No. 260PA22 TENTH DISTRICT

****

SUPREME COURT OF NORTH CAROLINA

****

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

Plaintiffs-Appellants,

v.

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

Defendants-Appellees.

From Wake County
No. COA21-558

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REPLY BRIEF FOR PLAINTIFFS-APPELLANTS

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INTRODUCTION

There are some choices the legislature can't make. Try as the State might to frame this case as an untouchable policy debate, the State's 88-page brief never really grapples with a basic truth: Some policies violate the Constitution. *See Trs. of UNC v. Foy*, 5 N.C. 58, 83 (1805) (noting the founding generation wanted "some rights secured to them, beyond the control of the Legislature, and these they have expressed in the bill of rights"). Laws that exceed the police power are not "law[s] of the land." Art. I, § 19. Laws that grant "exclusive or separate . . . privileges" or "monopolies" are invalid. Art. I, §§ 32, 34. This Court has a duty to say when the legislature has crossed these lines. *Corum v. UNC ex rel. Bd. of Govs.*, 330 N.C. 761, 783, 413 S.E.2d 276, 290 (1992). The separation of powers demands nothing less.

Of course, the merits of the CON law are not before the Court. One could easily miss that reading the State's brief, which implies that the entire CON law is on trial. But this is an as-applied challenge at the pleadings stage. Dr. Singleton is merely asking for a chance to prove his case on the merits. And, "unless it appears beyond doubt that [he] can prove no set of facts in support of [his] claim[s] which would entitle [him] to relief," *Intersal, Inc. v. Hamilton*, 373 N.C. 89, 98, 834 S.E.2d 404, 411 (2019) (cleaned up), he is entitled to that chance. The State fails to show otherwise. Dr. Singleton's constitutional claims are valid and he is not required to slog through the CON process before he can challenge the CON requirement.

First, the State's law of the land argument requires the Court to hold that Dr. Singleton's factual allegations are irrelevant. But they aren't. Economic laws must be "reasonably necessary" to protect the public. Dr. Singleton alleged that, as applied, the CON law does not protect—and in fact harms—real patients. At the pleadings stage, the Court must accept these allegations as true. The State's contrary arguments simply fight the posture of the case. And they reveal, not a respect for the separation of powers (as the State claims), but a desire to prevent this Court from playing its part in that separation. The Court should decline.

Second, at every turn, the State's privilege and monopoly arguments try to bring rational basis review into the analysis. But "the framers of these . . . clauses wanted them to mean *something*. As [two] redundant copies of federal due process doctrine, they do not." Richard Dietz, *Factories of Generic Constitutionalism*, 14 Elon L. Rev. 1, 35 (2022). Dr. Singleton is the only one who has offered a reading of these clauses that honor their unique text, history, and (correct) jurisprudence. That all leads to a simple point here: The legislature can't grant *exclusive rights* to provide *private services*—even if it thinks those privileges are a good idea. Because CarolinaEast holds an exclusive right to provide private operating room services, Dr. Singleton stated valid claims.

Third, in a final effort to shield the CON law from constitutional review, the State says Dr. Singleton was required to exhaust administrative remedies. He was not. Dr. Singleton alleges the CON *requirement* is unconstitutional. Forcing

him to beg DHHS to make a CON available, to apply for that hypothetical CON, and then to spend years and thousands of dollars battling with CarolinaEast for that CON is not a "remedy" for the CON requirement. Because exhaustion was not required and Dr. Singleton stated valid claims, the Court should reverse and give Dr. Singleton a chance to prove his claims on the merits.

ARGUMENT

I. The State's law of the land arguments fail.

The State desperately wants this case to be about whether the CON law's rationality was "debatable" "when the General Assembly first passed the law in 1978." State's Br. 61–62. So framed, Dr. Singleton's "detailed" allegations that forcing him to get a CON harms real patients are "irrelevant." State's Br. 47, 58, 61, 63. That is wrong. Much as the State would prefer a fact-free test,[1] the law of the land clause requires that economic laws be "reasonably necessary" to protect the public. Under that test, Dr. Singleton's allegations don't just matter. (Part A). At the pleading stage, they control. (Part B). The State, perhaps worried it will be unable to refute Dr. Singleton's evidence on the merits, stokes fear about judicial overreach. In truth, however, the State just wants a rule that condones *legislative* overreach. (Part C). North Carolinians deserve better.

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[1] The State is beating the same fact-free drum in *Kinsley v. Ace Speedway Racing, Ltd.*, No. 280PA22 (pending). *See* New Br. for Plaintiff-Appellant Secretary Kinsley, 2023 WL 3467853, at *31, *48–49, *51 (May 3, 2023).

A. Dr. Singleton's factual allegations matter.

The crux of the State's argument is that Dr. Singleton's factual allegations are "irrelevant" because economic laws need only be "debatable" when enacted. State's Br. 50, 56–57, 61–62. But the right to earn a living is "not so yielding." *State v. Harris*, 216 N.C. 746, 759, 6 S.E.2d 854, 863 (1940). In a challenge to an economic law, any "presumptions or burdens which may exist are satisfied *when the facts are laid bare to the Court* and the situation is found to be wanting in those conditions and those circumstances upon which alone . . . the police power must depend." *Id.* at 763, 6 S.E.2d at 866 (emphasis added).

That fact-based approach is firmly rooted in text, history, and "on-point" cases—the factors this Court uses to discern "the meaning of [a] constitutional provision." *Cmty. Success Initiative v. Moore*, 384 N.C. 194, 213, 886 S.E.2d 16, 33 (2023). The text forbids restraints on "liberty" that are not "law[s] of the land." Art. I, § 19. History shows that "liberty" includes the fundamental right to earn a living and that statutes beyond the valid scope of the police power are not "law[s] of the land." Singleton's Br. 12–20. And this Court's most on-point cases—the ones that honor text and history—apply a fact-based "reasonably necessary" test to hold that line. *Id.* at 20–27 (collecting cases).

The State largely ignores *Moore*. The State does not brief text. The State does not brief history. The State does not dispute that the right to earn a living is "fundamental." *King v. Town of Chapel Hill*, 367 N.C. 400, 408, 758 S.E.2d 364,

371 (2014) (citing *Roller v. Allen*, 245 N.C. 516, 518–19, 96 S.E.2d 851, 854 (1957)). The State merely points to a few cases that apply a fact-free test—one the Court of Appeals has called "insurmountable." *Treants Enters., Inc. v. Onslow County*, 83 N.C. App. 345, 356, 350 S.E.2d 365, 372 (1986), *aff'd*, 320 N.C. 776, 360 S.E.2d 783 (1987). Even if this Court could discern the right test without reference to text or history, though, the State's cases are not "on-point."

The State cites four main cases—*Rhyne v. K-Mart Corp.*, 358 N.C. 160, 594 S.E.2d 1 (2004), *Town of Beech Mountain v. County of Watauga*, 324 N.C. 409, 378 S.E.2d 780 (1989), *Powe v. Odell*, 312 N.C. 410, 322 S.E.2d 762 (1984), and *A-S-P Assocs. v. City of Raleigh*, 298 N.C. 207, 258 S.E.2d 444 (1979)—to support its fact-free test. State's Br. 57, 62, 64–65. But none of these involved the fundamental right to earn a living. Surely the State knows that a right's status—fundamental or otherwise—affects the degree of scrutiny this Court applies to secure that right. *Moore*, 384 N.C. at 230, 886 S.E.2d at 43. Surely the State knows that fundamental rights, and even quasi-fundamental rights, get fact-based review. Singleton's Br. 24. Yet the State never explains how its cases—which involved non-fundamental rights—justify departing from that rule here.

The State's cases are distinguishable in other ways too. *Rhyne* was a facial challenge to a punitive damages cap, where "evidence" showing "a low incidence of punitive damages awards" could not have proved—as the plaintiffs needed to—that the cap was irrational in *every* context. 358 N.C. at 165, 181–83, 594 S.E.2d at

16–17. But Dr. Singleton's as-applied challenge does not need to address every context; it turns on "the facts in [his] particular case." *State v. Grady*, 372 N.C. 509, 522, 831 S.E.2d 542, 554 (2019) (cite omitted).

Town of Beech Mountain and *Powe* resolved equal protection claims, which Dr. Singleton does not raise here and which hew more closely to federal law. *See Blankenship v. Bartlett*, 363 N.C. 518, 522, 681 S.E.2d 759, 762 (2009).

And the last case, *A-S-P*, directly undercuts the State's argument. There, the Court held that whether a historic overlay ordinance was "within the scope of the police power" turned on the "facts of the case." *A-S-P*, 298 N.C. at 214, 258 S.E.2d at 448–49. Accordingly, *A-S-P* was resolved at summary judgment after the parties "had an opportunity to and did submit evidentiary materials on all aspects of the case." *Id.* at 212, 258 S.E.2d at 448. If anything, then, *A-S-P* shows that Dr. Singleton deserves a chance to prove his case on the merits.

More on-point, though, are this Court's decisions applying a fact-based "reasonably necessary" test to protect the right to earn a living. Singleton's Br. 20–27 & n.5.

Start with the most on-point case the Court could hope for: *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 193 S.E.2d 729 (1973). There, the Court asked whether the prior CON law was "reasonably necessary" to promote public health. *Id.* at 550–51, 193 S.E.2d at 735 (citing *State v. Ballance*, 229 N.C. 764, 769, 51 S.E.2d 731, 735 (1949)). To answer that question, the Court looked to

"this record" (at least four times) and held that denying a safe hospital the right to serve patients because it was not "needed" had "no . . . reasonable relation" to "public health." *Aston Park*, 282 N.C. at 543, 547–51, 193 S.E.2d at 731–35.

The licensing cases are helpful too. *Contra* State's Br. 67–71. Those cases—decided on a full record—held that forcing dry cleaners, tilers, and photographers to get a license was not "reasonably necessary" to protect the public. *Roller*, 245 N.C. at 522–23, 96 S.E.2d at 856–57 (relying on "the record"); *Ballance*, 229 N.C. at 767–71, 51 S.E.2d at 733–36 (appeal from "trial"); *Harris*, 216 N.C. at 760, 6 S.E.2d at 863–64 (relying on "the record"). Dr. Singleton makes a similar point: Forcing a *licensed* physician to get a CON to use a *safe* facility "has nothing to do with protecting the health or safety of real patients." (R pp 10, 33, ¶¶ 3, 145).

There is even a case squarely rejecting the State's theory that—at least in as-applied challenges like this one—an economic law is forever constitutional if it was "debatable" when enacted. *See City of Winston-Salem v. S. Ry. Co.*, 248 N.C. 637, 105 S.E.2d 37 (1958). There, an ordinance would have required a railroad to rebuild a bridge. *Id.* at 639, 105 S.E.2d at 38. But the railroad offered "voluminous evidence" that the bridge was not "necessary by considerations of public safety" and was irrational in light of "changed economic conditions." *Id.* at 639–55, 105 S.E.2d at 38–50. The State would have dismissed the railroad's facts as "legally irrelevant," State's Br. 47, 58, 63—but this Court did not. Instead, the evidence

proved the ordinance was "void, as applied." *S. Ry. Co.*, 248 N.C. at 655–56, 105 S.E.2d at 50. The Court should take the same approach here.

B. Dr. Singleton's factual allegations control.

Because the State applies the wrong constitutional test, the State spends much of its brief arguing that the CON law's merits are "debatable." State's Br. 8–15, 52–57, 61. But even if the State were right about the test, its argument would still fail. There is no "debate" at the pleadings stage. Dr. Singleton's allegations must be "treated as true," construed "liberally," and "treated in [the] light most favorable to [him]." *Wells Fargo Ins. Servs. USA, Inc. v. Link*, 372 N.C. 260, 265–66, 827 S.E.2d 458, 465 (2019). The State's attempt to stir up a "debate" about the CON law's merits fights the posture of the case. To give a few examples:

The State says the CON law is "debatable" because it was based on a 1977 report that studied "the present health care system" and recommended requiring a CON for new facilities. State's Br. 8–9, 51–57.[2] But Dr. Singleton alleged that, *today*, restricting competition in the Craven/Jones/Pamlico area harms the public. (R pp 27–28, ¶¶ 104, 106).

[2] Never mind that the 1977 report did not recommend a CON for the type of operating room Dr. Singleton owns. *See* Report, http://tinyurl.com/2mf3jzd6, at PDF 147, 149, 162 (proposed CON law exempting operating rooms in "offices of private physicians" or "operated solely as part of the medical practice of . . . an independent practitioner"). And never mind that—as Dr. Singleton pointed out in his complaint—the report proposed the CON law in response to a now-repealed federal law. *See id.* at PDF 99; (R pp 18–19, ¶¶ 46–48, 52).

The State says the CON law is "debatable" because the 1977 report found that requiring a CON would promote quality, reduce costs, and increase access. State's Br. 52–55. But Dr. Singleton alleged that, *today*, forcing him to get a CON "has nothing to do with protecting the health or safety of real patients." (R p 10, ¶ 3). Nor is there any "evidence" that excluding him from the market—as the CON law has for over a decade—"actually increase[s] access to safe, affordable surgeries in the Craven/Jones/Pamlico service area." (R pp 33–34, ¶¶ 148–49).[3]

The State says the CON law is "debatable" because it contains "findings of fact" that retain the 1977 report's findings on quality, costs, and access. State's Br. 12–13, 59. But Dr. Singleton alleged "these 'findings of fact' are false as a matter of fact today" and "CON requirements actually *increase* costs and *reduce* access to care." (R pp 18–20, ¶¶ 49–59). He also alleged that, as in *Aston Park*, the only real "purpose and effect of the CON law is to protect established healthcare providers from competition." (R p 34, ¶ 150).

Dr. Singleton could go on—he could cite an allegation for every line in the State's brief—but that would defeat the point. He "is not required to prove [his] entire case at the initial pleading stage." *U.S. Bank Nat'l Ass'n for C-Bass Mortg. Loan Asset-Backed Certs. v. Pinkney*, 369 N.C. 723, 727–28, 800 S.E.2d 412, 416

[3] The legislature's recent decision to exempt "urban" ambulatory surgical facilities from the CON law makes it even more likely Dr. Singleton will be able to prove these allegations on the merits. *See* Act to Provide North Carolina Citizens with Greater Access to Healthcare Options, Sess. Law 2023-7, § 3.2(a).

(2017). Rather, under North Carolina's liberal pleading standard, he was merely required to give "sufficient notice of the claim asserted to enable the [State] to answer and prepare for trial . . . and to show the type of case brought." *Id.* at 728, 800 S.E.2d at 416 (cleaned up). The State's detailed response—right or wrong—confirms that it has the notice it needs to litigate this case on the merits.

Speaking of the merits, the State and one of its amici cite cases upholding CON laws under the more deferential federal rational basis test. State's Br. 53 (citing *Tiwari v. Friedlander*, 26 F.4th 355 (6th Cir. 2022) (Kentucky CON law), *cert denied* 143 S. Ct. 444; *Colon Health Ctrs. of Am., LLC v. Hazel*, 813 F.3d 145 (4th Cir. 2016) (Virginia CON law)); Provider Br. 14–15 (citing *Birchansky v. Clabaugh*, 955 F.3d 751 (8th Cir. 2020) (Iowa CON law); *Madarang v. Bermudes*, 889 F.2d 251 (9th Cir. 1989) (Northern Mariana Islands CON law)).[4] At the pleadings stage, though, these cases just prove Dr. Singleton's point.

Even under the more deferential federal test, all four of these cases were decided at summary judgment or trial—not at the pleadings stage. In *Birchansky*, for example, the district court held the plaintiffs had "plausibly alleged" the CON

[4] The Providers cite *Planned Parenthood of Greater Iowa, Inc. v. Atchison*, 126 F.3d 1042 (8th Cir. 1997), as a case applying "rational basis review" to "uph[o]ld" a CON law. Provider Br. 14. But *Atchison* does not say anything like that. The court held—after a trial and without mentioning the rational basis test—that "the CON review process . . . would impose a substantial and unconstitutional burden on the right of access to an abortion." *Atchison*, 126 F.3d at 1048. And, perhaps worse for the State, the court held the plaintiffs did not need to "exhaust administrative remedies" to challenge the CON law. *Id.* at 1047.

law "lacks a rational basis." *Birchansky v. Clabaugh*, 421 F. Supp. 3d 658, 681 (S.D. Iowa 2018). In *Tiwari*, likewise, the district court held the plaintiffs had "plausibly alleged" that "requiring a Certificate of Need for a home health company worsens all the problems it purports to fix," which would make the law "irrational" on the merits. *Tiwari v. Friedlander*, No. 3:19-CV-884-JRW-CHL, 2020 WL 4745772, at *2 (W.D. Ky. Aug. 14, 2020).[5] If well-pled factual allegations are enough to survive a motion to dismiss under the *federal* rational basis test, they are more than enough under North Carolina's more protective "reasonably necessary" test.

C. The State wants to shield legislative abuse.

Perhaps worried it won't be able to refute Dr. Singleton's allegations on the merits, the State stokes fear that applying a fact-based test would "encroach[] on" the legislature's power. State's Br. 47. But the Constitution was adopted to place our rights "beyond the control of the Legislature." *Trs. of UNC v. Foy*, 5 N.C. 58, 83 (1805). There is no "separation of powers" principle that requires this Court to bury its head in the sand and ignore reality when the legislature violates our rights. *Contra* State's Br. 47. To the contrary, this Court has consistently held that it has a "duty" to say when the legislature goes too far. *State v. Williams*, 146 N.C. 618, 61

[5] Even on the merits, the Sixth Circuit held that CON laws "teeter on the edge of rationality" and that the plaintiffs might have won under a more protective "State Constitution." *Tiwari*, 26 F.4th at 369–70 (Sutton, C.J.). This case, which invokes the more protective North Carolina Constitution, is exactly what Judge Sutton had in mind.

S.E. 61, 62 (1908); *see also Moore*, 384 N.C. at 212–13, 886 S.E.2d at 32 (reaffirming point last year and citing *Roller*, *Ballance*, and *Harris*).

Weighing the evidence offered by the parties is part of what makes judicial review meaningful. The Court does it when laws restrict other rights—from free speech, *State v. Bishop*, 368 N.C. 869, 876, 787 S.E.2d 814, 819 (2016), to privacy, *State v. Grady*, 372 N.C. 509, 541, 831 S.E.2d 542, 566 (2019), to gun rights, *Britt v. State*, 363 N.C. 546, 550, 681 S.E.2d 320, 323 (2009), to voting rights, *Stephenson v. Bartlett*, 355 N.C. 354, 378, 562 S.E.2d 377, 393 (2002)—and plenty more. And, by and large, economic laws have been no exception. Singleton's Br. 20–24 & n.5. Given all that, the State's suggestion that this Court is somehow not "equipped" to weigh Dr. Singleton's factual allegations (State's Br. 48) rings hollow.[6]

Sister courts similarly reject the State's tepid theory of judicial review:

Last year—in a unanimous decision—the Georgia Supreme Court applied a "reasonably necessary" test under its state constitution and held that, while a law forcing lactation consultants to get a license might be "desirable as a policy matter . . . that is not a sufficient interest to justify an unreasonable burden on the ability to pursue a lawful occupation." *Raffensperger v. Jackson*, 888 S.E.2d 483, 493–96

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[6] Dr. Singleton has never argued the State bears the evidentiary burden in challenges to economic laws. *Contra* State's Br. 61. He has a far more modest ask: When a law restricts the right to earn a living—as the CON law does—and a party alleges the law is not reasonably necessary to protect the public—as Dr. Singleton has—the party deserves a chance to prove his case. Every other fundamental right gets at least that much respect. Why not the fundamental right to earn a living?

(Ga. 2023). The court's application of the "reasonably necessary" test repeatedly relied on the summary judgment record. *See, e.g.*, *id.* at 494 ("undisputed evidence establishes"), 495 ("the evidence shows"), 496 ("there is no evidence of harm"), 497 (rejecting "speculation, in the face of substantial evidence"). North Carolina's "reasonably necessary" test works the same way.

In 2020, the Pennsylvania Supreme Court applied a similar test under its state constitution and reversed the dismissal of a property manager's as-applied challenge to a licensing law, reasoning that her "allegations present a colorable claim that [the licensing] requirements, as applied to her self-described services, are unreasonable." *Ladd v. Real Estate Comm'n*, 230 A.3d 1096, 1116 (Pa. 2020). Not only did the court reject the notion that it was stepping beyond its role, *see id.* at 1123 (Wecht, J., dissenting), but a lower court later held a trial and ruled for the plaintiff, *Ladd v. Real Estate Comm'n*, No. 321 M.D. 2017, 2022 WL 19332047 (Pa. Commw. Ct. Oct. 31, 2022).

And in 2015, the Texas Supreme Court applied an engaged test under its state constitution—reviewing "the entire record, including evidence offered by the parties"—and held that forcing eyebrow threaders to complete largely irrelevant cosmetology training was "oppressive." *Patel v. Tex. Dep't of Licensing & Regul.*, 469 S.W.3d 69, 87, 90 (Tex. 2015). Dissenters, like the State here, raised the specter of judicial "policymaking." *Id.* at 139 (Hecht, C.J., dissenting). But as the

majority explained, holding statutes to constitutional standards "is not legislating; it is judging." *Id.* at 91.

What the State really wants is for this Court to adopt a toothless test under which the government always wins. Under which irrational, harmful, protectionist, laws—laws that plainly exceed the police power—can be quietly swept under the rug. Under which cases like *In re Moore's Sterilization*, 289 N.C. 95, 221 S.E.2d 307 (1976), were correctly decided.

Moore's Sterilization upheld a statute allowing the forced sterilization of children on the theory that eugenics "may be" benign. *Id.* at 103–04, 221 S.E.2d at 312–13 (citing *Buck v. Bell*, 274 U.S. 200 (1927)). If the State is right that laws are forever constitutional if they were "debatable" when enacted, then *Sterilization* is good law. After all, eugenics—widely regarded as heinous and harmful now—was the subject of policy debate through the mid-1970s. *See generally* Alfred Brophy & Elizabeth Troutman, *The Eugenics Movement in North Carolina*, 94 N.C. L. Rev. 1871 (2016). It's no surprise the State doesn't cite *Sterilization*.[7] Who would?

But even if the State won't face the implications of its argument, this Court should. The Court can follow *Sterilization*'s reasoning and ignore Dr. Singleton's factual allegations. Or it can follow its better precedents—*Aston Park*, *Southern*

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[7] At least not directly. *Rhyne*, on which the State relies, cites *Sterilization* for the proposition that the law of the land clause is "synonymous" with the federal due process clause. *Rhyne*, 358 N.C. at 180, 594 S.E.2d at 15 (citing *Sterilization*, 289 N.C. at 98, 221 S.E.2d at 309).

Railway Co., *Roller*, *Harris*, *Ballance*, and plenty more—and take Dr. Singleton's allegations seriously. Text, history, and a respect for the fundamental right to earn a living favor the second path. Singleton's Br. 12–27. And that path leads one way here: Dr. Singleton stated a claim that the CON law, as applied, violates the law of the land clause.

II. The State's privilege and monopoly arguments fail.

The State's desire for a hyper-deferential rational basis test bleeds into its privilege and monopoly arguments. As the State sees it, the CON law does not grant CarolinaEast an exclusive privilege if the government might one day let Dr. Singleton compete; CarolinaEast's privilege meets the textual "public services" exception if the legislature thinks the privilege is a good idea; and nobody has a right to be free from monopolies anyway if their services are subject to the police power. None of that is correct. CarolinaEast holds an exclusive privilege *today*. (Part A). That privilege is for purely private services that do not qualify for the "public services" exception—regardless of what the legislature thinks. (Part B). And monopolies are banned whether they are for services beyond the scope of the police power or for services that, like Dr. Singleton's, may be regulated. (Part C). The State's privilege and monopoly arguments fail.

A. CarolinaEast holds an exclusive privilege.

The State agrees that the privilege and monopoly clauses prohibit "state-granted 'exclusive' privileges." State's Br. 74. The State agrees, too, that whether

a privilege is exclusive turns on whether it "leaves the door open to new market entrants." *Id.* at 75. The parties disagree, though, on duration. The State says a privilege is not exclusive if it "preserve[s] the possibility of future competition" *ever*. *Id.* at 76. Dr. Singleton, on the other hand, argues that a privilege is exclusive if it forbids competition *today*. Text, history, and precedent favor Dr. Singleton. *Cf. Moore*, 384 N.C. at 213, 886 S.E.2d at 33.

Begin with text. Article I, § 32 targets "exclusive or separate emoluments or privileges." Article I, § 34 bars "[p]erpetuities and monopolies." Both clauses, on their "plain meaning," *Town of Boone v. State*, 369 N.C. 126, 132, 794 S.E.2d 710, 715 (2016), forbid exclusivity without reference to time. Further, giving effect to "[e]ach word," *id.*, the fact that "[p]erpetuities" are listed separately from "monopolies" implies they are distinct. Perpetuities last "forever." John Orth, *Allowing Perpetuities in North Carolina*, 31 Campbell L. Rev. 399, 401–02 (2009). But "[a] monopoly need not be a perpetuity," *Thrift v. Bd. of Comm'rs of Elizabeth City*, 122 N.C. 31, 30 S.E. 349, 351 (1898)—it's forbidden today even if it expires tomorrow.

The State's argument also conflicts with how this Court reads "exclusive" in the federal patents clause. That clause allows Congress to "secur[e] for *limited Times* to Authors and Inventors the *exclusive Right* to their respective Writings and Discoveries." U.S. Const. art. I, § 8 (emphasis added). This Court, following the text, has read the patents clause to allow "exclusive use . . . for a limited time."

Maxwell v. Chem. Constr. Co., 200 N.C. 500, 157 S.E. 606, 607 (1931). That would make no sense if, as the State says, "exclusive" means exclusive "'for all time in perpetuity.'" State's Br. 78 (quoting *Town of Clinton v. Standard Oil Co.*, 193 N.C. 432, 137 S.E. 183, 184 (1927)).

Reading a "perpetuity" condition into the text would also be ahistorical. The State concedes that Article I, §§ 32 and 34 were a response to the Crown's practice of granting royal monopolies to sell goods or provide services. State's Br. 72–73. But royal monopolies were not perpetual. They typically "expired" after a period of time. *See* Edward Walterscheid, *The Early Evolution of the United States Patent Law: Antecedents (Part 2)*, 76 J. Pat. & Trademark Off. Soc'y 849, 868–70 (1994). Indeed, perhaps the most famous monopoly of the age—the playing card monopoly struck down in *Darcy* (1602)—lasted only for "a term of 12 years." *Id.* at 867. The founding generation understood monopolies the same way. *See, e.g.*, J. Madison, *Letter to Thomas Jefferson* (July 31, 1788), http://tinyurl.com/356zj24f (noting that, while there may be benefits to granting a "monopoly for a limited time, as of 14 years . . . the benefit even of limited monopolies is too doubtful" to justify them). The State offers no historical evidence to the contrary.

Consistent with text and history, this Court has repeatedly struck down exclusive privileges that lasted only for a period of time. In 1879, the Court struck down a toll-bridge monopoly that was "limited to eighty years" "yet . . . comes within the mischiefs these constitutional declarations were intended to remedy."

Wash. Toll Bridge Co. v. Comm'rs of Beaufort, 81 N.C. 491, 505 (1879). In 1898, the Court struck down a waterworks monopoly "for a term of thirty years." *Thrift*, 122 N.C. 31, 30 S.E. at 350. And in 1954, the Court struck down an exclusive "twenty-five year" privilege to provide gambling services. *State v. Felton*, 239 N.C. 575, 586, 80 S.E.2d 625, 634 (1954).

The State tries to distinguish the *Town of Clinton* gas station monopoly because it was perpetual. State's Br. 74. But two years later, this Court struck down a similar monopoly that lasted *less than a year*. *See Burden v. Town of Ahoskie*, 198 N.C. 92, 150 S.E. 808 (1929). In *Burden*, ordinances forbade gas stations from operating near schools but gave existing stations until January 1930 to comply. *Id.*, 150 S.E. at 809. A plaintiff sued in May 1929—eight months before the existing stations would have to close—and argued the ordinances granted a monopoly. *Id.* The town claimed "there would be no monopoly" because any exclusive privilege would soon expire. *Id.*, 150 S.E. at 810. But this Court disagreed. When deciding whether a law grants a monopoly, the "sole question for determination is whether the plaintiff is entitled to the relief requested *upon the record as now presented*." *Id.* (emphasis added). Because the existing stations held an exclusive right "to operate until January 1st," the ordinances were invalid. *Id.*

The State's only other support for its atextual, ahistorical take is *Madison Cablevision, Inc. v. City of Morganton*, 325 N.C. 634, 386 S.E.2d 200 (1989). The State seizes on the Court's note that, when the city became the sole provider of

cable services, there was no exclusive privilege because the city "left open the possibility that other cable companies could [compete] . . . in the future." *Id.* at 654, 386 S.E.2d at 211. But that was dicta. Article I, § 32 allows privileges "in consideration of public services." A city providing its own services, the Court held, is "directly within the words and meaning of the constitutional exception." *Madison Cablevision*, 325 N.C. at 654, 386 S.E.2d at 212. Given that holding, there is no reason to assume the Court was silently overruling decades of precedent.

Applying that precedent here, CarolinaEast holds an exclusive privilege. The State admits that, *today*, Dr. Singleton can't compete with CarolinaEast (the sole CON-holder in his area). State's Br. 23. Indeed, below, "Defendants clearly and correctly admitted that the CON statutes are restrictive, anti-competitive, and create monopolistic policies." *Singleton v. DHHS*, 284 N.C. App. 104, 115, 874 S.E.2d 669, 677 (2022). Thus, even if the State is correct that Dr. Singleton could petition to adjust the need determination,[8] apply for the hypothetical CON, and then win a years-long battle with CarolinaEast for that CON—a "doomed" path per the complaint (R p 30, ¶¶ 118–19)—the fact remains that *today*, Dr. Singleton can't compete. That's an exclusive privilege.

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[8] Dr. Singleton does not "acknowledge . . . that a [2020] petition could have resulted in a need determination." *Contra* State's Br. 24. To show an operating room "need," Dr. Singleton would have had to show a "deficit" of "at least two" operating rooms in his service area. 2020 Plan, http://tinyurl.com/bddtxm23, at 52, 56. But Dr. Singleton just wants to use *one* operating room—his own—and the Plan has never projected a need for even *that*. (R p 27, ¶¶ 100–03).

B. CarolinaEast provides private services.

Even though CarolinaEast holds an exclusive privilege, the State argues it falls under Article I, § 32's exception for privileges granted "in consideration of public services." As the State tells it, that exception is so broad that it covers any law that "promotes the general welfare." State's Br. 80. But the State offers no textual or historical support for its expansive reading. This Court could not have been clearer last year: "Our interpretive endeavor begins with the text" and "the available historical record." *Moore*, 384 N.C. at 213, 886 S.E.2d at 33. The State blows past that framework and—to borrow a phrase—pushes the "test that they prefer. That is not how the law works." State's Br. 81.

Dr. Singleton's reading, by contrast, honors text and history. The original meanings of "public" and "service" suggest that "public services" means work performed *by* the government *for* the people. Singleton's Br. 32. History supports that reading. The framers did not trust the government to make "policy" choices about who should be allowed to compete in a market. *Id.* at 32–34. That distrust makes it "more likely" that they "understood there were some rational grounds for awarding monopolies, but believed them on-balance to be so repugnant that the constitution should prohibit them entirely." Richard Dietz, *Factories of Generic Constitutionalism*, 14 Elon L. Rev. 1, 18 (2022). Dr. Singleton's reading of "public services" threads the needle: It honors the text, leaves room for the government to

provide services, and forbids the anti-competitive power that prompted Article I, §§ 32 and 34 to begin with. Singleton's Br. 31–36.

The most the State does to justify its "general welfare" test is cherry-pick three cases from a 27-year period that apply it. State's Br. 81 (citing *State v. Knight*, 269 N.C. 100, 152 S.E.2d 179 (1967), *Town of Emerald Isle ex rel. Smith v. State*, 320 N.C. 640, 360 S.E.2d 756 (1987), and *State ex rel. Utils. Comm'n v. Carolina Util. Customers Ass'n*, 336 N.C. 657, 446 S.E.2d 332 (1994)). These cases—even setting aside their break with text and history—are not persuasive:

First, they broke with precedent. Before the U.S. Supreme Court adopted the rational basis test, this Court never used anything like a "general welfare" test when discussing the "public services" exception. *See* John Orth, *Unconstitutional Emoluments: The Emoluments Clauses of the North Carolina Constitution*, 97 N.C. L. Rev. 1727, 1733–35 (2019) (noting the State's cases "radically restated the 'public services'" exception). Rather, the Court asked whether the *services* were *public*. *See, e.g.*, *Simonton v. Lanier*, 71 N.C. 498, 502–03 (1874) (striking down private bank's privilege to charge special interest because it had not "rendered" public services, like "a turnpike, canal or railroad" built so "the people have the right to their use"); *Motley v. S. Finishing & Warehouse Co.*, 122 N.C. 347, 30 S.E. 3, 4 (1898) (striking down private warehouse's exemption from tort liability because "What public services has it performed[?]"); *Felton*, 239 N.C. at 586–88, 80

S.E.2d at 634–35 (striking down "private corporation['s]" exclusive privilege to provide gambling services even though the public "reaped financial benefits").

Second, the State's cases pivoted to federal law yet "never bothered to explain why those [earlier] cases were flawed, or why federal due process doctrine offered a more suitable standard." Dietz, 14 Elon L. Rev. at 13. That silence puts them on shaky ground.

Third, the Court's most recent word on the "public services" exception brought back the original approach. *See Leete v. County of Warren*, 341 N.C. 116, 462 S.E.2d 476 (1995). *Leete* was about whether a severance payment to a county commissioner was granted "in consideration of public services." *Id.* at 118, 462 S.E.2d 477–78. The Court did not ask, as the State would, whether the payment promoted the public welfare. Rather, the Court asked whether the payment was connected to "the rendition of the public services related to his office." *Id.* at 119, 462 S.E.2d at 478. Because the manager had already been fully paid "for services previously rendered," the exception did not apply. *Id.* at 121, 462 S.E.2d at 479. *Leete* ended the Court's 27-year experiment with a "general welfare" test.

Under the original approach, Dr. Singleton properly alleged CarolinaEast's CON was not granted "in consideration of public services." As a matter of law, "privately operated, managed and controlled" hospitals do not provide "public" services. *Foster v. N.C. Med. Care Comm'n*, 283 N.C. 110, 125–27, 195 S.E.2d 517, 527–29 (1973). Thus, Dr. Singleton alleged CarolinaEast "is a private healthcare

provider that serves private patients." (R p 32, ¶ 141). That was enough to state a claim. *See Aston Park*, 282 N.C. at 551, 193 S.E.2d at 736 (prior CON law granted hospitals "a monopoly" and "exclusive privileges forbidden by Article I, § 32").

C. The CON law restricts common rights.

The State last argues that the concept of "monopoly" applies only when the government restricts a "common right"—which it defines to mean any right not subject to the police power. State's Br. 84. Because the practice of medicine is subject to the police power, the State says, the CON law does not restrict common rights and Dr. Singleton "cannot state a claim under the anti-monopoly clause." *Id.* at 86. But the State's premise is false: Article I, § 34 protects all lawful trades—whether subject to the police power or not—from "monopolies."

The State's "common right" idea stems from Edward Coke's definition of "monopoly." State's Br. 84. It's true that Coke defined "monopoly" to mean an exclusive privilege to enjoy a "freedom, or liberty [the public] had before." State's Br. 84 (quoting E. Coke, *The Third Part of the Institutes of the Laws of England* 181 (1809), http://tinyurl.com/yam8euwd). But the State drops the rest of the quote: "*or hindred in their lawfull trade.*" Coke, *supra*, at 181 (emphasis added). That broad language reflected the idea that "[a]t common law every man might use what trade he pleased." 1 Blackstone, *Commentaries* *427. The State offers no

evidence that when the founding generation claimed the "rights of Englishmen,"[9] they secretly meant " —but only for some occupations."

Precedent likewise rejects the State's argument. This Court has repeatedly distinguished valid police *regulations* (which do not grant monopolies) from market *exclusions* (which do). *Compare Town of Clinton*, 193 N.C. at 432, 137 S.E. at 184 (law limiting gas stations granted monopoly because "[i]t is no regulation; it is a prohibition"), *and State v. Sasseen*, 206 N.C. 644, 175 S.E. 142, 143–44 (1934) (law requiring taxis to hold "prohibitive" insurance granted monopoly because, "not discussing . . . policy," it handed "the business over to a privileged class"), *with State v. Pendegrass*, 106 N.C. 664, 10 S.E. 1002, 1003 (1890) (law requiring meat to be sold in sanitary markets did not grant monopoly because it "regulate[d] trade, as contradistinguished from restraining it"), *and State v. Call*, 121 N.C. 643, 28 S.E. 517, 517 (1897) (law licensing physicians did not grant monopoly because it was a valid police regulation and "[t]he door stands open to all").

If the State's theory were correct, these cases would all have been resolved the same way. The Court could simply have held that the work at issue—running gas stations, driving taxis, selling meat, practicing medicine—was within the scope of the police power and therefore Article I, § 34 did not apply. But that's not how

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[9] *Minutes of the Provincial Congress of North Carolina*, *1044 (Aug. 25–27, 1774), https://tinyurl.com/2x3934f5; *see also id.* at *547 (Apr. 4–May 14, 1776), https://tinyurl.com/2mm29w7p.

it went. The cases came out different ways because *some* cases involved regulations (*Pendegrass*, *Call*) and *other* cases involved exclusions (*Town of Clinton*, *Sasseen*).

The closest the State comes to citing cases that support its theory is with *Roller*, *Harris*, and *Ballance*, which held that occupational licensing requirements for dry cleaners, tilers, and photographers violated the law of the land clause and granted monopolies. State's Br. 84–85. But these cases can't carry the weight the State needs them to. They merely hold that when licensing laws exceed the police power, they necessarily also grant monopolies. *See Roller*, 245 N.C. at 525–26, 95 S.E.2d at 859; *Harris*, 216 N.C. at 764, 6 S.E.2d at 866; *Ballance*, 229 N.C. at 772, 51 S.E.2d at 736. These cases do not hold—and the State fails to cite any case that holds—that the police power includes the power to monopolize.[10]

What, then, is the "common right" at issue here? The right to practice medicine *consistent with* valid police regulations. Medicine is a "lawful calling." *Dent v. West Virginia*, 129 U.S. 114, 121 (1889). Everybody agrees the legislature

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[10] The State points to a stray line that rights are not common when their "restraint becomes necessary for the public good." State's Br. 84 (quoting *Thrift*, 122 N.C. 31, 30 S.E. at 351). Yet again, though, the State cuts the quote short. It continues: "and municipal corporations are beginning to be considered rather in the light of public agencies." *Thrift*, 122 N.C. 31, 30 S.E. at 351. Read in context, the Court was merely making the same point Dr. Singleton made above about the "public services" exception: Exclusive privileges for *government* services create no constitutional problems. Moreover, even if the State's reading is right, this Court has never cited *Thrift*'s "public good" line. And the Court of Appeals—the only court to ever engage with it—performed a "common right" analysis more in line with Dr. Singleton's approach. *See Rockford-Cohen Grp., LLC v. N.C. Dep't of Ins.*, 230 N.C. App. 317, 322, 749 S.E.2d 469, 473 (2013).

can require physicians to get a license to ensure competence. *Call*, 121 N.C. 643, 28 S.E. at 517. Everybody agrees the legislature can require them to operate in safe facilities. *Aston Park*, 282 N.C. at 546–51, 193 S.E.2d at 732–35. But the CON law is not about competence or safety—it's about "protect[ing] existing hospitals from competition otherwise legitimate." *Id.* at 552, 193 S.E.2d at 736. Dr. Singleton's privilege and monopoly claims are valid.

III. The State's exhaustion arguments fail.

In a final attempt to shield the CON law from review, the State argues Dr. Singleton must slog through the CON process before he can challenge the CON requirement. That is not how exhaustion doctrine works. Dr. Singleton alleges the CON requirement is unconstitutional. (Part A). Spending years and thousands of dollars seeking a CON is not an "effective" way to challenge the requirement that he get a CON in the first place. (Part B). Nor, for much the same reason, was Dr. Singleton required to allege "inadequacy"—though he did so anyway. (Part C). The State's exhaustion arguments lack merit.

A. The CON requirement is the injury.

The State accuses Dr. Singleton of "sidestepp[ing] an entire administrative process that could provide [him] with the relief [he] seek[s]." State's Br. 4. Here too, though, the State is fighting the complaint. Dr. Singleton alleges that forcing him to get a CON is unconstitutional: A CON "has nothing to do with protecting the health or safety of real patients"—a law of the land violation. (R pp 10–11,

¶¶ 3–4). A CON grants an exclusive right to provide private services—privilege and monopoly clause violations. (R pp 32–33, ¶¶ 134, 140–42). Because he alleges the CON *requirement* is unconstitutional, he seeks declaratory and injunctive relief that will allow him to "apply for a [facility] license" *without* a CON. (R pp 11, 30–31, 34, ¶¶ 6, 117, 128–29, Prayer for Relief ¶¶ A–D).[11]

B. The CON process is not an effective remedy.

Dr. Singleton need only exhaust administrative remedies if two conditions are met. The CON law must have "a specific statutory exhaustion requirement." *Intersal, Inc. v. Hamilton*, 373 N.C. 89, 104, 834 S.E.2d 404, 415 (2019). And the CON law must offer a "procedure which specifically applies to [his] . . . claim." *Id.* at 103, 834 S.E.2d at 414–15. That is, the CON process must supply an "effective" remedy for Dr. Singleton's injury. *Charlotte-Mecklenburg Hosp. Auth. v. N.C. Indus. Comm'n*, 336 N.C. 200, 209, 443 S.E.2d 716, 722 (1994) (cleaned up), *superseded by statute on other grounds as stated in Mehaffey v. Burger King*, 367 N.C. 120, 125, 749 S.E.2d 252, 255–56 (2013). Neither condition is met here.

First, the CON law does not expressly require exhaustion for constitutional claims. The State purports to find such a requirement in the law's "definitions" section (State's Br. 34–36), which defines "State Medical Facilities Plan" to allow

[11] As a reminder, Dr. Singleton embraces the requirement that his operating room be licensed under the Ambulatory Surgical Facility Licensure Act, and if the CON law were struck down as applied to him, he would immediately apply for and obtain a license under that Act. (R p 31, ¶¶ 128–29).

"comments from the public concerning the Plan." N.C. Gen. Stat. § 131E-176(25). But even assuming the legislature "hide[s] elephants in mouseholes," *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001), that definition says nothing about exhausting constitutional claims. Nor could it, given this Court's "well-settled rule that a statute's constitutionality shall be determined by the judiciary, not [by] an administrative board." *Meads v. N.C. Dep't of Agric.*, 349 N.C. 656, 670, 509 S.E.2d 165, 174 (1998).

Second, the CON process is not an effective remedy for Dr. Singleton's injury. Petitioning to adjust the need determination, applying for that CON if his petition is successful (*but see supra* n.8), and litigating against other entities for that CON is a process for selecting CON-holders. State's Br. 12–22, 24 (noting process might "allow[] Dr. Singleton to apply for a CON"). But again, Dr. Singleton does not want a CON. He wants freedom from the unconstitutional CON requirement —something the CON process can't grant.

For that reason, the State's reliance on *Jackson ex rel. Jackson v. DHHS*, 131 N.C. App. 179, 505 S.E.2d 899 (1998), is misplaced. DHHS denied benefits to a child and the plaintiff, rather than appealing the denial through the APA, sought an injunction to require DHHS to pay the benefits. *Id.* at 181–86, 505 S.E.2d at 900–03. The court held that the plaintiff failed to exhaust because, even though her complaint technically sought an injunction, the point was to compel payment of benefits she could have received through the APA. *Id.* at 185–89, 505 S.E.2d at

903–05. To analogize to the facts of this case: The plaintiff wanted a CON, was denied a CON, and failed to appeal as required to get that CON.

Because Dr. Singleton challenges the CON *requirement*, this case is on all fours with *Charlotte-Mecklenburg Hospital Authority*. There, a group of hospitals alleged that a new Industrial Commission fee schedule was both statutorily and constitutionally invalid. *Charlotte-Mecklenburg Hosp. Auth.*, 336 N.C. at 205–06, 443 S.E.2d at 720. The Commission argued that the hospitals needed to exhaust by seeking the Commission's approval of their preferred fee, receiving a denial, and then appealing to the Court of Appeals for relief from the fee schedule. *Id.* at 208–09, 443 S.E.2d at 721–22. This Court disagreed. Because the fee-approval process did "not address challenges to rules and regulations," there was no "adequate remedy for plaintiffs" to exhaust. *Id.* at 209–10, 443 S.E.2d at 722–23.

In keeping with *Hospital Authority*, the Court of Appeals does not require plaintiffs to exhaust when they challenge the constitutionality of laws the agency is charged with enforcing. *See, e.g.*, *Shell Island Homeowners Ass'n v. Tomlinson*, 134 N.C. App. 217, 224, 517 S.E.2d 406, 412 (1999) (seeking erosion-control permit was not an effective way to challenge constitutionality of permitting law); *Swan Beach Corolla, LLC v. County of Currituck*, 234 N.C. App. 617, 624–25, 760 S.E.2d 302, 309 (2014) (seeking variance for development was not an effective way to challenge constitutionality of local building restrictions). These cases resolve the

exhaustion issue here: Dr. Singleton was not required to seek a CON to challenge the constitutionality of forcing him to get a CON.[12]

C. Dr. Singleton alleged the CON process is inadequate.

The State faults Dr. Singleton for supposedly failing to allege that the CON process is "inadequate or futile." State's Br. 42. It's true that, generally, plaintiffs must "alleg[e] both the inadequacy and the futility of the available administrative remedies" in the complaint. *Abrons Fam. Prac. & Urgent Care, PA v. DHHS*, 370 N.C. 443, 451, 810 S.E.2d 224, 231 (2018). However, plaintiffs "need not" do so if "no administrative procedure . . . specifically applies to plaintiff's . . . claim" and the trial court "had jurisdiction" over it. *Intersal*, 373 N.C. at 103, 106, 834 S.E.2d at 414–16. This case checks both boxes for all the reasons discussed above.

Even though Dr. Singleton was not required to allege inadequacy or futility, he *did* allege them. An inadequate remedy provides no "possibility of relief." *Craig ex rel. Craig v. New Hanover Cnty. Bd. of Educ.*, 363 N.C. 334, 340, 678 S.E.2d 351, 355 (2009). A futile remedy is "useless . . . as a legal or practical matter." *Abrons*,

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[12] This is why courts don't require exhaustion when plaintiffs challenge licensing laws. On the State's theory, no plaintiff could ever challenge a licensing law because the process—even if unconstitutional—would one day allow that plaintiff to work. But courts routinely decide these cases on the merits without a word on exhaustion. *See, e.g.*, *Roller v. Allen*, 245 N.C. 516, 96 S.E.2d 851 (1957) (challenge to tiling license); *Raffensperger v. Jackson*, 888 S.E.2d 483 (Ga. 2023) (challenge to lactation-care license); *Ladd v. Real Estate Comm'n*, 230 A.3d 1096 (Pa. 2020) (challenge to real-estate license); *Patel v. Tex. Dep't of Licensing & Regul.*, 469 S.W.3d 69 (Tex. 2015) (challenge to cosmetology license).

370 N.C. at 452, 810 S.E.2d at 231 (cite omitted). Dr. Singleton alleged that forcing him to get a CON is unconstitutional. (R pp 31–34, ¶¶ 130–52). Necessarily, then, forcing him to beg DHHS to make a CON available, to apply for that hypothetical CON, and to spend years and thousands of dollars battling with CarolinaEast over that CON, would not "remedy Dr. Singleton's injury." (R pp 29–30, ¶¶ 116–18). It would inflict it. The State's exhaustion arguments fail.

CONCLUSION

Dr. Singleton stated constitutional claims and was not required to exhaust administrative remedies. The decision below should be reversed.

Respectfully submitted this 5th day of February, 2024.

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CONTENTS OF APPENDIX

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

N.C.G.S.A. § 131E-176

§ 131E-176. Definitions

Effective: March 27, 2023
Currentness

The following definitions apply in this Article:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Repealed by Laws 1993, c. 7, § 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The review is not competitive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Physical, occupational, or speech therapy.

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

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

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

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

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

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

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

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

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

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

(14c) Reserved.

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

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

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

a. Is not presently operating.

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

c. Within the last 24 months:

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

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

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

(14h) Reserved.

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

(14j) Reserved.

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

(14*l*) Reserved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Any change in bed capacity.

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

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

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

1. Bone marrow transplantation services.

2. Burn intensive care services.

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

3. Neonatal intensive care services.

4. Open-heart surgery services.

5. Solid organ transplantation services.

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

1. Air ambulance.

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

3. Cardiac catheterization equipment.

4. Gamma knife.

5. Heart-lung bypass machine.

5a. Linear accelerator.

6. Lithotriptor.

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

7. Magnetic resonance imaging scanner.

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

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

8. Positron emission tomography scanner.

9. Simulator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(24c) Reserved.

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

(24e) Reserved.

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

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

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

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

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

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

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

Credits

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

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

The statutes and Constitution are current through S.L. 2023-133 of the 2023 Regular Session of the General Assembly, subject to changes made pursuant to direction of the Revisor of Statutes. Some statute sections may be more current; see credits for details.

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