) Local county departments of social services and Division of Health Service Regulation personnel shall submit proposed penalty recommendations to the Department within 45 days of the citation of a violation.
 - (d) The Department shall impose a civil penalty of fifty dollars (\$50.00) per day on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.
 - (e) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:
 - (1) The reasonableness of the amount of any civil penalty assessed, and
 - (2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.
- If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.
- (e1) Notwithstanding the notice requirements of G.S. 131E-24, any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the citation is imposed.
 - (f) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:
 - (1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty; or
 - (2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(g) The penalty review committee established pursuant to G.S. 131D-34(h) shall review administrative penalties assessed pursuant to this section.

(g1) In lieu of assessing all or some of the administrative penalty, the Secretary may order a facility to provide staff training if the training is:

- (1) Specific to the violation;
- (2) Approved by the Department of Health and Human Services; and
- (3) Taught by an individual approved by the Department.

(h) The Department shall not assess an administrative penalty against a facility under this section if a civil monetary penalty has been assessed for the same violation under federal enforcement laws and regulations.

(i) The clear proceeds of civil penalties provided for in this section shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. (1987, c. 600, s. 2; 1989, c. 556, s. 2; 1993, c. 390, s. 2; 1995, c. 396, s. 1; 1995 (Reg. Sess., 1996), c. 602, s. 2; 1997-431, s. 2; 1997-443, s. 11A.122; 1998-215, s. 78(b); 2007-182, s. 1.1; 2011-249, s. 3; 2012-194, s. 29.)

§ 131E-130. First available bed priority for certain nursing home patients.

(a) If a patient is temporarily absent, for no more than 15 days, from a nursing home to obtain medical treatment at a hospital other than a State mental hospital, the nursing home; (i) shall provide the patient with the first bed available at or after the time the nursing home receives written notification of the specific date of discharge from the hospital; and (ii) shall grant the patient priority of admission over applicants for admission to the nursing home.

The duration of the temporary absence shall be calculated from the day of the patient's admission to a hospital until the date the nursing home receives written notice of the specific date of discharge.

This subsection shall not apply in instances in which the patient's treatment can no longer be provided by the nursing home upon re-admission.

(b) If the Department finds that a nursing home has violated the provisions of subsection (a) of this section, the Department may assess a civil penalty of fifty dollars (\$50.00) a day, up to a maximum of one thousand five hundred dollars (\$1,500), against the nursing home, for each violation.

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

(c) The provisions of Chapter 150B of the General Statutes that govern contested cases apply to appeals from Department action pursuant to this section. (1987 (Reg. Sess., 1988), c. 1080, s. 1; 1998-215, s. 79.)

§ 131E-131. Rule-making authority; enforcement.

The Commission shall adopt rules necessary for the implementation of this Part.

The Department shall enforce the rules adopted by the Commission to implement this Part. (1993, c. 499, s. 2.)

§ 131E-132. Reserved for future codification purposes.

§ 131E-133. Reserved for future codification purposes.

§ 131E-134. Reserved for future codification purposes.

Part 3. Home Care Agency Licensure Act.

§ 131E-135. Title; purpose.

- (a) This Part shall be known as "Home Care Agency Licensure Act."
- (b) The purpose of this Part is to establish licensing requirements for home care agencies. (1983, c. 775, s. 1; 1991, c. 59, s. 1; c. 761, s. 34.)

§ 131E-136. Definitions.

As used in this Part, unless otherwise specified:

- (1) "Commission" means the North Carolina Medical Care Commission.
- (1a) "Geographic service area" means the geographic area in which a licensed agency provides home care services.
- (2) "Home care agency" means a private or public organization that provides home care services.
- (2a) "Home care agency director" means the person having administrative responsibility for the operation of the licensed agency site.
- (2b) "Home care client" means an individual who receives home care services.
- (3) "Home care services" means any of the following services and directly related medical supplies and appliances, which are provided to an individual in a place of temporary or permanent residence used as an individual's home:
 - a. Nursing care provided by or under the supervision of a registered nurse.
 - b. Physical, occupational, or speech therapy, when provided to an individual who also is receiving nursing services, or any other of these therapy services, in a place of temporary or permanent residence used as the individual's home.
 - c. Medical social services.
 - d. In-home aide services that involve hands-on care to an individual.
 - e. Infusion nursing services.
 - f. Assistance with pulmonary care, pulmonary rehabilitation or ventilation.
 - g. In-home companion, sitter, and respite care services provided to an individual.
 - h. Homemaker services provided in combination with in-home companion, sitter, respite, or other home care services.

The term does not include: health promotion, preventative health and community health services provided by public health departments; maternal and child health services provided by public health departments, by employees of the Department of Health and Human Services under G.S. 130A-124, or by developmental evaluation centers under contract with the Department of Health and Human Services to provide services under G.S. 130A-124; hospitals licensed under Article 5 of Chapter 131E of the General Statutes when providing follow-up care initiated to patients within six months after their discharge from the hospital; facilities and programs operated under the authority of G.S. 122C and providing services within the scope of G.S. 122C;

schools, when providing services pursuant to Article 9 of Chapter 115C; the practice of midwifery by a person licensed under Article 10A of Chapter 90 of the General Statutes; hospices licensed under Article 10 of Chapter 131E of the General Statutes when providing care to a hospice patient; an individual who engages solely in providing his own services to other individuals; incidental health care provided by an employee of a physician licensed to practice medicine in North Carolina in the normal course of the physician's practice; or nursing registries if the registry discloses to a client or the client's responsible party, before providing any services, that (i) it is not a licensed home care agency, and (ii) it does not make any representations or guarantees concerning the training, supervision, or competence of the personnel provided. The term sitter does not include child care facilities licensed in accordance with Chapter 110 of the General Statutes. The term respite care does not include facilities or services licensed in accordance with Chapter 122C of the General Statutes. The terms in-home companion, sitter, homemaker, and respite care services do not include (i) services certified or otherwise overseen by the Department as not providing personal care or (ii) services administered on a voluntary basis for which there is not reimbursement from the recipient or anyone acting on the recipient's behalf.

- (4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E. (1971, c. 539, s. 1; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1022, s. 4; 1987, c. 34, s. 1; 1991, c. 59, s. 1; c. 761, s. 34; 1997-443, s. 11A.90; 2005-276, s. 10.40A(m); 2008-127, s. 1.)

§ 131E-137. Services to be provided in all counties.

(a) Every county shall provide part-time, intermittent home care nursing services, and at least one of the following home care services: part-time, intermittent physical therapy, occupational therapy, speech therapy, medical social work, or home health aide services.

(b) Repealed by Session Laws 1991, c. 59, s. 1.

(c) These services shall be provided by a home care agency licensed under this Part. The county may provide these services by contract with another home care agency in another county.

(d) Repealed by Session Laws 1985, c. 8, s. 1. (1977, 2nd Sess., c. 1184; 1979, c. 754, s. 1; 1983, c. 775, s. 1; 1985, c. 8; 1991, c. 59, s. 1, c. 761, s. 34.)

§ 131E-138. Licensure requirements.

(a) No person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

(b) Repealed by Session Laws 1991, c. 59, s. 1.

(c) An application for a license shall be available from the Department, and each application filed with the Department shall contain all information requested by the Department. A license shall be granted to the applicant upon a determination by the Department that the

applicant has complied with the provisions of this Part and the rules promulgated by the Commission under this Part. The Department shall charge the applicant a nonrefundable annual license fee in the amount of five hundred ten dollars (\$510.00).

(d) The Department shall renew the license in accordance with the rules of the Commission.

(e) Each license shall be issued only for the premises and persons named in the license and shall not be transferable or assignable except with the written approval of the Department.

(f) The license shall be posted in a conspicuous place on the licensed premises.

(g) The Commission shall adopt rules to ensure that a home care agency shall be deemed to meet the licensure requirements and issued a license without further review or inspection if: (i) the agency is already certified or accredited by the Joint Commission on Accreditation of Health Care Organizations, National League for Nursing, National Home Caring Council, North Carolina Accreditation Commission for In-Home Aide Services, or other entities recognized by the Commission and (ii) the agency is certified or accredited for all of the home care services that it provides; or (iii) in the case of continuing care retirement communities licensed by the North Carolina Department of Insurance under Article 64 of Chapter 58 which also have nursing beds licensed by the Department of Health and Human Services under Article 6 of Chapter 131E, the Department certifies, as part of its licensure review or survey of the nursing beds, that the facility also meets all of the rules and regulations adopted by the Commission pursuant to this Part. The Department may, at its discretion, determine the frequency and extent of the review and inspection of home health agencies already certified as meeting federal requirements, but not more frequently than on an annual basis for routine reviews. (1971, c. 539, s. 1; 1973, c. 476, s. 128; 1983, c. 775, s. 1; 1991, c. 59, s. 1; c. 761, s. 34; 1997-443, s. 11A.118(a); 2003-284, s. 34.4(a); 2005-276, s. 41.2(d); 2008-127, s. 2; 2009-451, s. 10.76(d).)

§ 131E-138.1. Licensure fees for nursing beds and adult care home beds in continuing care retirement communities.

The Department shall charge continuing care retirement communities licensed under Article 64 of Chapter 58 of the General Statutes that have nursing home beds or adult care home beds licensed by the Department a nonrefundable annual base license fee in the amount of four hundred fifty dollars (\$450.00) plus a nonrefundable annual per-bed fee in the amount of twelve dollars and fifty cents (\$12.50). (2003-284, s. 34.9(a); 2005-276, s. 41.2(i).)

§ 131E-139. Adverse action on a license.

(a) The Department may suspend, revoke, annul, withdraw, recall, cancel or amend a license when there has been a substantial failure to comply with the provisions of this Part or the rules promulgated under this Part.

(b) The provisions of Chapter 150B of the General Statutes, The Administrative Procedure Act, shall govern all administrative action and judicial review in cases where the Department has taken the action described in subsection (a). (1971, c. 539, s. 1; 1973, c. 476, s. 128; 1983, c. 775, s. 1; 1987, c. 827, s. 1; 1991, c. 59, s. 1, c. 761, s. 34.)

§ 131E-140. Rules and enforcement.

(a) The Commission may adopt, amend and repeal all rules necessary for the implementation of this Part and Part 3A of Article 6 of this Chapter. Provided, these rules shall not extend, modify, or limit the licensing of individual health professionals by their respective

licensing boards; nor shall these rules in any way be construed to extend the appropriate scope of practice of any individual health care provider. Rules authorized under this section include rules:

- (1) That recognize the different types of home care services and shall adopt specific requirements for the provision of each type of home care service.
- (2) To establish staff qualifications, including professional requirements for home care agency staff. The rules may require that one or more staff of an agency be either licensed or certified. The rules may establish minimum training and education qualifications for staff and may include the recognition of professional certification boards for those professions not licensed or certified under other provisions of the North Carolina General Statutes provided that the professional board evaluates applicants on a basis that protects the public health, safety, or welfare.
- (3) For the purpose of ensuring effective supervision of in-home aide staff and timely provision of services, the Commission shall adopt rules defining geographic service areas for in-home aide services and staffing qualifications for licensed home care agencies.
- (4) Prohibiting licensed home care agencies from hiring individuals listed on the Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).
- (5) Requiring applicants for home care licensure to receive training in the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.

(a1) The Commission shall adopt rules defining the scope of permissible advertising and promotional practice by home care agencies.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to home care agencies and shall conduct an inspection of each agency at least every three years. (1971, c. 539, s. 1; 1973, c. 476, s. 128; 1983, c. 775, s. 1; 1991, c. 59, s. 1; c. 761, s. 34; 2005-276, ss. 10.40A(a), 10.40A(o).)

§ 131E-141. Inspection.

(a) The Department shall inspect home care agencies in accordance with rules adopted by the Commission to determine compliance with the provisions of this Part and the rules established by the Commission.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been clients of the agency being inspected unless that client objects in writing to review of that client's records. Physicians, psychiatrists, nurses, and anyone else involved in giving treatment at or through an agency who may be interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law; provided the client has not made written objection to this disclosure. The agency, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews, except as noted in G.S.

131E-124(c), shall be kept confidential by the Department and not disclosed without written authorization of the client or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning an agency without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, " 'Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the client must be advised in writing by the licensed agency that the client has the right to object in writing to release of information or review of the client's records and that by an objection in writing the client may prohibit the inspection or release of the records.

(c) An agency must provide each client with a written notice of the Division of Health Service Regulation hotline number in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services. (1971, c. 539, s. 1; 1973, c. 476, s. 128; 1981, c. 586, s. 2; 1983, c. 775, s. 1; 1991, c. 59, s. 1; c. 761, s. 34; 1999-113, s. 4; 2005-276, s. 10.40A(b); 2007-182, s. 1.)

§ 131E-141.1. Penalties for violation.

Any person who knowingly and willfully establishes, conducts, manages or operates any home care agency without a license is guilty of a Class 3 misdemeanor and upon conviction is liable only for a fine of not more than five hundred dollars (\$500.00) for the first offense and not more than five hundred dollars (\$500.00) for each subsequent offense. (1991, c. 59, s. 1, c. 761, s. 34; 1993, c. 539, s. 961; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-142. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department shall, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of a home care agency without a license.

(b) If any person shall hinder the proper performance of duty of the Secretary or a representative in carrying out the provisions of this Part, the Secretary may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure. (1983, c. 775, s. 1; 1991, c. 59, s. 1, c. 761, s. 34.)

§ 131E-143. Smoking prohibited; penalty.

(a) A home care agency shall prohibit its employees from smoking while providing services to an individual in the individual's home. The home care agency shall inform its clients that employees of the agency are prohibited from smoking in a client's home. As used in this section:

- (1) "Employee" includes an individual under contract with the home care agency to provide home care services.

- (2) "Smoking" means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.

(b) The Department may impose an administrative penalty not to exceed two hundred dollars (\$200.00) for each violation on any person who owns, manages, operates, or otherwise controls the home care agency and fails to comply with this section. A violation of this section constitutes a civil offense only and is not a crime. (2007-459, s. 4.)

§ 131E-144. Reserved for future codification purposes.

Part 3A. Home Care Clients' Bill of Rights.

§ 131E-144.1. Legislative intent.

It is the intent of the General Assembly to support an individual's desire to live at home and receive home care services. (2005-276, s. 10.40A(n).)

§ 131E-144.2. Definitions.

Unless otherwise specified, the definitions that are provided in Part 3 of Article 6 of this Chapter apply in this Part. (2005-276, s. 10.40A(n).)

§ 131E-144.3. Declaration of home care clients' rights.

Each client of a home care agency shall have the following rights:

- (1) To be informed and participate in his or her plan of care.
- (2) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.
- (3) To receive care and services that are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
- (4) To voice grievances about care and not be subjected to discrimination or reprisal for doing so.
- (5) To have his or her personal and medical records kept confidential and not be disclosed except as permitted or required by applicable State or federal law.
- (6) To be free of mental and physical abuse, neglect, and exploitation.
- (7) To receive a written statement of services provided by the agency and the charges the client is liable for paying.
- (8) To be informed of the process for acceptance and continuance of service and eligibility determination.
- (9) To accept or refuse services.
- (10) To be informed of the agency's on-call service.
- (11) To be informed of supervisory accessibility and availability.
- (12) To be advised of the agency's procedures for discharge.
- (13) To receive a reasonable response to his or her requests of the agency.
- (14) To be notified within 10 days when the agency's license has been revoked, suspended, canceled, annulled, withdrawn, recalled, or amended.
- (15) To be advised of the agency's policies regarding patient responsibilities. (2005-276, s. 10.40A(n); 2011-314, s. 6.)

§ 131E-144.4. Notice to client.

(a) During the agency's initial evaluation visit or before furnishing services, a home care agency shall provide each client with the following:

- (1) A copy of the declaration of home care clients' rights.
- (2) A copy of the agency's policies regarding client responsibilities as it relates to safety and care plan compliance.
- (3) The address and telephone number for information, questions, or complaints about services provided by the agency.
- (4) The address and telephone number of the section of the Department of Health and Human Services responsible for the enforcement of the provisions of this Part.

(b) Receipts for the declaration of home care clients' rights and contact information required in this section shall be signed by the client and shall be retained in the agency's files. (2005-276, s. 10.40A(n).)

§ 131E-144.5. Implementation.

Responsibility for implementing the provisions of this Part shall rest with the home care agency director. Each agency shall provide appropriate training to implement this Part. (2005-276, s. 10.40A(n).)

§ 131E-144.6. Enforcement and investigation.

(a) The Department of Health and Human Services shall be responsible for enforcing the provisions of this Part. The Department shall investigate complaints made to it and reply within a reasonable period of time, not to exceed 60 days.

(a1) When the Department of Health and Human Services receives a complaint alleging a violation of the provisions of this Part pertaining to client care or client safety, the Department shall initiate an investigation as follows:

- (1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.
- (2) Within 24 hours if the complaint alleges abuse of a client as defined by G.S. 131D-20(1).
- (3) Within 48 hours if the complaint alleges neglect of a client as defined by G.S. 131D-20(8).
- (4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory and reporting requirements for health care personnel pursuant to Article 15 of this Chapter, or for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

(b) A home care agency shall investigate, within 72 hours, complaints made to the agency by a home care client or the client's family and must document both the existence of the complaint and the resolution of the complaint. (2005-276, s. 10.40A(n).)

§ 131E-144.7. Confidentiality.

(a) The Department of Health and Human Services may inspect home care clients' medical records maintained at the agency when necessary to investigate any alleged violation of this Part.

(b) The Department shall maintain the confidentiality of all persons who register complaints with the Department and of all medical records inspected by the Department. A person who has filed a complaint shall have access to information about a complaint investigation involving a specific home care client if written authorization is obtained from the client or legal representative. (2005-276, s. 10.40A(n).)

Part 4. Ambulatory Surgical Facility Licensure.

§ 131E-145. Title; purpose.

(a) This Part shall be known as the "Ambulatory Surgical Facility Licensure Act."

(b) The purpose of this Part is to provide for the development, establishment and enforcement of basic standards:

- (1) For the care and treatment of individuals in ambulatory surgical facilities; and
- (2) For the maintenance and operation of ambulatory surgical facilities so as to ensure safe and adequate treatment of such individuals in ambulatory surgical facilities. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1.)

§ 131E-146. Definitions.

As used in this Part, unless otherwise specified:

- (1) "Ambulatory surgical facility" means a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room as defined in subdivision (1c) of this section or at least one gastrointestinal endoscopy room as defined in subdivision (1b) of this section and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under G.S. Chapter 131E, Article 6, Part 4, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1a) and which are performed in a physician or dentist's office does not make that office an ambulatory surgical facility.
- (1a) "Ambulatory surgical program" means a formal program for providing on a same-day basis those surgical procedures which require local, regional or general anesthesia and a period of post-operative observation to patients whose admission for more than 24 hours is determined, prior to surgery or gastrointestinal endoscopy, to be medically unnecessary.
- (1b) "Gastrointestinal endoscopy room" means a room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.

- (1c) "Operating room" means a room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.
- (2) "Commission" means the North Carolina Medical Care Commission. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1064, s. 1; 1997-456, s. 49(a); 2001-242, s. 1; 2005-346, s. 4.)

§ 131E-147. Licensure requirement.

(a) No person shall operate an ambulatory surgical facility without a license obtained from the Department.

(b) Applications shall be available from the Department, and each application filed with the Department shall contain all necessary and reasonable information that the Department may by rule require. A license shall be granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of this Part and the rules promulgated by the Commission under this Part. The Department shall charge the applicant a nonrefundable annual base license fee in the amount of eight hundred fifty dollars (\$850.00) plus a nonrefundable annual per-operating room fee in the amount of seventy-five dollars (\$75.00).

(c) A license to operate an ambulatory surgical facility shall be annually renewed upon the filing and the department's approval of a renewal application. The renewal application shall be available from the Department and shall contain all necessary and reasonable information that the Department may by rule require.

(d) Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the written approval of the Department.

(e) Licenses shall be posted in a conspicuous place on the licensed premises. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1; 2003-284, s. 34.5(a); 2005-276, s. 41.2(e); 2009-451, s. 10.76(b).)

§ 131E-147.1. Fair billing and collections practices for ambulatory surgical facilities.

All ambulatory surgical facilities licensed under this Part shall be subject to the fair billing and collections practices set out in G.S. 131E-91. (2013-382, s. 13.3.)

§ 131E-148. Adverse action on a license.

(a) Subject to subsection (b), the Department is authorized to deny a new or renewal application for a license, and to amend, recall, suspend or revoke an existing license upon a determination that there has been a substantial failure to comply with the provisions of this Part or the rules promulgated under this Part.

(b) The provisions of Chapter 150A of the General Statutes, the Administrative Procedure Act, shall govern all administrative action and judicial review in cases where the Department has taken the action described in subsection (a). (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1.)

§ 131E-149. Rules and enforcement.

(a) The Commission is authorized to adopt, amend and repeal all rules necessary for the implementation of this Part. These rules shall be no stricter than those issued by the Commission under G.S. 131E-79 of the Hospital Licensing Act.

(b) The Department shall enforce the rules adopted or amended by the Commission with respect to ambulatory surgical facilities. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1.)

§ 131E-150. Inspections.

(a) The Department shall make or cause to be made inspections of ambulatory surgical facilities as necessary. The Department is authorized to delegate to a State officer, agent, board, bureau or division of State government the authority to make inspections according to the rules adopted by the Commission. The Department may revoke this delegated authority in its discretion.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been patients of the facility being inspected unless that patient objects in writing to review of that patient's records. Physicians, psychologists, psychiatrists, nurses, and anyone else involved in giving treatment at or through a facility who may be interviewed by representatives of the Department may disclose to these representatives information related to an inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law; Provided the patient has not made written objection to this disclosure. The facility, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews shall be kept confidential by the Department and not disclosed without written authorization of the patient or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning a facility without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "'Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the patient must be advised in writing by the facility that the patient has the right to object in writing to this release of information or review of the records and that by objecting in writing, the patient may prohibit the inspection or release of the records. (1977, 2nd Sess., c. 1214, s. 1; 1981, c. 586, s. 5; 1983, c. 775, s. 1.)

§ 131E-151. Penalties.

A person who owns in whole or in part or operates an ambulatory surgical facility without a license is guilty of a Class 3 misdemeanor, and upon conviction will be subject only to a fine of not more than fifty dollars (\$50.00) for the first offense and not more than five hundred dollars (\$500.00) for each subsequent offense. Each day of continuing violation after conviction is considered a separate offense. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1; 1993, c. 539, s. 962; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-152. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other

process against any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of an ambulatory surgical facility without a license.

(b) If any person shall hinder the proper performance of duty of the Secretary or a representative in carrying out the provisions of this Part, the Secretary may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure. (1977, 2nd Sess., c. 1214, s. 1; 1983, c. 775, s. 1.)

§ 131E-153. Reserved for future codification purposes.

§ 131E-154. Reserved for future codification purposes.

Part 5. Nursing Pool Licensure Act.

§ 131E-154.1. Title; purpose.

(a) This Part shall be known as "Nursing Pool Licensure Act".

(b) The purpose of this Part is to establish licensing requirements for nursing pools. (1989, c. 744, s. 1.)

§ 131E-154.2. Definitions.

The following definitions apply in this Part:

- (1) Commission. – The North Carolina Medical Care Commission.
- (2) Department. – The Department of Health and Human Services.
- (3) Health care facility. – A hospital; psychiatric facility; rehabilitation facility; long-term care facility; home health agency; intermediate care facility for individuals with intellectual disabilities; chemical dependency treatment facility; and ambulatory surgical facility.
- (4) Nursing pool. – Any person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nursing personnel, including nurses, nursing assistants, nurses aides, and orderlies. "Nursing pool" does not include an individual who engages solely in providing the individual's own services on a temporary basis to health care facilities.
- (5) Trauma. – Acute physical injury to the human body that is judged, by the use of standardized field triage criteria (anatomic, physiologic, or mechanism of injury), to create a significant risk of mortality or major morbidity. (1989, c. 744, s. 1; 1993, c. 336, s. 2; 1997-443, s. 11A.118(a); 2019-76, s. 18.)

§ 131E-154.3. Licensing.

(a) No person shall operate or represent himself to the public as operating a nursing pool without obtaining a license from the Department.

(b) The Department shall provide applications for nursing pool licensure. Each application filed with the Department shall contain all information requested. A license shall be granted to the applicant upon a determination by the Department that the applicant has complied with the provisions of this Part and with the rules adopted by the Commission. Each license shall be issued only for the premises and persons named, shall not be transferrable or assignable except with the written approval of the Department, and shall be posted in a conspicuous place on the licensed premises.

(c) The Department shall renew the license in accordance with this Part and with rules adopted pursuant to it.

(d) Nursing pools administered by health care facilities and agencies licensed under Article 5 or 6 of Chapter 131E of the General Statutes shall not be required to be separately licensed under this Article. However, any facility or agency exempted from licensure as a nursing pool under this subsection shall be subject to rules adopted pursuant to this Article. (1989, c. 744, s. 1.)

§ 131E-154.4. Rules and enforcement.

(a) The Commission shall adopt, amend, and repeal all rules necessary for the implementation of this Part. These rules shall include the following requirements:

- (1) The nursing pool shall document that each employee who provides care meets the minimum licensing, training, and continuing education standards for the position in which the employee will be working;
- (2) The nursing pool shall comply with all other pertinent regulations relating to the health and other qualifications of personnel;
- (3) The nursing pool shall carry general and professional liability insurance to insure against the loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of health care services by the nursing pool or its employees;
- (4) The nursing pool shall have written administrative and personnel policies to govern the services that it provides. These policies shall include those concerning patient care, personnel, training and orientation, supervision, employee evaluation, and organizational structure; and
- (5) Any other aspects of nursing pool services that may need to be regulated to protect the public.

(b) The Commission shall adopt no rules pertaining to the regulation of charges by the nursing pool or to wages paid by the nursing pool. (1989, c. 744, s. 1.)

§ 131E-154.5. Inspections.

The Department shall inspect all nursing pools that are subject to rules adopted pursuant to this Part in order to determine compliance with the provisions of this Part and with rules adopted pursuant to it. Inspections shall be conducted in accordance with rules adopted by the Commission. (1989, c. 744, s. 1.)

§ 131E-154.6. Adverse action on a license; appeal procedures.

(a) The Department may suspend, revoke, annul, withdraw, recall, cancel, or amend a license when there has been a substantial failure to comply with the provisions of this Part or with the rules adopted pursuant to it.

(b) The provisions of Chapter 150B of the General Statutes, the Administrative Procedure Act, shall govern all administrative action and judicial review in cases in which the Department has taken the action described in subsection (a) of this section. (1989, c. 744, s. 1.)

§ 131E-154.7. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process against any person to restrain or prevent the establishment, conduct, management, or operation of a nursing pool without a license or to restrain or prevent substantial noncompliance with this Part or the rules adopted pursuant to it.

(b) If any person hinders the proper performance of duty of the Department in carrying out the provisions of this Part, the Department may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance. (1989, c. 744, s. 1.)

§ 131E-154.8. Confidentiality.

(a) Notwithstanding G.S. 8-53 or any other law pertaining to confidentiality of communications between physician and patient, in the course of an inspection conducted pursuant to G.S. 131E-154.5:

- (1) Department representatives may review any writing or other record concerning the admission, discharge, medication, treatment, medical condition, or history of any person who is or has been a nursing pool patient; and
- (2) Any person involved in treating a patient at or through a nursing pool may disclose information to a Department representative unless the patient objects in writing to review of his records or disclosure of the information. A nursing pool shall not release any information or allow any inspections under this section without first informing each affected patient in writing of his right to object to and thus prohibit release of information or review of records pertaining to him.

A nursing pool, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of the information to the Department.

(b) The Department shall not disclose:

- (1) Any confidential or privileged information obtained under this section unless the patient or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure; or
- (2) The name of anyone who has furnished information concerning a nursing pool without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. Any Department employee who willfully discloses this information without appropriate authorization or court order shall be guilty of a Class 3 misdemeanor and, upon conviction, only fined at the discretion of the court but not in excess of five hundred dollars (\$500.00).

(c) All confidential or privileged information obtained under this section and the names of all persons providing this information are exempt from Chapter 132 of the General Statutes. (1989, c. 744, s. 1; 1993, c. 539, s. 963; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-154.9. Reserved for future codification purposes.

§ 131E-154.10. Reserved for future codification purposes.

§ 131E-154.11. Reserved for future codification purposes.

Part 6. North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation.

§ 131E-154.12. Title; purpose.

(a) This Part shall be known as the "North Carolina New Organizational Vision Award (NC NOVA) Special Licensure Designation."

(b) The purpose of this Part is to establish special licensure designation requirements for nursing homes and home care agencies licensed pursuant to this Chapter and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes. Application for the Special Licensure Designation is voluntary. (2006-104, s. 1.)

§ 131E-154.13. Definitions.

The following definitions apply in this Part, unless otherwise specified:

- (1) Independent Review Organization. – The organization responsible for the application, review, and determination process for NC NOVA designation.
- (2) North Carolina New Organizational Vision Award (NC NOVA). – A special licensure designation for home care agencies and nursing homes licensed pursuant to this Chapter, and adult care homes licensed pursuant to Article 1 of Chapter 131D of the General Statutes, that have been determined through written and on-site review by an independent review organization to have met a comprehensive set of workplace related interventions intended to improve the recruitment and retention, quality, and job satisfaction of direct care staff and the care provided to long-term care clients and residents.
- (3) NC NOVA Partner Team. – The entity responsible for developing the criteria and protocols for the NC NOVA special licensure designation. The Partner Team is inclusive of representatives from the following organizations: Association for Home and Hospice Care of North Carolina, Direct Care Workers Association of North Carolina, Duke University Gerontological Nursing Program, Friends of Residents in Long Term Care, North Carolina Assisted Living Association, North Carolina Association of Long Term Care Facilities, LeadingAge North Carolina, North Carolina Department of Health and Human Services, North Carolina Foundation for Advanced Health Programs, North Carolina Health Care Facilities Association, The Carolinas Center for

Medical Excellence, and the University of North Carolina at Chapel Hill – Institute on Aging.

- (4) NC NOVA Provider Information Manual. – The document developed by the NC NOVA Partner Team that specifies the scope of criteria for NC NOVA designation as well as information and procedures pertaining to the application, review, determination, and termination process. (2006-104, s. 1; 2015-264, s. 17.)

§ 131E-154.14. NC NOVA program established.

- (a) The Department of Health and Human Services shall establish the NC NOVA program.
- (b) The Department shall adopt rules to implement the NC NOVA program in accordance with the criteria and protocols established by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.
- (c) Any information submitted by applicants or obtained by the independent review organization related to NC NOVA, as well as annual turnover data voluntarily submitted by home care agencies, adult care homes, and nursing facilities for the purposes of assessing statewide turnover trends, shall not be considered a public record under G.S. 132-1.
- (d) Any licensed home care agency, adult care home, or nursing home that is determined not to have met the criteria for NC NOVA designation may reapply at intervals specified by the NC NOVA Partner Team and detailed in the NC NOVA Provider Information Manual.
- (e) The Department of Health and Human Services, Division of Health Service Regulation, shall issue a NC NOVA special licensure designation document to any licensed home care agency, adult care home, or nursing home that is determined by the independent review organization to have met the criteria for NC NOVA designation. The special licensure designation document shall be in addition to the operating license issued by the Division.
- (f) The Division of Health Service Regulation shall issue the NC NOVA special licensure document to successful applicants within 30 days of notification by the independent review organization.
- (g) The NC NOVA special licensure designation shall be in effect for a two-year period unless the provider has a change in ownership.
 - (1) Upon a change in ownership, if the new owner wishes to continue the NC NOVA designation, the new owner must communicate the desire in writing to the independent review organization within 30 days of the effective date of the change of ownership and proceed with an expedited review in accordance with procedures detailed by the NC NOVA Partner Team and included in the NC NOVA Provider Information Manual.
 - a. If the new owner continues to meet the NC NOVA criteria, based upon the expedited review, the special licensure designation will remain in effect for the remainder of the two-year period.
 - b. If the new owner fails to meet NC NOVA criteria, the special designation document shall be immediately returned to the Division of Health Service Regulation. The new owner may reapply for NC NOVA designation under subsection (e) of this section.
 - (2) Within 30 days of the effective date of the change of ownership, if the new owner fails to notify the independent review organization in writing of the desire to retain the special licensure designation by undergoing an expedited

review, the designation will become null and void, and the special designation document must be immediately returned to the Division of Health Service Regulation. (2006-104, s. 1; 2007-182, s. 1.)

Article 7.

Regulation of Emergency Medical Services.

§ 131E-155. Definitions.

As used in this Article, unless otherwise specified:

- (1) "Advanced emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an advanced emergency medical technician by the Department.
- (1a) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State.
- (2) Repealed by Session Laws 1997-443, s. 11A.129C.
- (3) Recodified as subdivision (13a).
- (4) "Commission" means the North Carolina Medical Care Commission.
- (5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and has been credentialed as an emergency medical dispatcher by the Department.
- (5a) "Emergency medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been credentialed as an emergency medical responder by the Department.
- (6) "Emergency medical services" means services rendered by emergency medical services personnel in responding to improve the health and wellness of the community and to address the individual's need for emergency medical care within the scope of practice as defined by the North Carolina Medical Board in accordance with G.S. 143-514 in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.
- (6a) "Emergency medical services instructor" means an individual who has completed educational requirements approved by the Department and has been credentialed as an emergency medical services instructor by the Department.
- (6b) "Emergency Medical Services Peer Review Committee" means a panel composed of EMS program representatives to be responsible for

analyzing patient care data and outcome measures to evaluate the ongoing quality of patient care, system performance, and medical direction within the EMS system. The committee membership shall include physicians, nurses, EMS personnel, medical facility personnel, and county government officials. Review of medical records by the EMS Peer Review Committee is confidential and protected under G.S. 143-518. An EMS Peer Review Committee, its members, proceedings, records and materials produced, and materials considered shall be afforded the same protections afforded Medical Review Committees, their members, proceedings, records, and materials under G.S. 131E-95.

- (7) "Emergency medical services personnel" means all the personnel defined in subdivisions (1), (5), (5a), (6a), (8), (9), (10), (15), and (15a) of this section.
- (8) "Emergency medical services-nurse practitioner" means a registered nurse who is licensed to practice nursing in North Carolina and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-nurse practitioners shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.
- (9) "Emergency medical services-physician assistant" means a physician assistant who is licensed by the North Carolina Medical Board. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-physician assistants shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.
- (10) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician by the Department.
- (11) Repealed by Session Laws 2003-392, s. 2(a), effective August 7, 2003.
- (12), (13) [Reserved.]
- (13a) "EMS provider" means a firm, corporation or association which engages in or professes to provide emergency medical services.
- (14) [Reserved.]
- (15) "Mobile intensive care nurse" means a registered nurse who is licensed to practice nursing in North Carolina and is approved by the medical

director, following successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.

- (15a) "Paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as a paramedic by the Department.
- (16) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be anticipated.
- (17) "Practical examination" means a test where an applicant for credentialing as an emergency medical technician, emergency medical responder, advanced emergency medical technician, or paramedic demonstrates the ability to perform specified emergency medical care skills. (1983, c. 775, s. 1; 1997-443, s. 11A.129C; 2001-210, s. 1; 2003-392, s. 2(a); 2015-290, s. 1.)

§ 131E-155.1. EMS Provider License required.

(a) No firm, corporation, or association shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to provide emergency medical services or transport patients upon the streets or highways, waterways, or airways in North Carolina unless a valid EMS Provider License has been issued by the Department.

(b) Before an EMS Provider License may be issued, the firm, corporation, or association seeking the license shall apply to the Department for this license. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal EMS Provider License, the Department shall determine that the applicant meets all requirements for this license as set forth in this Article and in the rules adopted under this Article. EMS Provider Licenses shall be valid for a period specified by the Department, provided that the period shall be a minimum of four years unless action is taken under subsection (d) of this section.

(c) The Commission shall adopt rules setting forth the qualifications required for obtaining or renewing an EMS Provider License.

(d) The Department may deny, suspend, amend, or revoke an EMS Provider License in any case where the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules adopted under this Article. The Department's decision to deny, suspend, amend, or revoke an EMS Provider License may be appealed by the applicant or licensee pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

(e) Operating as an EMS provider without a valid EMS Provider License is a Class 3 misdemeanor. Each day's operation as an EMS provider without a license is a separate offense. (1995, c. 413, s. 1; 2001-210, s. 1.)

§ 131E-156. Permit required to operate ambulance.

(a) No person, firm, corporation, or association, either as owner, agent, provider, or otherwise, shall furnish, operate, conduct, maintain, advertise, or otherwise engage in or profess to be engaged in the business or service of transporting patients upon the streets or highways, waterways or airways in North Carolina unless a valid permit from the Department has been issued for each ambulance used in the business or service.

(b) Before a permit may be issued for a vehicle to be operated as an ambulance, the EMS provider shall apply to the Department for an ambulance permit. Application shall be made upon forms and according to procedures established by the Department. Prior to issuing an original or renewal permit for an ambulance, the Department shall determine that the vehicle for which the permit is issued meets all requirements as to equipment, design, supplies and sanitation as set forth in this Article and in the rules of the Commission and that the EMS provider has the credentialed personnel necessary to operate the ambulance in accordance with this Article. Permits issued for ambulances shall be valid for a period specified by the Department, not to exceed four years.

(c) Duly authorized representatives of the Department may issue temporary permits for vehicles not meeting required standards for a period not to exceed 60 days, when it determines the public interest will be served.

(d) When a permit has been issued for an ambulance as specified by this Article, the vehicle and records relating to the maintenance and operation of the vehicle shall be open to inspection by duly authorized representatives of the Department at all reasonable times. (1967, c. 343, s. 3; 1973, c. 476, s. 128; c. 1224, s. 1; 1983, c. 775, s. 1; 2001-210, s. 1.)

§ 131E-157. Standards for equipment; inspection of equipment and supplies required for ambulances.

(a) The Commission shall adopt rules specifying equipment, sanitation, supply and design requirements for ambulances.

(b) The Department shall inspect each ambulance for compliance with the requirements set forth by the Commission and this Article when it deems an inspection is necessary. The Department shall maintain a record of the inspection.

(c) Upon a determination, based upon an inspection, that an ambulance fails to meet the requirements of this Article or rules adopted under this Article, the Department may deny, suspend, or revoke the permit for the ambulance concerned until these requirements are met. (1967, c. 343, s. 3; 1973, c. 476, s. 128; c. 1224, s. 1; 1983, c. 775, s. 1; 2001-210, s. 1.)

§ 131E-158. Credentialed personnel required.

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

- (1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual with higher credentials is available.

- (2) One emergency medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest. (1967, c. 343, s. 3; 1973, c. 476, s. 128; c. 725; c. 1224, s. 1; 1975, c. 612; 1983, c. 775, s. 1; 1989, c. 300; 1997-443, s. 11A.129D; 2001-210, s. 1; 2015-290, s. 2.)

§ 131E-159. Credentialing requirements.

(a) Individuals seeking credentials as an emergency medical technician, advanced emergency medical technician, paramedic, emergency medical responder, emergency medical dispatcher, or emergency medical services instructor shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant by either written, practical, or written and practical examination. The Department shall issue appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for credentialing. Emergency medical technician, emergency medical responder, emergency medical dispatcher, advanced emergency medical technician, paramedic, and emergency medical services instructor credentials shall be valid for a period not to exceed four years and may be renewed if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend these credentials at any time it determines that the holder no longer meets the qualifications prescribed.

(b) The Commission shall adopt rules setting forth the qualifications required for credentialing of emergency medical responders, emergency medical technicians, advanced emergency medical technicians, paramedics, emergency medical dispatchers, and emergency medical services instructors.

(c) Individuals currently credentialed as an emergency medical technician, advanced emergency medical technician, paramedic, emergency medical responder, and emergency medical services instructor by the National Registry of Emergency Medical Technicians or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted EMS provider offering service within North Carolina, may be eligible for credentialing as an emergency medical technician, advanced emergency medical technician, paramedic, emergency medical responder, and emergency medical services instructor without examination. This

credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

(d) An individual currently credentialed as an emergency medical dispatcher by a national credentialing agency, or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules issued by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with an emergency medical dispatcher program approved by the Department of Health and Human Services offering service within North Carolina, may be eligible for credentialing as an emergency medical dispatcher without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

(e) Duly authorized representatives of the Department may issue temporary credentials with or without examination upon finding that this action will be in the public interest. Temporary credentials shall be valid for a period not exceeding 90 days.

(f) The Department may deny, suspend, amend, or revoke the credentials of an emergency medical responder, emergency medical technician, advanced emergency medical technician, paramedic, emergency medical dispatcher, or emergency medical services instructor in any case in which the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules issued under this Article. Prior to implementation of any of the above disciplinary actions, the Department shall consider the recommendations of the EMS Disciplinary Committee pursuant to G.S. 143-519. The Department's decision to deny, suspend, amend, or revoke credentials may be appealed by the applicant or credentialed personnel pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

(g) An individual who applies for EMS credentials, seeks to renew EMS credentials, or holds EMS credentials is subject to a criminal background review by the Department. At the request of the Department, the Emergency Medical Services Disciplinary Committee, established by G.S. 143-519, shall review criminal background information and make a recommendation regarding the eligibility of an individual to obtain initial EMS credentials, renew EMS credentials, or maintain EMS credentials. The Department and the Emergency Medical Services Disciplinary Committee shall keep all information obtained pursuant to this subsection confidential. The Medical Care Commission shall adopt rules to implement the provisions of this subsection, including rules to establish a reasonable fee to offset the actual costs of criminal history information obtained pursuant to G.S. 143B-952.

(h) A person who is required to register as a sex offender under Article 27A of Chapter 14 of the General Statutes, or who was convicted of an offense which would have required registration if committed at a time when such registration would have been required by law, shall not be granted EMS credentials. The Department shall not renew the credentials of any person who would be ineligible for EMS credentials under this subsection. (1967, c. 343, s. 3; 1973, c. 476, s. 128; c. 725; c. 1224, s. 1; 1975, c. 612; 1983, c. 775, s. 1; 1987, c. 495, s. 2; 1993, c. 135, s. 1; 1997-443, ss. 11A.118(a),

11A.129E; 2001-210, s. 1; 2003-392, s. 2(b); 2007-411, s. 1; 2011-37, s. 1; 2014-100, s. 17.1(hhh); 2015-290, s. 3.)

§ 131E-160. Exemptions.

All of the following vehicles are exempt from the provisions of this Article:

- (1) Privately owned vehicles not used in the business of transporting patients.
- (2) A vehicle rendering service as an ambulance in case of a major catastrophe or emergency, when the permitted ambulances based in the locality of the catastrophe or emergency are insufficient to render the services required.
- (3) Any ambulance based outside this State, except that an ambulance which receives a patient within this State for transportation to a location within this State shall comply with the provisions of this Article.
- (4) Ambulances owned and operated by an agency of the United States government.
- (5) Vehicles owned and operated by rescue squads chartered by the State of North Carolina as nonprofit corporations or associations which are not regularly used to transport sick, injured, wounded or otherwise incapacitated or helpless persons except as a part of rescue operations. (1967, c. 343, s. 3; c. 1257, s. 2; 1983, c. 775, s. 1; 2001-210, s. 1.)

§ 131E-161. Violation declared misdemeanor.

It shall be the responsibility of the EMS provider to ensure that the ambulance operation complies with the provisions of this Article and all rules adopted for this Article. Upon the violation of any part of this Article or any rule adopted under authority of this Article, the Department shall have the power to deny, revoke, or suspend the permits of all vehicles owned or operated by the violator. The operation of an ambulance without a valid permit or after a permit has been denied, suspended, or revoked or without appropriate credentialed staffing as required by G.S. 131E-158, shall constitute a Class 1 misdemeanor. (1967, c. 343, s. 3; 1973, c. 476, s. 128; 1983, c. 775, s. 1; 1993, c. 539, s. 964; 1994, Ex. Sess., c. 24, s. 14(c); 1997-443, s. 11A.129F; 2001-210, s. 1.)

Article 7A.

Statewide Trauma System Act of 1993.

§ 131E-162. Statewide trauma system.

The Department shall establish and maintain a program for the development of a statewide trauma system. The Department shall consolidate all State functions relating to trauma systems, both regulatory and developmental, under the auspices of this program.

The Commission shall adopt rules to carry out the purpose of this Article. These rules shall be adopted with the advice of the State Emergency Medical Services Advisory Council and shall include the operation of a statewide trauma registry, statewide educational requirements fundamental to the implementation of the trauma system. The rules adopted by the Commission

shall establish guidelines for monitoring and evaluating the system including standards and criteria for the denial, suspension, voluntary withdrawal, or revocation of credentials for trauma center designation, and the establishment of regional trauma peer review committees. Each regional trauma peer review committee shall be responsible for analyzing trauma patient care data and outcome measures to evaluate the ongoing quality of patient care, system performance, and medical direction within the regional trauma system. The committee membership shall include physicians, nurses, EMS personnel, trauma registrars, and hospital administrators. Review of medical records by the Trauma Peer Review Committee is confidential and protected under G.S. 143-518. A Trauma Peer Review Committee, its members, proceedings, records and materials produced, and materials considered shall be afforded the same protections afforded Medical Review Committees, their members, proceedings, records, and materials under G.S. 131E-95. The rules adopted by the Commission shall avoid duplication of reporting and minimize the cost to hospitals or other persons reporting under this section. The Office of Emergency Medical Services shall be the agency responsible for monitoring system development, ensuring compliance with rules, and overseeing system effectiveness.

With respect to collection of data and educational requirements regarding trauma, rules adopted by the Medical Care Commission shall limit the authority of the Department to hospitals and Emergency Medical Services providers. Nothing in this Article shall be interpreted so as to grant the Department authority to require private physicians, schools, or universities, except those participating in the trauma system, to provide information or data or to conduct educational programs regarding trauma. (1993, c. 336, s. 1; 2001-210, s. 2; 2003-392, s. 2(c).)

§ 131E-163. Reserved for future codification purposes.

§ 131E-164. Reserved for future codification purposes.

Article 8.

Cardiac Rehabilitation Certification Program.

§ 131E-165. Title; purpose.

- (a) This Article shall be known as the "Cardiac Rehabilitation Certification Program."
 - (b) The purpose of this Article is to provide for the development, establishment, and enforcement of rules and certification:
 - (1) For the care and treatment of individuals in outpatient cardiac rehabilitation programs; and
 - (2) For the maintenance and operation of cardiac rehabilitation programs to ensure safe and adequate treatment of individuals in cardiac rehabilitation programs.
- (1983, c. 775, s. 1; 1995, c. 182, s. 1.)

§ 131E-166. Definitions.

As used in this Article, unless otherwise specified:

- (1) "Cardiac Rehabilitation Program" means a program certified under this Article for the delivery of cardiac rehabilitation services to outpatients and includes, but shall not be limited to, coordinated, physician-directed, individualized

programs of therapeutic activity and adaption designed to assist the cardiac patient in attaining the highest rehabilitative potential.

- (2) "Certification" means the issuance of a certificate by the Department upon determination that cardiac rehabilitation services offered at a given program site meet all cardiac rehabilitation program rules. (1983, c. 775, s. 1; 1995, c. 182, s. 2.)

§ 131E-167. Certificate requirement.

(a) Applications for certification shall be available from the Department, and each application filed with the Department shall contain all necessary and reasonable information that the Department may by rule require. A certificate shall be granted to the applicant for a period not to exceed one year upon a determination by the Department that the applicant has substantially complied with the provisions of this Article and the rules promulgated by the Department under this Article. The Department shall charge the applicant a nonrefundable annual certification fee in the amount of three hundred eighty-five dollars (\$385.00).

(b) A provisional certificate may be issued for a period not to exceed six months to a program:

- (1) That does not substantially comply with the rules, when failure to comply does not endanger the health, safety, or welfare of the clients being served by the program;
- (2) During the initial stages of operation if determined appropriate by the Department.

(c) Prior to offering a cardiac rehabilitation program as defined in this Article, such a program must be inspected, evaluated, and certified as having substantially met the rules adopted by the Department under this Article.

(d) A certificate to operate a Cardiac Rehabilitation Program shall be renewed upon the successful re-evaluation of the program as stated in the rules adopted pursuant to this Article.

(e) Each certificate shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the written approval of the Department.

(f) A certificate shall be posted in a conspicuous place on the certified premises. (1983, c. 775, s. 1; 2003-284, s. 34.6(a); 2005-276, s. 41.2(f); 2009-451, s. 10.76(c).)

§ 131E-168. Adverse action on a certificate.

(a) Subject to subsection (b), the Department is authorized to deny a new or renewal certificate and to suspend or revoke an existing certificate upon determination that there has been a substantial failure to comply with the provisions of this Article or the rules promulgated under this Article.

(b) The provisions of Chapter 150A of the General Statutes, the Administrative Procedure Act, shall govern all administrative action and judicial review in cases where the Department has taken the action described in subsection (a). (1983, c. 775, s. 1.)

§ 131E-169. Rules and enforcement.

(a) The Department is authorized to adopt, amend, and repeal all rules as may be designed to further the accomplishment of this Article.

(b) The Department shall enforce the rules adopted for the certification of cardiac rehabilitation programs. (1983, c. 775, s. 1.)

§ 131E-170. Inspections.

(a) The Department shall make or cause to be made inspections of Cardiac Rehabilitation Programs as it deems necessary. The Department is empowered to delegate to a State officer, agent, board, bureau or division of State government the authority to make these inspections according to the rules promulgated by the Department. In addition, an individual who is not a State officer or agent and who is delegated the authority to make these inspections must be approved by the Department. The Department may revoke this delegated authority in its discretion.

(b) Notwithstanding the provisions of G.S. 8-53, "Communications between physician and patient," or any other provision of law relating to the confidentiality of communications between physician and patient, the representatives of the Department who make these inspections may review any writing or other record in any recording medium which pertains to the admission, discharge, medication, treatment, medical condition, or history of persons who are or have been patients of the program being inspected unless that patient objects in writing to review of that patient's records. Physicians, psychiatrists, nurses, and anyone else involved in giving treatment at or through a program who may be interviewed by representatives of the Department may disclose to these representatives information related to any inquiry, notwithstanding the existence of the physician-patient privilege in G.S. 8-53, "Communication between physician and patient," or any other rule of law, provided the patient has not made written objection to this disclosure. The program, its employees, and any person interviewed during these inspections shall be immune from liability for damages resulting from the disclosure of any information to the Department. Any confidential or privileged information received from review of records or interviews shall be kept confidential by the Department and not disclosed without written authorization of the patient or legal representative, or unless disclosure is ordered by a court of competent jurisdiction. The Department shall institute appropriate policies and procedures to ensure that this information shall not be disclosed without authorization or court order. The Department shall not disclose the name of anyone who has furnished information concerning a facility without the consent of that person. Neither the names of persons furnishing information nor any confidential or privileged information obtained from records or interviews shall be considered "public records" within the meaning of G.S. 132-1, "'Public records' defined." Prior to releasing any information or allowing any inspections referred to in this section, the patient must be advised in writing by the program that the patient has the right to object in writing to the release of information or review of the records and that by an objection in writing the patient may prohibit the inspection or release of the records. (1983, c. 775, s. 1.)

§§ 131E-171 through 131E-174. Reserved for future codification purposes.

Article 9.

Certificate of Need.

§ 131E-175. Findings of fact.

The General Assembly of North Carolina makes the following findings:

- (1) That the financing of health care, particularly the reimbursement of health services rendered by health service facilities, limits the effect of free market competition and government regulation is therefore necessary to control costs, utilization, and distribution of new health service facilities and the bed complements of these health service facilities.
- (2) That the increasing cost of health care services offered through health service facilities threatens the health and welfare of the citizens of this State in that citizens need assurance of economical and readily available health care.
- (3) That, if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur and, further, less than equal access to all population groups, especially those that have traditionally been medically underserved, would result.
- (3a) That access to health care services and health care facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process.
- (4) That the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to unnecessary use of expensive resources and overutilization of health care services.
- (5) Repealed by Session Laws 1987, c. 511, s. 1.
- (6) That excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.
- (7) That the general welfare and protection of lives, health, and property of the people of this State require that new institutional health services to be offered within this State be subject to review and evaluation as to need, cost of service, accessibility to services, quality of care, feasibility, and other criteria as determined by provisions of this Article or by the North Carolina Department of Health and Human Services pursuant to provisions of this Article prior to such services being offered or developed in order that only appropriate and needed institutional health services are made available in the area to be served.
- (8) That because persons who have received exemptions under Section 11.9(a) of S.L. 2000-67, as amended, and under Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as amended by Section 1 of S.L. 1999-135, have had sufficient time to complete development plans and initiate construction of beds in adult care homes.
- (9) That because with the enactment of this legislation, beds allowed under the exemptions noted above and pending development will count in the inventory of adult care home beds available to provide care to residents in the State Medical Facilities Plan.
- (10) That because State and county expenditures provide support for nearly three-quarters of the residents in adult care homes through the State County Special Assistance program, and excess bed capacity increases costs per

resident day, it is in the public interest to promote efficiencies in delivering care in those facilities by controlling and directing their growth in an effort to prevent underutilization and higher costs and provide appropriate geographical distribution.

- (11) That physicians providing gastrointestinal endoscopy services in unlicensed settings should be given an opportunity to obtain a license to provide those services to ensure the safety of patients and the provision of quality care.
- (12) That demand for gastrointestinal endoscopy services is increasing at a substantially faster rate than the general population given the procedure is recognized as a highly effective means to diagnose and prevent cancer. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 1; 1983, c. 775, s. 1; 1987, c. 511, s. 1; 1993, c. 7, s. 1; 1997-443, s. 11A.118(a); 2001-234, s. 1; 2005-346, s. 5.)

§ 131E-176. Definitions.

The following definitions apply in this Article:

- (1) Adult care home. – A facility with seven or more beds licensed under Part 1 of Article 1 of Chapter 131D of the General Statutes or under this Chapter that provides residential care for aged individuals or individuals with disabilities whose principal need is a home which provides the supervision and personal care appropriate to their age and disability and for whom medical care is only occasional or incidental.
- (1a) Air ambulance. – Aircraft used to provide air transport of sick or injured persons between destinations within the State.
- (1b) Ambulatory surgical facility. – A facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional, or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours and must provide at least one designated operating room or gastrointestinal endoscopy room and at least one designated recovery room, have available the necessary equipment and trained personnel to handle emergencies, provide adequate quality assurance and assessment by an evaluation and review committee, and maintain adequate medical records for each patient. An ambulatory surgical facility may be operated as a part of a physician or dentist's office, provided the facility is licensed under Part 4 of Article 6 of this Chapter, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program and which are performed in a physician's or dentist's office does not make that office an ambulatory surgical facility.
- (1c) Ambulatory surgical program. – A formal program for providing on a same-day basis those surgical procedures which require local, regional, or general anesthesia and a period of post-operative observation to

patients whose admission for more than 24 hours is determined, prior to surgery or gastrointestinal endoscopy, to be medically unnecessary.

- (2) **Bed capacity.** – Space used exclusively for inpatient care, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.
- (2a) **Bone marrow transplantation services.** – The process of infusing bone marrow into persons with diseases to stimulate the production of blood cells.
- (2b) **Burn intensive care services.** – Services provided in a unit designed to care for patients who have been severely burned.
- (2c) **Campus.** – The adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health service facility and related health care entities.
- (2d) **Capital expenditure.** – An expenditure for a project, including but not limited to the cost of construction, engineering, and equipment which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance. Capital expenditure includes, in addition, the fair market value of an acquisition made by donation, lease, or comparable arrangement by which a person obtains equipment, the expenditure for which would have been considered a capital expenditure under this Article if the person had acquired it by purchase.
- (2e) Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.
- (2f) **Cardiac catheterization equipment.** – The equipment used to provide cardiac catheterization services.
- (2g) **Cardiac catheterization services.** – Those procedures, excluding pulmonary angiography procedures, in which a catheter is introduced into a vein or artery and threaded through the circulatory system into the heart specifically to diagnose abnormalities in the motion, contraction, and blood flow of the moving heart or to perform surgical therapeutic interventions to restore, repair, or reconstruct the coronary blood vessels of the heart.
- (3) **Certificate of need.** – A written order which affords the person so designated as the legal proponent of the proposed project the opportunity to proceed with the development of the project.
- (4) Repealed by Session Laws 1993, c. 7, s. 2.

- (5) Change in bed capacity. – Any of the following:
 - a. Any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another.
 - b. Any redistribution of health service facility bed capacity among the categories of health service facility bed.
 - c. Any increase in the number of health service facility beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.
- (5a) Chemical dependency treatment facility. – A public or private facility, or unit in a facility, which is engaged in providing 24-hour a day treatment for chemical dependency or a substance use disorder. This treatment may include detoxification, administration of a therapeutic regimen for the treatment of individuals with chemical dependence or substance use disorders, and related services. The facility or unit may be any of the following:
 - a. A unit within a general hospital or an attached or freestanding unit of a general hospital licensed under Article 5 of this Chapter.
 - b. A unit within a psychiatric hospital or an attached or freestanding unit of a psychiatric hospital licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes.
 - c. A freestanding facility specializing in treatment of individuals with chemical dependence or substance use disorders that is licensed under Article 1A of former Chapter 122 of the General Statutes or Article 2 of Chapter 122C of the General Statutes. The facility may be identified as "chemical dependency, substance abuse, alcoholism, or drug abuse treatment units," "residential chemical dependency, substance use disorder, alcoholism or drug abuse facilities," or by other names if the purpose is to provide treatment of individuals with chemical dependence or substance use disorders. The term, however, does not include social setting detoxification facilities, medical detoxification facilities, halfway houses, or recovery farms.
- (5b) Chemical dependency treatment beds. – Beds that are licensed for the inpatient treatment of chemical dependency. Residential treatment beds for the treatment of chemical dependency or substance use disorder are chemical dependency treatment beds. Chemical dependency treatment beds do not include beds licensed for detoxification.
- (6) Department. – The North Carolina Department of Health and Human Services.
- (7) Develop. – When used in connection with health services, means to undertake those activities which will result in the offering of institutional health service or the incurring of a financial obligation in relation to the offering of such a service.
- (7a) Diagnostic center. – A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories,

radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars (\$10,000) or more exceeds five hundred thousand dollars (\$500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars (\$500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

- (7b) Expedited review. – The status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:
 - a. The review is not competitive.
 - b. The proposed capital expenditure is less than five million dollars (\$5,000,000).
 - c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.
 - d. The agency has not determined that a public hearing is in the public interest.
- (7c) Gamma knife. – Equipment which emits photon beams from a stationary radioactive cobalt source to treat lesions deep within the brain and is one type of stereotactic radiosurgery.
- (7d) Gastrointestinal endoscopy room. – A room used for the performance of procedures that require the insertion of a flexible endoscope into a gastrointestinal orifice to visualize the gastrointestinal lining and adjacent organs for diagnostic or therapeutic purposes.
- (8), (9) Repealed by Session Laws 1987, c. 511, s. 1.
- (9a) Health service. – An organized, interrelated activity that is medical, diagnostic, therapeutic, rehabilitative, or a combination thereof and that is integral to the prevention of disease or the clinical management of an individual who is sick or injured or who has a disability. "Health service" does not include administrative and other activities that are not integral to clinical management.
- (9b) Health service facility. – A hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; chemical dependency treatment facility; diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility.

- (9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) psychiatric beds; (iii) rehabilitation beds; (iv) nursing home beds; (v) intermediate care beds for individuals with intellectual disabilities; (vi) chemical dependency treatment beds; (vii) hospice inpatient facility beds; (viii) hospice residential care facility beds; (ix) adult care home beds; and (x) long-term care hospital beds.
- (10) Health maintenance organization (HMO). – A public or private organization which has received its certificate of authority under Article 67 of Chapter 58 of the General Statutes and which either is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act or satisfies all of the following:
 - a. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage.
 - b. Is compensated, except for copayments, for the provision of the basic health care services listed in sub-subdivision a. of this subdivision to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided.
 - c. Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organizations, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.
- (10a) Heart-lung bypass machine. – The equipment used to perform extra-corporeal circulation and oxygenation during surgical procedures.
- (11) Repealed by Session Laws 1991, c. 692, s. 1.
- (12) Home health agency. – A private organization or public agency, whether owned or operated by one or more persons or legal entities, which furnishes or offers to furnish home health services.
- (12a) Home health services. – Items and services furnished to an individual by a home health agency, or by others under arrangements with such others made by the agency, on a visiting basis, and except for sub-subdivision e. of this subdivision, in a place of temporary or permanent residence used as the individual's home as follows:
 - a. Part-time or intermittent nursing care provided by or under the supervision of a registered nurse.
 - b. Physical, occupational, or speech therapy.
 - c. Medical social services, home health aid services, and other therapeutic services.
 - d. Medical supplies, other than drugs and biologicals and the use of medical appliances.

- e. Any of the items and services listed in this subdivision which are provided on an outpatient basis under arrangements made by the home health agency at a hospital or nursing home facility or rehabilitation center and the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual at home, or which are furnished at the facility while the individual is there to receive any such item or service, but not including transportation of the individual in connection with any such item or service.
- (13) Hospital. – A public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. The term includes all facilities licensed pursuant to G.S. 131E-77, except long-term care hospitals.
- (13a) Hospice. – Any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.
- (13b) Hospice inpatient facility. – A freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting. For purposes of this Article only, a hospital which has a contractual agreement with a licensed hospice to provide inpatient services to a hospice patient as defined in G.S. 131E-201(4) and provides those services in a licensed acute care bed is not a hospice inpatient facility and is not subject to the requirements in sub-subdivision (5)b. of this section for hospice inpatient beds.
- (13c) Hospice residential care facility. – A freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.
- (14) Repealed by Session Laws 1987, c. 511, s. 1.
- (14a) Intermediate care facility for individuals with intellectual disabilities. – Facilities licensed pursuant to Article 2 of Chapter 122C of the General

Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

- (14b) Repealed by Session Laws 1991, c. 692, s. 1.
- (14c) Reserved for future codification.
- (14d) Repealed by Session Laws 2001-234, s. 2, effective January 1, 2002.
- (14e) Kidney disease treatment center. – A facility that is certified as an end-stage renal disease facility by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 405.
- (14f) "Legacy Medical Care Facility" means a facility that meets all of the following requirements:
 - a. Is not presently operating.
 - b. Has not continuously operated for at least the past six months.
 - c. Within the last 24 months:
 - 1. Was operated by a person holding a license under G.S. 131E-77; and
 - 2. Was primarily engaged in providing to inpatients or outpatients, by or under supervision of physicians, (i) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or (ii) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- (14g) Linear accelerator. – A machine used to produce ionizing radiation in excess of 1,000,000 electron volts in the form of a beam of electrons or photons to treat cancer patients.
- (14h) Reserved for future codification.
- (14i) Lithotripter. – Extra-corporeal shock wave technology used to treat persons with kidney stones and gallstones.
- (14j) Reserved for future codification.
- (14k) Long-term care hospital. – A hospital that has been classified and designated as a long-term care hospital by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, pursuant to 42 C.F.R. § 412.
- (14l) Reserved for future codification.
- (14m) Magnetic resonance imaging scanner. – Medical imaging equipment that uses nuclear magnetic resonance.
- (14n) Main campus. – All of the following for the purposes of G.S. 131E-184(f) and (g) only:
 - a. The site of the main building from which a licensed health service facility provides clinical patient services and exercises financial and administrative control over the entire facility, including the buildings and grounds adjacent to that main building.

- b. Other areas and structures that are not strictly contiguous to the main building but are located within 250 yards of the main building.
- (14o) Major medical equipment. – A single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than seven hundred fifty thousand dollars (\$750,000). In determining whether the major medical equipment costs more than seven hundred fifty thousand dollars (\$750,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Major medical equipment does not include replacement equipment.
- (15) Repealed by Session Laws 1987, c. 511, s. 1.
- (15a) Multispecialty ambulatory surgical program. – A formal program for providing on a same-day basis surgical procedures for at least three of the following specialty areas: gynecology, otolaryngology, plastic surgery, general surgery, ophthalmology, orthopedic, or oral surgery.
- (15b) Neonatal intensive care services. – Those services provided by a health service facility to high-risk newborn infants who require constant nursing care, including but not limited to continuous cardiopulmonary and other supportive care.
- (16) New institutional health services. – Any of the following:
 - a. The construction, development, or other establishment of a new health service facility.
 - b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding two million dollars (\$2,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds two million dollars (\$2,000,000).
 - c. Any change in bed capacity.
 - d. The offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.
 - e. A change in a project that was subject to certificate of need review and for which a certificate of need was issued, if the change is proposed during the development of the project or within one year after the project was completed. For purposes of this subdivision, a change in a project is a change of more than fifteen percent (15%) of the approved capital

- expenditure amount or the addition of a health service that is to be located in the facility, or portion thereof, that was constructed or developed in the project.
- f. The development or offering of a health service as listed in this subdivision by or on behalf of any person:
 - 1. Bone marrow transplantation services.
 - 2. Burn intensive care services.
 - 2a. Cardiac catheterization services, except cardiac catheterization services provided on equipment furnished by a person authorized to operate the equipment in North Carolina pursuant to either a certificate of need issued for mobile cardiac catheterization equipment or a settlement agreement executed by the Department for provision of cardiac catheterization services.
 - 3. Neonatal intensive care services.
 - 4. Open-heart surgery services.
 - 5. Solid organ transplantation services.
 - f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:
 - 1. Air ambulance.
 - 2. Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.
 - 3. Cardiac catheterization equipment.
 - 4. Gamma knife.
 - 5. Heart-lung bypass machine.
 - 5a. Linear accelerator.
 - 6. Lithotripter.
 - 7. Magnetic resonance imaging scanner.
 - 8. Positron emission tomography scanner.
 - 9. Simulator.
 - g. to k. Repealed by Session Laws 1987, c. 511, s. 1.
 - l. The purchase, lease, or acquisition of any health service facility, or portion thereof, or a controlling interest in the health service facility or portion thereof, if the health service facility was developed under a certificate of need issued pursuant to G.S. 131E-180.
 - m. Any conversion of nonhealth service facility beds to health service facility beds.
 - n. The construction, development or other establishment of a hospice, hospice inpatient facility, or hospice residential care facility;
 - o. The opening of an additional office by an existing home health agency or hospice within its service area as defined by rules adopted by the Department; or the opening of any office by an existing home health agency or hospice outside its service area as defined by rules adopted by the Department.

- p. The acquisition by purchase, donation, lease, transfer, or comparable arrangement by any person of major medical equipment.
 - q. The relocation of a health service facility from one service area to another.
 - r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.
 - s. The furnishing of mobile medical equipment to any person to provide health services in North Carolina, which was not in use in North Carolina prior to the adoption of this provision, if the equipment would otherwise be subject to review in accordance with sub-subdivision f1. of this subdivision or sub-subdivision p. of this subdivision if it had been acquired in North Carolina.
 - t. Repealed by Session Laws 2001-242, s. 4, effective June 23, 2001.
 - u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.
 - v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.
- (17) North Carolina State Health Coordinating Council. – The Council that prepares, with the Department of Health and Human Services, the State Medical Facilities Plan.
- (17a) Nursing care. – Any of the following:
- a. Skilled nursing care and related services for residents who require medical or nursing care.
 - b. Rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.
 - c. Health-related care and services provided on a regular basis to individuals who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities.
- These are services which are not primarily for the care and treatment of mental diseases.
- (17b) Nursing home facility. – A health service facility whose bed complement of health service facility beds is composed principally of nursing home facility beds.
- (18) Offer. – In connection with health services, the act by a person of holding out as capable of providing, or as having the means to provide, specified health services.

- (18a) Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.
- (18b) Open-heart surgery services. – The provision of surgical procedures that utilize a heart-lung bypass machine during surgery to correct cardiac and coronary artery disease or defects.
- (18c) Operating room. – A room used for the performance of surgical procedures requiring one or more incisions and that is required to comply with all applicable licensure codes and standards for an operating room.
- (19) Person. – An individual; a trust or estate; a partnership; a corporation, including associations, joint stock companies, and insurance companies; the State; or a political subdivision or agency or instrumentality of the State.
- (19a) Positron emission tomography scanner. – Equipment that utilizes a computerized radiographic technique that employs radioactive substances to examine the metabolic activity of various body structures.
- (20) Project or capital expenditure project. – A proposal to undertake a capital expenditure that results in the offering of a new institutional health service. A project, or capital expenditure project, or proposed project may refer to the project from its earliest planning stages up through the point at which the specified new institutional health service may be offered. In the case of facility construction, the point at which the new institutional health service may be offered must take place after the facility is capable of being fully licensed and operated for its intended use, and at that time it shall be considered a health service facility.
- (21) Psychiatric facility. – A public or private facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes and which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of individuals with mental illnesses.
- (22) Rehabilitation facility. – A public or private inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of individuals with disabilities through an integrated program of medical and other services which are provided under competent, professional supervision.
- (22a) Replacement equipment. – Equipment that costs less than two million dollars (\$2,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than two million dollars (\$2,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be

deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

- (23) Repealed by Session Laws 1991, c. 692, s. 1.
- (24) Repealed by Session Laws 1993, c. 7, s. 2.
- (24a) Service area. – The area of the State, as defined in the State Medical Facilities Plan or in rules adopted by the Department, which receives services from a health service facility.
- (24b) Simulator. – A machine that produces high quality diagnostic radiographs and precisely reproduces the geometric relationships of megavoltage radiation therapy equipment to the patient.
- (24c) Reserved for future codification.
- (24d) Solid organ transplantation services. – The provision of surgical procedures and the interrelated medical services that accompany the surgery to remove an organ from a patient and surgically implant an organ from a donor.
- (24e) Reserved for future codification.
- (24f) Specialty ambulatory surgical program. – A formal program for providing on a same-day basis surgical procedures for only the specialty areas identified on the ambulatory surgical facility's 1993 Application for Licensure as an Ambulatory Surgical Center and authorized by its certificate of need.
- (25) State Medical Facilities Plan. – The plan prepared by the Department of Health and Human Services and the North Carolina State Health Coordinating Council, and approved by the Governor. In preparing the Plan, the Department and the State Health Coordinating Council shall maintain a mailing list of persons who have requested notice of public hearings regarding the Plan. Not less than 15 days prior to a scheduled public hearing, the Department shall notify persons on its mailing list of the date, time, and location of the hearing. The Department shall hold at least one public hearing prior to the adoption of the proposed Plan and at least six public hearings after the adoption of the proposed Plan by the State Health Coordinating Council. The Council shall accept oral and written comments from the public concerning the Plan.
- (26) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1002, s. 9.
- (27) Repealed by Session Laws 1987, c. 511, s. 1. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, ss. 1, 2; c. 1127, ss. 24-29; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1002, ss. 1-9; c. 1022, ss. 2, 3; c. 1064, s. 1; c. 1110, ss. 1, 2; 1985, c. 589, ss. 42, 43(a); c. 740, ss. 1, 2, 6; 1985 (Reg. Sess., 1986), c. 1001, s. 2; 1987, c. 34; c. 511, s. 1; 1991, c. 692, s. 1; c. 701, s. 1; 1993, c. 7, s. 2; c. 376, ss. 1-4; 1997-443, s. 11A.118(a); 2000-135, ss. 1, 2; 2001-234, s. 2; 2001-242, ss. 2, 4; 2003-229, s. 13; 2003-390, ss. 1, 2; 2005-325, s. 1; 2005-346, s. 6(a)-(d); 2009-145, s. 2; 2009-462, s. 4(k); 2013-360, s. 12G.3(a); 2015-288, s. 1; 2018-81, s. 3(a); 2019-76, s. 19.)

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

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

- (1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this Article;
- (2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such grants-in-aid;
- (3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this Article;
- (4) Develop policy, criteria, and standards for health service facilities planning; shall conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and services; and develop a State Medical Facilities Plan;
- (5) Implement, by rule, criteria for project review;
- (6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this Article;
- (7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this Article; and
- (8) Repealed by Session Laws 1987, c. 511, s. 1.
- (9) Collect fees for submitting applications for certificates of need.
- (10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 1; 1983, c. 713, s. 96; c. 775, ss. 1, 6; 1987, c. 511, s. 1; 1991, c. 692, s. 2; 1993, c. 7, s. 3; c. 383, ss. 2, 3; 1997-443, s. 11A.118(a); 2007-323, s. 30.4(a); 2011-284, s. 90.)

§ 131E-178. Activities requiring certificate of need.

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

- (1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;
- (2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;
- (3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and
- (4) The license application includes a commitment and plan for serving indigent and medically underserved populations.

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

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

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

- (1) An enforceable contract, excepting contracts which are expressly contingent upon issuance of a certificate of need, is entered into by a person for the construction, acquisition, lease or financing of a capital asset;
- (2) A person takes formal action to commit funds for a construction project undertaken as his own contractor; or
- (3) In the case of donated property, the date on which the gift is completed.

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

- (1) The certified estimated cost is prepared in writing 60 days or more before the obligation for the capital expenditure is incurred. Certified cost estimates shall be available for inspection at the facility and sent to the Department upon its request.
- (2) The facility on whose behalf the expenditure was made notifies the Department in writing within 30 days of the date on which such expenditure is made if the expenditure exceeds the expenditure minimum for capital expenditures. The notice shall include a copy of the certified cost estimate.

(e) The Department may grant certificates of need which permit capital expenditures only for predevelopment activities. Predevelopment activities include the preparation of architectural designs, plans, working drawings, or specifications, the preparation of studies and surveys, and the acquisition of a potential site. (1977, 2nd Sess., c. 1182, s. 2; 1979, c. 876, s. 2; 1981, c. 651, s. 3; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1110, s. 3; 1985, c. 740, s. 3; 1985 (Reg. Sess., 1986), c. 1001, s. 1; 1987, c. 511, s. 1; c. 768; 1991, c. 692, s. 3; 1993, c. 7, s. 4; 2005-346, s. 7; 2007-182, s. 1.)

§ 131E-179. Research activities.

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

- (1) Affect the charges of the health service facility for the provision of medical or other patient care services other than services which are included in the research;
- (2) Substantially change the bed capacity of the facility; or
- (3) Substantially change the medical or other patient care services of the facility.

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

(c) Any of the activities described in subsection (a) of this section shall be deemed to be solely for research even if they include patient care provided on an occasional and irregular basis and not as a part of the research program. (1983, c. 775, s. 1; 1987, c. 511, s. 1; 1991, c. 692, s. 4.)

§ 131E-180: Repealed by Session Laws 2005-325, s. 2, effective August 26, 2005.

§ 131E-180.1: Expired.

§ 131E-181. 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 transferred or assigned except as provided in G.S. 131E-189(c).

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

- (1) Any increase in the consumer price index;
- (2) Any increased cost incurred because of Government requirements, including federal, State, or any political subdivision thereof; and
- (3) Any increase in cost due to professional fees or the purchase of services and supplies.

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

(d) A project authorized by a certificate of need is complete when the health service or the health service facility for which the certificate of need was issued is licensed and certified and is in material compliance with the representations made in the certificate of need application. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 5; 1983, c. 775, s. 1; 1985, c. 521, s. 1; 1985 (Reg. Sess., 1986), c. 968, s. 1; 1987, c. 511, s. 1; 1989, c. 233, c. 751, s. 9(c); 1991, c. 692, s. 5; 1991 (Reg. Sess., 1992), c. 959, s. 85; 1993, c. 7, s. 5.)

§ 131E-182. Application.

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

(b) An application for a certificate of need shall be made on forms provided by the Department. The application forms, which may vary according to the type of proposal, shall require such information as the Department, by its rules deems necessary to conduct the review. An applicant shall be required to furnish only that information necessary to determine whether the

proposed new institutional health service is consistent with the review criteria implemented under G.S. 131E-183 and with duly adopted standards, plans and criteria.

(c) An application fee is imposed on an applicant for a certificate of need. An applicant must submit the fee with the application. The fee is not refundable, regardless of whether a certificate of need is issued. Fees collected under this section shall be credited to the General Fund as nontax revenue. The application fee is five thousand dollars (\$5,000) plus an amount equal to three-tenths of one percent (.3%) of the amount of the capital expenditure proposed in the application that exceeds one million dollars (\$1,000,000). In no event may the fee exceed fifty thousand dollars (\$50,000). (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 6; 1983, c. 713, s. 97; c. 775, ss. 1, 6; 1987, c. 511, s. 1; 2005-325, s. 3; 2005-346, s. 8; 2007-323, s. 30.4(b).)

§ 131E-183. Review criteria.

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

- (1) (**See note**) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.
- (2) Repealed by Session Laws 1987, c. 511, s. 1.
- (3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.
- (3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.
- (4) Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.
- (5) Financial and operational projections for the project shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.
- (6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.

- (7) The applicant shall show evidence of the availability of resources, including health manpower and management personnel, for the provision of the services proposed to be provided.
- (8) The applicant shall demonstrate that the provider of the proposed services will make available, or otherwise make arrangements for, the provision of the necessary ancillary and support services. The applicant shall also demonstrate that the proposed service will be coordinated with the existing health care system.
- (9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.
- (10) When applicable, the applicant shall show that the special needs of health maintenance organizations will be fulfilled by the project. Specifically, the applicant shall show that the project accommodates:
 - a. The needs of enrolled members and reasonably anticipated new members of the HMO for the health service to be provided by the organization; and
 - b. The availability of new health services from non-HMO providers or other HMOs in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In assessing the availability of these health services from these providers, the applicant shall consider only whether the services from these providers:
 - 1. Would be available under a contract of at least five years' duration;
 - 2. Would be available and conveniently accessible through physicians and other health professionals associated with the HMO;
 - 3. Would cost no more than if the services were provided by the HMO; and
 - 4. Would be available in a manner which is administratively feasible to the HMO.
- (11) Repealed by Session Laws 1987, c. 511, s. 1.
- (12) Applications involving construction shall demonstrate that the cost, design, and means of construction proposed represent the most reasonable alternative, and that the construction project will not unduly increase the costs of providing health services by the person proposing the construction project or the costs and charges to the public of providing health services by other persons, and that applicable energy saving features have been incorporated into the construction plans.
- (13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs

identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall show:

- a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically underserved;
 - b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the applicant;
 - c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed services; and
 - d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient services, admission by house staff, and admission by personal physicians.
- (14) The applicant shall demonstrate that the proposed health services accommodate the clinical needs of health professional training programs in the area, as applicable.
- (15) through (18) Repealed by Session Laws 1987, c. 511, s. 1.
- (18a) The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.
- (19) Repealed by Session Laws 1987, c. 511, s. 1.
- (20) An applicant already involved in the provision of health services shall provide evidence that quality care has been provided in the past.
- (21) Repealed by Session Laws 1987, c. 511, s. 1.

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

(c) Repealed by Session Laws 1987, c. 511, s. 1. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 7; 1983, c. 775, s. 1; c. 920, s. 2; 1983 (Reg. Sess., 1984), c. 1002, s. 10; 1985, c. 445, s. 1; 1987, c. 511, s. 1; 1991, c. 692, s. 6; c. 701, s. 2; 1993, c. 7, s. 6; 2001-242, s. 3.)

§ 131E-184. Exemptions from review.

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

- (1) To eliminate or prevent imminent safety hazards as defined in federal, State, or local fire, building, or life safety codes or regulations.
- (1a) To comply with State licensure standards.
- (1b) To comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that act.
- (2) Repealed by Session Laws 1987, c. 511, s. 1.
- (3) To provide data processing equipment.
- (4) To provide parking, heating or cooling systems, elevators, or other basic plant or mechanical improvements, unless these activities are integral portions of a project that involves the construction of a new health service facility or portion thereof and that is subject to certificate of need review.
- (5) To replace or repair facilities destroyed or damaged by accident or natural disaster.
- (6) To provide any nonhealth service facility or service.
- (7) To provide replacement equipment.
- (8) To acquire an existing health service facility, including equipment owned by the health service facility at the time of acquisition. A facility not currently licensed as an adult care home that was licensed as an adult care home within the preceding 12 months is considered an existing health service facility for the purposes of this subdivision.
- (9) To develop or acquire a physician office building regardless of cost, unless a new institutional health service other than defined in G.S. 131E-176(16)b. is offered or developed in the building.

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

(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric beds provided all of the following are true:

- (1) The hospital proposing the conversion has executed a contract with the Department's Division of Mental Health, Developmental Disabilities, and

Substance Abuse Services, one or more of the area mental health, developmental disabilities, and substance abuse authorities, or a combination thereof to provide psychiatric beds to patients referred by the contracting agency or agencies.

- (2) The total number of beds to be converted shall not be more than twice the number of beds for which the contract pursuant to subdivision (1) of this subsection shall provide.

(d) In accordance with, and subject to the limitations of G.S. 148-19.1, the Department shall exempt from certificate of need review the construction and operation of a new chemical dependency or substance abuse facility for the purpose of providing inpatient chemical dependency or substance abuse services solely to inmates of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety. If an inpatient chemical dependency or substance abuse facility provides services both to inmates of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety and to members of the general public, only the portion of the facility that serves inmates shall be exempt from certificate of need review.

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the two million dollar (\$2,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

- (1) The proposed capital expenditure would meet all of the following requirements:
 - a. Be used solely for the purpose of renovating, replacing on the same site, or expanding any of the following existing facilities:
 1. Nursing home facility.
 2. Adult care home facility.
 3. Intermediate care facility for individuals with intellectual disabilities.
 - b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.
- (2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:
 - a. Conversion of semiprivate resident rooms to private rooms.
 - b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
 - c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents.

(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the two million dollar (\$2,000,000) threshold set forth in G.S. 131E-176(22a) if all of the following conditions are met:

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

- (2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.
- (3) The licensed health service facility proposing to purchase the replacement equipment shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the two million dollar (\$2,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

- (1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus.
- (2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.
- (3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

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

- (1) Its intention to acquire or reopen a Legacy Medical Care Facility within the same county and the same service area as the facility that ceased continuous operations. If the Legacy Medical Care Facility will become operational in a new location within the same county and the same service area as the facility that ceased continuous operations, then the person responsible for giving the written notice required by this section shall notify the Department, as soon as reasonably practicable and prior to becoming operational, of the new location of the Legacy Medical Care Facility. For purposes of this subdivision, "service area" means the service area identified in the North Carolina State Medical Facilities Plan in effect at the time the written notice required by this section is given to the Department.
- (2) That the facility will be operational within 36 months of the notice.

The Department shall extend the time by which a facility must be operational in order to be exempt from certificate of need review under this subsection by one additional 36-month period if the person seeking to reopen or acquire the Legacy Medical Care Facility gives the Department written notice of extension within 36 months of the original notice of intent to acquire or reopen the Legacy Medical Care Facility. The written notice

of extension must notify the Department (i) that the person has undertaken all reasonable efforts to make the facility operational within 36 months of the notice of intent, (ii) that, despite these reasonable efforts, the person does not anticipate the facility will be operational within that time, and (iii) of its intention that the facility will be operational within 36 months of the notice of extension. (1983, c. 775, s. 1; 1987, c. 511, s. 1; 1991 (Reg. Sess., 1992), c. 1030, s. 37; 1993, c. 7, s. 7; 2001-424, s. 25.19(c); 2002-159, s. 41; 2009-145, s. 1; 2009-487, s. 3; 2011-145, s. 19.1(h); 2013-360, s. 12G.3(b); 2013-363, s. 4.6; 2014-100, s. 12G.1(a); 2015-288, s. 2; 2017-184, s. 7(a); 2017-186, s. 2(XXXXX); 2018-81, s. 3(b); 2018-145, s. 15; 2019-76, s. 20.)

§ 131E-185. Review process.

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

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

- (1) Any person may file written comments and exhibits concerning a proposal under review with the Department, not later than 30 days after the date on which the application begins review. These written comments may include:
 - a. Facts relating to the service area proposed in the application;
 - b. Facts relating to the representations made by the applicant in its application, and its ability to perform or fulfill the representations made;
 - c. Discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with relevant review criteria, plans, and standards.
- (2) No more than 20 days from the conclusion of the written comment period, the Department shall ensure that a public hearing is conducted at a place within the appropriate service area if one or more of the following circumstances apply; the review to be conducted is competitive; the proponent proposes to spend five million dollars (\$5,000,000) or more; a written request for a public hearing is received before the end of the written comment period from an affected party as defined in G.S. 131E-188(c); or the agency determines that a hearing is in the public interest. At such public hearing oral arguments may be made regarding the application or applications under review; and this public hearing shall include the following:
 - a. An opportunity for the proponent of each application under review to respond to the written comments submitted to the Department about its application;
 - b. An opportunity for any person, except one of the proponents, to comment on the applications under review;
 - c. An opportunity for a representative of the Department, or such other person or persons who are designated by the Department to conduct the hearing, to question each proponent of applications under review with regard to the contents of the application;

The Department shall maintain a recording of any required public hearing on an application until such time as the Department's final decision is issued, or until a final agency decision is issued pursuant to a contested case hearing,

whichever is later; and any person may submit a written synopsis or verbatim statement that contains the oral presentation made at the hearing.

- (3) The Department may contract or make arrangements with a person or persons located within each service area for the conduct of such public hearings as may be necessary. The Department shall publish, in each service area, notice of the contracts that it executes for the conduct of those hearings.
- (4) Within 15 days from the beginning of the review of an application or applications proposing the same service within the same service area, the Department shall publish notice of the deadline for receipt of written comments, of the time and place scheduled for the public hearing regarding the application or applications under review, and of the name and address of the person or agency that will preside.
- (5) The Department shall maintain all written comments submitted to it during the written comment stage and any written submissions received at the public hearing as part of the Department's file respecting each application or group of applications under review by it. The application, written comments, and public hearing comments, together with all documents that the Department used in arriving at its decision, from whatever source, and any documents that reflect or set out the Department's final analysis of the application or applications under review, shall constitute the Department's record for the application or applications under review.

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

(b) Repealed by Session Laws 1991 (Reg. Sess., 1992), c. 900, s. 137(a).

(c) The Department may extend the review period for a period not to exceed 60 days and provide notice of such extension to all applicants. For expedited reviews, the Department may extend the review period only if it has requested additional substantive information from the applicant. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, ss. 9, 10; 1983, c. 775, s. 1; 1987, c. 511, s. 1; 1991, c. 692, s. 7; 1991 (Reg. Sess., 1992), c. 900, s. 137(a), (b); 1993, c. 7, s. 8; 2005-325, s. 4.)

§ 131E-186. Decision.

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

(b) Within five business days after it makes a decision on an application, the Department shall provide written notice of all the findings and conclusions upon which it

based its decision, including the criteria used by the Department in making its decision, to the applicant. (1977, 2nd Sess., c. 1182, s. 2; 1983, c. 775, s. 1; 1987, c. 511, s. 1; 1991 (Reg. Sess., 1992), c. 900, s. 137(c); 2019-76, s. 21.)

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

(a),(b) Repealed by Session Laws 2009-373, s. 1, effective July 31, 2009.

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

- (1) Thirty-five days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188.
- (2) Five business days after it receives a file-stamped copy of the notice of voluntary dismissal, unless the voluntary dismissal is a stipulation of dismissal without prejudice.
- (3) Thirty-five days of the date of the written notice of the final agency decision affirming or approving the issuance, unless a notice of appeal to the North Carolina Court of Appeals is timely filed.
- (4) Twenty days after a mandate is issued by the North Carolina Court of Appeals affirming the issuance of a certificate of need, unless a notice of appeal or petition for discretionary review to the North Carolina Supreme Court is timely filed.
- (5) Five business days after the North Carolina Supreme Court issues a mandate affirming the issuance of a certificate of need or an order declining to certify the case for discretionary review if the order declining to certify the case disposes of the appeal in its entirety. (1977, 2nd Sess., c. 1182, s. 2; 1983, c. 775, s. 1; 1987, c. 511, s. 1; 2009-373, s. 1.)

§ 131E-188. Administrative and judicial review.

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

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

- (1) An administrative law judge or a hearing officer, as appropriate, shall be assigned within 15 days after a petition is filed.
- (2) The parties shall complete discovery within 90 days after the assignment of the administrative law judge or hearing officer.

- (3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.
- (4) The administrative law judge or hearing officer shall make a final decision within 75 days after the hearing.
- (5) Repealed by Session Laws 2011-398, s. 46, as amended by Session Laws 2011-326, s. 23, effective January 1, 2012, and applicable to contested cases commenced on or after that date.

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

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

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

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

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

- (1) The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the appeal, but may not be less than five thousand dollars (\$5,000) and may not exceed fifty thousand dollars (\$50,000); provided that the applicant who received approval of the

certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its discretion, not to exceed three hundred thousand dollars (\$300,000). A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

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

(c) The term "affected persons" includes: the applicant; any individual residing within the service area or the geographic area served or to be served by the applicant; any individual who regularly uses health service facilities within that geographic area or the service area; any person who provides services, similar to the services under review, to individuals residing within the service area or the geographic area proposed to be served by the applicant; any person who, prior to receipt by the agency of the proposal being reviewed, has provided written notice to the agency of an intention to provide similar services in the future to individuals residing within the service area or the geographic area to be served by the applicant; third party payers who reimburse health service facilities for services in the service area in which the project is proposed to be located; and any agency which establishes rates for health service facilities or HMOs located in the service area in which the project is proposed to be located. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 11; 1983, c. 775, s. 1; 1983 (Reg. Sess., 1984), c. 1000, s. 1; 1987, c. 511, s. 1; 1991, c. 692, s. 8; c. 701, s. 3; 1993, c. 7, s. 9; 1997-443, s. 11A.118(a); 2005-325, s. 5; 2007-182, s. 1; 2009-373, s. 2; 2011-326, s. 23; 2011-398, s. 46.)

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

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

the timetable, the Department may, at the request of the holder, extend the timetable for a specified period.

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

(c) The Department may immediately withdraw any certificate of need if the holder of the certificate, before completion of the project or operation of the facility, transfers ownership or control of the facility, the project, or the certificate of need. Any transfer after that time will be subject to the requirement that the service be provided consistent with the representations made in the application and any applicable conditions the Department placed on the certificate of need. Transfers resulting from death or personal illness or other good cause, as determined by the Department, shall not result in withdrawal if the Department receives prior written notice of the transfer and finds good cause. Transfers resulting from death shall not result in withdrawal. (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 12; 1983, c. 775, s. 1; 1987, c. 511, s. 1; 1993, c. 7, s. 10.)

§ 131E-190. 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 formal commitments made for financing, construction, or acquisition regarding the offering or development of a new institutional health service shall be made by any person unless a certificate of need for such service or activities has been granted.

(c) Repealed by Session Laws 1993, c. 7, s. 11.

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

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

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

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

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

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

(i) If the Department determines that the recipient of a certificate of need, or its successor, is operating a service which materially differs from the representations made in its application for that certificate of need, the Department may bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized for injunctive relief, temporary or permanent, requiring the recipient, or its successor, to materially comply with the representations in its application. The Department may also bring an action in Wake County Superior Court or the superior court of any county in which the certificate of need is to be utilized to enforce the provisions of this subsection and G.S. 131E-181(b) and the rules adopted in accordance with this subsection and G.S. 131E-181(b). (1977, 2nd Sess., c. 1182, s. 2; 1981, c. 651, s. 13; 1983, c. 775, s. 1; 1985 (Reg. Sess., 1986), c. 968, s. 2; 1987, c. 511, s. 1; 1991, c. 692, s. 9; 1993, c. 7, s. 11; 1997-443, s. 11A.118(a); 1998-215, s. 80.)

§ 131E-191. Repealed by Session Laws 1987, c. 511, s. 1.

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

No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the North Carolina State Health Coordinating Council. No person previously registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on the North Carolina State Health Coordinating Council within 120 days after the expiration of the lobbyist's registration. (2009-477, s. 2; 2017-6, s. 3; 2018-146, ss. 3.1(a), (b), 6.1.)

§ 131E-192. Reserved for future codification purposes.

Article 9A.

Certificate of Public Advantage.

§§ 131E-192.1 through 131E-192.13: Repealed by Session Laws 2015-288, s. 4, as amended by Session Laws 2016-94, s. 12G.4(a), effective September 30, 2016.

§§ 131E-193 through 131E-199. Reserved for future codification purposes.

Article 10.

Hospice Licensure Act.

§ 131E-200. Title; purpose.

This Article shall be known as the "Hospice Licensure Act." The purpose of this Article is to establish licensing requirements for hospices. (1983 (Reg. Sess., 1984), c. 1022, s. 1; 1987, c. 34.)

§ 131E-201. Definitions.

As used in this Article, unless a different meaning or construction is clearly required by the context:

- (1) "Commission" means the North Carolina Medical Care Commission.
- (2) "Department" means the Department of Health and Human Services.
- (3) "Hospice" means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.
- (3a) "Hospice inpatient facility" means a freestanding licensed hospice facility or a designated inpatient unit in an existing health service facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in an inpatient setting.
- (4) "Hospice patient" means a patient diagnosed as terminally ill by a physician licensed to practice medicine in North Carolina, who the physician anticipates to have a life expectancy of weeks or months, generally not to exceed six months, and who alone, or in conjunction with designated family members, has voluntarily requested and been accepted into a licensed hospice program.
- (5) "Hospice patient's family" means the hospice patient's immediate kin, including a spouse, brother, sister, child, or parent. Other relations and individuals with significant personal ties to the hospice patient may be designated as members of the hospice patient's family by mutual agreement among the hospice patient, the relation or individual and the hospice team.
- (5a) "Hospice residential care facility" means a freestanding licensed hospice facility which provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of terminally ill patients and their families in a group residential setting.
- (5b) "Hospice services" means the provision of palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.
- (6) "Hospice team" or "Interdisciplinary team" means the following hospice personnel: physician licensed to practice medicine in North Carolina; nurse holding a valid, current license as required by North Carolina law; social worker; clergy member; and trained hospice volunteer. Other health care practitioners may be included on the team as the needs of the patient dictate or

at the request of the physician. Other providers of special services may also be included as the needs of the patient dictate.

- (7) "Identifiable hospice administration" means an administrative group, individual, or legal entity that has an identifiable organizational structure, accountable to a governing board directly or through a chief executive officer. This administration shall be responsible for the management of all aspects of the program.
- (8) "Palliative care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient and family as they experience the stress of the dying process, rather than the treatment aimed at investigation and intervention for the purpose of cure or prolongation of life. (1983 (Reg. Sess., 1984), c. 1022, s. 1; 1993, c. 376, s. 5; 1997-443, s. 11A.118(a).)

§ 131E-202. Licensing.

(a) The Commission shall adopt rules for the licensing and regulation of hospices, hospice inpatient facilities, and hospice residential care facilities pursuant to this Article for the purpose of providing care, treatment, health, safety, welfare, and comfort of hospice patients. These rules shall include, but not be limited to:

- (1) The qualifications and supervision of licensed and nonlicensed personnel;
- (2) The provision and coordination of home and inpatient care, including the development of a written care plan;
- (3) The management, operation, staffing, and equipping of the hospice program;
- (4) Clinical and business records kept by the hospice, hospice inpatient care facility, and hospice residential care facility; and
- (5) Procedures for the review of utilization and quality of care.

(b) The Department shall provide applications for hospice licensure. Each application filed with the Department shall contain all information requested therein. A license shall be granted to the applicant upon determination by the Department that the applicant has complied with the provisions of this Article and with the rules adopted by the Commission thereunder. Each license shall be issued only for the premises and persons named therein, shall not be transferable or assignable except with the written approval of the Department, and shall be posted in a conspicuous place on the licensed premises. The Department shall charge the applicant a nonrefundable annual license fee in the amount of four hundred dollars (\$400.00).

(c) The Department shall renew the license in accordance with this Article and with rules adopted thereunder. (1983 (Reg. Sess., 1984), c. 1022, s. 1; 1993, c. 376, s. 6; 2009-451, s. 10.76(h).)

§ 131E-203. Coverage.

(a) Except as provided in subsection (b) of this section, no person or other entity shall operate or represent himself or itself to the public as operating a hospice, a hospice inpatient facility, or a hospice residential care facility, or offer or represent himself or itself to the public as offering hospice services without obtaining a license from the Department pursuant to this Article.

(b) Hospices administered by local health departments established under Article 2 of Chapter 130A of the General Statutes shall not be required to be licensed under this Article. Additionally, health care facilities and agencies licensed under Article 5 or 6 of Chapter 131E of

the General Statutes shall not be required to be separately licensed under this Article. However, any facility or agency exempted from licensure under this subsection which operates a hospice, a hospice inpatient facility, or a hospice residential care facility, or offers hospice services shall be subject to rules adopted pursuant to this Article.

(c) Hospice care shall be available 24 hours a day, seven days a week. (1983 (Reg. Sess., 1984), c. 1022, s. 1; 1993, c. 376, s. 7.)

§ 131E-204. Inspections.

The Department shall inspect all hospices that are subject to rules adopted pursuant to this Article in order to determine compliance with the provisions of this Article and with rules adopted thereunder. Inspections shall be conducted in accordance with rules adopted by the Commission. (1983 (Reg. Sess., 1984), c. 1022, s. 1.)

§ 131E-205. Adverse action on a license; appeal procedures.

(a) The Department may suspend, revoke, cancel, or amend a license when there has been a substantial failure to comply with this Article or with rules and regulations adopted thereunder.

(b) Chapter 150A of the General Statutes, the Administrative Procedure Act, shall govern all administrative action pursuant to subsection (a) and all judicial review arising therefrom. (1983 (Reg. Sess., 1984), c. 1022, s. 1.)

§ 131E-206. Injunction.

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process against any person to restrain or prevent the establishment, conduct, management, or operation of a hospice without a license.

(b) Notwithstanding the provisions of G.S. 131E-203(b) or the existence of any other remedy, the Department may maintain an action in the name of the State for injunctive relief or other process against any person to restrain or prevent substantial noncompliance with this Article or the rules adopted thereunder.

(c) If any person shall hinder the proper performance of duty of the Department in carrying out the provisions of this Article, the Department may institute an action in the superior court of the county in which the hindrance occurred for injunctive relief against the continued hindrance. (1983 (Reg. Sess., 1984), c. 1022, s. 1.)

§ 131E-207. Confidentiality.

(a) Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131E-204:

- (1) Department representatives may review any writing or other record concerning the admission, discharge, medication, treatment, medical condition, or history of any person who is or has been a hospice patient; and
- (2) Any person involved in treating a patient at or through a hospice may disclose information to a Department representative unless the patient objects in writing to review of his records or disclosure of the information. A hospice shall not release any information or allow any inspections under this section without first

informing each affected patient in writing of his right to object to and thereby prohibit release of information or review of records pertaining to him.

A hospice, its employees and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department.

(b) The Department shall not disclose:

- (1) Any confidential or privileged information obtained under this section unless the patient or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure; or
- (2) The name of anyone who has furnished information concerning a hospice without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. Any Department employee who willfully discloses this information without appropriate authorization or court order shall be guilty of a Class 3 misdemeanor and upon conviction only fined at the discretion of the court but not to exceed five hundred dollars (\$500.00).

(c) All confidential or privileged information obtained under this section and the names of persons providing this information shall be exempt from Chapter 132 of the General Statutes. (1983 (Reg. Sess., 1984), c. 1022, s. 1; 1993, c. 539, s. 965; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 131E-208. Reserved for future codification purposes.

§ 131E-209. Reserved for future codification purposes.

Article 11.

North Carolina Medical Database Commission.

§§ 131E-210 through 131E-213: Repealed by Session Laws 1995, c. 517, s. 39.

Article 11A.

Medical Care Data.

§ 131E-214. Title and purpose.

(a) This Article is the Medical Care Data Act.

(b) The General Assembly finds that, as a result of rising medical care costs and the concern expressed by medical care providers, medical care consumers, third-party payors, and health care planners involved with planning for the provision of medical care, there is an urgent and continuing need to understand patterns and trends in the use and cost of medical care services in this State. The purposes of this Article are as follows:

- (1) To ensure that there is an information base containing medical care data from throughout the State that can be used to improve the appropriate and efficient use of medical care services and maintain an acceptable quality of health care services in this State.
- (2) To ensure that the necessary medical care data is available to university researchers, State public policymakers, and all other interested persons to

- improve the decision-making process regarding access, identified needs, patterns of medical care, charges, and use of appropriate medical care services.
- (3) To ensure that a data processor receiving data under this Article protects patient confidentiality.

These purposes are to be accomplished by requiring that all hospitals and freestanding ambulatory surgical facilities submit information necessary for a review and comparison of charges, utilization patterns, and quality of medical services to a data processor that maintains a statewide database of medical care data and that makes medical care data available to interested persons, including medical care providers, third-party payors, medical care consumers, and health care planners. (1995, c. 517, s. 39(b).)

§ 131E-214.1. Definitions.

The following definitions apply in this Article:

- (1) Division. – The Division of Health Service Regulation of the Department of Health and Human Services.
- (2) Freestanding ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.
- (3) Hospital. – A facility licensed under Article 5 of this Chapter or Article 2 of Chapter 122C of the General Statutes, but does not include the following:
 - a. A facility with all of its beds designated for medical type "LTC" (long-term care).
 - b. A facility with the majority of its beds designated for medical type "PSY-3" (intellectual/developmental disability).
 - c. A facility operated by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.
- (4) Patient data. – Data that includes a patient's age, sex, race, ethnicity, zip code, third-party coverage, principal and other diagnoses, date of admission, procedure and discharge date, principal and other procedures, total charges and components of the total charges, attending physician identification number, and hospital or freestanding ambulatory surgical facility identification number.
- (5) Patient identifying information. – The name, address, social security number, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a health care provider if that number does not consist of or contain numbers, including social security or drivers license numbers, that could be used to identify a patient with reasonable accuracy and speed from sources external to the health care provider.
- (6) Statewide data processor. – A data processor certified by the Division as capable of complying with the requirements of G.S. 131E-214.4. The Division may deny, suspend, or revoke a certificate, in accordance with

Chapter 150B of the General Statutes, if the statewide data processor does not comply with or is not capable of complying with the requirements of G.S. 131E-214.4. The Division may promulgate rules concerning the receipt, consideration, and limitation of a certificate applied for or issued under this Article. (1995, c. 517, s. 39(b); 1997-443, s. 11A.118(a); 2007-182, s. 1; 2008-119, s. 2; 2011-145, s. 19.1(h); 2012-83, s. 44; 2017-186, s. 2(yyyyy); 2019-76, s. 22.)

§ 131E-214.2. Data submission required.

Except as prohibited by federal law or regulation, each hospital and freestanding ambulatory surgical facility shall submit patient data to a statewide data processor within 60 calendar days after the close of each calendar quarter for patients that were discharged or died during that quarter. (1995, c. 517, s. 39(b).)

§ 131E-214.3. Patient data not public records.

- (a) The following are not public records under Chapter 132 of the General Statutes:
 - (1) Patient data furnished to and maintained by a statewide data processor pursuant to this Article.
 - (2) Compilations of patient data prepared for release or dissemination by a statewide data processor pursuant to this Article.
 - (3) Patient data furnished by a statewide data processor to the State.
- (b) Compilations of data under subdivision (a)(3) of this section, prepared for release or dissemination by the State, are public records.
- (c) The State shall not allow proprietary information, including patient data, that it receives from a statewide data processor to be used by a person for commercial purposes. The State shall require the person requesting this information to certify that it will not use the information for commercial purposes.
- (d) A person is immune from liability for actions arising from the required submission of data under this Article. (1995, c. 517, s. 39(b).)

§ 131E-214.4. Statewide data processor.

- (a) A statewide data processor shall perform the following duties:
 - (1) Make available annually to the Division, at no charge, a report that includes a comparison of the 35 most frequently reported charges of hospitals and freestanding ambulatory surgical facilities. The report is a public record and shall be made available to the public in accordance with Chapter 132 of the General Statutes. Publication or broadcast by the news media shall not constitute a resale or use of the data for commercial purposes.
 - (2) Receive patient data from hospitals and freestanding ambulatory surgical facilities throughout this State.
 - (3) Compile and maintain a uniform set of data from the patient data submitted.
 - (4) Analyze the patient data.
 - (5) Compile reports from the patient data and make the reports available upon request to interested persons at a reasonable charge determined by the data processor.

- (6) Ensure that adequate measures are taken to provide system security for all data and information received from hospitals and freestanding ambulatory surgical facilities pursuant to this Article.
- (7) Protect the confidentiality of patient records and comply with applicable laws and regulations concerning patient confidentiality, including the confidentiality of patient-identifying information. The data processor shall not disclose patient-identifying information unless (i) the information was originally submitted by the party requesting disclosure or (ii) the State Health Director requests specific individual records for the purpose of protecting and promoting the public health under Chapter 130A of the General Statutes, and the disclosure is not otherwise prohibited by federal law or regulation. Such records shall be made available to the State Health Director at a reasonable charge. Such records made available to the State Health Director are not public records; the State Health Director shall maintain their confidentiality and shall not make the records available notwithstanding G.S. 130A-374(a)(2).

(b) The Department of Health and Human Services may take adverse action against a hospital under G.S. 131E-78 or G.S. 122C-24 or against a freestanding ambulatory surgical center under G.S. 131E-148 for a violation of this Article. (1995, c. 517, s. 39(b); 1997-443, s. 11A.118(a).)

§§ 131E-214.5 through 131E-214.10. Reserved for future codification purposes.

Article 11B.

Transparency in Health Care Costs.

§ 131E-214.11. Title.

This article shall be known as the Health Care Cost Reduction and Transparency Act of 2013. (2013-382, s. 10.1.)

§ 131E-214.12. Purpose; Department to publish price information.

(a) It is the intent of this Article to improve transparency in health care costs by providing information to the public on the costs of the most frequently reported diagnostic related groups (DRGs) for hospital inpatient care and the most common surgical procedures and imaging procedures provided in hospital outpatient settings and ambulatory surgical facilities.

(b) The Department of Health and Human Services shall make available to the public on its internet Web site the most current price information it receives from hospitals and ambulatory surgical facilities pursuant to G.S. 131E-214.13. The Department shall provide this information in a manner that is easily understood by the public and meets the following minimum requirements:

- (1) Information for each hospital shall be listed separately and hospitals shall be listed in groups by category as determined by the North Carolina Medical Care Commission in rules adopted pursuant to G.S. 131E-214.13.

- (2) Information for each hospital outpatient department and each ambulatory surgical facility shall be listed separately.

(c) Any data disclosed to the Department by a hospital or ambulatory surgical facility pursuant to the Health Care Cost Reduction and Transparency Act of 2013 shall be and will remain the sole property of the facility that submitted the data. Any data or product derived from the data disclosed pursuant to this act, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Department shall not allow proprietary information it receives pursuant to this act to be used by any person or entity for commercial purposes. (2013-382, s. 10.1.)

§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.

- (a) The following definitions apply in this Article:

- (1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.
- (2) Commission. – The North Carolina Medical Care Commission.
- (3) Health insurer. – An entity that writes a health benefit plan and is one of the following:
 - a. An insurance company under Article 3 of Chapter 58 of the General Statutes.
 - b. A service corporation under Article 65 of Chapter 58 of the General Statutes.
 - c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.
 - d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).
- (4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.
- (5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the reporting period ending September 30, 2015, and annually thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the Department:

- (1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.
- (2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.
- (3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.
- (4) The amount of Medicare reimbursement for each DRG.

- (5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before March 1, 2016, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

- (1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.
- (2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.

(d) Beginning with the reporting period ending September 30, 2015, and annually thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before March 1, 2016, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish and define no fewer than 10 quality measures for licensed hospitals and licensed ambulatory surgical facilities.

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

(g) G.S. 150B-21.3 does not apply to rules adopted under subsections (c) and (e) of this section. A rule adopted under subsections (c) and (e) of this section becomes effective on the last day of the month following the month in which the rule is approved by the Rules Review Commission. (2013-382, s. 10.1; 2014-100, s. 12G.2; 2015-241, s. 12A.15(a).)

§ 131E-214.14. Disclosure of charity care policy and costs.

(a) Requirements. – A hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code must provide the public access to its financial assistance policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted annually to the Department in the time, manner, and format required by the Department. The Department must post all of the information submitted pursuant to this subsection on its internet Web site in one location and in a manner that is searchable. The posting requirement shall not be satisfied by posting links to internet Web sites. The information must also be displayed in a conspicuous place in the organization's place of business.

(b) Definitions. – The following definitions apply in this section:

- (1) Code. – Defined in G.S. 105-228.90.
- (2) Financial assistance costs. – The information reported on Schedule H, federal form 990, related to the organization's financial assistance at cost and the amounts reported on that schedule related to the organization's bad debt expense and the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy.
- (3) Financial assistance policy. – A policy that meets the requirements of section 501(r) of the Code. (2013-382, s. 10.1; 2015-241, s. 12A.15(b).)

Article 12.

Disclosure and Contract Requirements for Continuing Care Facilities.

§§ 131E-215 through 131E-224: Repealed by Session Laws 1989, c. 758, s. 2.

§§ 131E-225 through 131E-229. Reserved for future codification purposes.

Article 13.

Temporary Management of Long-Term Care Facilities.

§ 131E-230. Legislative findings.

The General Assembly finds that:

- (1) A substantial number of citizens of this State now reside, or in the future may reside, in long-term care facilities within this State;
- (2) Improper operation of long-term care facilities may tend to create a substantial risk of serious physical injury to residents;
- (3) The closure of a long-term care facility can have adverse effects on the residents thereof, especially if the closure and transfer of residents is done hastily;
- (4) The general health and welfare of the people of this State, particularly those persons residing in long-term care facilities within this State, would be enhanced by development of a procedure for the court appointment of a temporary manager to assure the proper operation of a long-term care facility in certain instances until a manager chosen by the facility is prepared to properly operate the facility, or until the residents can be safely transferred to a proper alternative setting; and
- (5) The use of a temporary manager is intended as a temporary measure and the ongoing or long-term operation of a nursing facility by a temporary manager is neither beneficial nor appropriate. (1993, c. 390, s. 1.)

§ 131E-231. Definitions.

As used in this Article, unless otherwise specified:

- (1) "Long-term care facility" means a nursing home as defined in G.S. 131E-101(6) and an adult care home as defined in G.S. 131D-2.1(3) or G.S. 131E-101(4).
- (2) "Resident" means a person who has been admitted to a long-term care facility.
- (3) "Respondent" means the person or entity holding a license pursuant to G.S. 131E-102 or G.S. 131D-2.4 or a person or entity operating a long-term care facility subject to licensure without a license. (1993, c. 390, s. 1; 1995, c. 535, s. 26; 2008-187, s. 38(b); 2009-462, s. 4(l).)

§ 131E-232. Who may petition; contents of petition.

The Department may petition a court of competent jurisdiction to appoint a temporary manager to operate a long-term care facility. The petition shall set forth material facts showing that one or more of the grounds for appointment of a temporary manager set forth in G.S. 131E-234 exist, that the facts set forth in the petition have been brought to the attention of the respondent, and that the conditions described in the petition have not been remedied within a reasonable period of time. The petition shall also set forth a brief description of the action or actions necessary to remedy the alleged conditions. (1993, c. 390, s. 1.)

§ 131E-233. Procedures for appointment; evidence in defense.

(a) The procedure for petitioning the superior court for the appointment of a temporary manager, including service of process shall be in accordance with the North Carolina Rules of Civil Procedure. If personal service of a copy of the petition cannot be made with due diligence upon the respondent, service may be made upon the respondent by sending a copy of the summons and petition to the respondent by registered mail at the respondent's last known address and by hand-delivering or mailing a copy to the administrative or staff person in charge of the facility.

(b) A hearing shall be held on the petition within 20 days of service of the petition upon the respondent. Both the Department and the respondent may present evidence and written and

oral argument at the hearing regarding the allegations of the petition. It shall be relevant evidence in defense to a petition that the conditions alleged in the petition do not in fact exist, that such conditions do not exist to the extent alleged, or that such conditions have been remedied or removed.

- (c)
 - (1) Upon petition by the Department for emergency intervention, a court may order the appointment of an emergency temporary manager after finding that there is reasonable cause to believe that:
 - a. Conditions or a pattern of conditions exist in the long-term care facility that create an immediate substantial risk of death or serious physical harm to residents; or
 - b. The long-term care facility is closing or intends to close before the time in which a hearing would ordinarily be scheduled, and:
 - 1. Adequate arrangements for relocating residents have not been made, or
 - 2. Quick relocation would not be in the best interest of residents.
 - (2) The court shall appoint an emergency temporary manager to serve until a hearing is conducted in accordance with ordinary procedures and shall direct the temporary manager to make only such changes in administration as necessary to protect the health or safety of residents until the emergency condition is resolved.
 - (3) The court shall schedule a hearing on the appointment of an emergency temporary manager within three days after service of notice of the filing of the petition. Notice of the filing of the petition and other relevant information, including the factual basis of the belief that an emergency temporary manager is needed shall be served upon the facility as provided in this Article. The notice shall be given at least 24 hours prior to the hearing of the petition for emergency intervention, except that the court may issue an immediate emergency order ex parte upon a finding as fact that:
 - a. The conditions specified above exist, and
 - b. There is likelihood that a resident may suffer irreparable injury or death if the order is delayed.

The order shall contain a show-cause notice to each person upon whom the notice is served directing the person to appear immediately or at any time up to and including the time for the hearing of the petition for emergency services and show cause, if any exists, for the dissolution or modification of the order. Unless dissolved by the court for good cause shown, the emergency order ex parte shall be in effect until the hearing is held on the petition for emergency services. At the hearing, if the court determines that the emergency continues to exist, the court may order the provision of emergency services in accordance with subsections (a) and (b) of this section. (1993, c. 390, s. 1; 1999-334, s. 1.11.)

§ 131E-234. Grounds for appointment of temporary manager.

Upon a showing by the Department that one or more of the following grounds exist, the court may appoint a temporary manager for an initial period of 30 days or the first review by a superior court judge pursuant to G.S. 131E-243, whichever is longer:

- (1) Conditions or a pattern of conditions exist in the long-term care facility that create a substantial risk of death or serious physical harm to residents or that death or serious physical harm has occurred, and it is probable that the facility will not or cannot immediately remedy those conditions or pattern of conditions, or the facility has shown a pattern of failure to comply with applicable laws and rules and continues to fail to comply;
- (2) The long-term care facility is operating without a license;
- (3) The license of the long-term care facility has been revoked or the long-term care facility is closing or intends to close and: (i) adequate arrangements for relocating residents have not been made, or (ii) quick relocation would not be in the best interest of the residents; or
- (4) A previous court order has been issued requiring the respondent to act or refrain from acting in a manner directly affecting the care of the residents and the respondent has failed to comply with the court order. (1993, c. 390, s. 1; 1999-334, s. 1.12.)

§ 131E-235. Alternative to appointment of temporary manager.

(a) After the hearing described in G.S. 131E-233(b), if the court finds that the evidence warrants the granting of the relief sought and the respondent applies to the court for permission to promptly remove or remedy the conditions or pattern specified in the petition and demonstrates the ability to promptly undertake and complete the removal or remedying of such conditions or pattern, the court, in lieu of appointing a temporary manager, may issue an order permitting the respondent to remove or remedy the conditions in accordance with a time schedule and subject to conditions determined by the court, including the posting of security for the performance of the work as may be fixed by the court.

(b) If, after entry of an order pursuant to subsection (a) of this section, it appears that the respondent is not proceeding in accordance with the court's order in removing or remedying the conditions found by the court to exist, the Department, upon notice to the respondent, may move the court for an order appointing a temporary manager pursuant to the court's findings at the original hearing. If upon hearing the matter, the court finds that the respondent is not proceeding in accordance with the court's order, the court may appoint a temporary manager as authorized by G.S. 131E-234. If the respondent has posted security to ensure removal or remedying of the conditions found by the court, the security or any part of the security as is necessary may be used by the temporary manager to remedy the conditions. (1993, c. 390, s. 1.)

§ 131E-236. Compensation of temporary manager.

The court shall set the compensation of the temporary manager. (1993, c. 390, s. 1.)

§ 131E-237. Candidates for temporary managers.

In the petition the Department shall nominate at least one candidate for temporary manager and shall include the name, address, and qualifications of each nominee. The Department shall maintain a list of persons qualified to act as temporary managers. The person or persons nominated by the Department to serve as temporary manager shall either be employed by the Department or

be one of the persons on the list of qualified persons maintained by the Department. This nominee shall be approved by the court reviewing the Department's petition for appointment of a temporary manager. (1993, c. 390, s. 1.)

§ 131E-238. Temporary manager; powers and duties.

A temporary manager appointed under this section:

- (1) May exercise those powers and shall perform those duties ordered by the court;
- (2) Shall operate the long-term care facility in compliance with State and federal laws and assure the safety of the residents and the delivery of services to them;
- (3) May operate the facility under a temporary license issued by the Department in the event that the license of the original operator has been revoked or suspended or was never issued;
- (4) Shall have the same rights as the respondent to possession of the building in which the long-term care facility is located and of all goods and fixtures located in the building at the time the temporary manager is appointed. If the court finds that between the time the petition is filed and the temporary manager is appointed, the respondent has transferred assets for the purpose of frustrating the intent of this section, the court may require the respondent to repay to the temporary manager the value of such transferred assets. The temporary manager shall take all actions necessary to protect and conserve the assets and property of which the temporary manager takes possession, and the proceeds of any transfer, and may use them only in the performance of the powers and duties set forth in this section and as may be ordered by the court;
- (5) May use the building, fixtures, furnishings, and any accompanying consumable goods in providing care and services to residents and to any other persons receiving services from the long-term care facility at the time the petition for temporary management was filed. The temporary manager shall collect payment for all goods and services provided to residents or others at the same rate and method of payment as was charged by the respondent at the time the petition for temporary management was filed, unless a different rate is set by the State or other third-party payors. The temporary manager shall owe a duty to the owner of the long-term care facility to protect and preserve, and to avoid the waste or diminution of, the building, fixtures, furnishings, consumable goods, receipts, and other assets of the facility and to prevent the use of those assets for any purpose other than the reasonable operation of the facility;
- (6) May correct or eliminate any deficiency in the structure or furnishings of the long-term care facility that endangers the safety or health of residents, provided the total cost of correction of all such deficiencies does not exceed one thousand dollars (\$1,000);
- (7) Shall submit to the court a plan in accordance with G.S. 131E-239 for correction or elimination of any deficiency or deficiencies in the structure or furnishings of the long-term care facility that endanger the safety or health of residents and that are estimated to exceed one thousand dollars (\$1,000), and shall carry out the plan with any modification approved by the court;
- (8) May enter into contracts and hire agents and employees to carry out the powers and duties created under this section, provided that the temporary manager must

notify the court and the respondent prior to entering into any substantially new contract obligating the respondent to pay more than one thousand dollars (\$1,000);

- (9) Except as specified in G.S. 131E-241, shall honor all leases, mortgages, and secured transactions governing the building in which the long-term care facility is located and all goods and fixtures in the building of which the temporary manager has taken possession, but, in the case of a rental agreement, only to the extent of payments that are for the use of the property during the period of the temporary management, or, in the case of a purchase agreement, come due during the period of the temporary management;
- (10) Shall have full power to direct, manage, and discharge employees of the long-term care facility, consistent with applicable State and federal laws governing the employment of these employees;
- (11) If transfer of the residents is necessary, shall cooperate with the Department or local departments of social services or both in carrying out the transfer of residents to an alternative placement;
- (12) Shall be entitled to and shall take possession of all property or assets of residents in the possession of the respondents. The temporary manager shall preserve all property, assets, and records of residents of which the temporary manager takes possession and shall provide for the prompt transfer of the property, assets, and records to the alternative placement of any transferred resident. No owner, licensee, or administrator of a facility under temporary management shall be liable for the waste, mismanagement, or other negligent or intentional wrongful act of a temporary manager with respect to the property or assets of residents; and
- (13) May be held liable in his personal capacity only for his own gross negligence or intentional acts. (1993, c. 390, s. 1.)

§ 131E-239. Plan for correction of deficiencies in excess of one thousand dollars (\$1,000).

(a) If the temporary manager determines that it is necessary to correct a deficiency or deficiencies in the structure or furnishings reasonably estimated by the temporary manager to cost in excess of one thousand dollars (\$1,000), the temporary manager shall submit to the court a written plan that contains the following:

- (1) A description of the deficiency or deficiencies that require correction;
- (2) A description of the method proposed by the temporary manager for correction of the deficiency or deficiencies; and
- (3) An estimate of the cost of the correction or corrections.

(b) A copy of the plan shall be served upon the Department and the respondent on the same day that it is submitted to the court.

(c) If the Department or respondent makes a written request for a hearing within seven days after the submission of the plan to the court, a hearing on the proposed plan of correction shall be held. If a hearing is requested by a party, the hearing shall be held within 14 days of the written request. The Department, respondent, and temporary manager shall have the opportunity to present evidence at the hearing regarding the proposed plan. Upon hearing the evidence, the court may approve the plan, modify the plan, or, if the court determines as a result of the evidence that the alleged deficiency does not require correction, it may reject the plan. If no party requests

a hearing on the plan in accordance with this subsection, the court may order the temporary manager to proceed to implement the plan.

(d) In the event of an emergency situation involving the structure or furnishings of the facility the correction of which will cost in excess of one thousand dollars (\$1,000) and where failure to correct the situation immediately will likely result in serious physical harm or death to residents, the temporary manager may proceed to correct the situation in the most economical and efficient manner under the circumstances without prior court approval of a plan. If the court later determines pursuant to G.S. 131E-244(b) that the expenditure was not necessary or reasonable under the circumstances, payment for the expenditure or any part determined to be unreasonable or unnecessary by the court, must be paid from the contingency fund described in G.S. 131E-242. If the payment was initially made by the temporary manager from the contingency fund, the respondent shall have no obligation to repay those funds to the contingency fund upon a finding that the expenditure was unreasonable or unnecessary. If the payment was initially made by the temporary manager from operating revenues of the facility, the respondent shall be entitled to repayment of those amounts from the contingency fund. (1993, c. 390, s. 1.)

§ 131E-240. Payment to temporary manager.

(a) A person served with notice of an order of the court appointing a temporary manager and of the temporary manager's name and address shall be liable to pay the temporary manager for any goods or services provided by the temporary manager after the date of the order if the person would have been liable for the goods or services supplied by the respondent or an agent of the respondent. The temporary manager shall give a receipt for each payment and shall keep a copy of each receipt on file. The temporary manager shall deposit amounts received in a special account and shall use this account for all disbursements.

(b) The temporary manager may bring an action to enforce the liability created by subsection (a) of this section. Proof of payment to the temporary manager is as effective in favor of the person making the payment as payment of the amount to the person who, but for this subsection, would have been entitled to receive the sum paid.

(c) A resident may not be discharged, nor may any contract or rights be forfeited or impaired, nor may forfeiture or liability be increased, by reason of an omission to pay a respondent, licensee, or other person a sum paid to the temporary manager. (1993, c. 390, s. 1.)

§ 131E-241. Avoidance of preexisting leases, mortgages, and contracts.

(a) A temporary manager shall not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the respondent, licensee, or administrator of the long-term care facility if the temporary manager demonstrates to the court that the rental price, rate of interest, or other compensation to be paid under the contract or agreement is unreasonable in light of conditions existing at the time the agreement was entered into by the parties or in light of the relationship of the parties.

(b) If the temporary manager is in possession of real estate or goods subject to a lease, mortgage, security interest, or other contract that the temporary manager is permitted to avoid under subsection (a) of this section, and if the real estate or goods are necessary for the continued operation of the long-term care facility, the temporary manager may apply to the court to set a reasonable rental price, rate of interest, or other compensation to be paid by the temporary manager during the duration of the temporary management. The court shall hold a hearing on the application within 15 days after receipt of the application. At least 10 days prior to the hearing,

the temporary manager shall send notice of the application to any known person with any beneficial interest in the property involved.

(c) Payment by the temporary manager of the amount determined by the court to be reasonable is a defense to any action against the temporary manager for payment or for possession of the goods or real estate subject to the lease, mortgage, security interest, or other contract involved by any person who received such notice, but the payment does not relieve the obligee of liability for the difference between the amount paid by the temporary manager and the amount due under the original lease, mortgage, or security interest involved. (1993, c. 390, s. 1.)

§ 131E-242. Contingency fund.

(a) The Department may maintain a temporary management contingency fund.

(b) Upon a showing that proper expenses of the temporary management under this Article exceed the operating funds of the long-term care facility, the court, in its discretion, may order that the Department provide funds from the contingency fund to the temporary manager to operate the facility and compensate the temporary manager.

(c) When the total funds available in the contingency fund exceed five hundred thousand dollars (\$500,000), the Department may reallocate any or all of the amount in excess of five hundred thousand dollars (\$500,000) for other activities intended to protect the health and property of residents. (1993, c. 390, s. 1; 1995, c. 535, s. 27; 1998-215, s. 78(d); 1999-334, s. 1.13.)

§ 131E-243. Review and termination of temporary management.

(a) The operations and continuing need for a temporary manager shall be reviewed by the court every 30 days following the appointment of the temporary manager.

(b) The court may order the replacement of a temporary manager upon a showing that the temporary manager has mismanaged the long-term care facility.

(c) The court shall order the termination of the temporary management upon the recommendation of the Department or upon a showing that the conditions leading to imposition of the temporary management have been resolved.

(d) When a long-term care facility is returned to its owner, the court may impose conditions to assure compliance with applicable laws and regulations. (1993, c. 390, s. 1.)

§ 131E-244. Accounting lien for expenses.

(a) Within 30 days after termination of the temporary management, the temporary manager shall give the court a complete accounting of:

- (1) All property of which the temporary manager took possession;
- (2) All funds collected under this Article;
- (3) Expenses of the temporary management; and
- (4) All disbursements or transfers of facility funds or other assets made during the period of temporary management. On the same day the accounting is filed with the court, the temporary manager shall serve on the respondent by registered mail a copy of this accounting.

(b) If the operating funds collected during the temporary management exceed the reasonable expenses of the temporary management, the court shall order payment of the excess to the respondent, after reimbursement to the contingency fund. If the operating funds are insufficient to cover the reasonable expenses of the temporary management, the respondent shall be liable for the deficiency, except as described in this section. If the respondent demonstrates to the court that

repayment of amounts spent from the contingency fund would significantly impair the provision of appropriate care or services to residents, the court may order repayment over a period of time with or without interest or may order that the respondent be required to repay only part or none of the amount spent from the contingency fund. In reaching this decision, the court may consider all assets, revenues, debts and other obligations of the long-term care facility, the likelihood of the sale of the long-term care facility where repayment forgiveness would result in unjust enrichment of the respondent, and shall consider the impact of its determination on the provision of care to residents. The respondent may petition the court to determine the reasonableness of any expenses of the temporary management. The respondent shall not be responsible for expenses in excess of amounts the court finds to be reasonable. Payment recovered from the respondent shall be used to reimburse the contingency fund for amounts used by the temporary manager.

(c) The court may order that the Department have a lien for any reasonable costs of the temporary management that are not covered by the operating funds collected by the temporary manager and for any funds paid out of the contingency fund during the temporary management upon any beneficial interest, direct or indirect, of any respondent in the following property:

- (1) The building in which the long-term care facility is located;
- (2) The land on which the long-term care facility is located;
- (3) Any fixtures, equipment, or goods used in the operation of the long-term care facility; or
- (4) The proceeds from any conveyance of property described in subdivisions (1), (2), and (3) of this subsection made by the respondent within one year prior to the filing of the petition for temporary management unless such transfers were made in good faith, in the ordinary course of business, and without intent to frustrate the intent of subsection (b) of this section. Transfers made coincidental with serious deficiencies in resident care may be considered evidence of intent to frustrate the intent of subsection (b) of this section.

(d) To the extent permitted by other provisions of applicable State or federal law, the lien provided for in this section is superior to any lien or other interest that arises subsequent to the filing of the petition for temporary management under this section, except for a construction or mechanic's lien arising out of work performed with the express consent of the temporary manager.

(e) The clerk of court in the county in which the long-term care facility is located shall record the filing of the petition for temporary management in the lien docket opposite the names of the respondents and licensees named in the petition.

(f) Within 60 days after termination of the temporary management, the temporary manager shall file a notice of any lien created under this section. If the lien is on real property, the notice shall be filed with the clerk of court in the county where the long-term care facility is located and entered on the lien docket. If the lien is on personal property, the lien shall be filed with the person against whom the lien is claimed, and shall state the name of the temporary manager, the date of the petition for temporary management, the date of the termination of temporary management, a description of the property involved, and the amount claimed. No lien shall exist under this section against any person, on any property, or for any amount not specified in the notice filed under this section. (1993, c. 390, s. 1.)

§ 131E-245. Obligations of licensee.

Nothing in this Article shall relieve any respondent, licensee, or administrator of a long-term care facility placed in temporary management of any civil or criminal liability, or any duty imposed

by law, by reason of acts or omissions of the respondent, licensee, or administrator prior to the appointment of the temporary manager. Nothing in this Article shall suspend during the temporary management any obligation of the respondent, licensee, or administrator for payment of taxes, other operating and maintenance expenses of the long-term care facility, nor the respondent, licensee, or administrator or any other person for the payment of mortgages or liens. No owner, licensee, or administrator shall be held personally liable for acts or omissions of the temporary manager or the temporary manager's employees during the term of the temporary management. No licensee or administrator may be held responsible or liable for licensure fines, sanctions or penalties, or other administrative sanctions, arising or imposed as a result of acts or omissions occurring during the period of temporary management unless those sanctions result from acts or omissions by the licensee or administrator. (1993, c. 390, s. 1.)

§ 131E-246. Conflict of laws.

In the event of a conflict between federal laws or regulations and State law or rules, the federal laws or regulations shall control. (1993, c. 390, s. 1.)

§ 131E-247. Reserved for future codification purposes.

§ 131E-248. Reserved for future codification purposes.

§ 131E-249. Reserved for future codification purposes.

Article 14.

Disposal of Surplus Property to Aid Other Countries.

§ 131E-250. Disposition of surplus property by public and State hospitals.

(a) As used in this section, "public hospital" has the same meaning as in G.S. 159-39. A State hospital is any hospital operated by the State.

(b) A public hospital or a State hospital may donate medical equipment it determines is no longer needed by the hospital to any of the following if the property so donated is to be used by a hospital or medical facility in another country:

- (1) A corporation that is exempt from taxation under section 501(c) of the Internal Revenue Code of 1986.
- (2) The United States or any agency of it.
- (3) The government of a foreign country or any political subdivision of that country.
- (4) The United Nations or an agency of it.
- (5) Other eleemosynary institutions and groups. (1993, c. 529, s. 7.6; 1995, c. 509, s. 73.)

§§ 131E-251 through 131E-254. Reserved for future codification purposes.

Article 15.

Health Care Personnel Registry.

§ 131E-255. Nurse Aide Registry.

(a) Pursuant to 42 U.S.C. § 1395i-3(e) and 42 U.S.C. § 1396r(e), the Department shall establish and maintain a registry containing the names of all nurse aides working in nursing facilities in North Carolina. The Department shall include in the nurse aide registry any findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide.

(b) A nurse aide who wishes to contest a finding of resident neglect, resident abuse, or misappropriation of resident property made against the aide, is entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice by certified mail of the Department's intent to place findings against the aide in the nurse aide registry.

(c) "Nursing facility", as used in this section, means a "combination home" as defined in G.S. 131E-101(1) and a "nursing home" as defined in G.S. 131E-101(6) and also means "facility" as that term is defined in G.S. 131E-116(2).

(d) The Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(e) No person shall be liable for providing any information for the nurse aide registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the nurse aide registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee. (1991, c. 185, s. 1; c. 761, s. 26; 1995 (Reg. Sess., 1996), c. 713, ss. 3(a), (b).)

§ 131E-256. Health Care Personnel Registry.

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

- a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
- b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.
- c. Misappropriation of the property of a health care facility.
- d. Diversion of drugs belonging to a health care facility.
- d1. Diversion of drugs belonging to a patient or client of the health care facility.
- e. Fraud against a health care facility.
- e1. Fraud against a patient or client for whom the employee is providing services.

- (2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(a1) The Department shall include in the registry a brief statement of any individual disputing the finding entered against the individual in the health care personnel registry pursuant to subdivision (1) of subsection (a) of this section.

(b) For the purpose of this section, the following are considered to be "health care facilities":

- (1) Adult Care Homes as defined in G.S. 131D-2.1.
- (2) Hospitals as defined in G.S. 131E-76.
- (3) Home Care Agencies as defined in G.S. 131E-136.
- (4) Nursing Pools as defined by G.S. 131E-154.2.
- (5) Hospices as defined by G.S. 131E-201.
- (6) Nursing Facilities as defined by G.S. 131E-255.
- (7) State-Operated Facilities as defined in G.S. 122C-3(14)f.
- (8) Residential Facilities as defined in G.S. 122C-3(14)e.
- (9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.
- (10) Licensable Facilities as defined in G.S. 122C-3(14)b.
- (11) Multiunit Assisted Housing with Services as defined in G.S. 131D-2.1.
- (12) Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C of the General Statutes.
- (13) Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

(c) For the purpose of this section, the term "health care personnel" means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a

contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer at a health care facility or potential employer at a health care facility of any person listed on the Health Care Personnel Registry information concerning the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.

(g1) Health care facilities defined in subsection (b) of this section are permitted to provide confidential or other identifying information to the Health Care Personnel Registry, including social security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for verifying the identity of accused health care personnel. Confidential or other identifying information received by the Health Care Personnel Registry is not a public record under Chapter 132 of the General Statutes.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

- (1) The employment and personal history of the health care personnel does not reflect a pattern of abusive behavior or neglect;
- (1a) The health care personnel's name was added to the registry for a single finding of neglect;

- (2) The neglect involved in the original finding was a singular occurrence; and
- (3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section.

(i1) Health care personnel who wish to contest a decision by the Department to deny a removal of a single finding of neglect from the Health Care Personnel Registry under subdivision (1a) of subsection (i) of this section are entitled to an administrative hearing under Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's denial of a removal of a finding of neglect.

(j) Removal of a finding of neglect from the registry under this section may occur only once with respect to any person. (1995 (Reg. Sess., 1996), c. 713, s. 3(b); 1998-212, s. 12.16E; 1999-159, s. 1; 2000-55, s. 1; 2004-203, ss. 52(a), (b), (c); 2007-544, s. 2; 2009-316, ss. 1(a), (b), 2; 2009-462, s. 4(m).)

§ 131E-256.1. Adverse action on a license; appeal procedures.

(a) The Department may suspend, cancel, or amend a license when a facility subject to this Article has substantially failed to comply with this Article or rules adopted under this Article.

(b) Administrative action taken by the Department under this section shall be in accordance with Chapter 150B of the General Statutes. (2000-55, s. 2.)

Article 15A.

Public Hospital Personnel Act.

§ 131E-257. Title; purpose; applicability of other laws; "public hospital" defined.

(a) This Article shall be known and may be cited as the "Public Hospital Personnel Act".

(b) The purpose of this Article is to protect the privacy of the personnel records of public hospital employees and to authorize public hospitals to determine employee compensation and personnel policies and to establish employee benefit plans.

(c) Unless otherwise provided, none of the provisions of Part 4, Article 5, Chapter 153A and Part 4, Article 7, Chapter 160A shall apply to public hospitals.

(d) If any provision of this Article is inconsistent with any provision of any other law, the provision of this Article shall be controlling.

(e) As used in this Article, unless the context clearly indicates otherwise, the term "public hospital" has the same meaning as in G.S. 159-39. (1997-517, s. 2.)

§ 131E-257.1. Compensation; personnel policies; employee benefits plans.

(a) A public hospital shall determine the pay, expense allowances, and other compensation of its officers and employees, and may establish position classification and pay plans and incentive compensation plans.

(b) A public hospital may:

- (1) Adopt personnel policies and procedures regarding, without limitation, vacations, personal leave, service award programs, other personnel policies and

procedures, and any other measures that enhance the ability of a public hospital to hire and retain employees.

- (2) Determine the work hours, workdays, and holidays applicable to its employees.
- (3) Establish and pay all or part of the cost of benefit plans for its employees and former employees, including without limitation, life, health and disability plans, pension, profit sharing, deferred compensation and other retirement plans, and other fringe benefit plans.
- (4) Pay severance payments and provide other employee severance benefits to its employees and former employees pursuant to a severance plan established in connection with a reduction in the size of the workforce of a public hospital or, with respect to an individual employee, pursuant to an employment agreement entered into prior to the date the employee receives notice of termination of employment.

(c) The provisions of G.S. 159-30 and G.S. 159-31 are not applicable to public hospitals with respect to the investment of escrowed or trustee retirement and deferred compensation funds. Public hospitals may invest such escrowed and trustee funds in property or securities in which trustees, guardians, personal representatives, and others acting in a fiduciary capacity may legally invest funds under their control. (1997-517, s. 2.)

§ 131E-257.2. Privacy of employee personnel records.

(a) Notwithstanding the provisions of G.S. 132-6 or any other general law or local act concerning access to public records, personnel files of employees and applicants for employment maintained by a public hospital are subject to inspection and may be disclosed only as provided by this section. For purposes of this section, an employee's personnel file consists of any information in any form gathered by the public hospital with respect to an employee and, by way of illustration but not limitation, relating to the employee's application, selection or nonselection, performance, promotions, demotions, transfers, suspensions and other disciplinary actions, evaluation forms, employment contracts, leave, salary, and termination of employment. As used in this section, "employee" includes both current and former employees of a public hospital.

(b) The following information with respect to each public hospital employee is a matter of public record:

- (1) Name.
- (2) Age.
- (3) Date of original employment.
- (4) Current position title.
- (5) Date of the most recent promotion, demotion, transfer, suspension, separation or other change in position classification.
- (6) The office to which the employee is currently assigned.

In addition, the following information with respect to each licensed medical provider employed by or having privileges to practice in a public hospital shall be a matter of public record: educational history and qualifications, date and jurisdiction or original and current licensure; and information relating to medical board certifications or other qualifications of medical specialists.

(b1) In addition, the following information for the last completed fiscal year, beginning with the fiscal year ending in 2008, of a public hospital with respect to each Covered Officer and the five key employees (who are not Covered Officers) with the highest annual compensation of a public hospital is a matter of public record:

- (1) Base salary.
 - (2) Bonus compensation.
 - (3) Plan-based incentive compensation.
 - (4) Dollar value of all other compensation, which includes any perquisites and other personal benefits.
- (b2) As used in this section:
- (1) "Covered Officer" means each of the following:
 - a. All individuals serving as the public hospital's chief executive officer or acting in a similar capacity at any time during the last completed fiscal year, regardless of compensation level.
 - b. The public hospital's four most highly compensated executive officers, determined by the aggregate amount reportable under subdivisions (1) through (4) of subsection (b1) of this section, other than the chief executive officer, who were serving as executive officers at the end of the last completed fiscal year.
 - c. Any individual for whom disclosure would have been provided pursuant to sub-subdivision b. of this subsection but for the fact that the individual's service as an executive officer of the public hospital terminated during the last completed fiscal year.
 - (2) "Executive officer" means each employee of the public hospital specifically appointed by the governing board of the public hospital to serve as an officer.
 - (3) "Key employee" means any person having responsibilities, powers, or influence similar to those of an officer. The term includes the chief management and administrative officials of a public hospital.

(b3) The governing board of a public hospital shall determine in what form and by whom this information will be maintained. Any person may have access to this information for the purpose of inspection, examination, and copying, during regular business hours, subject only to such rules and regulations for the safekeeping of public records as the governing board of the public hospital may have adopted. Any person denied access to this information may apply to the appropriate division of the General Court of Justice for an order compelling disclosure, and the court shall have jurisdiction to issue such orders.

(c) All information contained in a public hospital employee's personnel file, other than the information made public by subsection (b) of this section, is confidential and shall be open to inspection only in the following instances:

- (1) The employee or the employee's duly authorized agent may examine all portions of the employee's personnel file, except letters of reference solicited prior to employment.
- (2) A licensed physician designated in writing by the employee may examine the employee's medical record.
- (3) A public hospital employee having supervisory authority over the employee may examine all material in the employee's personnel file.
- (4) By order of a court of competent jurisdiction, any person may examine such portion of an employee's personnel file as may be ordered by the court.
- (5) An official of an agency of the State or federal government, or any political subdivision of the State, may inspect any portion of a personnel file when the inspection is deemed by the person having custody of the file to be inspected to

be necessary and essential to the pursuance of a proper function of the inspecting agency, but no information shall be divulged for the purpose of assisting in criminal prosecution of the employee, or for the purpose of assisting in an investigation of the employee's tax liability. However, the official having custody of the records may release the name, address, and telephone number from a personnel file for the purpose of assisting in a criminal investigation.

- (6) An employee may sign a written release, to be placed with the employee's personnel file, that permits the person with custody of the file to provide, either in person, by telephone, or by mail, information specified in the release to prospective employers, educational institutions, or other persons specified in the release.

(d) Even if considered part of an employee's personnel file, the following information need not be disclosed to an employee nor to any other person:

- (1) Testing or examination material used solely to determine individual qualifications for appointment, employment, or promotion in the public hospital's service, when disclosure would compromise the objectivity or the fairness of the testing or examination process.
- (2) Investigative reports or memoranda and other information concerning the investigation of possible criminal actions of an employee, until the investigation is completed and no criminal action taken, or until the criminal action is concluded.
- (3) Information that might identify an undercover law enforcement officer or a law enforcement informer.
- (4) Notes, preliminary drafts, and internal communications concerning an employee. In the event such materials are used for any official personnel decision, then the employee or his duly authorized agent shall have a right to inspect such materials.

(e) The governing board of a public hospital may permit access, subject to limitations they may impose, to selected personnel files by a professional representative of a training, research, or academic institution if that representative certifies that he or she will not release information identifying the employees whose files are opened and that the information will be used solely for statistical, research, or teaching purposes. This certification shall be retained by the public hospital as long as each personnel file so examined is retained.

(f) The governing board of a public hospital that maintains personnel files containing information other than the information mentioned in subsection (b) of this section shall establish procedures whereby an employee who objects to material in his or her file on grounds that it is inaccurate or misleading may seek to have the material removed from the file or may place in the file a statement relating to the material.

(g) A public hospital director, trustee, officer, or employee who knowingly, willfully, and with malice permits any person to have access to information contained in a personnel file, except as is permitted by this section, is guilty of a Class 3 misdemeanor; however, conviction under this subsection shall be punishable only by a fine not to exceed five hundred dollars (\$500.00).

(h) Any person not specifically authorized by this section to have access to a personnel file designated as confidential, who shall knowingly and willfully examine in its official filing place, or remove, or copy any portion of a confidential personnel file shall be guilty of a Class 3

misdemeanor; however, conviction under this subsection shall be punishable, in the discretion of the court, by a fine not to exceed five hundred dollars (\$500.00). (1997-517, s. 2; 2007-508, s. 5.5.)

§§ 131E-258 through 131E-264. Reserved for future codification purposes.

Article 16.

Miscellaneous Provisions.

§ 131E-265. Criminal history record checks required for certain applicants for employment.

(a) Requirement; Nursing Home or Home Care Agency. – An offer of employment by a nursing home licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. An offer of employment by a home care agency licensed under this Chapter to an applicant to fill a position that requires entering the patient's home is conditioned on consent to a criminal history record check of the applicant. In addition, employment status change of a current employee of a home care agency licensed under this Chapter from a position that does not require entering the patient's home to a position that requires entering the patient's home shall be conditioned on consent to a criminal history record check of that current employee. If the applicant for employment or if the current employee who is changing employment status has been a resident of this State for less than five years, then the offer of employment or change in employment status is conditioned on consent to a State and national criminal history record check. The national criminal history record check shall include a check of the applicant's or current employee's fingerprints. If the applicant or current employee has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant or current employee applying for a change in employment status. A nursing home or a home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. In addition, a home care agency shall not change a current employee's employment status from a position that does not require entering the patient's home to a position that requires entering the patient's home who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a nursing home or home care agency shall submit a request to the Department of Public Safety under G.S. 143B-939 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding

G.S. 143B-939, the Department of Public Safety shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the nursing home or home care agency as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the nursing home or home care agency. Nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the home or agency is confidential and may not be disclosed, except to the applicant as provided in subsection (b) of this section.

(a1) Requirement; Contract Agency of Nursing Home or Home Care Agency. – An offer of employment by a contract agency of a nursing home or home care agency licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned upon consent to a criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A contract agency of a nursing home or home care agency shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Within five business days of making the conditional offer of employment, a contract agency of a nursing home or home care agency shall submit a request to the Department of Public Safety under G.S. 143B-939 to conduct a State or national criminal history record check required by this section, or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 143B-939, the Department of Public Safety shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the contract agency of the nursing home or home care agency as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the contract agency of the nursing home or home care agency. Contract agencies of nursing homes and home care agencies shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. All criminal history information received by the contract agency is confidential and may not be disclosed, except to the applicant as provided by subsection (b) of this section.

(b) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the nursing home or home care agency, or the contract

agency of a nursing home or home care agency, shall consider all of the following factors in determining whether to hire the applicant:

- (1) The level and seriousness of the crime.
- (2) The date of the crime.
- (3) The age of the person at the time of the conviction.
- (4) The circumstances surrounding the commission of the crime, if known.
- (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
- (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
- (7) The subsequent commission by the person of a relevant offense.

The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the nursing home or home care agency, or the contract agency of the nursing home or home care agency. If a nursing home, home care agency, or contract agency of a nursing home or home care agency disqualifies an applicant after consideration of the relevant factors, then the nursing home, home care agency, or contract agency may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.

(c) Limited Immunity. – An entity and an officer or employee of an entity that, in good faith, complies with this section is not liable for the failure of the entity to employ an individual on the basis of information provided in the criminal history record check of the individual.

(d) Relevant Offense. – As used in this section, the term "relevant offense" has the same meaning as in G.S. 131D-40.

(e) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(f) Conditional Employment. – A nursing home or home care agency may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

- (1) The nursing home or home care agency shall not employ an applicant prior to obtaining the applicant's consent for a criminal history record check as required in subsection (a) of this section or the completed fingerprint cards as required in G.S. 143B-939.
- (2) The nursing home or home care agency shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment.

(g) Immunity From Liability. – An entity and officers and employees of an entity shall be immune from civil liability for failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.

(h) For purposes of this section, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (1995 (Reg. Sess., 1996), c. 606, s. 3; 1997-125, s. 2; 1997-140, s. 4; 2000-154, ss. 3(a),(b); 2004-124, s. 10.19D(a); 2005-4, ss. 8, 9; 2007-444, s. 3.2; 2014-100, s. 17.1(iii).)

§ 131E-266. Compliance history provider file.

The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes. (1999-334, s. 3.8.)

§ 131E-267. Fees for departmental review of licensed health care facility or Medical Care Commission bond-financed construction projects.

(a) The Department of Health and Human Services shall charge a fee for the review of each health care facility construction project to ensure that project plans and construction are in compliance with State law. The fee shall be charged on a one-time, per-project basis as provided in this section. In no event may a fee imposed under this section exceed two hundred thousand dollars (\$200,000) for any single project. The first seven hundred twelve thousand six hundred twenty-six dollars (\$712,626) in fees collected under this section shall remain in the Division of Health Service Regulation. Additional fees collected shall be credited to the General Fund as nontax revenue and are intended to offset rather than replace appropriations made for this purpose.

(b) The fee imposed for the review of a hospital construction project varies depending upon the square footage of the project:

Over	Up To	Project Fee
0	5,000	\$1,500 plus \$0.25 per square foot
5,000	10,000	\$3,000 plus \$0.25 per square foot
10,000	20,000	\$4,500 plus \$0.45 per square foot
20,000	NA	\$6,000 plus \$0.45 per square foot

(c) The fee imposed for the review of a nursing home construction project varies depending upon the square footage of the project:

Over	Up To	Project Fee
0	2,000	\$250.00 plus \$0.15 per square foot
2,000	NA	\$500.00 plus \$0.25 per square foot

(d) The fee imposed for the review of an ambulatory surgical facility construction project varies depending upon the square footage of the project:

Over	Up To	Project Fee
0	2,000	\$200.00 plus \$0.15 per square foot
2,000	NA	\$400.00 plus \$0.25 per square foot

(e) The fee imposed for the review of a psychiatric hospital construction project varies depending upon the square footage of the project:

Over	Up To	Project Fee
0	5,000	\$750.00 plus \$0.25 per square foot

5,000	10,000	\$1,500.00 plus \$0.25 per square foot
10,000	20,000	\$2,250.00 plus \$0.45 per square foot
20,000	NA	\$3,000.00 plus \$0.45 per square foot

(f) The fee imposed for the review of an adult care home construction project varies depending upon the square footage of the project:

Over	Up To	Project Fee
0	2,000	\$175.00 plus \$0.10 per square foot
2,000	NA	\$350.00 plus \$0.20 per square foot

(g) The fee imposed for the review of the following residential construction projects is:

Residential Project	Project Fee
Family Care Homes	\$225.00 flat fee
ICF/MR Group Homes	\$350.00 flat fee
Group Homes: 1-3 beds	\$125.00 flat fee
Group Homes: 4-6 beds	\$225.00 flat fee
Group Homes: 7-9 beds	\$275.00 flat fee
Adult Day Care	
Overnight Respite Facility	\$225.00 flat fee
Adult Day Health	
Overnight Respite Facility	\$225.00 flat fee
Other residential:	
More than 9 beds	\$275.00 plus \$0.15 per square foot of project space. (2003-284, s. 34.11(a); 2005-276, s. 41.2(j); 2006-66, s. 10.22; 2007-323, s. 30.5(a); 2008-107, s. 29.5(a); 2015-241, s. 12G.3(c).)

§ 131E-268. Reserved for future codification purposes.

§ 131E-269. Authorization to charge fee for certification of facilities suitable to perform abortions.

The Department of Health and Human Services shall charge each hospital or clinic certified by the Department as a facility suitable for the performance of abortions, as authorized under G.S. 14-45.1, a nonrefundable annual certification fee in the amount of seven hundred dollars (\$700.00). (2003-284, s. 34.7(a); 2005-276, s. 41.2(g).)

§ 131E-270. Medication Aide Registry.

(a) The Department shall establish and maintain a Medication Aide Registry containing the names of all health care personnel in North Carolina who have successfully completed a medication aide training program that has been approved by the North Carolina Board of Nursing, passed a State-administered medication aide competency exam, and met any other requirements set by the Medical Care Commission.

(b) Before allowing an individual to serve as a medication aide, an employer shall access the Medication Aide Registry to verify that the individual is listed on the Registry

and shall note each incidence of access in the appropriate business file. Employers may not use an individual as a medication aide unless the individual is listed on the Medication Aide Registry.

(c) Employers shall access the Health Care Personnel Registry prior to employing a medication aide. Any substantiated action as defined in G.S. 131E-256(a)(1) listed against the medication aide shall disqualify the medication aide from employment in any facility or agency covered by Part 1 of Article 6 of this Chapter. (2005-276, s. 10.40C(c); 2007-444, s. 4(b).)

§ 131E-271: Reserved for future codification purposes.

§ 131E-272. Initial licensure fees for new facilities.

The following fees are initial licensure fees for new facilities and are applicable as follows:

Facility Type	Number of Beds	Initial License Fee	Initial Bed Fee
Adult Care Licensure	More than 6	\$400.00	\$19.00
	6 or Fewer	\$350.00	\$ -
Acute and Home Care			
General Acute Hospitals	1-49	\$550.00	\$19.00
	50-99	\$750.00	\$19.00
	100-199	\$950.00	\$19.00
	200-399	\$1150.00	\$19.00
	400-699	\$1550.00	\$19.00
	700+	\$1950.00	\$19.00
Other Hospitals		\$1050.00	\$19.00
Home Care	-	\$560.00	\$ -
Ambulatory Surgical Ctrs.	-	\$900.00	\$85.00
Hospice (Free Standing)	-	\$450.00	\$ -
Abortion Clinics	-	\$750.00	\$ -
Cardiac Rehab. Centers	-	\$425.00	\$ -
Nursing Home & L&C			
Nursing Homes		\$470.00	\$19.00
All Others		\$ -	\$19.00
Mental Health Facilities			
Nonresidential		\$265.00	\$ -
Non ICF-MR	6 or fewer	\$350.00	\$ -
ICF-MR only	6 or fewer	\$900.00	\$ -
Non ICF-MR	More than 6	\$525.00	\$19.00
ICF-MR only	More than 6	\$850.00	\$19.00."

(2009-451, s. 10.77.)

§ 131E-273. Certain charges/payments prohibited.

It shall be unlawful for any provider of health care services to charge or accept payment for any health care procedure or component of any health care procedure that was not performed or supplied. If a procedure requires the informed consent of a patient, the charge

for any component of the procedure performed prior to consent being given shall not exceed the actual cost to the provider if the patient elects not to consent to the procedure. (2013-382, s. 11.1; 2013-393, s. 1.)

§ 131E-274: Reserved for future codification purposes.

Article 17.

Provider Sponsored Organization Licensing.

§ 131E-275. General provisions.

(a) The General Assembly acknowledges that section 1855, et seq., of the federal Social Security Act permits provider sponsored organizations that are organized and licensed under State law as risk-bearing entities, or that are otherwise certified as such by the federal government, to be eligible to offer Medicare health insurance or health benefits coverage in each state in which the provider sponsored organization offers a Medicare+Choice plan. The General Assembly declares that provider sponsored organizations are beneficial to North Carolina citizens who are Medicare beneficiaries and should be encouraged, subject to appropriate regulation by the Division of Health Benefits of the Department of Health and Human Services. The General Assembly further declares that, because provider sponsored organizations provide health care directly and assume responsibility for the provision of health care services to Medicare beneficiaries under the requirements of the federal Medicare program, they require different regulatory oversight to protect the public than health maintenance organizations and insurance companies. The General Assembly further declares that the organizers and operators of provider sponsored organizations which are licensed under the terms of this Article as risk-bearing entities authorized to contract directly with the federal Medicare+Choice program shall not be subject to Chapter 58 of the General Statutes or the insurance laws of this State, unless otherwise specified in this Article.

It is the intent of the General Assembly to encourage innovative methods by which sponsoring providers can directly or indirectly share substantial financial risk in the PSO in any lawful manner.

(b) As set forth in this Article, the Division of Health Benefits of the Department of Health and Human Services shall be the agency of the State authorized to license provider sponsored organizations to contract with Medicare to provide health care services to Medicare beneficiaries and to engage in the other related activities described in this Article.

(c) Each provider sponsored organization shall obtain a license from the Division or shall otherwise be certified by the federal government prior to establishing, maintaining, and operating a health care plan in this State for Medicare+Choice beneficiaries. Nothing in this Article shall be construed to authorize a provider sponsored organization to establish, maintain, or operate a health care plan other than exclusively for Medicare+Choice beneficiaries. (1998-227, s. 1; 2019-81, s. 15(a).)

§ 131E-276. Definitions.

As used in this Article, unless the context clearly implies otherwise, the following definitions apply:

- (1) "Affiliated provider" means a health care provider that is affiliated with another provider if, through contract, ownership, or otherwise: (i) one provider directly controls, is controlled by, or is under common control with the other provider; (ii) each provider participates in a lawful combination under which they share substantial financial risk for the organization's operation; (iii) both providers are part of a controlled group of corporations as defined under section 1563 of the Internal Revenue Code of 1986; or (iv) both providers are part of an affiliated service group under section 414 of this Code. Control is presumed if one party directly or indirectly owns, controls, or holds the power to vote, or proxies for, at least fifty-one percent (51%) of the voting or governance rights of another.
- (2) "Beneficiary" or "beneficiaries" means a beneficiary or beneficiaries of the Medicare+Choice program who are enrolled with the provider sponsored organization (PSO) under the terms of a contract between the PSO and the Medicare program.
- (3) "Current assets" means cash, marketable securities, accounts receivable, and other current items that will be converted into cash within 12 months.
- (4) "Current liabilities" means accounts payable and other accrued liabilities, including payroll, claims, and taxes that will need to be paid within 12 months.
- (5) "Current ratio" means the ratio of current assets divided by current liabilities calculated at the end of any accounting period.
- (6) "Division" means the Division of Health Benefits of the Department of Health and Human Services.
- (7) "Emergency services" has the same meaning as defined in G.S. 58-50-61(a)(5).
- (8) "Health care delivery assets" means any tangible asset that is part of a PSO operation, including hospitals, medical facilities, and their ancillary equipment, and any property that may reasonably be required for the PSO's principal office or for any purposes that may be necessary in the transaction of the business of the PSO.
- (9) "Health plan contract" or "Medicare contract" means a PSO's direct contract with the United States Department of Health and Human Services under section 1857 of the federal Social Security Act.
- (10) "Out-of-network services" means health care items or services that are covered services under a PSO's Medicare contract and that are provided to beneficiaries by health care providers that are not participating providers in the PSO's network of health care providers.

- (11) "Parent of a sponsoring provider" means the public or private entity that owns or controls a controlling interest in the sponsoring provider or that has the power to appoint a controlling number of the governing board of a sponsoring provider or that has the power to direct the management policy and decisions of the sponsoring provider.
- (12) "Provider" or "health care provider" means: (i) any individual that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; (ii) any entity that is engaged in the delivery of health care services and that is required by North Carolina law or regulation to be licensed to engage in the delivery of these health care services and is so licensed; or (iii) any entity that is owned or controlled entirely by individuals or entities described in subparts (i) or (ii) of this definition.
- (13) "Provider sponsored organization" or "PSO" means a public or private entity domiciled in this State, including a business corporation, a nonprofit corporation, a partnership, a limited liability company, a professional limited liability company, a professional corporation, a sole proprietorship, a public hospital, a hospital authority, a hospital district, or a body politic: (i) that is established, organized, and operated by sponsoring providers; (ii) in which physicians licensed pursuant to Article 1 of Chapter 90 of the General Statutes or to the laws of any state of the United States comprise no less than fifty percent (50%) of the governing board or body, unless otherwise prohibited by law; and (iii) that provides a substantial proportion of the services under each Medicare contract directly through the sponsoring provider. The requirement in subpart (ii) of this definition shall not preclude a PSO that includes a tax-exempt hospital from adopting a bylaw provision that provides a veto for the tax-exempt hospital over actions of the PSO necessary to maintain the hospital's tax-exempt status. A PSO shall not be out of compliance with the requirement in subpart (ii) due to temporary vacancies on its governing board or body. Subpart (ii) of this subdivision applies only if a hospital licensed under this Chapter or Chapter 122C of the General Statutes is the sponsoring provider or a member of the group of affiliated health care providers that comprises the sponsoring provider.
- (14) "Sponsoring providers" of a PSO means the health care provider domiciled in this State that assumes, or group of affiliated health care providers that directly or indirectly shares, substantial financial risk in the PSO and that has at least a majority financial interest in the PSO.
- (15) "Substantial proportion of the services" means at least seventy percent (70%), or sixty percent (60%) for PSOs whose beneficiaries reside primarily in rural areas, of the annual health care expenditures. (1998-227, s. 1; 2019-81, s. 15(a).)

§ 131E-277. Direct or indirect sharing of substantial financial risk.

In order for sponsoring providers to directly or indirectly share substantial financial risk in the PSO, the PSO shall do one or more of the following:

- (1) Provide services under its Medicare contract at a capitated rate;
- (2) Provide designated services or classes of services under its Medicare contract for a predetermined percentage of premium or revenue from the Medicare program;
- (3) Use significant financial incentives for its sponsoring providers, as a group to achieve specified cost-containment and utilization management goals either by:
 - a. Withholding from all sponsoring providers a substantial amount of the compensation due to them, with distribution of that amount to the sponsoring providers based on performance of all sponsoring providers in meeting the cost-containment goals of the network as a whole; or
 - b. Establishing overall cost or utilization targets for the PSO, with the sponsoring providers subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; or
- (4) Agree to provide a complex or extended course of treatment that requires the substantial coordination of care by sponsoring providers in different specialties offering a complementary mix of services, for a fixed, predetermined payment, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's treatment or other factors; or
- (5) Agree to any other arrangement that the Division determines to provide for the sharing of substantial financial risk by the sponsoring providers. (1998-227, s. 1.)

§ 131E-278. Applicability of other laws.

Unless otherwise required by federal law, provider sponsored organizations licensed pursuant to the terms of this Article are exempt from all regulation under Chapter 58 of the General Statutes. Plan contracts, provider contracts, and other arrangements related to the provision of covered services by these licensed networks or by health care providers of these PSOs when operating through these PSOs shall likewise be exempt from regulation under Chapter 58 of the General Statutes. (1998-227, s. 1.)

§ 131E-279. Approval.

(a) Unless otherwise required by federal law, the Division shall be the agency of the State that shall license provider sponsored organizations that seek to contract with the federal government to provide health care services directly to Medicare beneficiaries under the Medicare+Choice program.

(b) Provider sponsored organizations which have been granted a waiver pursuant to 42 U.S.C. § 1395w-25(a)(2) and which otherwise meet the requirements of the PSO's

Medicare contract shall be deemed by the State to be licensed under this Article for so long as the waiver or Medicare contract remains in effect. The foregoing shall not limit the Division's authority to regulate such PSOs and their respective sponsoring providers and affiliated providers as may be permitted in 42 U.S.C. § 1395w-25(a)(2)(G) or the PSO's Medicare contract.

(c) The Division shall license a PSO as a risk-bearing entity eligible to offer health benefits coverage in this State to Medicare beneficiaries if the PSO complies with the requirements of this Article. This license shall be granted or denied by the Division not longer than 90 days after the receipt of a substantially complete application for licensing. Within 45 days after the Division receives an application for licensing, the Division shall either notify the applicant that the application is substantially complete, or clearly and accurately specify in writing to the applicant all additional specific information required by the applicant to make the application a substantially completed application. This agency response shall set forth a date and time for a meeting within 30 days after it is sent to the applicant, at which a representative of the Division will explain with particularity the additional information required by the Division in the response to make the application substantially complete. The Division shall be bound by the response unless the Division determines that it must be modified in order to meet the purposes of this Article. The Division shall not delegate the authority to modify the response. If an applicant provides the additional information set forth in the response, the application shall be considered substantially complete. If the Division has not acted on an application within 90 days after it is deemed substantially complete, the Division shall immediately issue a license to the applicant, and the applicant shall be considered to have been licensed by the Division. Any reapplication which corrects the deficiencies which were specified by the Division in the response shall be approved by the Division.

(d) For purposes of determining, under 42 U.S.C. § 1395w-25(a)(2)(B), or any successor thereof, the date of receipt by the State of a substantially complete application, the date the Division receives the applicant's written response to the agency response or an earlier date considered by the Division shall be considered to be that date. The foregoing shall not limit the Division's authority to consider an application not substantially complete under subsection (c) of this section if the applicant's response to the response does not provide substantially the information specified in the response.

(e) A license shall be denied only after the Division complies with the requirements of G.S. 131E-305. (1998-227, s. 1.)

§ 131E-280. Applicants for license.

Each application for licensing as a provider sponsored organization authorized to do business in North Carolina shall be certified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Division, and shall be set forth or be accompanied by the following:

- (1) A copy of the basic organizational document, if any, of the applicant and each sponsoring organization that holds greater than a five percent (5%) interest in the PSO, such as the articles of incorporation, articles of

organization, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

- (2) A copy of the respective bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant and each sponsoring provider which holds greater than a five percent (5%) interest in the PSO;
- (3) Copies of the document evidencing the arrangements between the applicant and each sponsoring provider that create the relationships and obligations described in G.S. 131E-276(1);
- (4) A list of the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant and of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO, respectively, including all members of the respective boards of directors, boards of trustees, executive committees, or other governing boards or committees, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;
- (5) A copy of any contract form made or to be made between any class of providers and the PSO and a copy of any contract form made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision (3) of this subsection and the PSO;
- (6) A statement generally describing the provider sponsored organization, its sponsoring providers, its health care plan or plans, facilities, and personnel and certifying that its medical director or other person charged with determining and overseeing the PSO's medical policies is a medical doctor holding an unrestricted license to practice medicine under Article 1 of Chapter 90 of the General Statutes;
- (7) A copy of the hospital license of each sponsoring provider that is a hospital, a copy of the license to practice medicine of each sponsoring provider or owner of a sponsoring provider that is a licensed physician, and a copy of the health care service or facility license held by any other licensed sponsoring provider;
- (8) Financial statements showing the applicant's assets, liabilities, sources of financial support, and the financial statements of each sponsoring provider that holds greater than a five percent (5%) interest in the PSO showing the sponsoring provider's assets, liabilities, and sources of support. If the applicant's or any such sponsoring provider's financial affairs are audited by independent certified public accountants, a copy of the applicant's or sponsoring provider's most recent regular certified financial statement shall be considered to satisfy this requirement unless the Division directs that additional or more recent financial information is required for the proper administration of this Article;
- (9) If the applicant's obligations under G.S. 131E-282, 131E-283, 131E-297, 131E-298, and 131E-299 are guaranteed by one or more guarantors:

- a. Documentation that each guarantor meets the following requirements:
 1. The guarantor is a legal entity authorized to conduct business in North Carolina.
 2. The guarantor is not under federal bankruptcy or State receivership or rehabilitation proceedings.
 3. The guarantor has a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the PSO's guarantee.
 - b. Financial statements showing each guarantor's assets, liabilities, and source of financial support.
 - c. If a guarantor's financial affairs are audited by independent certified public accountants, a copy of the guarantor's most recent regular audited financial statement shall be considered to satisfy this requirement unless the Division directs that additional or more recent financial information is required for the proper administration of this Article.
 - d. The guarantee document, including a statement of the financial obligation covered by the guarantee, an agreement to unconditionally fulfill the financial obligations covered by the guarantee, an agreement not to subordinate the guarantee to any other claim on the resources of the guarantor and a declaration that the guarantor must act on a timely basis to satisfy the financial obligations covered by the guarantee.
- (10) A financial plan, satisfactory to the Division, covering the first 12 months of operation under the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the financial plan projects losses, the financial plan must cover the period through 12 months beyond the projected breakeven;
 - (11) A statement reasonably describing the geographic area or areas to be served;
 - (12) A description of the procedures to be implemented to meet the protection against insolvency requirements of G.S. 131E-298; and
 - (13) Any other information the Division may require to make the determinations required in G.S. 131E-282. (1998-227, s. 1.)

§ 131E-281. Additional information.

- (a) In addition to the information filed under G.S. 131E-280, each application shall include a description of the following:
 - (1) The program to be used to evaluate whether the applicant's network of sponsoring providers and contracted providers is sufficient, in numbers and types of providers, to assure that all health care services will be accessible without unreasonable delay;
 - (2) The program used to evaluate whether the sponsoring providers provide a substantial portion of services under each Medicare contract of the PSO;
 - (3) The program to be used for verifying provider credentials;

- (4) The utilization review program for the review and control of health care services provided or paid for by the applicant;
- (5) The quality management program to assure quality of care and health care services managed and provided through the health care plan; and
- (6) The applicant's network of sponsoring providers and contracted providers and evidence of the ability of that network to provide all health care services other than out-of-network services and emergency services to the applicant's prospective beneficiaries.

(b) The Division may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items it deems unnecessary. (1998-227, s. 1.)

§ 131E-282. Issuance of license.

(a) Before issuing a PSO license, the Division may make an examination or investigation as it deems expedient. The Division shall issue a license after receipt of a substantially complete application and upon satisfaction of the following requirements:

- (1) The applicant is duly organized as a provider sponsored organization as defined by this Article.
- (2) The PSO has initially a minimum net worth of one million five hundred thousand dollars (\$1,500,000). In the event the PSO submits a financial plan that demonstrates that the PSO does not have to create but has or has available to it an administrative infrastructure that shall reduce the PSO's start-up costs, the Division may lower the initial minimum net worth required to one million dollars (\$1,000,000) or to any lower amount as determined by the Division if the PSO operates primarily in rural areas.
- (3) The PSO shall have at least seven hundred fifty thousand dollars (\$750,000) in cash or equivalents on its balance sheet, except that the Division may permit a PSO operating primarily in rural areas to have a lesser amount held in cash or equivalents on its balance sheets.
- (4) The applicant submits a financial plan satisfactory to the Division which covers the first 12 months of operation of the PSO's Medicare contract and which meets the requirements of G.S. 131E-283. If the plan projects losses, the financial plan shall cover the period through 12 months beyond projected breakeven.
- (5) The Division determines that the applicant has sufficient cash flow to meet its obligations as they become due. In making that determination, the Division shall consider the following:
 - a. The timeliness of payment;
 - b. The extent to which the current ratio is maintained at one-to-one, or whether there is a change in the current ratio over a period of time; and
 - c. The availability of outside financial resources.

(b) In calculating the net worth of a PSO, the Division shall admit the following:

- (1) One hundred percent (100%) of the book value of health care delivery assets on the balance sheet of the applicant.
- (2) One hundred percent (100%) of the value of cash and cash equivalents on the balance sheet of the applicant.
- (3) If at least one million dollars (\$1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents, then one hundred percent (100%) of the book value of the PSO's intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than one million dollars (\$1,000,000) of the initial minimum net worth requirement is met by cash or cash equivalents or if the Division has used its discretion to reduce the initial net worth requirement below one million five hundred thousand dollars (\$1,500,000), then the Division shall admit one hundred percent (100%) of the book value of intangible assets of the PSO up to ten percent (10%) of the minimum net worth amount required.
- (4) Standard accounting principles treatment shall be given to other assets of the PSO not used in the delivery of health care for the purposes of meeting the minimum net worth requirement.
- (5) Deferred acquisition costs shall not be admitted. (1998-227, s. 1.)

§ 131E-283. Financial plan.

- (a) The financial plan shall include the following:
 - (1) A detailed marketing plan;
 - (2) Statements of revenue and expense on an accrual basis;
 - (3) Cash flow statements;
 - (4) Balance sheets; and
 - (5) The assumptions and justifications in support of the financial plan.
- (b) In the financial plan, the PSO shall demonstrate that it has the resources available to meet the projected losses for the entire period to break even. Except for the use of guaranties as provided in subsection (c) of this section, letters of credit as provided in subsection (e) of this section, and other means as provided in subsection (f) of this section, the resources must be assets on the balance sheet of the PSO in a form that is either cash or convertible to cash in a timely manner, pursuant to the financial plan.
- (c) Guaranties shall be acceptable as a resource to meet projected losses, under the following conditions:
 - (1) For the first year of the PSO's operation of the PSO's Medicare contract, the guarantor must provide the PSO with cash or cash equivalents to fund the projected losses, as follows:
 - a. Prior to the beginning of the first quarter, in the amount of the projected losses for the first two quarters;
 - b. Prior to the beginning of the second quarter, in the amount of the projected losses through the end of the third quarter; and

- c. Prior to the beginning of the third quarter, in the amount of the projected losses through the end of the fourth quarter.
- (2) If the guarantor provides the cash or cash equivalents to the PSO in a timely manner on the above schedule, this funding shall be considered in compliance with the guarantor's commitment to the PSO. In the third quarter, the PSO shall notify the Division if the PSO intends to reduce the period of funding of projected losses. The Division shall notify the PSO within 60 days of receiving the PSO's notice if the reduction is not acceptable.
- (3) If the above guaranty requirements are not met, the Division may take appropriate action, such as requiring funding of projected losses through means other than a guaranty. The Division retains discretion which shall be reasonably exercised to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.
- (d) The Division may modify the conditions in subsection (c) of this section in order to clarify the acceptability of guaranty arrangements.
- (e) An irrevocable, clean, unconditional letter of credit may be used as an acceptable resource to fund projected losses in place of cash or cash equivalents if satisfactory to the Division.
- (f) If approved by the Division, based on appropriate standards promulgated by the Division, PSOs may use the following to fund projected losses for periods after the first year: lines of credit from regulated financial institutions, legally binding agreements for capital contributions, or other legally binding contracts of a similar level of reliability.
- (g) The exceptions in subsections (c), (e), and (f) of this section may be used in an appropriate combination or sequence. (1998-227, s. 1.)

§ 131E-284. Modifications.

(a) A provider sponsored organization shall file a notice describing any significant change in the information required by the Division under G.S. 131E-280. Such notice shall be filed with the Division prior to the change. If the Division does not disapprove within 90 days after the filing, this modification shall be considered approved. Changes subject to the terms of this section include expansion of service area, addition or deletion of sponsoring providers, changes in provider contract forms, and group contract forms when the distribution of risk is significantly changed, and any other changes that the Division describes in properly adopted rules. Every PSO shall report to the Division for the Division's information material changes in the network of sponsoring providers and affiliated providers of services to beneficiaries enrolled with the PSO, the addition or deletion of any Medicare contracts of the PSO or any other information the Division may require. This information shall be filed with the Division within 15 days after implementation of the reported changes. Every PSO shall file with the Division all subsequent changes in the information or forms that are required by this Article to be filed with the Division.

(b) The Division may adopt rules exempting from the filing requirements of subsection (a) of this section those items it considers unnecessary. (1998-227, s. 1.)

§ 131E-285. Deposits.

(a) At the time of application, the Division shall require a deposit of one hundred thousand dollars (\$100,000) in cash or securities or a combination thereof for all provider sponsored organizations. The deposits shall be included in the calculations of a PSO's or applicant's net worth.

(b) All deposits required by this section shall be restricted to use in the event of insolvency to help assume continuation of services or pay costs associated with receivership or liquidation. (1998-227, s. 1.)

§ 131E-286. Ongoing financial standards – Net worth.

(a) Beginning the first day of operation of the PSO and except as otherwise provided in subsection (d) of this section, every PSO shall maintain a minimum net worth equal to the greatest of the following amounts:

- (1) One million dollars (\$1,000,000);
- (2) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Division on the first one hundred fifty million dollars (\$150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of one hundred fifty million dollars (\$150,000,000);
- (3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the Division;
- (4) An amount equal to the sum of:
 - a. Eight percent (8%) of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers as reported on the most recent financial statement filed with the Division; and
 - b. Four percent (4%) of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and
 - c. Zero percent (0%) of annual health care expenditures paid on a capitated basis to affiliated providers regardless of downstream arrangements from the affiliated provider.

(b) In calculating net worth, liabilities shall not include fully subordinated debt or subordinated liabilities. For purposes of this provision, subordinated liabilities are claims liabilities otherwise due to providers that are retained by the PSO to meet net worth requirements and are fully subordinated to all creditors.

(c) In calculating net worth for purposes of this section, the items described in G.S. 131E-282(b) shall be admitted, except as follows:

- (1) For intangible assets, if at least the greater of one million dollars (\$1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Division

shall admit the book value of intangible assets up to twenty percent (20%) of the minimum net worth amount required. If less than the greater of one million dollars (\$1,000,000) or sixty-seven percent (67%) of the ongoing minimum net worth requirement is met by cash or cash equivalents, then the Division shall admit the book value of intangible assets up to ten percent (10%) of the minimum net worth amount required; and

(2) Deferred acquisition costs shall not be admitted.

(d) The Division may lower the minimum ongoing net worth threshold, and the amount held in cash or cash equivalents for PSOs that operate primarily in rural areas.

(e) During the start-up phase of the PSO, the pre-break-even financial plan requirements shall apply. After the point of breakeven, the financial plan requirement shall address cash needs and the financing required for the next three years.

(f) If a PSO, or the legal entity of which the PSO is a component, did not earn a net operating surplus during the most recent fiscal year, the PSO shall submit a financial plan, satisfactory to the Division, meeting all of the requirements established for the initial financial plan. (1998-227, s. 1.)

§ 131E-287. PSO Reporting.

(a) The PSO shall file with the Division financial information relating to PSO solvency standards described in this Article, according to the following schedule:

(1) On a quarterly basis until breakeven; and

(2) On an annual basis after breakeven, if the PSO has a net operating surplus;
or

(3) On a quarterly or monthly basis, as specified by the Division, after breakeven, if the PSO does not have a net operating surplus.

(b) To the extent not preempted by federal law or otherwise mandated by the Medicare program, the PSO shall annually, on or before the first day of March of each year, file with the Division the following information for the previous calendar year:

(1) The number of and reasons for grievances and complaints received from Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract regarding medical treatment. The report shall include the number of covered lives, total number of grievances categorized by reason for the grievance, the number of grievances referred to the second level grievance review, the number of grievances resolved at each level and their resolution, and a description of the actions that are being taken to correct the problems that have been identified through grievances received. Every PSO shall file with the Division, as part of its annual grievance report, a certificate of compliance stating that the PSO has established and follows, for its Medicare contract, grievance procedures that comply with this Article.

(2) The number of Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract who terminated their enrollment with the PSO for any reason.

- (3) The number of provider contracts between the PSO and network providers for the provision of covered services to Medicare beneficiaries that were terminated and reasons for termination. This information shall include the number of providers leaving the PSO network and the number of new providers in the network. The report shall show voluntary and involuntary terminations separately.
- (4) Data relating to the utilization, quality, availability, and accessibility of service. The report shall include the following:
 - a. Information on the PSO's program to determine the level of network availability, as measured by the numbers and types of network providers, required to provide covered services to covered persons. This information shall include the PSO's methodology under its Medicare+Choice program for:
 - 1. Establishing performance targets for the numbers and types of providers by specialty, area of practice, or facility type, for each of the following categories: primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities.
 - 2. Determining when changes in PSO Medicare+Choice program enrollees will necessitate changes in the provider network.

The report shall also include: the availability performance targets for the previous and current years; the numbers and types of providers currently participating in the PSO's provider network; and an evaluation of actual plan performance against performance targets.

- b. The PSO's method for arranging or providing health care services from nonnetwork providers, both within and outside of its service area, when network providers are not available to provide covered services.
- c. Information on the PSO's program under its Medicare+Choice program to determine the level of provider network accessibility necessary to serve its Medicare enrollees. This information shall include the PSO's methodology for establishing performance targets for member access to covered services from primary care physicians, specialty care physicians, nonphysician health care providers, hospitals, and nonhospital health care facilities. The methodology shall establish targets for:
 - 1. The proximity of network providers to members, as measured by member driving distance, to access primary care, specialty care, hospital-based services, and services of nonhospital facilities.
 - 2. Expected waiting time for appointments for urgent care, acute care, specialty care, and routine services for prevention and wellness.

The report shall also include: the accessibility performance targets for the previous and current years; data on actual overall accessibility as measured by driving distance and average appointment waiting time; and an evaluation of actual Medicare+Choice plan performance against performance targets. Measures of actual accessibility may be developed using scientifically valid random sample techniques.

- d. A statement of the PSO's methods and standards for determining whether in-network services are reasonably available and accessible to a Medicare enrollee for the purpose of determining whether such enrollee should receive the in-network level of coverage for services received from a nonnetwork provider.
 - e. A description of the PSO's program to monitor the adequacy of its network availability and accessibility methodologies and performance targets, Medicare+Choice plan performance, and network provider performance.
 - f. A summary of the PSO's utilization review program activities for the previous calendar year under its Medicare+Choice program. The report shall include the number of: each type of utilization review performed, noncertifications for each type of review, each type of review appealed, and appeals settled in favor of Medicare enrollees. The report shall be accompanied by a certification from the carrier that it has established and follows procedures that comply with this Article.
- (5) Aggregate financial compensation data, including the percentage of providers paid under a capitation arrangement, discounted fee-for-service or salary, the services included in the capitation payment, and the range of compensation paid by withhold or incentive payments. This information shall be submitted on a form prescribed by the Division.

The name, or group or institutional name, of an individual provider may not be disclosed pursuant to this subsection. No civil liability shall arise from compliance with the provisions of this subsection, provided that the acts or omissions are made in good faith and do not constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing.

(c) Disclosure Requirements. – To the extent not otherwise prohibited by federal law or under the terms of the PSO's Medicare contract, each PSO shall provide the following applicable information to Medicare beneficiaries enrolled with the PSO under the PSO's Medicare contract and bona fide prospective enrollees upon request:

- (1) The evidence of coverage under the Medicare+Choice plan provided by the PSO to Medicare beneficiaries under the terms of the PSO's Medicare contract;
- (2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective enrollee. This explanation shall be in writing if so requested;
- (3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;

- (4) The plan's restrictive formularies or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary, and the circumstances under which a nonformulary drug may be covered; and
 - (5) The procedures and medically based criteria under the PSO's Medicare contract for determining whether a specified procedure, test, or treatment is experimental.
- (d) Effective January 1, 1999, PSOs shall make the reports that are required under subsection (b) of this section and that have been filed with the Division available on their business premises and shall provide any Medicare beneficiary enrolled with the PSO access to them upon request, unless otherwise prohibited by federal law or under the terms of the PSO's Medicare contract.
- (e) Every PSO licensed under this Article shall annually on or before the first day of March of each year, file with the Division a sworn statement verified by at least two of the principal officers of the PSO showing its condition on the thirty-first day of December, then next preceding; which shall be in such form as the Division shall prescribe. In case the PSO fails to file the annual statement as herein required, the Division is authorized to suspend the license issued to the PSO until the statement shall be properly filed.
- (f) A PSO shall report to the Division the efforts it has undertaken to foster measurable improvements in the health status of the community's Medicare population, increase access to health care for noncovered benefits, and address critical health care needs of the community's Medicare population. (1998-227, s. 1.)

§ 131E-288. Liquidity.

- (a) Each PSO shall have sufficient cash flow to meet its obligations as they become due. In determining the ability of a PSO to meet this requirement, the Division shall consider the following:
- (1) The timeliness of payment;
 - (2) The extent to which the current ratio is maintained at one-to-one or whether there is a change in the current ratio over a period of time; and
 - (3) The availability of outside financial resources.
- (b) The following corresponding remedies apply:
- (1) If the PSO fails to pay obligations as they become due, the Division shall require the PSO to initiate corrective action to pay all overdue obligations.
 - (2) The Division may require the PSO to initiate corrective action if either of the following is evident: (i) the current ratio declines significantly; or (ii) there is a continued downward trend in the current ratio. The corrective action may include a change in the distribution of assets, a reduction of liabilities, or alternative arrangements to secure additional funding requirements to restore the current ratio to one-to-one.

- (3) If there is a change in the availability of the outside resources, the Division shall require the PSO to obtain funding from alternative financial resources.

(c) Nothing in the foregoing liquidity requirements shall be interpreted to require the PSO to maintain a current ratio of one-to-one if the PSO can demonstrate to the Division that it is able to pay its obligations as they become due and the current ratio maintained by the PSO has neither declined significantly nor is on a continued downward trend. (1998-227, s. 1.)

§ 131E-289. Minimum of net worth that must be in cash or cash equivalents.

(a) Except as otherwise provided in subsection (b) of this section, each PSO shall, on an ongoing basis, maintain a minimum net worth in cash or cash equivalents of the greater of:

- (1) Seven hundred fifty thousand dollars (\$750,000) cash or cash equivalents; or
- (2) Forty percent (40%) of the minimum net worth required.

(b) The Division may lower the threshold for minimum net worth held in cash or cash equivalents by PSOs that operate primarily in rural areas.

(c) Cash or cash equivalents held to meet the net worth requirement shall be current assets of the PSO. (1998-227, s. 1.)

§ 131E-290. Prohibited practice.

(a) No provider sponsored organization or sponsoring provider, unless licensed as an insurer under Chapter 58 of the General Statutes may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

(b) No provider sponsored organization or sponsoring provider shall engage in any activity or conduct which is prohibited by the terms of the PSO's Medicare contract.

(c) Unless otherwise preempted by federal law or mandated by the Medicare program, a PSO shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of that license or certification. This subsection does not preclude a PSO from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization. (1998-227, s. 1.)

§ 131E-291. Collaboration with local health departments.

A provider sponsored organization and a local health department shall collaborate and cooperate within available resources regarding health promotion and disease prevention efforts that are necessary to protect the public health. (1998-227, s. 1.)

§ 131E-292. Coverage.

(a) Provider sponsored organizations subject to this Article shall provide coverage for the medically appropriate and necessary services specified under the PSO's Medicare contract.

(b) In the event a PSO's Medicare contract or federal law, regulations, or rules governing coverage by the PSO of items or services to Medicare beneficiaries permits a PSO, sponsoring provider, or participating provider to object on moral or religious grounds to providing an item or service to Medicare beneficiaries, it is the policy of this State to permit this objection and allow the participating provider to refuse to provide the item or service. (1998-227, s. 1.)

§ 131E-293. Rates.

Rates charged by provider sponsored organizations to the Medicare program and charges by PSOs and sponsoring providers for items or services to beneficiaries shall be governed by the terms of the PSO's Medicare contract. (1998-227, s. 1.)

§ 131E-294. Additional consumer protection and quality standards.

Unless otherwise preempted by federal law or mandated by the Medicare program, the Division shall apply to provider sponsored organizations the same standards and requirements that the Department of Insurance applies to health maintenance organizations under Chapter 58 of the General Statutes with respect to the following consumer protection and quality matters:

- (1) Quality management programs (11 NCAC 20.0500, et seq.);
- (2) Utilization review procedures (G.S. 58-67-61 and G.S. 58-67-62);
- (3) Unfair or deceptive trade practices (Article 63 of Chapter 58 of the General Statutes);
- (4) Antidiscrimination (G.S. 58-3-25(b) and (c), 58-3-120, 58-63-15(7), and 58-67-75);
- (5) Provider accessibility and availability (11 NCAC 20.0300, et seq.);
- (6) Network provider credentialing (11 NCAC 20.0400, et seq.); and
- (7) Data reporting requirements under G.S. 58-67-50(e). (1998-227, s. 1.)

§ 131E-295. Powers of insurers and medical service corporations.

Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Articles 1 through 67 of Chapter 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a provider sponsored organization to provide insurance or similar protection against the cost of care provided through provider sponsored organizations and their sponsoring providers to beneficiaries and to provide coverage in the event of the failure of the provider sponsored organization or its sponsoring providers to meet its obligations under the PSO's Medicare contract. The beneficiaries of a provider sponsored organization constitute a permissible group under these laws. Among other things, under these contracts, the insurer or hospital or medical service corporation may make benefit payments to provider sponsored

organizations for health care services rendered by providers pursuant to the health care plan. (1998-227, s. 1.)

§ 131E-296. Examinations.

The Division may make an examination of the affairs of any provider sponsored organization and the contracts, agreements, or other arrangements pursuant to its health care plan as often as the Division considers necessary for the protection of the interests of the people of this State but not less frequently than once every three years. (1998-227, s. 1.)

§ 131E-297. Hazardous financial condition.

(a) Whenever the financial condition of any provider sponsored organization indicates a condition such that the continued operation of the provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, then the Division may order the provider sponsored organization to take any action that may be reasonably necessary to rectify the existing condition, including one or more of the following steps:

- (1) To reduce the total amount of present and potential liability for benefits by reinsurance;
- (2) To reduce the volume of new business being accepted;
- (3) To reduce the expenses by specified methods;
- (4) To suspend or limit the writing of new business for a period of time;
- (5) To require an increase to the provider sponsored organization's net worth by contribution;
- (6) To add or delete sponsoring providers;
- (7) To increase the amount of payments from the PSO which sponsoring providers agree to forego; or
- (8) To require additional guaranties from sponsoring providers or from parents of sponsoring providers.

(b) If the Division determines that the standards in G.S. 131E-286, 131E-288, and 131E-289 do not provide sufficient early warning that the continued operation of any provider sponsored organization might be hazardous to its beneficiaries, creditors, or the general public, the Division may adopt rules to set uniform standards and criteria for such an early warning and to set standards for evaluating the financial condition of any provider sponsored organization, which standards shall be consistent with the purposes expressed in subsection (a) of this section. (1998-227, s. 1.)

§ 131E-298. Protection against insolvency.

(a) The Division shall require deposits in accordance with the provisions of G.S. 131E-285.

(b) If a provider sponsored organization fails to comply with the net worth requirements of G.S. 131E-286, the Division may take appropriate action to assure that the

continued operation of the provider sponsored organization will not be hazardous to the beneficiaries enrolled with the PSO.

(c) Every provider sponsored organization shall have and maintain at all times an adequate plan for protection against insolvency acceptable to the Division. In determining the adequacy of such a plan, the Division shall consider:

- (1) A reinsurance agreement preapproved by the Division covering excess loss, stop-loss, or catastrophies. The agreement shall provide that the Division will be notified no less than 60 days prior to cancellation or reduction of coverage;
- (2) A conversion policy or policies that will be offered by an insurer to the beneficiaries in the event of the provider sponsored organization's insolvency;
- (3) Legally binding unconditional guaranties by adequately capitalized sponsoring provider or adequately capitalized sponsoring corporations of sponsoring providers;
- (4) Legally binding obligations of sponsoring providers to forego payment for items or services provided by the sponsoring provider in order to avoid the financial insolvency of the PSO;
- (5) Legally binding obligations of sponsoring providers or parents of sponsoring providers to make capital infusions to the PSO; and
- (6) Any other arrangements offering protection against insolvency that the Division may require. (1998-227, s. 1.)

§ 131E-299. Hold harmless agreements or special deposit.

(a) Unless the PSO maintains a special deposit in accordance with subsection (b) of this section, each contract between every PSO and a participating provider of health care services shall be in writing and shall set forth that in the event the PSO fails to pay for health care services as set forth in the contract, the Medicare subscriber or beneficiary shall not be liable to the provider for any sums owed by the PSO. No other provisions of these contracts shall, under any circumstances, change the effect of this provision. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against a subscriber or beneficiary to collect sums owed by the PSO.

(b) In the event that the participating provider contract has not been reduced to writing or that the contract fails to contain the required prohibition, the PSO shall maintain a special deposit in cash or cash equivalent as follows:

- (1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures the PSO shall either:
 - a. Place an uncovered expenditures insolvency deposit with the Division, or with any organization or trustee acceptable to the Division through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Division. This deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the PSO's outstanding liability for uncovered expenditures for

enrollees, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a PSO is not otherwise required to file a quarterly report, it shall file a report within 45 days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section; or

- b. Maintain adequate insurance or a guaranty arrangement approved in writing by the Division, to pay for any loss to beneficiaries claiming reimbursement due to the insolvency of the PSO. The Division shall approve a guaranty arrangement if the guarantying organization is a sponsoring provider, has been operating for at least 10 years, and has a net worth, including organization-related land, buildings, and equipment of at least fifty million dollars (\$50,000,000), unless the Division finds that the approval of this guaranty may be financially hazardous to beneficiaries.
- (2) The deposit required under sub-subdivision a. of subdivision (1) of this subsection is an admitted asset of the PSO in the determination of net worth. All income from these deposits or trust accounts shall be assets of the PSO and may be withdrawn from the deposit or account quarterly with the approval of the Division;
 - (3) A PSO that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this subsection is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the Division;
 - (4) The deposit required under sub-subdivision a. of subdivision (1) of this section is in trust and may be used only as provided under this section. The Division may use the deposit of an insolvent PSO for administrative costs associated with administering the deposit and payment of claims of enrollees of the PSO.

(c) Whenever the reimbursements described in this section exceed ten percent (10%) of the PSO's total costs for health care services over the immediately preceding six months, the PSO shall file a written report with the Division containing the information necessary to determine compliance with sub-subdivision a. of subdivision (1) of subsection (b) of this section no later than 30 business days from the first day of the month. Upon an adequate showing by the PSO that the requirements of this section should be waived or reduced, the Division may waive or reduce these requirements to an amount it deems sufficient to protect beneficiaries of the PSO consistent with the intent and purpose of this Article. (1998-227, s. 1.)

§ 131E-300. Continuation of benefits.

The Division shall require that each PSO have a plan for handling insolvency, which plan allows for continuation of benefits for the duration of the contract period for which

premiums have been paid and continuation of benefits to beneficiaries who are confined in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Division may require:

- (1) Insurance to cover the expenses to be paid for benefits after an insolvency;
- (2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the PSO's insolvency for which premium payment has been made and until the beneficiaries' discharge from inpatient facilities;
- (3) Insolvency reserves as the Division may require;
- (4) Letters of credit acceptable to the Division;
- (5) Additional guaranties from a sponsoring provider of the PSO or from the parent of a sponsoring provider;
- (6) Legally binding obligations of sponsoring providers to forego payment from the PSO for services provided to beneficiaries in order to avoid the insolvency of the PSO; and
- (7) Any other arrangements to assure that benefits are continued as specified. (1998-227, s. 1.)

§ 131E-301. Insolvency.

(a) In the event of an insolvency of a PSO upon order of the Division, all providers that were sponsoring providers of the PSO within the previous 12 months from the order of the Division shall, for 30 days after the order, offer all beneficiaries enrolled with the insolvent PSO, covered services without charge other than for any applicable co-payments, deductibles, or coinsurance permitted to be charged to beneficiaries under the PSO's Medicare contract.

(b) If the Division determines that the sponsoring providers lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the beneficiaries of the insolvent PSO, then, in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Division shall allocate the insolvent PSO's contracts for these groups among all other PSOs that operate within a portion of the insolvent PSO's service area, taking into consideration the health care delivery resources of each PSO. Each PSO to which beneficiaries are so allocated by the Division shall offer such group or groups that PSO's existing coverage that is most similar to each beneficiary's coverage with the insolvent PSO at rates determined in accordance with the successor PSO's existing rating methodology.

(c) Taking into consideration the health care delivery resources of each such PSO, then in the event the Health Care Financing Administration of the United States Department of Health and Human Services fails to make such allocations in a timely manner, the Division shall also allocate among all PSOs that operate within a portion of the insolvent PSO's service area the insolvent PSO's beneficiaries who are unable to obtain other coverage. Each PSO to which beneficiaries are so allocated by the Division shall

offer such beneficiaries that PSO's existing coverage for individual or conversion coverage as determined by the beneficiary's type of coverage in the insolvent PSO at rates determined in accordance with the successor PSO's Medicare contract. (1998-227, s. 1.)

§ 131E-302. Replacement coverage.

(a) Any carrier providing replacement coverage with respect to hospital, medical, or surgical expense or service benefits, within a period of 60 days from the date of discontinuance of a prior PSO contract or policy providing these hospital, medical, or surgical expense or service benefits, shall immediately cover all beneficiaries who were validly covered under the previous PSO contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to hospital confinement or pregnancy.

(b) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preceded the effective date of the succeeding carrier's contract shall be applied with respect to those beneficiaries validly covered under the prior carrier's contract on the date of discontinuance. (1998-227, s. 1.)

§ 131E-303. Incurred but not reported claims.

(a) Every PSO shall, when determining liability, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which such PSO is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

(b) These liabilities shall be computed in accordance with rules adopted by the Division upon reasonable consideration of the ascertained experience and character of the PSO. (1998-227, s. 1.)

§ 131E-304. Suspension or revocation of license.

(a) The Division may suspend, revoke, or refuse to renew a PSO license if the Division finds that the PSO:

- (1) Is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 131E-280, unless amendments to these submissions have been filed with and approved by the Division;
- (2) Issues evidences of coverage or uses a schedule of premiums for health care services that do not comply with Medicare or Medicaid program requirements as applicable;
- (3) No longer maintains the financial reserve specified in G.S. 131E-286 or is no longer financially responsible and may reasonably be expected to

be unable to meet its obligations to beneficiaries or prospective beneficiaries;

- (4) Knowingly or repeatedly fails or refuses to comply with any law or rule applicable to the PSO or with any order issued by the Division after notice and opportunity for a hearing;
- (5) Has knowingly made to the Division any false statement or report;
- (6) Has sponsoring providers that fail to provide a substantial proportion of the services under any health plan during any 12-month period;
- (7) Has itself or through any person on its behalf advertised or merchandised its items or services in an untrue, misrepresentative, misleading, or unfair manner;
- (8) If continuing to operate would be hazardous to beneficiaries; or
- (9) Has otherwise substantially failed to comply with this Article.

(b) A license shall be suspended or revoked only after compliance with G.S. 131E-305.

(c) When a PSO license is suspended, the PSO shall not, during the suspension, enroll any additional beneficiaries and shall not engage in any advertising or solicitation.

(d) When a PSO license is revoked, the PSO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the PSO. The PSO shall engage in no advertising or solicitation. The Division may, by written order, permit any further operation of the PSO that the Division may find to be in the best interest of beneficiaries, to the end that beneficiaries will be afforded the greatest practical opportunity to obtain continuing health care coverage. (1998-227, s. 1.)

§ 131E-305. Administrative procedures.

(a) When the Division has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, it shall notify the provider sponsored organization in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) After this hearing, or upon the failure of the provider sponsored organization to appear at this hearing, the Division shall take the action it considers advisable or make written findings that shall be mailed to the provider sponsored organization. The action of the Division shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Division in whole or in part.

(c) The provisions of Chapter 150B of the General Statutes apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b) of this section. (1998-227, s. 1.)

§ 131E-306. Expired.

§ 131E-307. Penalties and enforcement.

(a) The provisions of G.S. 58-2-70, modified to replace the word "Commissioner" by the word "Division", applies to this Article. The Division may, in addition to or in lieu of suspending or revoking a license under G.S. 131E-304, proceed under G.S. 58-2-70, as so modified, provided that the provider sponsored organization has a reasonable time within which to remedy the defect in its operations that gave rise to the procedure under G.S. 58-2-70.

(b) Any person who violates this Article shall be guilty of a Class 1 misdemeanor.

(c) If the Division shall for any reason have cause to believe that any violation of this Article has occurred or is threatened, the Division may give notice to the provider sponsored organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Division may deem appropriate under the circumstances.

(d) The Division may issue an order directing a provider sponsored organization or a representative of a provider sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this Article.

Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Article have occurred. These hearings shall be conducted pursuant to Chapter 150B of the General Statutes, and judicial review shall be available as provided by this Chapter.

(e) In the case of any violation of the provisions of this Article, if the Division elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the Division may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County. (1998-227, s. 1.)

§ 131E-308. Statutory construction and relationship to other laws.

(a) Except as otherwise provided in this Article, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any provider sponsored organization granted a license under this Article or to its sponsoring providers when operating under such a license. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its provider sponsored organization activities authorized and regulated pursuant to this Article.

(b) Solicitation of beneficiaries by a provider sponsored organization granted a license, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals or health care providers.

(c) Any provider sponsored organization licensed under this Article shall not be considered to be a provider of medicine and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine: provided, however, that this exemption does not apply to individual providers under contract with or employed by the provider sponsored organization or sponsoring providers or to the sponsoring providers.

(d) Except as otherwise limited by this Article, a PSO may organize in the same manner and may exercise the same prerogatives, powers, and privileges as other entities that are organized and existing under the same laws as the PSO. (1998-227, s. 1.)

§ 131E-309. Filings and reports as public documents.

Except for information that constitutes a bona fide trade secret, proprietary information or competitively sensitive information of a sponsoring provider or parent of a sponsoring provider, all applications, filings, and reports required under this Article shall be treated as public documents. (1998-227, s. 1.)

§ 131E-310. Confidentiality of medical information.

Any data or information pertaining to the diagnosis, treatment, or health of any beneficiary or applicant obtained from the person or from any provider by any provider sponsored organization or by any provider acting pursuant to its provider contract with a provider sponsored organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Article; or upon the express consent of the beneficiary or applicant; or pursuant to statute; or pursuant to court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the provider sponsored organization wherein such data or information is pertinent. A provider sponsored organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the provider sponsored organization is entitled to claim. (1998-227, s. 1; 1999-272, s. 2.)

§ 131E-311. Conflicts; severability.

To the extent that the provisions of this Article may be in conflict with any other provision of this Chapter, the provisions of this Article shall prevail and apply with respect to provider sponsored organizations. Notwithstanding the absence of adopted rules, the Division shall continue to process applications for provider sponsored organization licenses as described in this Article. If any section, term, or provision of this Article shall be adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Article, but the remaining sections, terms, and provisions shall be and remain in full force and effect. (1998-227, s. 1.)

§ 131E-312. Regulations.

This Article shall be self-implementing. No later than six months after the date of enactment of this Article, the Division may adopt rules consistent with this Article to authorize and regulate provider sponsored organizations to contract directly with the federal Medicare program to provide health care services to the beneficiaries of such programs. The Division shall issue permanent rules and, may issue temporary rules, to the extent these rules may be necessary. The Division shall limit its regulation of provider sponsored organizations to the licensing and regulating of these organizations as risk-bearing entities contracting directly with the Medicare program and to the consumer protection and quality standards as provided in G.S. 131E-294 and shall not regulate any matters described in 42 U.S.C. § 1395W-26(b)(3), or any successor thereof. (1998-227, s. 1.)

§ 131E-313. Utilization review and grievances.

Unless otherwise preempted by federal law or mandated by the Medicare program, the provisions of G.S. 58-50-61 and G.S. 58-50-62 apply to a PSO licensed under this Article as if the PSO was an "insurer" under those sections, except that the Division rather than the Commissioner of Insurance shall regulate a PSO's compliance with those sections. (1998-227, s. 1.)

§ 131E-314. Division Reporting.

The Division of Health Benefits of the Department of Health and Human Services shall report quarterly to the Joint Legislative Oversight Committee on Health and Human Services on its regulatory activities in the enforcement of this Article and shall provide the Committee with a summary of nonconfidential information on the financial plans and operations of PSOs. The report to the Committee shall include a description and explanation of any regulations or regulatory interpretations that differ from Department of Insurance regulations applicable to HMOs. The report shall also include PSO efforts to improve community health status. The Division shall develop processes or methods to measure improvements in health outcomes for Medicare beneficiaries served by managed care organizations and shall report quarterly to the Joint Legislative Oversight Committee on Health and Human Services on the development of these standards. (1998-227, ss. 4, 5; 2011-291, s. 2.49; 2019-81, s. 15(a).)