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UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

DIPENDRA TIWARI; KISHOR SAPKOTA; GRACE HOME CARE, INC., *Plaintiffs-Appellants*, *v.* ERIC FRIEDLANDER, in his official capacity as Secretary of the Kentucky Cabinet for Health and Family Services; ADAM MATHER, in his official capacity as Inspector General of Kentucky, *Defendants-Appellees*, KENTUCKY HOSPITAL ASSOCIATION, *Intervenor Defendant-Appellee.*	No. 21-5495

Appeal from the United States District Court
for the Western District of Kentucky at Louisville.
No. 3:19-cv-00884—
Gregory N. Stivers, District Judge.

Argued: January 27, 2022

Decided and Filed: February 14, 2022

Before: SUTTON, Chief Judge; GUY and DONALD, Circuit Judges.

COUNSEL

ARGUED: Andrew H. Ward, INSTITUTE FOR JUSTICE, Arlington, Virginia, for Appellants. David T. Lovely, CABINET FOR HEALTH AND FAMILY SERVICES, Frankfort, Kentucky, for Appellees Friedlander and Mather. David M. Dirr, DRESSMAN BENZINGER LA VELLE PSC, Crestview Hills, Kentucky, for Appellee Kentucky Hospital Association. **ON BRIEF**: Andrew H. Ward, INSTITUTE FOR JUSTICE, Arlington, Virginia, Jaimie N. Cavanaugh, INSTITUTE FOR JUSTICE, Minneapolis, Minnesota, for Appellants. David T. Lovely, CABINET FOR HEALTH AND FAMILY SERVICES, Frankfort, Kentucky, for Appellees Friedlander and Mather. David M. Dirr, Christopher B. Markus, DRESSMAN BENZINGER LA VELLE PSC, Crestview Hills, Kentucky, for Appellee Kentucky Hospital Association.

OPINION

SUTTON, Chief Judge. Dipendra Tiwari and Kishor Sapkota sought to establish a home healthcare company, called Grace Home Care, that would focus on serving Nepali-speaking individuals in the Louisville area. Like other companies that provide healthcare services, home healthcare companies face a number of

regulations. One of them is a certificate-of-need requirement, which restricts the number of such companies that may serve each county in Kentucky. When the Commonwealth denied their certificate-of-need application, Tiwari and Sapkota filed this lawsuit. They claim that the regulation violates their Fourteenth Amendment right to earn a living, serves only the illegitimate end of protecting incumbent home healthcare companies from competition, and through it all lacks a rational basis. At the motion to dismiss stage, the district court allowed the case to proceed to discovery. On summary judgment, the district court upheld the law. We affirm.

I.

Certificate-of-need laws control the number of healthcare resources in a geographical area. Unlike other licensing laws, these programs require the applicant to demonstrate a public need for its service in a given area to "prevent overinvestment in and maldistribution of health care facilities." *Colon Health Ctrs. of Am., LLC v. Hazel*, 813 F.3d 145, 153 (4th Cir. 2016). While certificate-of-need laws have fallen out of favor in the last few decades, many States still use them to regulate different parts of the healthcare industry. *See id.*; Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 Ky. L.J. 201, 256 (2017). At least 16 States today have certificate-of-need laws for home healthcare services. *See* Parento, *supra*, at 256; Certificate of Need State Laws, Nat'l Conf. of State Legislatures, https://www.ncsl.org/research/health/

con-certificate-of-need-state-laws.aspx#Interactive%20Map (last visited Feb. 9, 2022).

Anyone wishing to establish a "health facility" or to make certain substantial changes to an existing health facility in Kentucky must obtain approval from the State. Ky. Rev. Stat. § 216B.061(1); *see also id.* § 216B.020. A "health facility" broadly includes "any institution, place, building, agency, or portion thereof" that is "used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care," among other services. *Id.* § 216B.015(13). A covered entity must apply for a certificate of need to Kentucky's Cabinet for Health Services, the agency that administers the program. *Id.* § 216B.062; *see also id.* §§ 216B.040(1), 216B.015(6). The application goes through a review process, *id.* §§ 216B.040, 216B.095, which requires public notice with the opportunity for "affected persons"—often the applicant or a competitor—to request a hearing, *id.* § 216B.085(1)–(2); 900 Ky. Admin. Regs. 6:060.

By statute, the State looks at several factors in reviewing an application: (1) "interrelationships and linkages" to existing care; (2) "costs, economic feasibility, and resources availability"; (3) "quality of services"; (4) "need and accessibility" in the desired geographic area; and (5) "consistency with" the State Health Plan as determined by the Health Services agency. Ky. Rev. Stat. § 216B.040(2)(a)(2); *see* 900 Ky. Admin. Regs. 5:020.

The last two factors—"need and accessibility" and "consistency with plans"—tend to be the primary guideposts. In calculating need, the Plan compares the forecasted demands of the population to the number of people already receiving the service. The State Health Plan also contains guidelines and regulations for each type of facility or service. Ky. Rev. Stat. § 216B.015(28).

Dipendra Tiwari and Kishor Sapkota sought to establish a home healthcare company in Louisville. Named Grace Home Care, the company would provide healthcare services at the patient's home and serve, among other patients, those who spoke Nepali. Home healthcare, as Kentucky defines it, includes skilled nursing; therapeutic services such as physical, speech, or occupational therapy; and home healthcare support: bathing, using the bathroom, and taking medication. Kentucky's Health Plan requires new entrants to show that at least 250 patients need the service while it requires existing companies to show that at least 125 patients need the expanded service.

Unique among home healthcare companies, Grace Home Care wishes to focus its services on Louisville's Nepali residents. Because positive health outcomes often occur when the patient is comfortable with the provider, Tiwari and Sapkota thought Grace Home Care could deliver superior care for these Kentuckians by pairing them with home healthcare workers who spoke their language and understood their culture.

In March 2018, Grace Home Care submitted its certificate-of-need application. As permitted under state

law, Baptist Health, which also runs a home healthcare company in Louisville, intervened and argued that Grace Home Care's application did not fit the State's Health Plan because Jefferson County's need calculation fell below the threshold for new providers. Grace Home Care did not respond, and the State denied the application.

At that point, Tiwari, Sapkota, and Grace Home Care could have challenged this administrative decision in state court. Under Kentucky law, they could have claimed that the decision was "[a]rbitrary," unsupported by substantial evidence, or otherwise unlawful. Ky. Rev. Stat. § 13B.150. But they did not file such a challenge.

They instead filed this lawsuit against various Kentucky agencies and officials in federal court. They claim that the certificate-of-need law, as applied to home healthcare companies, violates the Due Process, Equal Protection, and Privileges or Immunities Clauses of the Fourteenth Amendment. The Kentucky Hospital Association successfully moved to intervene as a defendant.

At the outset, the State and the Hospital Association moved to dismiss the complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure. The district court rejected the motions in a thoughtful and thorough opinion. In the absence of discovery, it found plausible the complaint's allegations that the statutory scheme did not serve a rational purpose, reasoning that the law seemed to inhibit rather than further the law's proposed justifications, including lower costs and

better care. *Tiwari v. Friedlander*, No. 19-CV-884, 2020 WL 4745772, at *5–14 (W.D. Ky. Aug. 14, 2020). As a result, the court ruled, the plaintiffs adequately stated a claim for relief under the Fourteenth Amendment's Due Process and Equal Protection Clauses. *Id.*

The lawsuit proceeded to discovery and before long dueling summary judgment motions, which featured competing expert reports. In the face of this expanded record, the court determined that the State's justifications for the law rationally supported it. *Tiwari v. Friendlander*, No. 19-CV-00884, 2021 WL 1407953, at *13 (W.D. Ky. Apr. 14, 2021).

II.

Due Process. The Due Process Clause of the Fourteenth Amendment prevents a State from "depriv[ing] any person of life, liberty, or property, without due process of law." U.S. Const. amend. XIV. The textual focus of the clause is procedural—to require elemental process before the State takes the property of its citizens, infringes on their liberty, or deprives them of life. But this case does not implicate a process dispute. Tiwari and Sapkota do not complain about the nature of the State's procedures for obtaining a license in the sense of fair notice, an opportunity to be heard, or other procedures for determining who gets a license and who doesn't.

Tiwari and Sapkota instead complain about something else—the substance of Kentucky's certificate-of-need law. They claim that it violates the liberty

guarantee of the Due Process Clause. Over time, some substantive due process guarantees have become anchored in the language of the Bill of Rights. If, for example, Kentucky had denied this certificate-of-need application based on the applicant's unwillingness to speak favorably about the Governor, that denial would violate substantive due process, namely the free-speech guarantee of the First Amendment as incorporated through the liberty clause of the Fourteenth Amendment. But Tiwari and Sapkota do not rest their substantive due process claim on any of the first eight provisions of the Bill of Rights, nearly all of which the U.S. Supreme Court has incorporated into the Due Process Clause.

That leaves another possibility—that the certificate-of-need requirement violates a fundamental right unanchored in the Bill of Rights but recognized by the U.S. Supreme Court all the same. Infringements on such fundamental rights receive skeptical review from the courts. But the claimants do not make any such argument.

That brings us to the last possibility. Even if the claimants do not allege that Kentucky has violated a provision of the Bill of Rights or another fundamental right, they still may invoke the Fourteenth Amendment to target laws that impose substantive restrictions on individual liberty, including the right to engage in a chosen occupation. *See Conn v. Gabbert*, 526 U.S. 286, 291–92 (1999); *Greene v. McElroy*, 360 U.S. 474, 492 (1959); *Truax v. Raich*, 239 U.S. 33, 41 (1915). The threshold for invalidating a state law on

this basis is high. Economic regulations, even those affecting an individual's liberty to work in a given area, violate due process only when they "impose[] burdens without any rational basis for doing so." *Sheffield v. City of Fort Thomas*, 620 F.3d 596, 613 (6th Cir. 2010) (quotation omitted). In contrast to laws that are presumptively problematic—say laws that allocate benefits based on race, religion, or speech—economic laws carry "a presumption of legislative validity," requiring the challenger to show that there is "no rational connection between the enactment and a legitimate government interest." *Am. Express Travel Related Servs. Co. v. Kentucky*, 641 F.3d 685, 689 (6th Cir. 2011). All laws, whether the challenge arises under the Due Process or Equal Protection Clause, must satisfy rational-basis review, and as a result we look to cases resolved in this area under both Clauses.

Right or wrong, rational-basis review epitomizes a light judicial touch. *See F.C.C. v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313–14 (1993); *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487–88 (1955). So long as some "plausible" reason exists for the law—any plausible reason, even one that did not inspire the enacting legislators—the law must stand, no matter how unfair, unjust, or unwise the judges may see it as citizens. *Heller v. Doe*, 509 U.S. 312, 320, 324, 330 (1993); *Nordlinger v. Hahn*, 505 U.S. 1, 11, 17–18 (1992). States need not "convince the courts of the correctness of their legislative judgments," *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 464 (1981), and courts cannot subject legislative choices "to courtroom fact-finding,"

Beach Commc'ns, 508 U.S. at 315. A legislature's "rational speculation unsupported by evidence or empirical data" suffices. *Id.* An essential premise of all this is not that legislatures are beyond enacting silly or ineffective laws; it is that "even improvident decisions will eventually be rectified by the democratic process." *Vance v. Bradley*, 440 U.S. 93, 97 (1979). So it is that a law may be incorrigibly foolish but constitutional.

To critics of rational-basis review, the standard is too daunting. Whereas a claim implicating a fundamental right requires the State to run the gauntlet of strict scrutiny, a claim implicating rational-basis review seems to require the *individual* to run the gauntlet of strict scrutiny—so many and so modest are the explanations for upholding such laws. But that exaggerates. While the route is difficult, it is not beyond category. Laws premised on utterly illogical grounds or fantasy premises will not be upheld.

In this area, as in many areas, the concrete tends to inform the abstract. Take the measure of some cases that rejected a rational-basis challenge to a statute. At stake in *Clover Leaf Creamery* was whether a Minnesota statute that banned sales of milk in plastic containers rationally served the goal of protecting the environment. 449 U.S. at 458–60. The Minnesota Supreme Court invalidated the law based on "impressive supporting evidence" showing that nonplastic containers did more harm than good for the environment. *Id.* at 463–65. The U.S. Supreme Court reversed, concluding that, even if the statute did not ultimately serve the desired end of protecting the environment, it was

"at least debatable" for the legislature to think so. *Id.* at 469 (quotation omitted). "Whether *in fact* the Act will promote more environmentally desirable milk packaging is not the question," the Court concluded, so long as the legislature "*could rationally have decided* that" the law would serve that interest. *Id.* at 466.

At stake in *Vance v. Bradley* was whether a federal statute that required Foreign Service employees to retire at the age of 60 rationally served any legitimate end. 440 U.S. at 94–95. The government defended the age-based restriction on the theory that it rationally related to the officers' ability to perform their tasks abroad. *Id.* at 103–04. The Court upheld the law despite the plaintiffs' considerable evidence that many overseas posts do not pose security or safety concerns, that many Foreign Service personnel under 60 have health problems, that many employees in the area had successfully worked long after 60 in the past, and that age is not related to susceptibility to certain diseases and ailments commonly linked to life overseas. *Id.* at 110. Reasoning that the challengers had the burden of showing that "the legislative facts on which the classification is apparently based could not reasonably be conceived to be true," *id.* at 111, the Court upheld the retirement requirement because Congress arguably could believe that those over 60 were more susceptible to these risks, which "immunize[d]" the law "from constitutional attack," *id.* at 112.

Western & Southern Life Insurance Co. v. State Board of Equalization of California came to a similar conclusion. 451 U.S. 648 (1981). It concerned a

"retaliatory" tax placed on out-of-state insurance companies designed to deter States from imposing steep taxes on California insurers. *Id.* at 650, 669–70. Although scholars and economists "doubt[ed] the wisdom" of the tax and believed it was "not an effective means for" accomplishing this goal, the Court upheld it under rational-basis scrutiny because the legislature still "*rationally could have believed* that the retaliatory tax would promote its objective." *Id.* at 670–72.

Not all laws have cleared this low bar, however. Several cases go the other way. Hence the Court concluded it was constitutionally irrational to believe that public officials' familiarity with a community depends on their owning property there. *Quinn v. Millsap*, 491 U.S. 95, 107–08 (1989). Hence the Court concluded it was constitutionally irrational for a State to conclude that granting tax benefits only to those veterans who have lived in the State after a fixed year before the law's passage would encourage new veterans to move there. *Hooper v. Bernalillo Cnty. Assessor*, 472 U.S. 612, 619 (1985). Hence the Court concluded it was constitutionally irrational for a county to believe that assessing *recently sold* property based on purchase price would lead to a uniform assessment of *all* property given the disparate treatment for comparable unsold property. *Allegheny Pittsburgh Coal Co. v. Cnty. Comm'n*, 488 U.S. 336, 345 (1989). Other like-reasoned cases featured laws that contained logically untenable connections to their purported aims. *See, e.g.*, *Williams v. Vermont*, 472 U.S. 14, 23–25 (1985) (invalidating a Vermont vehicle-use tax that impermissibly treated

citizens differently based on when they became residents); *Plyler v. Doe*, 457 U.S. 202, 228–30 (1982) (invalidating a Texas law that withheld from school districts funds for the education of the children of illegal immigrants); *Zobel v. Williams*, 457 U.S. 55, 60–64 (1982) (invalidating an Alaska dividend distribution program that impermissibly based payments on length of residence); *Chappelle v. Greater Baton Rouge Airport Dist.*, 431 U.S. 159, 159 (1977) (per curiam) (invalidating a law that required parish commission appointees to own property there); *Lindsey v. Normet*, 405 U.S. 56, 77–78 (1972) (invalidating an Oregon law that required tenants to pay a double-rent fee in order to appeal a judgment); *James v. Strange*, 407 U.S. 128, 131, 141–42 (1972) (invalidating a Kansas recoupment statute that denied indigent defendants various protective exemptions provided for others); *Turner v. Fouche*, 396 U.S. 346, 363–64 (1970) (invalidating a requirement that members of a county board of education own real property). Through them all, these cases involved situations in which the law failed to serve a legitimate end or the law in application did not have a rational connection to its purpose.

Of special interest to us are the fortunes of licensing laws, which have much in common with certificate-of-need laws. Many cases uphold these laws, often because the licensing requirements arise in a heavily regulated field. *See, e.g.*, *Williamson*, 348 U.S. at 490 (eyeglasses); *N.D. State Bd. of Pharmacy v. Snyder's Drug Stores, Inc.*, 414 U.S. 156, 158, 164–67 (1973) (pharmacies); *Dent v. West Virginia*, 129 U.S. 114, 122

(1889) (physicians); *New Orleans v. Dukes*, 427 U.S. 297, 303–06 (1976) (per curiam) (street vendors); *Sensational Smiles, LLC v. Mullen*, 793 F.3d 281, 284–88 (2d Cir. 2015) (dentistry); *Powers v. Harris*, 379 F.3d 1208, 1211 (10th Cir. 2004) (casket sales).

But to the extent Justice Douglas meant to predict that the "day is gone" when Fourteenth Amendment challenges to state licensing laws could succeed, *Williamson*, 348 U.S. at 488, that did not turn out to be accurate. Our court and others have granted relief in the context of licensing laws that serve only protectionist goals and otherwise lack a rational basis for the lines they draw or the burdens they impose. *See Craigmiles v. Giles*, 312 F.3d 220, 224–29 (6th Cir. 2002) (invalidating a statute that permitted only licensed funeral home directors, but no one else, to sell caskets); *St. Joseph Abbey v. Castille*, 712 F.3d 215, 223–27 (5th Cir. 2013) (same); *Merrifield v. Lockyer*, 547 F.3d 978, 991–92, 991 n.15 (9th Cir. 2008) (invalidating a statute that exempted some pest control operators from licensing but not others); *see generally* Cass R. Sunstein, *Naked Preferences and the Constitution*, 84 Colum. L. Rev. 1689 (1984) (claiming that the Constitution should bar purely protectionist laws that do not serve a public good). Some state courts, for what it is worth, have come to similar conclusions in challenges to licensing regulations, though usually based on state constitutions and usually based on what appears to be a more rigorous form of scrutiny. *See, e.g.*, *Patel v. Tex. Dep't of Licensing and Regul.*, 469 S.W.3d 69, 90 (Tex. 2015) (invalidating "oppressive" licensing requirements for

eyebrow threaders because they went beyond any rational relationship to consumer protection and safety); *see id.* at 110–18 (Willett, J., concurring); *Ladd v. Real Est. Comm'n*, 230 A.3d 1096, 1106, 1111–13 (Pa. 2020) (invalidating licensing requirements for short-term vacation property managers on similar grounds).

Measured by the general rational-basis test and the specific ways in which it has been applied, Kentucky's certificate-of-need law passes, perhaps with a low grade but with a pass all the same. As for the goal of the law, the State contends that it furthers healthcare in Kentucky. All agree that this aim is legitimate. The only question is whether the law serves this objective, whether a rational connection exists between its ends and its avowed means—namely, increasing cost efficiency, improving quality of care, and improving the healthcare infrastructure in place.

Start with cost efficiency. One could plausibly think that, by tailoring services to need in a given market, current providers could use the larger market share and increased patient volume that come with the entry restriction to operate more efficiently and to ensure a wide range of services in areas with smaller populations. Providers could use their enhanced purchasing power to buy supplies and equipment at reduced prices. The increased patient volume also could permit the companies to spread fixed costs across more patients.

Move to quality of care. The State could plausibly think that a higher patient volume for all certified

providers in the market will lead to higher quality service. Whether by the downstream benefits of achieving scale or the quality-improving expertise and specialization that come from repeated services within a market, the State could plausibly think that the certificate-of-need program would increase quality in one way or another.

Home healthcare services are heavily regulated too. Deemed medical services under Kentucky law, they may be performed only with a doctor's prescription. *See* 902 Ky. Admin. Regs. 20:081 § 2. Prices in this market often are determined by the government (Medicare and Medicaid) or private insurance companies, and patients usually pay a minor cost of the care. Price shopping for healthcare services is the exception, not the rule. Heavy regulation of supply and pricing often comes with heavy regulation of the number of suppliers in the market.

Kentucky also has not made an eccentric policy-making decision. Far from being alone in applying certificate-of-need requirements to the home healthcare industry, it has considerable company in doing so, as at least 16 States have made this decision. *See* Parento, *supra*, at 256; Certificate of Need State Laws, *supra*. Nor are we alone in upholding such laws against Fourteenth Amendment challenges. Other circuits have reached the same conclusion. *See Birchansky v. Clabaugh*, 955 F.3d 751, 757–58 (8th Cir. 2020); *Colon Health Ctrs. of Am., LLC v. Hazel*, 733 F.3d 535, 547–48 (4th Cir. 2013). Certificate-of-need "laws in general have been recognized as a valid means of furthering a

legitimate state interest." *Planned Parenthood of Greater Iowa, Inc. v. Atchison*, 126 F.3d 1042, 1048 (8th Cir. 1997) (collecting cases). No court to our knowledge has invalidated a healthcare certificate-of-need law under the rational-basis requirements of the Fourteenth Amendment.

Tiwari and Sapkota have several responses, many formidable.

First, they point to considerable evidence showing that, in practice, certificate-of-need laws often undermine the very goals they purport to serve—lower costs and better care—whether with respect to healthcare in general or home healthcare in particular. There indeed is a rich body of economic scholarship questioning the value of certificate-of-need laws and often showing their pernicious effects, particularly when it comes to incumbency protection and undue barriers to new entrants in the market. *See, e.g.*, Thomas Stratmann & Jacob W. Russ, *Do Certificate-of-Need Laws Increase Indigent Care?* (Mercatus Ctr. Geo. Mason, Working Paper No. 14-20, 2014). Particularly galling for entrepreneurs like Tiwari and Sapkota is the reality that only those with these certificates can reap the often-government-fixed rates for healthcare—a market in which little price shopping occurs—and the reliable profits that follow. Barriers to entry thus operate as an additional monopolistic coating on an already controlled market. The district court's motion-to-dismiss opinion ably lays out the powerful case against these laws—cataloguing the ill effects they wreak on entrepreneurs and consumers alike and observing how

Kentucky's law seemingly "worsens all problems it purports to fix." *Tiwari*, 2020 WL 4745772, at *2, *8–11.

History has not been good to certificate-of-need laws either. They became a sensation in the 1970s, when Congress used its conditional spending power to require States to enact them. Through the National Health Planning and Resources Development Act of 1974, Congress required States to enact such laws in return for federal healthcare funding. *See id.* at *4; *Slaughter v. Dobbs*, No. 20-CV-789, 2022 WL 135424, at *2 (S.D. Miss. Jan. 13, 2022). Eight years later, as a result, every State in the country, save for Louisiana, had adopted a healthcare certificate-of-need program. *Slaughter*, 2022 WL 135424, at *2.

What went up eventually went down. In 1987, based on experiences gone awry and considerable critical scholarship, Congress repealed the law and its requirement that States adopt such laws. *Id.* The most populous State in the country and one not congenitally adverse to regulation, California, also repealed its restrictions. Parento, *supra*, at 222. Since 1987, the federal government—across different agencies and ideologically diverse administrations—continues to advocate against these laws, noting their tendency to increase costs while decreasing access and quality of care. Even so, 35 States still have some form of certificate-of-need laws, and as noted 16 States still apply them to home healthcare companies. But the public defenders of such laws are a shrinking minority.

While we cannot claim to have the expertise of the economists or other scholars critical of these laws or the knowledge of the federal and state legislators that have repealed them, we can say that the judgment that this was a failed experiment has the ring of truth to it. Were we Kentucky legislators ourselves, we would be inclined to think that certificate-of-need laws should be the exception, not the rule, and perhaps have outlived their own needs.

The problem for the challengers is that this is not the inquiry. "The Constitution does not prohibit legislatures from enacting stupid laws." *N.Y. State Bd. of Elections v. López Torres*, 552 U.S. 196, 209 (2008) (Stevens, J., concurring). A claimant does not prevail in a rational-basis case simply by severing the stated links between a law and its rationales with on-the-ground evidence that undermines the law—or showing that the lived experiences of the law have not delivered on its promises. The courts would be busy indeed if a law could be invalidated whenever evidence proves that it did not work as planned. Our custom instead is to assume that democracy eventually will fix the problem. That is because our Federal "Constitution presumes that, absent some reason to infer antipathy," flawed laws will "eventually be rectified by the democratic process." *Vance*, 440 U.S. at 97.

The other problem with this argument turns on the limited role the Fourteenth Amendment has to play in this area. Whatever the substantive limits of the Due Process Clause may be, they do not establish a cost-benefit imperative. The defect with

certificate-of-need laws is rarely that there is *no* rational benefit to them in a heavily regulated industry like healthcare. The real problem, and the most potent explanation for criticizing them, is that the costs of these laws—needless barriers to entry, protectionism for incumbents, the improbability of lowering prices by decreasing supply—*outweigh* their modest regulatory benefits. Yet it is precisely such weighing of costs and benefits that is so beyond judicial capacity. Who among us can identify a principled basis for concluding that some laws involve an irrational weighing of costs and benefits while others do not? Once we identify a plausible rational benefit of a law, the policymaking calculation of whether to adopt the law in the face of competing costs is eminently a legislative task, not a judicial one. Any other approach would require us not just to decide whether a plausible rational basis exists but then to balance out the totality of costs and benefits, a value-laden task that no two judges could ever do in the same way—and that even the same judge might do differently at different times during his tenure. It is one thing when legislatures enact laws on an ad hoc and inconsistent basis. It is quite another when judges remove them from the democratic process on an ad hoc and inconsistent basis.

Second, this last question and answer largely resolve the challengers' next two concerns. With respect to quality of care, Tiwari and Sapkota push back that certificate-of-need laws are illogical, not just bad policy. They again provide ample evidence that incumbents with reduced competition tend to provide lower quality

services. And we again do not balk at the general notion that increased competition usually improves quality of care and lowers prices. *Cf. Craigmiles*, 312 F.3d at 226 (noting that "a more competitive casket market would likely lead to that consumer procuring a higher quality casket"). Nor can we deny that the conceivable benefits of these laws would seem to diminish in the comparatively cheaper, simpler, and more labor-intensive home healthcare market. Providers of home healthcare, for example, rarely have large upfront capital costs, as say a hospital would. But we cannot say that it is irrational for a legislator to think otherwise about the law's merits, at least in the healthcare market, a market that has been heavily regulated for decades and in which the State is a buyer and a seller. The ways of Adam Smith, for good or ill, do not describe the ways of the healthcare market in America circa 2022.

None of Tiwari and Sapkota's evidence puts the law's connection to quality beyond dispute, even if it strengthens considerably one side of the policy dispute. Healthcare is uniquely complex, with "its own idiosyncrasies," and with many different metrics upon which to gauge success. *Colon Health Ctrs.*, 813 F.3d at 158. It is at least rationally possible for legislators in Kentucky (and 15 other States) to think that "the unique aspects of the health care market [] affect the behaviors of consumers and producers in ways not encountered in other industries." R.84-4 at 15.

The State, moreover, has some evidence of its own on this score. Economies of scale, it notes, permit providers to reinvest profits from higher patient volumes

into other areas of the business, say by buying expensive technology to improve patient care across the State or by providing better training for new employees. "[T]here is a relationship between the number of patients" a company serves, the State's expert plausibly says, "and its ability to offer programs and services that enhance the quality of care." *Id.* at 23. One certified home healthcare company says that it leverages the scale of its patient population to offer specialized programs for various conditions that home healthcare patients may face. The same company also claims that it would not be able to absorb the costs of technological investments—like electronic health records, tablets for caregivers, or remote telehealth equipment—without the patient volume that the Kentucky law helps to maintain. It is even possible that scale makes it easier for some companies to do what the claimants hope to do here—hire employees who can meet the language and cultural needs of their clients. While the denial of this license would seem to hurt efforts to match Nepali patients with home healthcare workers who speak their language in Louisville, it is at least conceivable that a system that encourages scale will further the broader goal of having healthcare companies that have employees who can match service options to service needs.

Third, and relatedly, Tiwari and Sapkota point to studies and expert testimony showing that certificate-of-need laws end up leading to higher healthcare costs for the State and its consumers—the opposite of the avowed goal of the law. Time and experience, they say,

have shown that what once might have been constitutional no longer is. Thus: "[T]he constitutionality of a statute predicated upon the existence of a particular state of facts may be challenged by showing to the court that those facts have ceased to exist." *United States v. Carolene Prods. Co.*, 304 U.S. 144, 153 (1938). We don't disagree. But the possibility of changed circumstances doesn't change something else either—the modest nature of the rational-basis inquiry. Even if time has shown that certificate-of-need laws do not lower costs for patients, that does not mean they do not create cost efficiency for providers. That is one rational explanation of the law, and no evidence categorically defeats the point—or for that matter categorically defeats the idea that the limitation on the number of home healthcare companies would lead to stabler and more efficient care. Tiwari and Sapkota's evidence does not reject beyond question the notion that a legislator could at least rationally think that the law would facilitate cost efficiency and that cost efficiency could benefit the public down the road.

Tiwari and Sapkota insist that their evidence is more reliable and more extensive than the State's. But it is "not within" this court's "competency" to consider who has the most reasonable view. *Vance*, 440 U.S. at 112 (quotation omitted). Confirming the difficulty of this endeavor, both parties' experts agree that the studies assessing certificate-of-need laws are imperfect on many dimensions. The dynamic complexities of this market, the many metrics upon which that care can be measured, and the reality that a State need not proffer

more than "rational speculation unsupported by evidence or empirical data" all make it difficult to push this law outside the universe of rationality. *Beach Commc'ns*, 508 U.S. at 315.

Fourth, Tiwari and Sapkota point to our decision in *Craigmiles*, which invalidated a law allowing only licensed funeral directors to sell caskets. 312 F.3d at 228–29. Yet the differences between that case and this one illustrate the forbidden side of the line. At issue in *Craigmiles* was a Tennessee law that permitted only licensed funeral directors to sell caskets. In doing so, the law purported to regulate public health and safety and protect consumers by dictating who could sell caskets, but it did so without regulating the products' quality in any way. *Id.* at 225. Absent any difference in the caskets sold, no plausible connection could exist between a casket's safety and its seller, whether the seller was a funeral home or a casket maker or a dealer. The court found the law unconstitutionally irrational and impermissibly protectionist—and rightly so. *Id.* at 229. A law that serves protectionist ends and nothing else—in that instance to insulate funeral homes from competition in selling caskets—does not satisfy rational-basis review. That essentially is a form of class legislation that the Fourteenth Amendment originally banned—and still should ban. *See* John O. McGinnis, *Reforming Constitutional Review of State Economic Legislation*, 14 Geo. J.L. & Pub. Pol'y 517, 529 (2016).

Consistent with *Craigmiles*, we agree that a law defended on protectionist grounds alone—denying individuals a right to ply their trade solely to protect

incumbents—would not satisfy rational-basis review. It is no doubt true that governments sometimes play favorites and sometimes enact protectionist laws, often fairly described as nothing more than wealth transfers. Think tax breaks for some companies but not others. Think subsidies for a stadium for a for-profit sports team. Think redistributionist tax policies and tax credits. And so on. But when courts uphold these laws, they tend to do so on the ground that a public interest (other than protectionism or a wealth transfer for its own sake) supports the law. *See St. Joseph Abbey*, 712 F.3d at 222–23 (rejecting mere protectionism as a legitimate government interest); *Merrifield*, 547 F.3d at 991–92, 991 n.15 (same); *Powers*, 379 F.3d at 1225–26 (Tymkovich, J., concurring) (same); *Sensational Smiles*, 793 F.3d at 288 (Droney, J., concurring in part) (same); *see also Hettinga v. United States*, 677 F.3d 471, 481 (D.C. Cir. 2012) (Brown, J., concurring).

But that is not this case. Protectionist though this law may be in some of its effects, that is not the only effect it has or the only goal it serves. As a matter of history, law, economics, and common sense, there is a lifetime of difference between the providing of healthcare and the making of caskets. In the intensely regulated market of healthcare, Kentucky has shown that its regulations potentially advance a legitimate cause. Courts no doubt will continue to encounter regulations that fall short of any rational basis. This is just not one of those cases.

Fifth, Tiwari and Sapkota target another protectionist feature of the law. They argue that the law

favors incumbents over new entrants based on the lower patient-need threshold to enter a market (125 versus 250). This disparity not only favors incumbents, but it also would allow a sharp-elbowed incumbent theoretically to expand whenever the 125-patient threshold was reached, forever prohibiting a start up from obtaining permission to enter the market by meeting the 250-patient threshold. But a rational basis, even if a debatable one, supports the discrepancy. The State set the baseline 250-patient threshold at a level where a company "would have sufficient volume to be able to maintain financial viability." R.84-6 at 20. New entrants will likely have more overhead and more difficulty spreading those costs than existing market participants with higher patient volumes. Hence the lower threshold for the incumbent. The disparity comports with the law's justifications, or at least a legislator plausibly could think so.

Sixth, Tiwari and Sapkota try to recalibrate the rational-basis test itself. True enough, many thoughtful commentators, scholars, and judges have shown that the current deferential approach to economic regulations may amount to an overcorrection in response to the *Lochner* era at the expense of otherwise constitutionally secured rights. *See, e.g.*, David E. Bernstein, *The Due Process Right to Pursue a Lawful Occupation: A Brighter Future Ahead?*, 126 Yale L.J. Forum 287, 287–302 (2016); Randy E. Barnett, *Our Republican Constitution: Securing the Liberty and Sovereignty of We the People* 222–47 (2016); *Hettinga*, 677 F.3d at 480–83 (Brown, J., concurring). We appreciate the points

and might add a few others. Is it worth considering whether a similar form of protectionism should receive more rigorous review under the dormant Commerce Clause solely when the entrant happens to be from another State? Put more specifically, should Tiwari and Sapkota's challenge have a better chance of success if they move to Indiana? *Cf. Walgreen Co. v. Rullan*, 405 F.3d 50, 59–60 (1st Cir. 2005). And is there something to Justice Frankfurter's criticism of the dichotomy between economic rights and liberty rights, *see, e.g.*, *Dennis v. United States*, 341 U.S. 494, 526–27 (1951) (Frankfurter, J., concurring), a dichotomy first identified in *Carolene Products*, 304 U.S. at 152 n.4? One could imagine Susette Kelo, and for that matter Tiwari and Sapkota, thinking their cases involved a liberty right. *Cf. Kelo v. City of New London*, 545 U.S. 469, 487–90 (2005). But any such recalibration of the rational-basis test and any effort to create consistency across individual rights is for the U.S. Supreme Court, not our court, to make.

Seventh, the claimants point to a recent Mississippi district court decision that allowed a challenge to a home healthcare certificate-of-need law to proceed. *Slaughter*, 2022 WL 135424, at *1. Addressing only the "sufficiency of the *Complaint*," the court concluded that the challengers plausibly alleged that a rational basis did not support the law. *Id.* at *3–6. In one sense, that case, like the motion-to-dismiss opinion in this case, *Tiwari*, 2020 WL 4745772, at *5–14, confirms what we accept today: Certificate-of-need laws teeter on the edge of rationality. In another sense, that case confirms

what we cannot resolve today: How will all other certificate-of-need laws fare under that review? Mississippi's restriction, it deserves note, ventured beyond Kentucky's, banning *all* new entry into the market for the last several decades regardless of any "need" for the service. *Slaughter*, 2022 WL 135424, at *2. As the court put it, "Mississippi's 40-year-old moratoria is an outlier." *Id.* at *5.

Eighth, Tiwari and Sapkota ask for a trial about the competing evidence, arguing that the record creates a triable issue of fact over the rationality of this law. We agree with one premise of this argument but not another. Under the circumstances of this case and of the Mississippi case, we agree with the district courts' initial decisions to reject the States' motions to dismiss. These cases both warranted discovery and the gathering of evidence and expert reports about the potential rationality of these laws. But it does not follow that, after discovery, a trial was in order. Summary judgment is an apt vehicle for resolving rational-basis claims. That's because the question is not whether a law in fact is rational. It's whether a legislator could plausibly think so. As to that modest inquiry, ample evidence supports the point—and a trial over whether the evidence shows that, at day's end, this or that legislator was in fact wrong is beside the point. Under rational-basis review, a law will survive constitutional scrutiny so long as the existence of a rational connection to its aim "is at least debatable." *W. & S. Life Ins.*, 451 U.S. at 674 (quotation omitted). Courts cannot subject legislative choices "to courtroom fact-finding,"

Beach Commc'ns, 508 U.S. at 315, and any factual dispute as to a law's rationality indeed "immunizes from constitutional attack the [legislative] judgment," *Vance*, 440 U.S. at 112. Because Tiwari and Sapkota's evidence does not push the rationality of this law beyond dispute, our Due Process Clause precedent dooms this claim "no matter what evidence they put in at the trial on the merits." *Chi. Bd. of Realtors, Inc. v. City of Chicago*, 819 F.2d 732, 745 (7th Cir. 1987).

Equal Protection. Tiwari and Sapkota also claim that the certificate-of-need law violates equal protection by irrationally exempting two entities—physician's offices and "continuing care retirement communities"—from its scope. *See* Ky. Rev. Stat. § 216B.020(1), (2)(a). What we have said so far goes a long way to rejecting this claim too. The Constitution, once again, "does not require" Kentucky "to draw the perfect line" or "even to draw a line superior to some other line it might have drawn." *Armour v. City of Indianapolis*, 566 U.S. 673, 685 (2012). So long as the Commonwealth has not drawn categories "along suspect lines," its classifications will survive scrutiny "if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose." *Id.* at 680 (quotation omitted).

As for physician's offices, at least three explanations stand out for treating them separately: the modest supply of physicians in parts of Kentucky, the more urgent need for physicians than home healthcare agencies throughout the State, and the more heavily regulated nature of the requirements for becoming a

physician. Ample rational bases exist for treating doctors' offices and home healthcare companies differently.

As for continuing care retirement communities, they are distinct in some of these ways and others too. They have a continuum of care depending on the needs of their residents. Ky. Rev. Stat. § 216B.015(11). True, these facilities sometimes provide services to their residents comparable to the services home healthcare companies provide. But the facilities serve only the residents that already live there, and they provide a vast array of services, both medical and nonmedical, that home healthcare companies do not. Moreover, these facilities do not receive Medicaid funding, meaning that the State does not subsidize this care in the same way it subsidizes home healthcare providers. Each distinction suffices to uphold the classifications.

The State could have "drawn [the line] differently" no doubt and perhaps should have. *U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 179 (1980). But that consideration is one for the legislature, not the judiciary, to make. *Id.* The State need not "choose between attacking every aspect of a problem or not attacking the problem at all." *Dandridge v. Williams*, 397 U.S. 471, 486–87 (1970).

Privileges or Immunities. Tiwari and Sapkota raise a claim under the Privileges or Immunities Clause of the Fourteenth Amendment. But they concede that this claim is foreclosed by the *Slaughter-House Cases*, 83 U.S. (16 Wall.) 36 (1872).

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While this opinion rejects the claims of Tiwari and Sapkota today, that is not necessarily the end of the road. Not only do they have the recourse of further review in the federal courts, but it is well to remember that state-law options remain available to them. They may file another certificate-of-need application. And if the State denies it, they may seek review in state court based on the procedural and substantive guarantees of state administrative law. As shown, Kentucky law does not countenance "arbitrary" decisions by state agencies, a standard that may be more toothsome than rational-basis review. The second option is the State Constitution. In the context of rational-basis review, it has happened before that the U.S. Supreme Court has denied relief under federal law with respect to an economic right, *see Fitzgerald v. Racing Ass'n of Cent. Iowa*, 539 U.S. 103, 110 (2003), only to see the state courts grant relief for the same claim under the State's Constitution, *see Racing Ass'n of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 3 (Iowa 2004). While judicial modesty often carries the day in a forum for 51 jurisdictions and 330 million people, *Beach Commc'ns*, 508 U.S. at 314, that is not always the case under state law in state court for one State.

We affirm.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION
CIVIL ACTION NO. 3:19-CV-00884-GNS-CHL

DIPENDRA TIWARI, et al. PLAINTIFFS

v.

ERIC FRIENDLANDER, et al. DEFENDANTS

MEMORANDUM OPINION AND ORDER

(Filed Apr. 14, 2021)

This matter is before the Court on Defendants' and Intervenor Defendant's Motion for Reconsideration (DN 68), Plaintiffs' Motion for Summary Judgment (DN 79), Defendants' and Intervenor Defendant's Motion for Summary Judgment (DN 84), Plaintiffs' Motion to Strike (DN 87), Plaintiffs' Motion to Withdraw their Motion to Strike (DN 89), Plaintiffs' Motion to Strike and Substitute (DN 90), and Defendants' and Intervenor Defendant's Motions in Limine (DN 93, 94). The matter is ripe for adjudication. For the reasons discussed below, the Court **GRANTS** Defendants' and Intervenor Defendant's Motion for Summary Judgment, Plaintiffs' Motion to Withdraw their Motion to Strike, and Plaintiffs' Motion to Strike and Substitute; **DENIES** Plaintiffs' Motion for Summary Judgment, Plaintiffs' Motion to Strike, and Defendants' and Intervenor Defendant's Motion for Reconsideration; and

DENIES AS MOOT Defendants' and Intervenor Defendant's Motions in Limine.[1]

I. STATEMENT OF FACTS

Plaintiffs Dipendra Tiwari and Kishor Sapkota are both Nepalese immigrants to the United States who partnered in 2017 to form Plaintiff Grace Home Care, Inc. ("Grace"), a home health services agency ("HHA") (collectively "Plaintiffs"). (Tiwari Aff. ¶ 15, DN 79-3). HHAs provide "part-time or intermittent health and health related services to a patient in his or her place of residence . . . as required by a plan of care prescribed by a license physician." 902 KAR 20:081 § 2. Plaintiffs hope was to provide these services to the Nepalese-speaking community in the Louisville Metro area because of an unmet need for services in a patient's native language. (Tiwari Aff. ¶ 15). To open the agency, Plaintiffs were required to obtain a Certificate of Need ("CON") from the Commonwealth of Kentucky's Cabinet for Health and Family Services ("Cabinet"). The Commonwealth's CON program, established in 1980, requires anyone wishing to establish a "health facility," or make any substantial change to

[1] Defendants and Intervenor Defendant request oral argument for both their Motion to Reconsider and Motion for Summary judgment, Plaintiffs similarly request oral argument for their Motion for Summary Judgment. The Court denies these requests, as it would not aid the Court. In addition, because the Court grants summary judgment for Defendants and Intervenor Defendant, their Motions in Limine are moot.

an existing health facility, to first obtain a CON.[2] KRS 216B.061(1). The purpose of the statute is to: (1) improve the quality of healthcare in the Commonwealth; (2) improve access to healthcare facilities, services, and providers; and (3) create a cost-efficient healthcare delivery system. *See* KRS 216B.010. The program is meant to accomplish these goals by preventing the "proliferation of unnecessary health-care facilities, health services, and major medical equipment. . . ." *Id.*

Plaintiffs applied for a CON and were denied because Grace did not show a need for its services in the area. (Pls.' Mot. Summ. J. Ex. 25, DN 79-30). Plaintiffs then filed suit against various state officials and agencies, alleging the CON program, as applied to HHAs, violated the Due Process, Equal Protection, and Privileges or Immunities Clauses of the Fourteenth Amendment. (Compl., DN 1; Am. Compl., DN 15). Kentucky Hospital Association, Inc. ("KHA"), intervened, and Defendants and KHA moved to dismiss. (Mem. Op. & Order, DN 40; Defs.' Mot. Dismiss, DN 18; Intervenor Def.'s Mot. Dismiss, DN 42). The Court granted in part and denied in part the motion, allowing Plaintiffs' claim for violation of the Due Process and Equal Protection Clauses to proceed against Eric Friedlander, in his official capacity as Acting Secretary of the Cabinet, and Adam Mather, in his official capacity as Inspector

[2] The term "health facility" refers to "any institution, place, building, agency, or portion thereof, public or private, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care and includes alcohol abuse, drug abuse, and mental health services." KRS 216B.015(13).

General of Kentucky ("Defendants"). (Mem. Op. & Order 1, DN 67). Furthermore, the Court found that Grace had standing, but ordered Plaintiffs to show cause why they have standing as individuals. (Mem. Op. & Order 1).

Defendants and KHA jointly moved for reconsideration on the Court's Order denying the motion to dismiss. (Defs.' & Intervenor Def.'s Joint Mot. Reconsideration, DN 68). Plaintiffs responded to the Court's show cause order, and moved for summary judgment. (Pls.' Br., DN 72; Pls.' Mot. Summ. J., DN 79). Defendants and KHA responded to Plaintiffs' motion for summary judgment with a cross-motion.[3] (Defs.' & Intervenor Def.'s Mem. Supp. Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J., DN 84 [hereinafter Defs.' Mot. Summ. J.]). Fully briefed on the matter, the Court finds that Plaintiffs have standing, grants Defendants' and KHA's Motion for Summary Judgment, denies Plaintiffs' Motion for Summary Judgment, and denies as moot Defendants' and KHA's Motion for Reconsideration.

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[3] Plaintiffs also moved to strike an untimely affidavit, but subsequently moved to withdraw their motion, and to strike and substitute their response, which addressed the motion to strike the affidavit. (Pls.' Mot. Strike, DN 87; Pls.' Mot. Withdraw, DN 89; Pls.' Mot. Strike & Substitute, DN 90). The Court grants Plaintiffs' motion to withdraw and motion to strike and substitute, and denies as moot Plaintiffs' motion to strike.

II. STANDARD OF REVIEW

In ruling on a motion for summary judgment, the Court must determine whether there is any genuine issue of material fact that would preclude entry of judgment for the moving party as a matter of law. *See* Fed. R. Civ. P. 56(a). The moving party bears the initial burden of stating the basis for the motion and identifying evidence in the record that demonstrates an absence of a genuine dispute of material fact. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). If the moving party satisfies its burden, the non-moving party must then produce specific evidence proving the existence of a genuine dispute of fact for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986).

While the Court must view the evidence in the light most favorable to the non-moving party, the non-moving party must do more than merely show the existence of some "metaphysical doubt as to the material facts." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986) (citation omitted). Rather, the non-moving party must demonstrate that a genuine factual dispute exists by "citing to particular parts of the materials in the record" or by "showing that the materials cited do not establish the absence . . . of a genuine dispute." Fed. R. Civ. P. 56(c)(1). "The mere existence of a scintilla of evidence in support of the [non-moving party's] position will be insufficient" to overcome summary judgment. *Anderson*, 477 U.S. at 252.

III. DISCUSSION

A. Standing

Although both parties recognize Grace has standing to pursue these claims, Defendants and KHA dispute whether the individual Plaintiffs have standing. Plaintiffs assert that although it is enough for Grace to have standing, they too have standing to bring the case because the CON laws prohibit them from opening an agency, whether through Grace or another entity. (Pls.' Br. 2). Defendants and KHA maintain that each party must have standing on their own to proceed, and that Plaintiffs do not suffer an injury separate from their status as shareholders. (Intervenor-Defs.' Br. 2-4, DN 74; Defs.' Br. 2-4, DN 76). Furthermore, Defendants and KHA argue that any harm Plaintiffs suffer individually from their inability to open another HHA is speculative. (Intervenor-Def.'s Br. 2-6; Defs.' Br. 4-5).

Plaintiffs' standing must be established as a threshold matter. *See Nikolao v. Lyon*, 875 F.3d 310, 315 (6th Cir. 2017). To establish standing a plaintiff must demonstrate: (1) that he or she suffered an injury in fact that is concrete, particularized, and actual or imminent, (2) that the injury was caused by the defendant, and (3) that the injury would likely be redressed by the requested judicial relief. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). "'At the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice'; more is required to defeat a motion for summary

judgment, and even more is required for a decision on the merits." *Sch. Dist. of City of Pontiac v. Sec'y of U.S. Dep't of Educ.*, 584 F.3d 253, 261 (6th Cir. 2009) (citing *Lujan*, 504 U.S. at 561).

The Supreme Court has held that "the presence of one party with standing is sufficient to satisfy Article III's case-or-controversy requirement." *Rumsfeld v. F. for Acad. & Institutional Rts., Inc.*, 547 U.S. 47, 53 n.2 (2006) (citation omitted). Specifically, "when one party has standing to bring a claim, the *identical claims* brought by other parties to the same lawsuit are justiciable." *Phillips v. Snyder*, 836 F.3d 707, 714 (6th Cir. 2016) (emphasis added) (citation omitted); *see also Parsons v. U.S. Dep't of Just.*, 801 F.3d 701, 710 (6th Cir. 2015) ("A plaintiff must have standing for each claim pursued in federal court. However, only one plaintiff needs to have standing in order for the suit to move forward." (internal citation omitted) (citation omitted)); *Am. Civil Liberties Union of Ky. v. Grayson Cty.*, 591 F.3d 837, 843 (6th Cir. 2010) ("The presence of one party with standing is sufficient." (citations omitted)). Therefore, Plaintiffs must show that at least one named Plaintiff has standing to bring these claims.

"[E]ach form of relief sought must pass the court's justiciability requirements for the plaintiff." *Priorities USA v. Benson*, 448 F. Supp. 3d 755, 761 (E.D. Mich. 2020) (citing *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 185 (2000)); *see also Davis v. FEC*, 554 U.S. 724, 734 (2008) ("'[S]tanding is not dispensed in gross.' Rather, 'a plaintiff must demonstrate standing for each claim he seeks to press'

and 'for each form of relief' that is sought." (alteration in original) (internal citation omitted) (citation omitted)). Ultimately, "[a]t least one plaintiff must have standing to seek each form of relief requested in the complaint." *Town of Chester v. Laroe Ests., Inc.*, 137 S. Ct. 1645, 1651 (2017).

In this instance, neither party disputes that Grace and the individual Plaintiffs not only pursue the same claims but seek the same relief. Accordingly, because Grace has standing, Plaintiffs have standing. *See, e.g.*, *Am. Civil Liberties Union v. Nat'l Sec. Agency*, 493 F.3d 644, 652 (6th Cir. 2007) (holding "it is only necessary that one plaintiff has standing" and where, as here, an injunction is predicated on a declaratory judgment "it follows that if the plaintiffs [have] standing to litigate their declaratory judgment claim, they must also [have] standing to pursue an injunction. The question is whether *any* plaintiff has standing to litigate the declaratory judgment claim."); *see also Priorities USA*, 448 F. Supp. 3d at 761 ("The court will not decide new issues outside of 'identical claims' brought by a plaintiff with standing and will not add damages or remedies based on claims brought by a plaintiff lacking standing." (citing *Phillips*, 836 F.3d at 714 n.2)). Defendants and KHA are correct that "a shareholder of a corporation does not have a personal or individual right of action based solely on an injury to the corporation[,]" but the Court already held that Grace has standing. *Gaff v. FDIC*, 814 F.2d 311, 315 (6th Cir.), *on reh'g in part*, 828 F.2d 1145 (6th Cir. 1987). Accordingly,

the Court will allow the individual Plaintiffs to proceed.[4]

B. CON Laws

Plaintiffs challenge the Commonwealth's CON laws for failing to relate rationally to any legitimate interest in violation of the Due Process Clause and for irrational discrimination in violation of the Equal Protection Clause.

1. *The CON Process*

The first step for an entity seeking a CON is to apply to the Office of Inspector General ("OIG") of the Cabinet for Health and Family Services ("Cabinet"). KRS 216B.062. Applications are evaluated using five statutory criteria: (1) consistency with plans; (2) need

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[4] Plaintiffs have also shown individual standing because they are "seeking 'prospective injunctive relief against enforcement of an occupational certification procedure that is allegedly unconstitutional.'" *Truesdell v. Friedlander*, No. 3:19-CV-00066-GFVT, 2020 WL 5111206, at *3 (E.D. Ky. Aug. 31, 2020) (citation omitted). For example, in the CON context, the Eastern District of Kentucky held that an ambulance service agency and its individual owners had standing, without distinguishing between them. *See id.* at *4 ("Plaintiffs have suffered an injury in fact due to their inability to receive a CON without first undergoing the challenged process."); *see also Birchansky v. Clabaugh*, 421 F. Supp. 3d 658, 672 (S.D. Iowa 2018), *aff'd*, 955 F.3d 751 (8th Cir. 2020) ("Because it is the entity through which [the individual plaintiff] administers his professional services, [the corporation] has an injury in fact under the same theory. Accordingly [both] . . . have standing specific to their own circumstances to challenge the constitutionality of the CON framework.").

and accessibility; (3) interrelationships and linkages; (4) costs, economic feasibility, and resources availability; and (5) quality of services.[5] Both parties essentially recognize the crux of the CON laws are the "consistency with plans" and "need and accessibility" criteria. (Pls.' Mot. Summ. J. 4; Sullivan Dep. 110:6-113:25, Sept. 25, 2020, DN 79-8).

The "consistency with plans" criterion requires the applicant's proposal be consistent with the State Health Plan for a type of facility or service. KRS 216B.040(2)(a)(2)(a), 216B.015(28). Specifically, the State Health Plan for establishing or expanding a HHA, like Grace, is based on a formula that provides the annual calculated "need" for services in each county.[6] (Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 1, at 32, DN 84-3); *see also* 900 KAR 5:020. To determine the need for each county, the formula looks at the statewide use rates of

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[5] Applications may be eligible for formula review, which requires all five factors, or non-substantive review, which is evaluated for consistency with the State Health Plan and the need criterion only, and there is a presumption of consistency with both. KRS 216B.095.

[6] To establish a HHA means "to establish a parent home health agency or a subunit as defined by Medicare in a county. . . ." (Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 1, at 32). To expand a HHA means "to add to the applicant's existing service area a Kentucky county or counties that are contiguous to the applicant's existing service area if the expansion does not involve the establishment of a parent home health agency or subunit as defined by Medicare." (Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 1, at 32).

home health services for respective age groups averaged over the previous two years. For each county, the formula multiples these base rates by the county's projected population in each age group and then totals them. The result is an estimate of how many people are expected to use home health services in each county. The formula then subtracts the patients in the county who used services, averaged over the last two years, to establish the statutory "need". If the State Health Plan calculation yields a need of at least 250 patients in a county, an application to establish a new HHA can move forward; if the plan yields a need of at least 125 patients, an application to expand an existing HHA may proceed. (*See* Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 1, at 32).

The "need and accessibility" criterion requires that the applicant show that the proposal meets an identified need in a defined geographic area and that it will be accessible to all residents of the area.[7] KRS

[7] The third criterion, "interrelationships and linkages", requires the applicant to show that it will have appropriate and effective linkages with other healthcare services and facilities to ensure comprehensive care, proper utilization of services, and efficient functioning of the healthcare system. KRS 216B.040(2)(a)(2)(c). The "costs, economic feasibility and resources availability" criterion requires the applicant to establish that its "proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical use of resources, not only of capital investment, but also ongoing requirements for health manpower and operational financing. . . ." KRS 216B.040(2)(a)(2)(d). The "quality of services" criterion requires the applicant to demonstrate that it will provide quality healthcare services. KRS 216B.040(2)(a)(2)(e).

216B.040(2)(a)(2)(b). To satisfy this criterion, an applicant must pay an application fee of at least $1,000 and complete a 20-page, 3,500-word application. *See* 900 KAR 6:020; (Pls.' Mot. Summ. J. Ex. 17, DN 79-22). Commonly, applicants seek out letters of support from community members, including politicians, and hire CON consultants, that can cost as much as $15,000, to complete the process. (Sullivan Dep. 79:14-80:14; 82:7-8; 73:21-25; 75:4-12).

After submission of an application, the Cabinet puts it on public notice. 900 KAR 6:060 §§ 2-3. An "Affected Person", including the applicant or its competitors, may then request a public hearing before an officer to adjudicate the application based upon a hearing and administrative record.[8] KRS 216B.085(1), 216B.015(3). If no hearing is requested, the officer makes a final decision upon the application alone.[9] A final decision granting or denying an application may be appealed to Franklin Circuit Court. KRS 216B.115.

2. *Due Process*

Plaintiffs contend the CON program is not rationally related to the statutorily enumerated government interest or any other conceivable interest. The Due Process Clause of the Fourteenth Amendment provides

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[8] The hearing mirrors an adversarial trial and can last from two to five days. (Sullivan Dep. 89:8-17; 90:17-24; 92:11-16; 102:16-103:18; 94:6-21).

[9] The entire process usually takes half a year. (Sullivan Dep. 180:23-181:1).

that a state may not deprive a citizen of life, liberty, or property without due process of law. U.S. Const. amend. XIV § 1. "The Fourteenth Amendment 'prohibits the government from imposing impermissible substantive restrictions on individual liberty,' for example, a liberty interest to engage in a chosen occupation." *Truesdell*, 2020 WL 5111206, at *6 (citing *Conn v. Gabbert*, 526 U.S. 286, 291-92 (1999)). "Generally speaking, freedom to choose and pursue a career, 'to engage in any of the common occupations of life,' qualifies as a liberty interest which may not be arbitrarily denied by the State." *Wilkerson v. Johnson*, 699 F.2d 325, 328 (6th Cir. 1983) (internal citation omitted). "In areas of social and economic policy, a statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld . . . if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993) (citations omitted). The parties agree rational basis review applies because a fundamental right is not at issue.

A law subject to rational basis review is constitutionally valid if:

> there is a plausible policy reason for the classification, the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental decisionmaker, and the relationship of the classification to its goal is not

> so attenuated as to render the distinction arbitrary or irrational.

Nordlinger v. Hahn, 505 U.S. 1, 11 (1992) (internal citations omitted) (citation omitted).

> [R]egulatory legislation affecting ordinary commercial transactions is not to be pronounced unconstitutional unless in the light of the facts made known or generally assumed it is of such a character as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators.

United States v. Carolene Prods. Co., 304 U.S. 144, 152 (1938). An "as-applied challenge to the [] [CON]'s constitutionality is subject to the same rational basis review as [a] facial challenge." *Heller v. Ross*, 682 F. Supp. 2d 797, 807 (E.D. Mich. 2010).

Under rational basis review laws are "accorded a strong presumption of validity." *Heller v. Doe by Doe*, 509 U.S. 312, 319 (1993). Furthermore, a legislature need not "actually articulate at any time the purpose or rationale supporting its classification." *Nordlinger*, 505 U.S. at 15 (citation omitted). In fact, courts can conceive of other rational bases and are "not bound by the explanations of the statute's rationality that may be offered by litigants or other courts." *Kadrmas v. Dickinson Pub. Schs.*, 487 U.S. 450, 463 (1988). "The burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it." *Madden v. Kentucky*, 309 U.S. 83, 88 (1940) (citation omitted).

"Judicial invalidation of economic regulations under the Fourteenth Amendment has been rare in the modern era." *Craigmiles v. Giles*, 312 F.3d 220, 229 (6th Cir. 2002) (citation omitted). "This standard is highly deferential; courts hold statutes unconstitutional under this standard of review only in rare or exceptional circumstances." *Doe v. Mich. Dep't of State Police*, 490 F.3d 491, 501 (6th Cir. 2007). It is fair to say that rational basis review "is not a rubber stamp of all legislative action. . . ." *Hadix v. Johnson*, 230 F.3d 840, 843 (6th Cir. 2000) (citation omitted). Ultimately, however, the rational basis standard "is not a license for courts to judge the wisdom, fairness, or logic of legislative choices." *Beach Commc'ns, Inc.*, 508 U.S. at 313. In the end, "[w]here there are 'plausible reasons' for [the legislature's] action, '[the court's] inquiry is at an end.'" *Id.* at 313-14 (citation omitted).

As a preliminary matter, Plaintiffs raise the issue of whether evidence can be used to overcome this standard. (*See* Pls.' Mot. Strike & Substitute Ex. 1, at 2, DN 90-1 [hereinafter Pls.' Resp. Defs.' Mot. Summ. J.]). Plaintiffs have marshalled numerous academic studies and statistical analyses which they insist provide overwhelming evidence that the CON laws harm the very interests it was meant to advance and is thus irrational. Defendants and KHA respond that a state's rational speculation is sufficient and that the Commonwealth is not saddled with a post-hoc evidentiary burden. (Defs.' Mot. Summ. J. 12-15). Defendants and KHA maintain the only issue is whether there is a conceivable rational relationship between the law and its

purpose, not if the law is reasonable in practice or supported by evidence. (Defs.' Mot. Summ. J. 13).

"A State . . . has no obligation to produce evidence to sustain the rationality of a statutory classification." *Heller*, 509 U.S. at 320. "[A] legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." *Beach Commc'ns, Inc.*, 508 U.S. at 315 (citation omitted). To Plaintiffs' point, "parties challenging legislation . . . may introduce evidence supporting their claim that it is irrational. . . ." *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 464 (1981) (citing *Carolene Prods. Co.*, 304 U.S. at 153-54). But the question is not, as they contend, whether the evidence shows the law "is so clearly a mistake that it is irrational." (Pls.' Resp. Defs.' Mot. Summ. J. 4). For the state's policy decisions "need not be supported by scientific studies or empirical data; *nor need they be effective in practice.*" *Sheffield v. City of Fort Thomas*, 620 F.3d 596, 614 (6th Cir. 2010) (emphasis added) (citation omitted). "[P]roffered explanation for the statute need not be supported by an exquisite evidentiary record; rather [the court] will be satisfied with the government's 'rational speculation' linking the regulation to a legitimate purpose, even 'unsupported by evidence or empirical data.'" *Craigmiles*, 312 F.3d at 224 (citations omitted). In fact, "[t]he assumptions underlying these rationales may be erroneous, but the very fact that they are 'arguable' is sufficient. . . ." *Beach Commc'ns, Inc.*, 508 U.S. at 320 (citation omitted). Ultimately, "litigants may not procure invalidation of the legislation

merely by tendering evidence in court that the legislature was mistaken." *Clover Leaf Creamery Co.*, 449 U.S. at 464.

Plaintiffs are correct that "[j]ust because the government does not have the burden of proof does not mean there is no burden of proof." (Pls.' Resp. Defs.' Mot. Summ. J. 4). But the court may only consider evidence of the factual circumstances underlying the policy which will show the assumptions or speculations supporting it, though permissibly erroneous, were impermissibly irrational. Specifically, evidence is only relevant for the question of whether Kentucky's legislature "*rationally could have believed* that the [CON laws] [] would promote its objective." *W. & S. Life Ins. Co. v. State Bd. of Equalization of Cal.*, 451 U.S. 648, 672 (1981) (citations omitted). The court is not, however, looking for evidence that the law did not subsequently work or even that it is counterproductive. *See James v. Strange*, 407 U.S. 128, 133 (1972) ("Misguided laws may nonetheless be constitutional. . . . Our task, however, is not to weigh this statute's effectiveness but its constitutionality."); *see also Fowler v. Benson*, 924 F.3d 247, 262 (6th Cir. 2019) (holding that even a counterproductive law can pass rational-basis review).

With this is mind, much of Plaintiffs' evidence regarding the effects of Kentucky's CON laws is irrelevant to whether there is any reasonably conceivable state of facts that could provide a rational basis for it.[10]

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[10] Plaintiffs cite cases where the issue was decided on evidence or at trial, specifically *Craigmiles* and a similar case, *St.*

Thus, we can address the question at hand. Neither party disputes the Commonwealth's interest in regulating healthcare agencies to promote cost-efficient, accessible, and quality health care services. The only dispute is whether the CON laws are rationally related to these goals.[11]

Joseph Abbey v. Castille, 712 F.3d 215 (5th Cir. 2013), where the courts invalidated a protectionist law. *See also Bokhari v. Metro. Gov't of Nashville & Davidson Cty.*, No. 3:11-00088, 2012 WL 1165907, at *6-8 (M.D. Tenn. Apr. 9, 2012) ("*Craigmiles*, which was decided after a trial on the merits. . . ."). Initially, the Sixth Circuit has explained "there is an outcome-determinative distinction [on] those 'rational basis with a bite' decisions. . . . In each . . . [the] Court concluded that the legislation at issue was in fact intended to further an improper government objective." *Am. Express Travel Related Servs. Co. v. Kentucky*, 641 F.3d 685, 691-93 (6th Cir. 2011) (citing *Craigmiles*). As discussed below, unlike *Craigmiles* there are rational bases that support the CON laws at issue here, beyond mere protectionism. *See also Hines v. Quillivan*, 982 F.3d 266, 274 (5th Cir. 2020) ("We do not read *St. Joseph Abbey* to hold that a plaintiff alleging an equal-protection claim is always entitled to present evidence. . . . *St. Joseph Abbey* dealt with a 'purported rational basis that rose to the level of 'fantasy.' " (internal citation omitted) (citation omitted)). More importantly, *Craigmiles* plainly held: "Our decision today is not a return to *Lochner*, by which this court would elevate its economic theory over that of legislative bodies. No sophisticated economic analysis is required to see the pretextual nature of the state's proffered explanations. . . ." *Craigmiles*, 312 F.3d at 228-29 (internal citation omitted).

[11] Plaintiffs initially argue the CON laws were enacted to limit services to what was needed to reduce costs under the old Medicare "cost-plus" scheme, which has since been abolished. (Pls.' Mot. Summ. J. 14 (citing *Carolene Prods. Co.*, 304 U.S. at 153 ("[C]onstitutionality of a statute predicated upon the existence of a particular state of facts may be challenged by showing to the court that those facts have ceased to exist."))). Regardless

a. Cost-efficiency

Defendants and KHA maintain that Kentucky CON laws rationally relate to cost-efficiency because without limiting the market of HHAs to a projected need, the resulting proliferation of HHAs could cause a reduction in patient volume in each agency, harming the important benefits associated with economies of scale. (Defs.' Mot. Summ. J. 9-10). Plaintiffs argue that restraining markets could not rationally serve the purpose of providing reasonable rates citing *Medigen of Kentucky, Inc. v. Public Service Commission of West Virginia*, 985 F.2d 164 (4th Cir. 1993), for the proposition that the "goal of providing universal service at reasonable rates may well be a legitimate state purpose, but restricting market entry does not serve that purpose." (Pls.' Mot. Summ. J. 16 (citing *Medigen of Ky., Inc.*, 985 F.2d at 167)). But *Medigen* was a Commerce Clause case and, as the Fourth Circuit also held, "[u]nlike the Commerce Clause, the Fourteenth Amendment is not primarily focused on commerce and economic discrimination against out-of-state interests, and its general provisions provide correspondingly less warrant for close judicial supervision." *Colon Health Ctrs. of Am., LLC v. Hazel*, 733 F.3d 535, 548 (4th Cir. 2013). Furthermore, the issue in *Medigen* was whether a statute requiring transporters of medical waste to obtain a CON was related to the goal of providing broad access throughout the state while also ensuring reasonable rates. *Medigen of Ky., Inc.*, 985 F.2d at 167. Defendants

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if this is true, Plaintiffs still must negate *every* conceivable basis for the law. *See Madden*, 309 U.S. at 88.

and KHA here contend the CON laws rationally promote cost-efficiency, not simply a reduction in rates.

Defendants and KHA have maintained throughout the lawsuit that "[r]educing costs and creating a cost-efficient system are not always the same objective." (Defs.' & Intervenor Def.'s Mot. Reconsideration 6 n.3, DN 68). Defendants and KHA argue "[r]educing costs is easy. One can quickly reduce costs by lowering quality, reducing access, or limiting services. Creating a cost-efficient system is much harder." (Defs.' & Intervenor Def.'s Mot. Reconsideration 6 n.3). Defendants and KHA posit that one example of cost-efficiency resulting from the CON laws is the ability to buy supplies and equipment in bulk at reduced prices due to the increased patient volume funneled to the HHAs. (Defs.' Mot. Summ. J. 10). Plaintiffs maintain, however, this is irrational because a strict pursuit of economies of scale would lead to the absurd result of only one HHA. (Pls.' Mot. Summ. J. 16-17). Of course, the CON laws on their face do not strictly pursue this theory, as evidenced by the fact that multiple HHAs exist in the Commonwealth. Plaintiffs also contend the CON laws were intended to regulate major capital investments that could lead to the wasteful duplication of MRI machines, hospital beds, etc., but that HHAs do not require large capital investment because they are primarily based on labor. (Pls.' Mot. Summ. J. 14). The CON laws were not enacted solely for capital investment, however, but for increased access to quality care through cost-effective services. (Defs.' Mot. Summ. J. 25). Defendants and KHA show that HHAs are

expensive to operate and similarly benefit from economies of scale. (Defs.' Mot. Summ. J. 25). It was entirely conceivable for Kentucky's General Assembly to have believed that the CON laws would result in fewer HHAs, which would result in sufficient patient volume, contributing to economies of scale and a more cost-efficient agency. Plaintiffs have not shown that this belief was irrational in the HHA context.

b. Quality

Defendants and KHA have similarly pointed to the plausible effects of the CON laws in the realm of HHA quality, maintaining there is a plausible relationship between patient volume and an agency's ability to offer better programs. (Defs.' Mot. Summ. J. 9). Essentially, Defendants and KHA contend that without a CON law, HHA proliferation in the marketplace would reduce patient volume at individual agencies and the resulting loss of economies of scale could harm an agency's ability to leverage resources to offer programs that enhance quality of care. (Defs.' Mot. Summ. J. 9). Plaintiffs counter that incumbents without competitors tend to provide lower quality services. (Pls.' Mot. Summ. J. 19). Ultimately, this dispute shows that although "[t]he assumptions underlying [Defendants' and KHA's] rationales may be erroneous, . . . the very fact that they are arguable is sufficient. . . ." *Beach Commc'ns, Inc.*, 508 U.S. at 320 (citation omitted).

Plaintiffs contend that in the HHA context, patient-volume sensitivity is irrelevant because the

nurse labor force staffing HHAs tend to work at full capacity. (Pls.' Mot. Summ. J. 21 n.26). Defendants and KHA show, however, that for HHAs, sufficient patient volume is critical to the ability of an agency to also provide specialized programs, beyond basic services, for example, services for heart failure, COPD, diabetes, vestibular/balance conditions, psychiatric diseases, neurological conditions, or orthopedic issues. (Defs.' Mot. Summ. J. 9). The General Assembly could have reasonably concluded "[t]hese programs, and the specialized caregivers needed to staff them, simply would not be financially feasible if the agency did not have an adequate number of patients over which to spread the costs." (Defs.' Mot. Summ. J. 9-10).

Plaintiffs argue the CON laws are a circuitous path to insuring quality services because the Commonwealth has a separate licensure requirement for HHAs. (Pls.' Mot. Summ. J. 22). "The Supreme Court, employing rational basis review, has been suspicious of a legislature's circuitous path to legitimate ends when a direct path is available." *Craigmiles*, 312 F.3d at 227. Defendants and KHA respond, however, that requiring licensure without a CON law could result in an unfunded mandate for quality. (Defs.' & Intervenor Def.'s Reply Mot. Summ. J. 11, DN 92 [hereinafter Defs.' Reply]). For example, "[t]he state could require all HHAs to have [computer] tablets at the bedside, but if there is no CON law to help ensure that HHAs will have sufficient patient volume, HHAs will not be able to comply." (Defs.' Reply 11). Defendants and KHA show that sufficient patient volume guaranteed by the CON

laws could allow HHAs to invest in technological upgrades that are arguably only possible with sufficient patient volume and that could increase quality of care even beyond standards for licensure. It is similarly conceivable that, for HHAs, market exit may be more attractive than investing in quality when compared to other sectors where losses are greater from exiting. (Defs.' Reply 11).

This raises an additional basis for the CON laws that supplements the effects of a licensure requirement, namely, stability. The Commonwealth's interest in quality of care extends not only to ensuring types of services, but the stable provision of services. It is entirely plausible for the General Assembly to have believed that leaving HHAs to the fluctuations of the market could lead to disruptions in care when HHAs close or downsize due to expensive quality standards, insufficient profits, or any other similar reason. Although Plaintiffs maintain it is irrational to believe patients moving to better agencies could have a net effect on quality, this dispute highlights its arguable basis. (Pls.' Resp. Defs.' Mot. Summ. J. 23).

"[E]ven if [Plaintiffs] have found a superior system, the Constitution does not require the [Commonwealth] to draw the perfect line nor even to draw a line superior to some other line it might have drawn." *Armour v. City of Indianapolis*, 566 U.S. 673, 686 (2012). "It is enough that there is an evil at hand for correction, and that it *might* be thought that the particular legislative measure was a rational way to correct it." *Kutrom Corp. v. City of Ctr. Line*, 979 F.2d 1171, 1174

(6th Cir. 1992) (quoting *Williamson v. Lee Optical of Okla. Inc.*, 348 U.S. 483, 487-88 (1955)). Through the CON laws, the Commonwealth has valued the plausible benefits of stable care in the HHA context above the plausible benefits of unfettered competition. Plaintiffs may reasonably dispute this theory in general, but they have not shown that it was *irrational* to believe the CON laws would result in quality services in the HHA context.[12]

c. Access

Plaintiffs also contest the CON laws' ability to increase access to HHAs in Kentucky, asserting that limiting the number of HHAs to increase access is irrational. (Pls.' Mot. Summ. J. 17). Plaintiffs specifically question Defendants' and KHA's contention that without a CON law, HHAs would proliferate in profitable urban areas, leaving rural areas underserved. (Pls.'

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[12] Plaintiffs maintain that because the CON laws forbid their business from opening, by definition, Nepali-speaking patients are not receiving quality care because of the linguistic mismatch with English-speaking staff. (Pls.' Resp. Defs.' Mot. Summ. J. 23). Accepting as true Plaintiffs' contention that receiving care in one's native language is important to quality care, HHAs are already required to have language interpretation services for Nepali speakers. 42 C.F.R. § 484.50(f). In fact, Defendants and KHA have pointed to a HHA in the Louisville Metro area providing video translation services to Nepali-speaking patients. (Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 8, ¶ 16, DN 84-10). While perhaps not a perfect solution, "[t]he problems of government are practical ones and may justify, if they do not require, rough accommodations. . . ." *Metropolis Theater Co. v. Chicago*, 228 U.S. 61, 69 (1913).

Mot. Summ. J. 18). Defendants' and KHA's position seems to imply that CON laws force agencies wishing to open a HHA to essentially "take what they can get." The First Circuit, in *Walgreen Co. v. Rullan*, 405 F.3d 50 (1st Cir. 2005), rejected this argument in the Commerce Clause context and held "the refusal to grant a proposed pharmacy market entry at its desired location will not encourage the proposed pharmacy to relocate to an underserved area (unless the government provides other incentives for it to do so)." *Id.* at 60. The Court noted:

> Presumably areas are underserved because pharmacies have determined that these locations are unlikely to be profitable. For this reason, the denial of a [CON] [] is likely to lead a pharmacy to seek to open in another potentially profitable (and therefore probably already served) area or to withdraw from the [state] [] market entirely.

Id. Although the Commerce Clause requires a more exacting standard than the Due Process Clause, the Defendants and KHA have not argued any additional government incentives that make this argument any less attenuated under rational basis review in the HHA context.

Defendants and KHA alternatively argue CON laws help prevent for-profit HHAs from *opening* in rural areas and poaching lucrative patients, which would destabilize existing agencies and potentially leave its low-income patients without stable access to care. (Defs.' Mot. Summ. J. 22). Further, though serving

Medicaid or underinsured populations is not required to receive a CON, an agency's participation in a Medicaid waiver program for indigent patients is a positive factor in evaluation of CON applications. (Defs.' Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 2, at 26, DN 84-4); *see Colon Health Ctrs. of Am., LLC v. Hazel*, 813 F.3d 145, 156 (4th Cir. 2016) ("[T]he CON program may help underserved and indigent populations access needed medical care. Certificates of need may be granted on the condition that the recipients provide a certain level of indigent care each year." (citations omitted)). Defendants' and KHA's position is premised on the assumption that HHAs are currently using profits to provide care at a loss for numerous unprofitable patients. Accordingly, it is entirely plausible that absent a CON law, new HHAs could target better-paying populations in rural areas, which could leave the burden of serving the less well-insured patients upon existing HHAs, thus reducing access to cost-efficient, stable, and quality care for these patients.

Plaintiffs have not negated every conceivable basis for the Commonwealth's CON program in the HHA context, and therefore, have not shown a violation of the Due Process Clause.

3. *Equal Protection*

Plaintiffs contend the CON program irrationally treats new HHAs differently from similarly situated existing HHAs and that the program's exceptions are irrational. As a sister court held, "the challenged

provisions [facially] treat all health care providers who are subject to them the same and apply the same requirements to them. Plaintiffs, therefore, can only argue the [CON] provisions have a discriminatory effect on a particular group." *Truesdell*, 2020 WL 5111206, at *8. Further, the parties agree rational basis review applies because the law does not affect a suspect class. Like substantive due process, the classification here "cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose." *Heller*, 509 U.S. at 319-20. Courts recognize that particularly in areas of "economic or social legislation," such as when "[d]efining the class of persons subject to a regulatory requirement," the legislature at times "must necessarily engage in a process of line-drawing," which "inevitably requires that some persons . . . be placed on different sides of the line. . . ." *Beach Commc'ns, Inc.*, 508 U.S. at 314 (internal citations omitted). A law will fail rational basis review if "the varying treatment of different groups of persons is so unrelated to the achievement of any combination of legitimate purposes that [the court] can only conclude that the legislature's actions were irrational." *Vance v. Bradley*, 440 U.S. 93, 97 (1979).

Plaintiffs claim the formula distinguishing between existing HHAs and new HHAs is irrational, specifically because it requires new HHAs to show 250 patients in need but only requires existing agencies to show 125. (*See* Pls.' Mot. Summ. J. 5-6). Initially, the Court is disinclined to "pick apart the [CON] statute

specialty by specialty or to unravel a complex medical regulatory scheme strand by strand." *Colon Health Ctrs. of Am.*, 733 F.3d at 548; *see also Truesdell*, 2020 WL 5111206, at *7 ("This Court takes the same approach and construes the legislative objective outlined in the statute above as applying to the CON process as a whole. . . ."). Further, Defendants and KHA have plausibly shown that requiring new HHAs show a need of 250 ensures sufficient patient volume, as 150 was the usual break-even point for HHAs. (Sullivan Dep. 68:7-69:4). Defendants and KHA reasonably maintain that a lower number is required for expansion than establishment because overhead costs are lower when an agency expands, as expansion does not entail starting a parent or subunit agency. (Defs.' Mot. Summ. J. 23). As addressed above, an agency's existing patient volume is rationally related to the interests of cost-efficiency, quality, and access, and therefore, it is logical to distinguish between expansion and establishment based on patient volume.

Plaintiffs then claim the formula for determining need is protectionist as-applied because there have been no CONs granted to new HHAs in the past twenty years. (*See* Pls.' Resp. Defs.' Mot. Summ. J. 11). Plaintiffs cite to *Bruner v. Zawacki*, No. 3:12-57-DCR, 2013 WL 2903241 (E.D. Ky. June 13, 2013), where the district court enjoined a CON statute applied to moving companies where the defendants "admitted that they know of no instance where, upon a protest by an existing moving company, a new applicant has been granted a certificate." *Id.* at *3. Plaintiffs claim the CON laws

are invalid under *Craigmiles*, where the court struck down a law requiring casket sellers to be licensed funeral directors as impermissibly protectionist. (Defs.' Mot. Summ. J. 23-24 (citing *Craigmiles*, 312 F.3d at 229)).

Between 2000 to 2020, of the ninety-five HHA CON applications considered, fifty-three were approved. (Pls.' Mot. Summ. J. Ex. 10, at 2, DN 79-15). Thirty-eight of those fifty-three were from existing HHAs that expanded, and thus were ostensibly approved based upon the lesser showing of need to expand rather than establish an agency. (Pls.' Mot. Summ. J. 11). In truth, the number of expansions is probably greater because, under Kentucky law, when an existing agency expands to a noncontiguous county it is considered a new agency. (Pls.' Mot. Summ. J. 11). Plaintiffs candidly acknowledge that at least six entirely new agencies were approved in Kentucky during this period, not zero. (Pls.' Mot. Summ. J. 11). Furthermore, Defendants and KHA note that ten applications to expand or establish a HHA were approved despite opposition. (Defs.' Mot. Summ. J. Ex. 2, at 9).

Accordingly, unlike *Bruner* where the Court held "to the extent that the protest and hearing procedure prevents excess entry into the moving business, it does so *solely* by protecting existing moving companies[,]" Kentucky's CON formula has not operated *solely* to protect existing HHAs. *Bruner v. Zawacki*, 997 F. Supp. 2d 691, 700 (E.D. Ky. 2014). Similarly, "this case is quite different from [*Craigmiles*] where there was another alternative reason which was both clear

and improper." *Norton Constr. Co. v. U.S. Army Corps of Eng'rs*, No. 1:03-CV-02257, 2007 WL 1431907, at *7 (N.D. Ohio May 14, 2007), *aff'd*, 280 F. App'x 490 (6th Cir. 2008) (citations omitted); *see also Craigmiles*, 312 F.3d at 225 (holding the law must "come close to striking us with 'the force of a five-week-old, unrefrigerated dead fish,' a level of pungence almost required to invalidate a statute under rational basis review." (internal citation omitted)). Importantly, the courts in *Craigmiles* and *Bruner* only held the respective laws unconstitutionally protectionist *after* finding there was no rational basis that supported the distinction.[13] *Craigmiles*, 312 F.3d at 228 ("*Finding no rational relationship to any of the articulated purposes of the state*, we are left with the more obvious illegitimate purpose to

[13] Again, Plaintiffs assert Nepali-speaking patients are not receiving greater access to care because the CON formula prevents a HHA like Grace from opening. Defendants and KHA point out that home health services are prescribed by a doctor and that the services Plaintiffs focused on in their Complaint, like transportation and food preparation, are considered incidental to home health services, but are not services themselves. (Defs.' Mot. Summ. J. 6-7). In fact, Plaintiffs already had a certificate that would have allowed them to provide incidental services. (Defs.' Mot. Summ. J. 7-8; Defs.' & Intervenor Def.'s Joint Mot. Summ. J. & Resp. Pls.' Mot. Summ. J. Ex. 7, DN 84-9). As to prescribed services, Plaintiffs admit they do not know of Nepali speakers in the Louisville Metro area that were not receiving services. (Pls.' Resp. Defs.' Mot. Summ. J. 14). A classification does not fail rational-basis review "simply because [it] 'is not made with mathematical nicety or because in practice it results in some inequality.'" *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) (citation omitted). Furthermore, Defendants and KHA plausibly posit that permitting a special HHA for each ethnic group could fractionalize and destabilize the market.

which licensure provision is very well tailored." (emphasis added)); *Bruner*, 997 F. Supp. 2d at 700-01.

Finally, Plaintiffs claim the exceptions in the CON laws irrationally exempt similarly situated medical providers. (Pls.' Mot. Summ. J. 22-23). "[T]he fact the line might have been drawn differently at some points is a matter for legislative, rather than judicial, consideration." *U.S. R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 179 (1980). The state need not "choose between attacking every aspect of a problem or not attacking the problem at all." *Dandridge*, 397 U.S. at 487 (citation omitted). But the Court does "insist on knowing the relation between the classification adopted and the object to be attained. The search for the link between classification and objective gives substance to the Equal Protection Clause. . . ." *Romer v. Evans*, 517 U.S. 620, 632 (1996). The exemptions here must at a minimum be reasonable. Under the CON program, continuing care retirement communities ("CCRC") and physician's offices are exempt from CON requirements. KRS 216B.020(1), (2)(a). Plaintiffs argue that CCRCs are similar to HHAs because of the small patient populations served and that presumedly both CCRCs and physician offices would benefit from patient-volume and economies of scale like HHAs. (Pls.' Mot. Summ. J. 22-23).

Regarding physician's offices, Defendants and KHA explain that due to the historic and current shortage of physicians in Kentucky and the different types of services provided, proliferation of physicians' offices has never been a concern. (Defs.' Mot. Summ. J. 24-25). Plaintiffs note this contradicts Defendants' and

KHA's previous argument that "[a]llowing HHAs to proliferate without regard to need would also exacerbate Kentucky's *shortage* of home health workers." (Pls.' Resp. Defs.' Mot. Summ. J. 24) (citing Defs.' Mot. Summ. J. 21 (emphasis in original)). This exemption, however, is plausibly based on a distinction between proliferation—the destabilizing growth in the number of providers—and expanded access to care—which includes cost-efficient and quality services. As Plaintiffs note, physician offices are more expensive to operate, and HHAs do not require the same level of expertise as other healthcare services. (Pls.' Mot. Summ. J. 20-21, 23). Accordingly, the General Assembly could have rationally believed it was less likely that physician offices would undesirably proliferate across the Commonwealth in the same way that HHAs might.

As to CCRCs, these entities are prohibited from providing home health services to patients other than their own, making the exception relatively small. (Sullivan Dep. 215:3-23). Also, CCRCs are not eligible to participate in the Kentucky's Medicaid program, which means the Commonwealth does not pay for the services like it does for HHAs. (Sullivan Dep. 257:16-21). Importantly, Defendants and KHA maintain the exemption is meant to guarantee continuity of care by the same staff throughout convalescence, rather than have the patient passed off to another HHA. (Defs.' Mot. Summ. J. 24). Plaintiffs reply that this proves CON laws are meant to limit access, as the exemption was intended to avoid barring CCRCs from the market. (Pls.' Resp. Defs.' Mot. Summ. J. 24). But all this shows

is that CON laws might have the effect of limiting access by *particular* staff. In the CCRC context, therefore, the interest in continuity of care *by the same staff* was reasonably addressed through an exemption. This is different from the continuity of care at issue for HHAs, where the concern is a gap in the middle of treatment.

"True, even the standard of rationality as we so often have defined it must find some footing in the realities of the subject addressed by the legislation." *Heller*, 509 U.S. at 321. But "courts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends." *Id.* "The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective." *McGowan v. Maryland*, 366 U.S. 420, 425 (1961). "Discrimination that can *only* be viewed as arbitrary and irrational *will* violate the Equal Protection Clause." *Hadix*, 230 F.3d at 843 (citing *Vance*, 440 U.S. at 93).

Plaintiffs have not shown that the CON laws irrationally discriminate against agencies in the HHA context, and therefore, have failed to show a violation of the Equal Protection Clause.

C. Conclusion

As the Fourth Circuit recognized, "[c]ertificate-of-need regimes—in place in many states across this country—are designed in the most general sense to

prevent overinvestment in and maldistribution of health care facilities." *Colon Health Ctrs. of Am.*, 813 F.3d at 155. These laws have been consistently upheld against Fourteenth Amendment attacks. *See Birchansky*, 955 F.3d at 758-59; *Colon Health Ctrs. of Am.*, 813 F.3d at 155; *Truesdell*, 2020 WL 5111206, at *6-8. To the extent Plaintiffs have submitted evidence that the CON laws are ineffective, a sister court recognized:

> Alas, what the Court may or may not think about the propriety of, or need for, a [regulation] is really of no moment. Legislative bodies "are accorded wide latitude in the regulation of their local economies under their police powers," they "may implement their program step by step in . . . economic areas, adopting regulations that only partially ameliorate a perceived evil," and "the judiciary may not sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines." As previously noted, "even foolish and misdirected provisions are generally valid" under the rational basis standard of review, and "the Constitution presumes that even improvident decisions will eventually be rectified by the democratic processes."

Bokhari, 2012 WL 1165907, at *7 (internal citations omitted) (citation omitted). Accordingly, Defendants' and KHA's motion for summary judgment is granted and Plaintiffs' motion is denied.

IV. CONCLUSION

For the reasons discussed above, **IT IS HEREBY ORDERED:**

1. Defendants' and Intervenor Defendant's Motion for Summary Judgment (DN 84), Plaintiffs' Motion to Withdraw their Motion to Strike (DN 89), and Plaintiffs' Motion to Strike and Substitute (DN 90) are **GRANTED**. Plaintiffs' claims are **DISMISSED WITH PREJUDICE**.

2. Defendants' and Intervenor Defendant's Motion for Reconsideration (DN 68), Plaintiffs' Motion for Summary Judgment (DN 79), and Plaintiffs' Motion to Strike (DN 87) are **DENIED**.

3. Defendants' and Intervenor Defendant's Motions in Limine (DN 93, 94) are **DENIED AS MOOT**.

4. The Clerk shall strike this matter from the active docket.

/s/ Greg N. Stivers
Greg N. Stivers, Chief Judge
United States District Court

April 14, 2021

cc: counsel of record

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY

DIPENDRA TIWARI, et al. PLAINTIFFS

v. CIVIL ACTION NO. 3:19-CV-884-JRW-CHL

ERIC FRIEDLANDER, et al. DEFENDANTS

and

KENTUCKY HOSPITAL ASSOCIATION INTERVENING DEFENDANT

ORDER

(Filed Aug. 14, 2020)

1. The Court **GRANTS in part** and **DENIES in part** the motion to dismiss filed by Eric Friedlander and Adam Mather, in their official capacities at the Kentucky Cabinet for Health and Family Services ("Kentucky") (DN 18).

2. The Court **GRANTS in part** and **DENIES in part** the motion to dismiss filed by the Intervening Defendant Kentucky Hospital Association (DN 42).

3. Under the *Slaughter-House Cases*, 83 U.S. 36 (1873), the Court **DISMISSES** Count III of the Amended Complaint **with prejudice**.

4. There is no question about Plaintiff Grace Home Care's standing. But the Court **ORDERS** Plaintiffs Dipendra Tiwari and Kishor Sapkota to show cause for why they have standing as individuals to pursue the remaining claims. Their deadline for filing

a notice dismissing those claims or a brief addressing the individuals' standing is **September 10**. Responses and replies, if any, are due in accordance with the Local Rules.

MEMORANDUM OPINION

Plaintiffs Dipendra Tiwari and Kishor Sapkota are immigrant entrepreneurs. They started a home health company called Grace Home Care to serve Nepali-speaking patients. But competitors convinced Kentucky to block them from doing business, denying them a "Certificate of Need."

Under Kentucky's Certificate of Need laws, some health care companies must get permission from the government before they do business. If Kentucky decides the new services aren't needed, the new health care business can't open. Kentucky can deny a Certificate of Need even if the new health care company will reduce patients' costs or deliver higher quality care than Kentuckians can currently access.

Under this system, the government — not doctors, not patients — decides if a community has enough hospitals. And enough hospital beds. And enough rehab centers. And enough mental health facilities. And enough nursing homes. And enough hospices. And enough outpatient surgery centers. And enough drug treatment. And, here, enough home health care businesses.

It's hard to picture this kind of central planning in most other American industries. Consider, for example, if Michigan had told Henry Ford he couldn't build a Model T factory because the market had enough Buicks. Just think how different our Commonwealth would look if Kentucky had told the innovators behind Louisville Slugger, Churchill Downs, and Kentucky Fried Chicken we already had enough baseball bats, race tracks, and fast food. And imagine if a Certificate of Need system had said:

- no need for Stanford (1891) because of Santa Clara (1851);[1]
- no need for MGM (1924) because of Universal Pictures (1912);[2]
- no need for Disneyland (1955) because of Knott's Berry Farm (1941);[3]

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[1] A HISTORY OF STANFORD, https://www.stanford.edu/about/history/; HISTORY — ABOUT SCU, https://www.scu.edu/aboutscu/history/.

[2] MGM HISTORY, https://www.mgm.com/corporate/history; UNIVERSAL, ABOUT: HISTORY, https://www.universalpictures.com/about#:~:text=Universal%20Studios%20is%20a%20member,Cochrane%2C%20and%20Jules%20Brulatour.

[3] Walt Disney: Reinventing the American Amusement Park, AMERICAN EXPERIENCE, https://www.pbs.org/wgbh/americanexperience/features/reinventing-american-amusement-park/; The History of Knott's Berry Farm, KNOTT'S BERRY FARM, https://www.knotts.com/blog/2020/april/the-history-of-knotts-berry-farm. It's hard to pinpoint an exact date for the founding of Knott's Berry Farm's amusement park. The family behind it moved to California to open the berry farm in 1920 and opened the berry market in 1927. Its services gradually expanded. Ghost Town was built in 1941. Guests could walk around for free and only had to pay if they

- no need for Barbie (1959) because of Raggedy Ann (1915);[4]
- no need for Netflix (1997) because of Blockbuster (1985);[5]
- no need for Google (1998) because of Yahoo (1994);[6]
- no need for iPhones (2007) because of Blackberries (1999);[7] and

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wanted to ride something or buy something, much like a state fair. It began charging admission in 1968. *Id.*

Of course, for every Disneyland, there's a Dickens World, a now-defunct English theme park where visitors could breathe soot, smell rotten cabbage, get scolded by an angry schoolteacher, and slide down a simulation of a sewer. SAM ANDERSON, *The Pippiest Place on Earth*, N.Y. TIMES, Feb. 12, 2012, at MM48. The free market promises only a shot at success, not a guarantee.

[4] THE BARBIE STORY: BARBIE WAS CREATED BY RUTH HANDLER — INVENTOR, WIFE, MOTHER. https://barbie.mattel.com/en-us/about/our-history.html; U.S. Patent No. 47,789 (filed May 28, 1915).

[5] ASHLEY RODRIGUEZ, *Netflix was Founded 20 Years Ago Today Because Reed Hastings Was Late Returning a Video*, QUARTZ, https://qz.com/1062888/netflix-was-founded-20-years-ago-today-because-reed-hastings-was-late-a-returning-video/; FRANK OLITO, *The Rise and Fall of Blockbuster*, BUSINESS INSIDER, https://www.businessinsider.com/rise-and-fall-of-blockbuster#david-cook-opened-the-first-blockbuster-in-1985-1.

[6] *From the Garage to the Googleplex*, https://about.google/intl/en_us/our-story/; DAN TYNAN, *The History of Yahoo, and How It Went from Phenom to Has-Been*, FAST COMPANY, https://www.fastcompany.com/40544277/the-glory-that-was-yahoo.

[7] THIS DAY IN HISTORY, JANUARY 9, 2007: STEVE JOBS DEBUTS THE IPHONE, https://www.history.com/this-day-in-history/steve-jobs-debuts-the-iphone; ALEXANDRA APPOLONIA, *How Blackberry Went From Controlling the Smartphone Market to a Phone of the*

- no need for Zoom (2012) because of Skype (2003).[8]

As important as innovation-through-competition has been to those industries, it's arguably even more important in health care, where the stakes are life and death.[9] Sure, health care differs from other industries in important ways. But Plaintiffs argue that the health care industry's unique qualities do not mean that requiring a Certificate of Need for a home health company serves a legitimate state interest.

On Plaintiffs' side are four decades of academic and government studies saying Certificate of Need laws accomplish nothing more than protecting monopolies held by incumbent companies. They also say these laws *worsen* the problems of cost, access, and quality of care that the laws are supposed to help fix.

Past, BUSINESS INSIDER, https://www.businessinsider.com/blackberry-smartphone-rise-fall-mobile-failure-innovate-2019-11.

[8] YITZI WEINER, *The Inspiring Backstory of Eric S. Yuan, Founder and CEO of Zoom*, MEDIUM, https://medium.com/thrive-global/the-inspiring-backstory-of-eric-s-yuan-founder-and-ceo-of-zoom-98b7fab8cacc; ALEX KONRAD, *Zoom, Zoom, Zoom! The Exclusive Inside Story of the New Billionaire Behind Tech's Hottest IPO*, FORBES, https://www.forbes.com/sites/alexkonrad/2019/04/19/zoom-zoom-zoom-the-exclusive-inside-story-of-the-new-billionaire-behind-techs-hottest-ipo/#3b32c3ec4af1; DOUG AAMOTH, *Smartphones: A Brief History of Skype*, TIME MAGAZINE, https://techland.time.com/2011/05/10/a-brief-history-of-skype/.

[9] *Cf.* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *Fact Sheet: Explaining Operation Warp Speed*, https://www.hhs.gov/about/news/2020/06/16/fact-sheet-explaining-operation-warp-speed.html.

If requiring a Certificate of Need for a home health company worsens all problems it purports to fix, the law is irrational. And if it's irrational, it's unconstitutional. At this point, Plaintiffs have plausibly alleged that it is.

I.

A.

If you've ever been close to an elderly relative who couldn't take care of herself, your loved one may have depended on the talent and dedication of a home health worker.[10]

Take, for example, an aging parent with early-onset dementia. Perhaps she's lived alone since her spouse died a decade ago. She doesn't want to impose on her kids and grandkids. And as willing as those kids and grandkids may be, they might not be able to provide the full-time care she requires.[11] She also doesn't

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[10] The Court takes the facts from the Amended Complaint and draws all reasonable inferences in Plaintiffs' favor. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007); *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The Court also considers the State Health Plan and Deloitte Report because both are central to Plaintiffs' claims. *See* DN 15 ¶¶ 63, 67, 76-78, 82, 88-91, 99, 120-1. At oral argument, Plaintiffs made clear that they don't object to considering the Deloitte Report, which the Kentucky Hospital Association attached to its reply.

[11] *See id.* ¶ 40 (Tiwari and Sapkota are "personally aware of Nepali-speaking individuals who cannot find adequate home health services from Nepali-speakers and who would have better health outcomes and would be less of a burden to their families if Grace Home Care were able to operate.").

want, and may not yet need, to move into a nursing home. But living alone twenty-four hours a day isn't an option because she can no longer keep her medicine straight, cook safely, or bathe without assistance.

For many seniors in that situation, home health care is their "first choice."[12] In-home aides help patients with "personal care and basic household tasks," take them to the doctor, and sometimes provide medication and physical therapy.[13] It is cheaper than a nursing home,[14] and patients "often have better outcomes."[15]

Of course, seniors aren't the only ones who hire home health aides. But seniors use them the most.[16] And as you can imagine, not every combination of patient and aide is the right match. In the home health context, the quarters are close, and personalities matter. Often, tranquility depends on a compassionate home health aide with the right mix of patience and communication skills.[17]

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[12] *Id.* ¶ 32.

[13] *Id.* ¶ 26; *see also* DN 48-2 at #461.

[14] DN 15 ¶ 30.

[15] DN 15 ¶ 33.

[16] *Id.* ¶ 28; *see also id.* ¶ 31 ("Home health care is vital for many patients who need extended or long-term care."); *and* DN 48-2 at #459-60 ("In this context, Home Health Agencies provide critically important services for long-term care at home.").

[17] *See* DN 15 ¶ 38 ("The inability of a patient to communicate with a home health aide presents health and safety risks.").

B.

In Kentucky, the government, not the market, decides whether there's a need for more home health services. That's because home health companies are among the health care providers that cannot serve patients until they obtain a Certificate of Need,[18] which says the company will serve an unmet need in a particular county.[19]

In deciding whether to grant a Certificate of Need to a home health company, Kentucky's Cabinet for Health and Family Services ("Kentucky") applies a complicated formula using target rates, age cohorts, and county populations.[20] The formula determines a county's "need" for more home health services.[21] Then, Kentucky applies the following rules:

1) A new home health business may open if the government says at least 250 additional patients in the county need home health.[22]

2) An existing home health business may expand if the government says at least

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[18] *Id.* ¶¶ 2, 73.

[19] Ky. Rev. Stat. § 216B.015(9); DN 15 ¶ 2. The parties generally agree about how Kentucky's Certificate of Need program operates. DN 31 at #233 n.1; DN 46 at #336 n.1. The defendants didn't challenge Plaintiffs' assertion in their replies. *See* DNs 45 & 48.

[20] *See* DN 42 at #312.

[21] *See id.*

[22] *Id.*; DN 15 ¶ 80.

125 additional patients in the county need home health.[23]

3) Existing hospitals may open a home health business if the government says at least 50 additional patients in the county need home health.[24]

Thus, "the need requirement is applied unequally depending on who the applicant is."[25]

That's not so bad if you want to start a home health company in Boone, Campbell, Daviess, Fayette, McCracken, or Oldham counties.[26] Kentucky's formula says those 6 counties have at least 250 untreated patients in need. But Kentucky has 114 other counties. And the doors to those 114 counties are closed to start-up home health businesses, even though a report commissioned by Kentucky and submitted here by the Intervening Defendants shows an unmet need for home health services across the Commonwealth.[27]

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[23] DN 42 at #312-13; DN 15 ¶ 84.

[24] DN 42 at #312; DN 15 ¶ 85.

[25] *Id.* ¶ 83.

[26] DN 42 at #315-17; DN 15 ¶ 82.

[27] DN 48-2 at #461 (map showing unmet need in many counties); *see also id.* at #451 ("Expanded use of home health services might require expanding the number of agencies to fill unmet demand in several counties."); *id.* at #460 ("Interestingly, counties that do not have a Home Health Agency based within the county itself appear to have lower utilization. This could be an indicator of potential unmet need. Conversely, [c]ounties in vicinity of a large Home Health Agency appear to use home health services more readily."); DN 15 ¶ 29 ("There is unmet need for home health services throughout Kentucky.").

C.

It's an understatement to say Kentucky's Certificate of Need laws favor incumbents.[28] Since 2000, in the home health context, Kentucky granted approximately 50 Certificates of Need when incumbents applied for the them.[29] But when a start-up files an application contested by an incumbent,[30] Kentucky either "always or almost always" rejects the start-up's application "on the basis that a lack of need existed."[31] According to Plaintiffs, "it is impossible for a new health agency to open in most counties in Kentucky because existing home health agencies and hospitals prevent the need determination for home health services from ever reaching the 250-person threshold."[32]

In other words, the deck is stacked against start-ups because of incumbents' successful "rent-seeking," with the "rents" referring to monopoly profits. Rent-seeking businesses make a sort-of "extralegal" contract with politicians: money and votes for the politicians, regulations that ensure a monopoly for the interest group.[33] Meanwhile, consumers lose out. Without the market competition that normally regulates businesses' behavior, the monopoly can charge otherwise

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[28] *See* DN 15 ¶ 165; *see also id.* ¶ 97.

[29] *Id.* ¶ 124.

[30] *Id.* ¶¶ 103-5.

[31] *Id.* ¶¶ 112, 123 (cleaned up).

[32] *Id.* ¶ 125.

[33] FRED S. MCCHESNEY, MONEY FOR NOTHING: POLITICIANS, RENT EXTRACTION, AND POLITICAL EXTORTION 21 (1997).

unsustainably high prices for otherwise unsustainably mediocre products.

Plaintiffs don't argue that the politicians who created Kentucky's Certificate of Need regime *intended* to harm patients. Certificate of Need laws were originally "based on the premise that restricting the supply of health care would somehow lead to greater control over health care costs."[34] Congress mandated these laws, and 49 states followed suit.[35] But as a general matter, imposing an artificial shortage on a service simply causes its price to rise. So, predictably, Certificate of Need laws were "not successful in containing health care costs."[36]

In response, in 1986, Congress repealed its mandate for states to create Certificate of Need regimes.[37] "In the wake of the federal repeal, a number of states followed suit and repealed their own [Certificate of Need] laws. Unsurprisingly, subsequent studies did not show a massive explosion in health care costs."[38]

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[34] DN 15 ¶ 44.

[35] *Id.* ¶ 53.

[36] *Id.* ¶ 58; *see also id.* ¶ 45 (limiting hospital beds "only insulated existing hospitals from new competition").

[37] *Id.* ¶ 55; *see also id.* ("Congress determined that certificate-of-need programs produced detrimental effects . . . ."). "At least twice since 1986, the federal government has reaffirmed its conclusion that certificate-of-need programs raise costs and harm patients." *Id.* ¶ 56; *see also id.* ¶¶ 57-58.

[38] MAUREEN OHLHAUSEN, *Certificate of Need Laws: A Prescription for Higher Costs*, ANTITRUST MAGAZINE 50, 52 (Dec. 21, 2015).

In 2013, Kentucky asked the consulting firm Deloitte to study its health care capacity.[39] It recommended that Kentucky consider suspending or discontinuing the home health Certificate of Need requirement.[40] Had Kentucky done so, it would have joined the majority of states, which don't subject home health services to a Certificate of Need regime.[41] And it would have moved in the direction of states that have eliminated Certificate of Need laws altogether.[42]

D.

Plaintiffs Dipendra Tiwari and Kishor Sapkota are Nepali immigrants who speak Nepali.[43] Tiwari is a certified public accountant who previously worked for a different home health company.[44] Sapkota is a home

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[39] DN 15 ¶ 63.

[40] DN 48-2 at #389 ("Strengthen home health and other community based services; Consider suspending [Certificate of Need] for home health"); *id.* at #466 ("Encourage expansion of home health agencies into areas that have already been identified by the Cabinet as being underserved, or consider suspending / discontinuing the [Certificate of Need] program for Home Health Agencies."); *id.* at #388 ("*Next step for consideration*: Strengthen home health and other community based services to facilitate transition and reduce readmissions to facility-based care (e.g. through expansion of [Home and Community Based Services] waiver programs or suspension / discontinuation of [Certificate of Need] for home health agencies").

[41] DN 15 ¶ 34.

[42] *Id.* ¶ 61.

[43] *Id.* ¶ 21.

[44] *Id.* ¶ 22.

health aide.[45] As Louisvillians in a city where the Nepali-speaking immigrant and refugee community "numbers in the thousands,"[46] Tiwari and Sapkota know Nepali-speaking people who can't find home health aides who speak their native language.[47] So in 2017, they started Grace Home Care to fulfill "their dream of opening a home health agency that would serve the Nepali-speaking community in Kentucky."[48]

As is obvious to anyone who has depended on good communication with a home health aide, or whose loved one has depended on it — or who has ever traveled to a foreign country without knowing the local language[49] — patients "have better health outcomes" if they can hire home health aides who speak their language.[50] So it's no surprise that many Nepali-speaking patients may forgo home health care completely if they can't get a Nepali-speaking home health aide,[51] a problem that will only worsen as the community ages.[52]

In this light, you might think the "need" for Grace Home Care would be clear. But when Grace Home Care

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[45] *Id.* ¶ 23.

[46] *Id.* ¶ 35. This opinion uses Louisville and Jefferson County synonymously. In 2003, the city and the county merged.

[47] *Id.* ¶¶ 40, 89, 163.

[48] *Id.* ¶ 41.

[49] *Cf. Lost in Translation* (Focus Features 2003).

[50] DN 15 ¶ 40.

[51] *Id.* ¶ 39.

[52] *Id.* ¶ 36. Translator services are a "useless" substitute because many Nepali speakers don't understand translators' formal language. *Id.*

applied for a Certificate of Need to do business in Louisville,[53] an incumbent home health provider, Baptist Healthcare, opposed the application.[54] And so Kentucky denied Grace Home Care's application for a Certificate of Need,[55] as it does nearly every time an incumbent opposes a start-up provider's application.[56]

Kentucky reasoned that the State Health Plan's formula projected a demand for fewer home health aides than Louisville's supply.[57] But the State Health Plan doesn't consider the "unique needs of the Nepali-speaking community."[58] So long as existing home health companies or hospitals ensure that Louisville's formula-defined need never exceeds 250 patients, Plaintiffs will "never" qualify for a Certificate of Need.[59] Kentucky's Certificate of Need law is thus "a nearly insurmountable barrier to opening a new home health agency,"[60] harming "both entrepreneurs and patients."[61]

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[53] *Id.* ¶ 116.

[54] *Id.* ¶ 119.

[55] *Id.* ¶ 120.

[56] *Id.* ¶¶ 112, 123, 124.

[57] *Id.* ¶ 120 ("the state health plan in effect at the time projected a need of negative 929 home health patients").

[58] *Id.* ¶ 121.

[59] *Id.* ¶ 169.

[60] *Id.* ¶ 161.

[61] *Id.* ¶ 98. Kentucky's Certificate of Need requirements are separate from its licensing requirements. *Id.* ¶ 24. Plaintiffs don't challenge Kentucky's licensing system for home health agencies and are prepared to comply with Kentucky's licensing requirements

According to Plaintiffs, this regime violates their constitutional rights.[62]

II.

Rational-basis scrutiny governs Plaintiffs' Equal Protection and Due Process claims.[63] Under rational-basis review, when the government regulates the economy — here, the health care market — it receives great deference. Kentucky doesn't need to demonstrate "mathematical precision in the fit between justification and means."[64] Rather, binding precedents require this Court to presume an economic regulation is constitutional, and Plaintiffs must "show that there is no rational connection between the enactment and a legitimate government interest."[65] Even if the

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and other laws. *Id.* ¶¶ 25, 129-60, 171, 173-6. But they can't get a license without a Certificate of Need. *Id.* ¶ 172.

[62] U.S. CONST. AM. XIV § 1; DN 15 ¶¶ 179-214; *see Washington v. Glucksberg*, 521 U.S. 702 (1997) (test for substantive due process); *Allegheny Pittsburgh Coal Co. v. County Commission*, 488 U.S. 336 (1989) (test for equal protection).

[63] As Plaintiffs concede, *Slaughter-House* bars their Privileges-or-Immunities Clause claim, which they brought solely to preserve for appeal. DN 15 ¶ 214; *see Slaughter-House Cases*, 83 U.S. 36, 80 (1872). Dismissing that claim is appropriate.

[64] *See Eastern Enterprises v. Apfel*, 524 U.S. 498, 550 (1998) (Kennedy, J., concurring in the judgment and dissenting in part) (cleaned up).

[65] *American Express Travel Related Services Co. v. Kentucky*, 641 F.3d 685, 689 (6th Cir. 2011) (cleaned up). In *American Express*, the Sixth Circuit reversed the district court's order declaring a law unconstitutional on due process grounds. *Id.* at 686. However, the district court's order came after cross motions for

government relies only on speculation "unsupported by evidence or empirical data," the plaintiff must disprove all conceivable reasons for the law.[66]

It's a high bar. But it's not a rubber stamp. Between 1970 to 2000, applying rational-basis review, the Supreme Court struck down at least a dozen economic laws as violating either the Equal Protection Clause or the Due Process Clause.[67]

That's because liberty means more than placing the rights of political minorities at the mercy of political majorities. So too does equal protection. A law cannot be "wholly irrelevant" to any legitimate state

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summary judgment, not at the motion to dismiss stage. *Id.* at 688. "In addition, the statute in *American Express* was a revenue raising statute that did not touch on the economic protectionism that is of particular concern in *Craigmiles* and in this case." *Bruner v. Zawacki*, 997 F.Supp.2d 691, 698 n.10 (E.D.Ky. 2014).

[66] *Craigmiles v. Giles*, 312 F.3d 220, 224 (6th Cir. 2002) (quoting *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313 (1993)). Of course, a statute need not always advance an economic interest. Non-economic interests can also be legitimate state interests.

[67] *Willowbrook v. Olech*, 528 U.S. 562 (2000) (per curiam); *Quinn v. Millsap*, 491 U.S. 95 (1989); *Allegheny Pittsburgh Coal Co. v. County Commission*, 488 U.S. 336 (1989); *Hooper v. Bernalillo County Assessor*, 472 U.S. 612 (1985); *Williams v. Vermont*, 472 U.S. 14 (1985); *Metropolitan Life Insurance Co. v. Ward*, 470 U.S. 869 (1985); *Plyler v. Doe*, 457 U.S. 202 (1982); *Zobel v. Williams*, 457 U.S. 55 (1982); *Chappelle v. Greater Baton Rouge Airport District*, 431 U.S. 159 (1977) (per curiam); *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973); *James v. Strange*, 407 U.S. 128 (1972); *Lindsey v. Normet*, 405 U.S. 56 (1972); *Mayer v. City of Chicago*, 404 U.S. 189 (1971); *Turner v. Fouche*, 396 U.S. 346 (1970).

interest.[68] It cannot be "arbitrary and irrational."[69] Instead, a law must be "reasonable, not arbitrary" and have "a fair and substantial relation" to its purpose.[70]

To be sure, that standard — arbitrary, irrational, unreasonable, or unrelated to its purpose — does not lend itself to precise or perfectly predictable applications. But at least this much about that standard should be clear: When a plaintiff's evidence proves that a statute makes worse the very interest it purports to serve, as well as any other legitimate state interest,[71] the statute is arbitrary, unreasonable, irrational, and unconstitutional.

When faced with that evidence, judges should not display a "disdain for facts."[72] True, judges must never

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[68] *Turner*, 396 U.S. at 362.

[69] *Lindsey*, 405 U.S. at 79.

[70] *F.S. Royster Guano Co. v. Commonwealth of Virginia*, 253 U.S. 412, 415 (1920); *see also id.* at 416 ("It is obvious that the ground of difference upon which the discrimination is rested has no fair or substantial relation to the proper object sought to be accomplished by the legislation.").

[71] *See St. Joseph Abbey v. Castille*, 712 F.3d 215, 223 (5th Cir. 2013) (under rational-basis review, a plaintiff can "negate a seemingly plausible basis for the law by adducing evidence of irrationality").

[72] DAVID E. BERNSTEIN, REHABILITATING LOCHNER: DEFENDING INDIVIDUAL RIGHTS AGAINST PROGRESSIVE REFORM 46 (2011); *cf., Bailey v. Alabama*, 219 U.S. 219, 238-9 (1911) ("That a legislative presumption of one fact from evidence of another may not constitute a denial of due process of law, or a denial of the equal protection of the law, it is only essential that there shall be some rational connection between the fact proved and the ultimate fact presumed, and that the inference of one fact from proof of another

substitute their policy judgment for that of elected legislators. But judges do not become policymakers when they apply the original meaning of constitutional text to a reality the state would prefer to disguise. Instead, they abdicate their judicial duty when they don't.[73] "The invalidation of legislation is not some extraordinary event in the life of a constitutional democracy; it is part of the original design."[74]

The alternative would unleash state power in the service of "not the public or common good but the good of a faction."[75] It "would be the rule of the strong, not

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shall not be so unreasonable as to be a purely arbitrary mandate.").

[73] *See Seal v. Morgan*, 229 F.3d 567, 579 (6th Cir. 2000) ("The fact that we must defer to the Board's rational decisions in school discipline cases does not mean that we must, or should, rationalize away its irrational decisions."); *Peoples Rights Organization, Inc. v. City of Columbus*, 152 F.3d 522, 532 (6th Cir. 1998) ("The rational basis test requires the court to ensure that the government has employed rational means to further its legitimate interest."); *cf. Berger v. City of Mayfield Heights*, 154 F.3d 621, 625 (6th Cir. 1998) ("In sum, we find that neither the City nor the district court have successfully articulated any rational basis to justify the onerous requirements imposed on the owners of vacant lots subject to C.O. 917.14(b) as opposed to the owners of all other vacant lots, and no such rationale is apparent to this court."). For an example of a Court that abdicated its judicial duty by displaying a disdain for facts, see *Plessy v. Ferguson*, 163 U.S. 537 (1896), overruled by *Brown v. Board of Education*, 347 U.S. 483 (1954).

[74] RICHARD A. EPSTEIN, Foreword to Stephen Macedo's *The New Right v. The Constitution* xii (1987).

[75] RANDY E. BARNETT, RESTORING THE LOST CONSTITUTION: THE PRESUMPTION OF LIBERTY at 341; *see also* THE FEDERALIST NO. 10 (J. Madison); *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 446-7 (1985) ("Furthermore, some objectives —

the rule of law."[76] And it would distort the Constitution's "limitations upon popular democracy," which "are as much a part of the Constitution as the institutions of democracy itself."[77]

III.

Kentucky treats some health care companies differently than others. Plaintiffs have plausibly alleged that those classifications don't rationally relate to a legitimate state interest.

A.

Kentucky treats home health start-ups differently than other health care companies in two ways.

First, some health care companies (like Plaintiffs' Grace Home Care) must obtain a Certificate of Need,

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such as a bare desire to harm a politically unpopular group — are not legitimate state interests.") (cleaned up)); *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 412 (1983) (distinguishing between legitimate state purposes and "providing a benefit to special interests"); *City of Philadelphia v. New Jersey*, 437 U.S. 617, 624 (1978) ("Thus, where simple economic protectionism is effected by state legislation, a virtually *per se* rule of invalidity has been erected."); *H.P. Hood & Sons, Inc. v. Du Mond*, 336 U.S. 525, 538 (1949) ("the state may not use its admitted powers to protect the health and safety of its people as a basis for suppressing competition"); *Craigmiles*, 312 F.3d at 224 ("protecting a discrete interest group from economic competition is not a legitimate governmental purpose"); *Bruner*, 997 F. Supp. 2d at 698 (same).

[76] *McGirt v. Oklahoma*, 140 S.Ct. 2452, 2474 (2020).

[77] EPSTEIN at xii.

while others can operate without one.[78] For example, Kentucky does not require a Certificate of Need for doctors' offices, assisted-living residences, and group homes.[79] Even in the field of home health services, "a continuing care retirement community" can do business without a Certificate of Need when it provides home health services "to its on-campus residents."[80]

Second, even among health care companies that must have a Certificate of Need, Kentucky differentiates between the "need" required. An existing hospital wishing to expand home health services must show that 50 would-be patients have an unmet need. An existing home health company must show that 125 would-be patients have an unmet need. And a new home health company (like Plaintiffs' Grace Home Care) must show that 250 would-be patients have an unmet need.

B.

Kentucky's General Assembly says this Certificate of Need regime serves three purposes: It reduces costs, increases quality, and expands access to medical services.[81] These purposes are undoubtedly legitimate, as

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[78] *Compare* Ky. Rev. Stat. §§ 216B.061 & 216B.015(13) *with* Ky. Rev. Stat. § 216B.020(1).

[79] *Id.* at §§ 216B.020(2)(a) & 216B.020(1).

[80] *Id.* at § 216B.020(1).

[81] *See id.* at § 216B.010 ("[T]he proliferation of unnecessary health-care facilities, health services, and major medical equipment results in costly duplication and underuse of such facilities, services, and equipment; and . . . such proliferation increases the

Plaintiffs conceded at oral argument. So the key question is whether requiring a Certificate of Need for home health start-ups rationally relates to those three legitimate state interests.[82]

1.

First, costs. As a general matter, limiting supply does not lower consumer costs.[83] Rather, it raises them.[84] This is "basic economics."[85]

Plaintiffs allege that there's "no evidence" of increased costs in states that have "eliminated their

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cost of quality health care within the Commonwealth. Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth."); DN 15 ¶ 69.

[82] *See United States Department of Agriculture v. Moreno*, 413 U.S. 528, 533 (1973).

[83] DN 15 ¶ 187.

[84] *Id.* ¶ 188.

[85] DN 31 at #235; DN 46 at #338; *see also* OHLHAUSEN at 51 ("Normally, if you want the price of something to decline, creating an artificial shortage of it is not the way to achieve that. There is no clear reason to expect that the basic laws of supply and demand would not apply, either when the states enacted the [Certificate of Need] laws or today.") (cleaned up); LAURETTA HIGGINS WOLFSON, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificate of Need*, 4 DEPAUL JOURNAL OF HEALTH CARE LAW 261, 270 (2001) ("high medical costs were shown to be especially severe in areas controlled by [Certificate of Need] laws") (cleaned up).

certificate-of-need programs altogether."[86] Here, Plaintiffs are alluding (albeit indirectly) to an extensive line of scholarly research that "casts considerable doubt on the proposition that [Certificate of Need] programs lead to reduced healthcare expenditures or that their repeal leads to a surge in unnecessary services in the market":[87]

- In 1998, a study in Duke's peer-reviewed[88] *Journal of Health Politics, Policy, and Law* "found no evidence of a surge in acquisition of facilities or in costs following removal of [Certificate of Need] regulations. The same study found that mature [Certificate of Need] programs were not associated with a significant reduction in per capita costs."[89]
- In 2003, a study in the peer-reviewed[90] *Inquiry: The Journal of Health Care Organization, Provision and Financing* "showed that states that repealed their

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[86] *See* DN 15 ¶ 61.

[87] EMILY WHALEN PARENTO, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KENTUCKY LAW JOURNAL 201, 228 (2017).

[88] DUKE UNIVERSITY PRESS, *Submission Guidelines*, https://read.dukeupress.edu/jhppl/pages/Submission_Guidelines.

[89] PARENTO at 227 (citing CHRISTOPHER J. CONOVER & FRANK A. SLOAN, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Healthcare Spending?*, 23 JOURNAL OF HEALTH POLICY, POLITICS, & LAW 455, 469 (1998)).

[90] *Journal Description, Inquiry: The Journal of Health Care Organization, Provision, and Financing*, SAGE JOURNALS, https://journals.sagepub.com/description/inq.

[Certificate of Need] laws did not experience significant growth in either nursing home or long-term care costs."[91]

- In 2007, a study in the peer-reviewed[92] *Health Education Journal* "showed that healthcare costs were, on average, higher in states with [Certificate of Need] programs."[93]
- In 2010, a "more rigorous" study in the *Journal of Healthcare Finances*, "concluded that [Certificate of Need] programs not only failed to correlate to lower costs, they might actually lead to *higher* costs per admission."[94]

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[91] PARENTO at 227 (citing DAVID C. GRABOWSKI, *The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures*, 40 INQUIRY 146, 154 (2003)).

[92] *Journal Description, Health Education Journal*, SAGE JOURNALS, https://journals.sagepub.com/description/HEJ.

[93] PARENTO at 227 (citing PATRICK A. RIVERS, *Does Certificate of Need Really Contain Hospital Costs in the United States?*, 66 HEALTH EDUCATION JOURNAL 229, 240-41 (2007)).

[94] *Id.* (citing PATRICK A. RIVERS, *The Effects of Certificate of Need Regulation on Hospital Costs*, JOURNAL OF HEALTHCARE FINANCE, Summer 2010, 1, 10-11). "While a 2014 study found lower hospital cost-inefficiency in [Certificate of Need] states than non-[Certificate of Need] states, as FTC Commissioner Ohlhausen observed, that particular study did not control for the possibility that the observed differences could be caused by many other differences between states without [Certificate of Need] laws, such as market and environmental characteristics, factors which were addressed in the 2010 study." *Id.* (citing MICHAEL D. ROSKO & RYAN L. MUTTER, *The Association of Hospital Cost-Efficiency with Certificate-of-Need Regulation*, 71 MEDICAL CARE RESEARCH AND REVIEW 280, 292-94 (2014)).

The federal government agrees. Congress repealed its Certificate-of-Need mandate in 1986 because "the evidence showed that certificate-of-need programs resulted in increased health care costs."[95] In addition, the Department of Justice and the Federal Trade Commission "have taken an active position against the continuance of [Certificate of Need] programs."[96] For example, in 2004, they cited "considerable evidence that [Certificate of Need] programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns."[97] They reaffirmed their opposition in 2007, 2008, and 2015.[98]

In sum, Plaintiffs may be on to something when they say Certificate of Need laws raise costs. And for home health in particular, the economics appear off: Nursing homes and hospitals are more expensive than home health.[99] Limiting home health care thus seems like a counter-productive way to reduce patient costs.[100]

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[95] DN 15 ¶ 55.

[96] PARENTO at 215; *see also* DN 15 ¶ 56 ("At least twice since 1986, the federal government has reaffirmed its conclusion that certificate-of-need programs raise costs and harm patients.").

[97] DN 15 ¶ 58.

[98] PARENTO at 215-18.

[99] DN 15 ¶ 30.

[100] *Id.* ¶ 164.

2.

Second, access. Generally, limiting the supply of home health care doesn't increase access to it.[101] Specifically, the State Health Plan effectively bars new home health companies from opening in 114 of Kentucky's 120 counties.[102] That seems like a recipe for *decreasing* Kentuckians' access to home health care.[103]

There's support for that suspicion in a report commissioned by Kentucky and submitted by the Intervening Defendant. The Deloitte Report suggests that far more than 6 counties have an unmet need for home health care.[104] And the Deloitte Report may actually understate the lack of access the Certificate of Need regime has created, since it shows Louisville needing no new services, while Plaintiffs know individuals in Louisville who can't access the home health care they need.[105]

Here again, academic research buttresses Plaintiffs' argument. Although "supply of services is an imprecise metric,"[106] evidence measuring supply "seems to support the conclusion that [Certificate of Need] programs restrict access to care. For example, a 2014

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[101] *Id.* ¶ 187.

[102] *Id.* ¶ 82; DN 42 at #315-17.

[103] DN 15 ¶ 188.

[104] DN 48-2 at #461.

[105] DN 15 ¶¶ 40, 89, 163.

[106] PARENTO at 228; *see id.* ("the fact that providers are located in a given geographic area does not mean that they are willing to provide services to all patients").

study by George Mason University showed that while the average state has 362 hospital beds per 100,000 population, this number falls to 263 hospital beds per 100,000 population in states with [Certificate of Need] programs."[107] Another study "found no evidence" that those programs enhanced a state's ability to provide indigent care.[108]

At this point, you might wonder how anyone could have thought that capping the supply of medicine would ever increase access to it. Well, the theory was that the government needed to incentivize capital investment in poor communities by promising a monopoly to companies that invested there. So, for example, if a company spends millions building a hospital in a rural county, the government rewards the company by limiting its competition. But regardless of whether that theory works out well in practice for poor patients outside the home health context — and, again, studies suggest it doesn't[109] — the idea makes little sense here, where "[s]tarting a home health agency does not require a large capital investment."[110]

At least in the home health context, Plaintiffs may be right that Kentucky's Certificate of Need regime reduces access to care.

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[107] *Id.* (citing THOMAS STRATMANN & JAKE RUSS, *Do Certificate-of-Need Laws Increase Indigent Care*? 11-12 (MERCATUS CENTER, GEORGE MASON UNIV., Working Paper No. 14-20, 2014)).

[108] *Id.* (citing STRATMANN & RUSS at 18).

[109] *Id.*

[110] DN 15 ¶ 27.

3.

Third and finally, quality. In general, limiting the supply of home health care doesn't increase the quality of that care; if anything, limiting supply decreases quality.[111]

A Certificate of Need program promises better outcomes for patients "by ensuring an adequate volume of patients."[112] So, for example, if you go to a surgeon who has performed 500 of the county's past 500 surgeries (because she hasn't had any competition), you might expect her to be better than the surgeon who has operated on patients only 5 times (because most of the county's patients chose her competitors). And "evidence has shown that patients experience better outcomes in hospitals with expertise (usually measured as higher volume) in particular procedures."[113]

But here's the catch: the regulatory regime's promise is unkept. The "link between volume and quality appears to be independent of the existence of a [Certificate of Need] program in a state. Moreover, some evidence suggests that stringent [Certificate of Need] programs decrease the quality of care in many settings":[114]

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[111] *Id.* ¶¶ 187-8.

[112] PARENTO at 229.

[113] *Id.* (citing HIMANSHU J. PATEL, *Aortic Valve Replacement: Using a Statewide Cardiac Surgical Database Identifies a Procedural Volume Hinge Point*, 96 ANNALS THORACIC SURGERY 1560, 1565 (2013)).

[114] *Id.*

- A 1988 study in the *New England Journal of Medicine* "showed higher mortality rates in hospitals in states with stringent [Certificate of Need] programs."[115]
- A 2009 study in *Health Services Research* "found that states that had dropped [Certificate of Need] regulations had lower mortality rates for [coronary artery bypass graft] surgery than states that kept their [Certificate of Need] programs."[116]
- An informal 2017 study in the *Kentucky Law Journal* concluded "hospitals in [Certificate of Need] states are approximately 50% more likely to be penalized [by Medicare] than those in non-[Certificate of Need] states."[117]

Proponents of Certificate of Need programs can point to other studies, including two about regulatory programs for heart surgery.[118] And if the constitutionality

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[115] *Id.* (citing STEPHEN M. SHORTELL & EDWARD F.X. HUGHES, *The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients*, 318 NEW ENGLAND JOURNAL OF MEDICINE 1100, 1101, 1102 (1988)).

[116] *Id.* at 230 (citing VIVIAN HO, *Certificate of Need (CON) for Cardiac Care: Controversy Over the Contributions of CON*, 44 HEALTH SERVICES RESEARCH, 483, 493-96 (2009)) (cleaned up).

[117] *Id.* (cleaned up).

[118] *Id.* at 229 (citing M. S. VAUGHAN-SARRAZIN, *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation*, 288 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1859, 1859 (2002); JOSEPH S. ROSS, *Certificate of Need Regulation and*

of Kentucky's regime depended on the outcome of dueling academic studies, Kentucky would survive rational basis review. But the issue here isn't the constitutionality of a Certificate of Need law for heart surgeons, or for any medical providers outside the context of home health.

Here, Plaintiffs plausibly allege that Kentucky's law isn't rationally related to Kentucky's interest in improving the quality of home health aides. That allegation is bolstered by the critical importance of communication between patients and home health aides. Kentucky laws make that communication worse. They prevent members of Louisville's large Nepali-speaking community from accessing health care in their homes from people who speak their language. That in turn hurts the health of those patients.[119]

Patients are more than numbers you plug in a formula. Old or young, rich or poor, English-speaking or Nepali-speaking, each patient is unique. And their unique health challenges are exacerbated when the patient and the aide literally don't speak the same language.

In that situation, the Alzheimer's patient has a harder time understanding directions that would be confusing even in her own language. So too for the mentally sharp but physically disabled patient who must spend hours upon hours with a stranger in

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Cardiac Catheterization Appropriateness After Acute Myocardial Infarction, 115 CIRCULATION 1012, 1014-16 (2007)).

[119] DN 15 ¶ 38.

her home. Of course, home health aides don't stay strangers, and the bond between the aide and the patient often becomes strong. But the quality of that bond can depend on the quality of the communication.

When Plaintiffs say that the wellbeing of Nepali-speaking "patients and their families depend on access to Nepali-speaking home health care,"[120] that allegation makes a lot of sense. Regardless of whether Certificate of Need programs improve quality in other contexts, it's plausible that they diminish quality in the context of home health.

C.

If requiring a Certificate of Need for a home health company doesn't improve costs, access, or quality, what *does* it do?

Binding precedent helps answer the question. In *Craigmiles v. Giles*, the Sixth Circuit found that a licensing requirement for the sale of caskets bore "no rational relationship to any of the articulated purposes of the state."[121] It then reasoned that the "weakness" of a state's "proffered explanations" indicated that the regulatory regime "was nothing more than an attempt

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[120] DN 15 ¶ 89.

[121] 312 F.3d 220, 228 (6th Cir. 2002); *see also St. Joseph Abbey v. Castille*, 712 F.3d 215, 226-27 (5th Cir. 2013) ("The great deference due state economic regulation does not demand judicial blindness to the history of a challenged rule or the context of its adoption nor does it require courts to accept nonsensical explanations for regulation.").

to prevent economic competition."[122] The court reaffirmed that "protecting a discrete interest group from economic competition is not a legitimate governmental purpose."[123]

Admittedly, in *Powers v. Harris*, the Tenth Circuit reached a different result.[124] Whereas the Sixth Circuit has said no law can "privilege certain businessmen over others at the expense of consumers,"[125] *Powers* limited that principle to interstate competition, rather than intrastate competition.[126]

Concurring only in part, Judge Tymkovich disagreed with that limitation.[127] So did the Fifth Circuit.[128] It held unconstitutional "the taking of wealth and handing it to others when it comes not as economic protectionism in service of the public good but as 'economic' protection of the rulemakers' pockets."[129] Such wealth transfers were among the framing generation's

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[122] *Craigmiles*, 312 F.3d at 225.

[123] *Id.* at 224 (citing cases); *cf. National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978) ("The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain — quality, service, safety, and durability — and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[124] 379 F.3d 1208 (2004).

[125] *Craigmiles*, 312 F.3d at 229.

[126] 379 F.3d at 1219.

[127] *Id.* at 1225-27 (Tymkovich, J., concurring in part and concurring in the judgment).

[128] *St. Joseph Abbey*, 712 F.3d 215.

[129] *Id.* at 226-27.

chief concerns — transfers from weak factions to strong factions "who are united and actuated by some common impulse of passion, or of interest, adversed to the rights of other citizens, or to the permanent and aggregate interests of the community."[130]

Of course, the best security against national factions is the Constitution's vertical and horizontal separation of powers. But the generation that ratified our Constitution supplemented its structural protections with a Bill of Rights, and the Civil War generation added still more protection against factions with the Fourteenth Amendment. Through its Due Process and Equal Protection Clauses, the Constitution erects "a virtually *per se* rule of invalidity" when "simple economic protectionism is effected by state legislation."[131]

That principle carried the day six years ago when our sister district invalidated a Certificate of Need regime for moving companies in *Bruner v. Zawacki.*[132]

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[130] THE FEDERALIST NO. 10 (J. Madison); *cf. id.* ("[T]he most common and durable source of factions has been the various and unequal distribution of property. Those who hold, and those who are without property, have ever formed distinct interests in society. Those who are creditors, and those who are debtors, fall under a like discrimination. A landed interest, a manufacturing interest, a mercantile interest, a moneyed interest, with many lesser interests, grow up of necessity in civilized nations, and divide them into different classes, actuated by different sentiments and views.") (cleaned up).

[131] *City of Philadelphia*, 437 U.S. at 624; *see also H.P. Hood & Sons, Inc.*, 336 U.S. at 538; *Energy Reserves Group, Inc.*, 459 U.S. at 413.

[132] 997 F. Supp. 2d 691 (E.D.Ky. 2014).

There, as in this case, Kentucky had either never or hardly ever issued a Certificate of Need to a start-up over an incumbent's protest.[133] There, as is alleged here, the statute was an "act of simple economic protectionism" that bore no "rational relationship to *any* legitimate purpose other than protecting the economic interests of existing . . . companies."[134]

Here, even beyond the "weakness" of Kentucky's "proffered explanations,"[135] three rent-seeking features of Kentucky's health care program make it especially disturbing: the formula; the review process; and status of home health companies that operate in continuing care retirement communities.

As for the formula, it's easier for incumbents to expand their services than for start-up competitors to enter the market, which prevents the formula from showing a "need" for the start-ups.[136] And even if incumbents' expansion creates an adequate quantity of services, it doesn't capture the need for adequate quality. For example, Kentucky's formula says Louisville has services accessible to 929 more patients than are using those services.[137] But Plaintiffs personally know

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[133] *Id.* at 694.

[134] *Id.* at 698, 701 (cleaned up).

[135] *Craigmiles*, 312 F.3d at 225.

[136] *See* DN 15 ¶¶ 125, 169. True, incumbents must obtain a Certificate of Need to expand their services. But that's easier for them than it is for start-ups. Incumbents can obtain a Certificate when there are only 50 or 125 patients in need, while start-ups can do so only when there are 250 patients in need.

[137] DN 15 ¶ 89.

patients in Louisville who lack access to the quality of care they desire — *i.e.*, Nepali-speaking home health aides.[138]

Another constitutionally troubling component of the regime is Kentucky's review process, which allows incumbents to "veto" new business.[139] Patients aren't the ones saying the services of start-ups aren't needed.[140] No patient opposed Plaintiffs' application, and no patient has intervened in this lawsuit. Instead, an incumbent, Baptist Healthcare, successfully objected to the Plaintiffs' administrative application,[141] just like "all or almost all of the denied home health agency certificate-of-need applications were objected to by a direct competitor."[142] Then, when Plaintiffs filed this lawsuit, the Kentucky Hospital Association intervened, as if to prove the point that incumbents, not patients, are the only ones threatened by Plaintiffs' constitutional challenge.

Perhaps the most glaring evidence of rent-seeking is the statute's disparate treatment of most home health companies from home health companies that

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[138] *Id.* ¶ 89.

[139] *Id.* ¶ 106.

[140] *Id.* ¶ 105; *cf. Bruner*, 997 F.Supp.2d at 694 ("no protest has ever been filed by a member of the general public").

[141] *See* DN 15 ¶ 119.

[142] *Id.* ¶ 123. *See* 997 F.Supp.2d at 694 ("In summary, the Cabinet has never issued a Certificate to a new applicant when a protest from a competing mover was made."); *id.* at 697 ("The evidence of record established that the denial is preordained where any protest is received.").

operate in continuing care retirement communities. Kentucky exempts the latter from its Certificate of Need requirement.[143] When both groups provide the exact same patient care, why distinguish between those serving patients in a private home (like Grace Home Care) from those serving patients in continuing care retirement communities? A plausible answer is that one group had better lobbyists than the other. If so, that is exactly the kind of "arbitrary classification" the Fourteenth Amendment prohibits.[144]

D.

Kentucky and the Kentucky Hospital Association rely on two non-binding circuit court opinions.[145] In *Colon Health Centers of America, LLC v. Hazel*, the Fourth Circuit affirmed the district court's dismissal of plaintiffs' challenges to Virginia's Certificate of Need requirement for MRI machines.[146] In *Birchansky v. Clabaugh*, the Eighth Circuit affirmed the district court's grant of summary judgment on plaintiffs' challenges to Iowa's Certificate of Need requirement for outpatient surgery centers.[147]

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[143] Ky. Rev. Stat. § 216B.020(1).

[144] *Engquist v. Oregon Department of Agriculture*, 553 U.S. 591, 598 (2008) (cleaned up); *see also Berger*, 154 F.3d at 625 ("We find no rational basis for such arbitrary results.").

[145] DN 18-1 at #128; DN 42 at #291; DN 58.

[146] 733 F.3d 535, 548 (4th Cir. 2013).

[147] 955 F.3d 751, 759 (8th Cir. 2020).

Of course, neither case binds this Court. More than that, neither involved the home health context. That matters for two reasons.

First, as mentioned earlier, it doesn't cost much to start a home health agency. In fact, aside from regulatory expenses, you don't need much more than a qualified worker with a car and gas money.[148] You don't need to buy a CT scanner or MRI machine, as in *Colon Health*.[149] And you don't need to construct a whole center for outpatient surgery, as in *Birchansky*.[150]

Because it doesn't cost much to start a home health agency, the government doesn't need to guarantee a home health company a monopoly in order to incentivize someone to make the capital investment for it.[151] Perhaps that's why most states "have no certificate-of-need requirements for home health care agencies."[152] And why most states contiguous to Kentucky,

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[148] *See* DN 15 ¶ 27.

[149] *Colon Health*, 733 F.3d at 541.

[150] *Birchansky*, 955 F.3d at 755.

[151] *See* DN 15 ¶ 186 ("No purported justification for certificates of need in other contexts, such as control of capital expenditures or cross-subsidization, exists in the home health context."); *see also id.* ¶ 185 ("Even if Kentucky's certificate-of-need program achieved any of its purported purposes for some types of health care services (which it does not), the certificate-of-need program does not achieve any legitimate state purpose in the home health context.").

[152] DN 15 ¶ 34; *cf. James v. Strange*, 407 U.S. 128, 139-40 (1972) ("Not only does this treatment not accord with the treatment of indigent recipients of public welfare or with that of other civil judgment debtors, but the Kansas statute also appears to be alone among recoupment laws applicable to indigent defendants

including Indiana, Illinois, Ohio, Missouri, and Virginia, don't subject home health agencies to those requirements.[153] And why the states that don't require home health companies to have a Certificate of Need "have not experienced any negative health or safety consequences."[154]

Second, unlike patients getting colonoscopies, MRIs, or outpatient surgery, home health patients can't travel to a provider outside their county. After all, the whole point of home health care is that it's *inside* your home.[155] Patients in 114 of the Commonwealth's 120 counties can't access service from an innovative home health start-up. But in the states covered by *Colon Health* and *Birchansky*, patients can travel to another county, or even another state, for innovative care from entrepreneurs providing the medical procedures at issue.

In short, even if the regulatory schemes in *Colon Health* and *Birchansky* rationally related to legitimate state interests, those decisions merely mean Kentucky's Certificate of Need laws might be constitutional for CT scanners, MRI machines, and outpatient surgery centers. They do not show how Kentucky's

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in expressly denying them the benefit of basic debtor exemptions.").

[153] DN 48-2 at #460.

[154] DN 15 ¶¶ 193, 204.

[155] *Id.* ¶ 32.

regime helps anyone in the home health context other than rent-seeking incumbents.[156]

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Fernando Martinez was born in Cuba. He was arrested as a teenager for running a restaurant without the government's permission. So he butchered his three pigs. He sold the meat. He used the money to buy parts for a homemade raft. He sailed for Florida. He survived a tropical storm. He found his way to Louisville. He spent the next eight years working in commercial kitchens. He saved all his money. He opened a Cuban restaurant called Havana Rumba. He worked there 120 hours a week. Then he opened a Mexican grill. And then a burger bar. And an Italian trattoria. And later a steak house. And a chain of taco shops. And more.[157]

Today, Fernando Martinez is "unique in Louisville history, not only for the number of restaurants he's opened but for the variety of concepts."[158] He is living proof that the American dream is real.

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[156] *See id.* ¶¶ 185, 192, 207; *see also id.* ¶ 208 ("Kentucky's nakedly protectionist certificate-of-need program harms entrepreneurs, like Plaintiffs, and further deprives consumers of home health services of their right to choose their home health provider.").

[157] JEFFREY LEE PUCKETT, *Building a Food Empire: Since Fleeing Cuba, Bold Chef's Cuisine Concepts Have Spread*, THE COURIER-JOURNAL (Louisville, Kentucky), March 1, 2018, at A8.

[158] *Id.*

But think back to the moment in Martinez's story when he opened his first restaurant. What if Kentucky had told him, "You must obtain a Certificate of Need"? What if he had been required to show there were not already *enough* restaurants in Louisville? What if his dream had depended on a formula created by a bureaucracy captured by a competitor like Olive Garden?

There are of course differences between the markets for food and medicine. Even if a Certificate of Need program would be irrational in the restaurant industry, perhaps Plaintiffs will be unable to marshal the evidence in discovery to prove their allegations of irrationality in the context of home health care. After all, in *Craigmiles*, the district court found the challenged Certificate of Need regime unconstitutional only after weighing the evidence at trial.[159] And under rational-basis review, Plaintiffs have a heavy burden.

But for now, at the very least, Plaintiffs' allegations are plausible.[160] On this limited record, there is every reason to think that Kentucky's law increases costs, reduces access, and diminishes quality — for no reason other than to protect the pockets of rent-seeking incumbents at the expense of entrepreneurs who

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[159] 312 F.3d at 224.

[160] *Cf. Williams v. Vermont*, 472 U.S. 14, 28 (1985) ("It is conceivable that, were a full record developed, it would turn out that in practice the statute does not operate in a discriminatory fashion. . . . We only hold that, when the statute is viewed on its face, appellants have stated a claim of unconstitutional discrimination.").

want to innovate and patients who want better home health care.

Even in the best times, those entrepreneurs and patients depend on our Constitution to curb irrational state burdens on medicine.

We especially depend on it in a pandemic.[161]

[SEAL]

/s/ Justin R. Walker

Justin R Walker, District Judge

United States District Court

8/14/2020

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[161] *Cf. Why the U.S. Is Running Out of Medical Supplies*, THE DAILY (Mar. 31, 2020) (downloaded using Google Podcasts) (discussing how Certificate of Need laws have contributed to hospital bed shortages in the pandemic).

Ky. Rev. Stat. § 216B.010

Legislative findings and purposes

The General Assembly finds that the licensure of health facilities and health services is a means to insure that the citizens of this Commonwealth will have safe, adequate, and efficient medical care; that the proliferation of unnecessary health-care facilities, health services, and major medical equipment results in costly duplication and underuse of such facilities, services, and equipment; and that such proliferation increases the cost of quality health care within the Commonwealth. Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost-efficient health-care delivery system for the citizens of the Commonwealth.

Ky. Rev. Stat. § 216B.020

(1) The provisions of this chapter that relate to the issuance of a certificate of need shall not apply to abortion facilities as defined in KRS 216B.015; any hospital which does not charge its patients for hospital services and does not seek or accept Medicare, Medicaid, or other financial support from the federal government or any state government; assisted living residences; family care homes; state veterans' nursing homes; services provided on a contractual basis in a rural primary-care hospital as provided under KRS 216.380; community mental health centers for services as defined in KRS Chapter 210; primary care centers; rural health clinics; private duty nursing services operating as health care services agencies as defined in Section 1 of this Act; group homes; licensed residential crisis stabilization units; licensed free-standing residential substance use disorder treatment programs with sixteen (16) or fewer beds, but not including Levels I and II psychiatric residential treatment facilities or licensed psychiatric inpatient beds; outpatient behavioral health treatment, but not including partial hospitalization programs; end stage renal disease dialysis facilities, freestanding or hospital based; swing beds; special clinics, including but not limited to wellness, weight loss, family planning, disability determination, speech and hearing, counseling, pulmonary care, and other clinics which only provide diagnostic services with equipment not exceeding the major medical equipment cost threshold and for which there are no review criteria in the state health plan; nonclinically related expenditures; nursing home beds that shall be exclusively limited to on-campus residents

of a certified continuing care retirement community; home health services provided by a continuing care retirement community to its on-campus residents; the relocation of hospital administrative or outpatient services into medical office buildings which are on or contiguous to the premises of the hospital; the relocation of acute care beds which occur among acute care hospitals under common ownership and which are located in the same area development district so long as there is no substantial change in services and the relocation does not result in the establishment of a new service at the receiving hospital for which a certificate of need is required; the redistribution of beds by licensure classification within an acute care hospital so long as the redistribution does not increase the total licensed bed capacity of the hospital; residential hospice facilities established by licensed hospice programs; or the following health services provided on site in an existing health facility when the cost is less than six hundred thousand dollars ($600,000) and the services are in place by December 30, 1991: psychiatric care where chemical dependency services are provided, level one (1) and level two (2) of neonatal care, cardiac catheterization, and open heart surgery where cardiac catheterization services are in place as of July 15, 1990. The provisions of this section shall not apply to nursing homes, personal care homes, intermediate care facilities, and family care homes; or nonconforming ambulance services as defined by administrative regulation. These listed facilities or services shall be subject to licensure, when applicable.

(2) Nothing in this chapter shall be construed to authorize the licensure, supervision, regulation, or control in any manner of:

(a) Private offices and clinics of physicians, dentists, and other practitioners of the healing arts, except any physician's office that meets the criteria set forth in KRS 216B.015(5) or that meets the definition of an ambulatory surgical center as set out in KRS 216B.015;

(b) Office buildings built by or on behalf of a health facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts; unless the physician's office meets the criteria set forth in KRS 216B.015(5), or unless the physician's office is also an abortion facility as defined in KRS 216B.015, except no capital expenditure or expenses relating to any such building shall be chargeable to or reimbursable as a cost for providing inpatient services offered by a health facility;

(c) Outpatient health facilities or health services that:

1. Do not provide services or hold patients in the facility after midnight; and

2. Are exempt from certificate of need and licensure under subsection (3) of this section;

(d) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees, if the facility does not contain inpatient or resident beds for patients or employees who generally

remain in the facility for more than twenty-four (24) hours;

(e) Establishments, such as motels, hotels, and boarding houses, which provide domiciliary and auxiliary commercial services, but do not provide any health related services and boarding houses which are operated by persons contracting with the United States Department of Veterans Affairs for boarding services;

(f) The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination and recognized by that church or denomination; and

(g) On-duty police and fire department personnel assisting in emergency situations by providing first aid or transportation when regular emergency units licensed to provide first aid or transportation are unable to arrive at the scene of an emergency situation within a reasonable time.

(3) The following outpatient categories of care shall be exempt from certificate of need and licensure on July 14, 2018:

(a) Primary care centers;

(b) Special health clinics, unless the clinic provides pain management services and is located off the campus of the hospital that has majority ownership interest;

(c) Specialized medical technology services, unless providing a State Health Plan service;

(d) Retail-based health clinics and ambulatory care clinics that provide nonemergency, noninvasive treatment of patients;

(e) Ambulatory care clinics treating minor illnesses and injuries;

(f) Mobile health services, unless providing a service in the State Health Plan;

(g) Rehabilitation agencies;

(h) Rural health clinics; and

(i) Off-campus, hospital-acquired physician practices.

(4) The exemptions established by subsections (2) and (3) of this section shall not apply to the following categories of care:

(a) An ambulatory surgical center as defined by KRS 216B.015(4);

(b) A health facility or health service that provides one (1) of the following types of services:

1. Cardiac catheterization;

2. Megavoltage radiation therapy;

3. Adult day health care;

4. Behavioral health services;

5. Chronic renal dialysis;

6. Birthing services; or

7. Emergency services above the level of treatment for minor illnesses or injuries;

(c) A pain management facility as defined by KRS 218A.175(1);

(d) An abortion facility that requires licensure pursuant to KRS 216B.0431; or

(e) A health facility or health service that requests an expenditure that exceeds the major medical expenditure minimum.

(5) An existing facility licensed as an intermediate care or nursing home shall notify the cabinet of its intent to change to a nursing facility as defined in Public Law 100–203. A certificate of need shall not be required for conversion of an intermediate care or nursing home to the nursing facility licensure category.

(6) Ambulance services owned and operated by a city government, which propose to provide services in coterminous cities outside of the ambulance service's designated geographic service area, shall not be required to obtain a certificate of need if the governing body of the city in which the ambulance services are to be provided enters into an agreement with the ambulance service to provide services in the city.

(7) Notwithstanding any other provision of law, a continuing care retirement community's nursing home beds shall not be certified as Medicaid eligible unless a certificate of need has been issued authorizing applications for Medicaid certification. The provisions of subsection (5) of this section notwithstanding, a continuing care retirement community shall not

change the level of care licensure status of its beds without first obtaining a certificate of need.

Ky. Rev. Stat. § 216B.040

Functions of cabinet in administering chapter; regulatory authority

(1) The cabinet shall have four (4) separate and distinct functions in administering this chapter:

(a) To approve or deny certificates of need in accordance with the provisions of this chapter, except as to those applications which have been granted nonsubstantive review status by the cabinet;

(b) To issue and to revoke certificates of need;

(c) To provide a due process hearing and issue a final determination on all actions by the cabinet to deny, revoke, modify, or suspend licenses of health facilities and health services issued by the cabinet; and

(d) To enforce, through legal actions on its own motion, the provisions of this chapter and its orders and decisions issued pursuant to its functions.

(2) The cabinet shall:

(a) Promulgate administrative regulations pursuant to the provisions of KRS Chapter 13A:

1. To establish the certificate of need review procedures, including but not limited to, application procedures, notice provisions, procedures for review of completeness of applications, and timetables for review cycles.

2. To establish criteria for issuance and denial of certificates of need which shall be limited to the following considerations:

    a. Consistency with plans. Each proposal approved by the cabinet shall be consistent with the state health plan, and shall be subject to biennial budget authorizations and limitations, and with consideration given to the proposal's impact on health care costs in the Commonwealth. The state health plan shall contain a need assessment for long-term care beds, which shall be based on a statistically valid analysis of the present and future needs of the state as a whole and counties individually. The need assessment shall be applied uniformly to all areas of the state. The methodology shall be reviewed and updated on an annual basis. The long-term care bed need criteria in the state health plan or as set forth by the appropriate certificate of need authority shall give preference to conversion of personal care beds and acute care beds to nursing facility beds, so long as the state health plan or the appropriate certificate of need authority establishes a need in the affected counties and the proposed conversions are more cost-effective than new construction. The fact that the state health plan shall not address the

specific type of proposal being reviewed shall not constitute grounds for disapproval of the proposal. Notwithstanding any other provision of law, the long-term care bed need criteria in the state health plan or as set forth by the appropriate certificate of need authority shall not consider, factor in, or include any continuing care retirement community's nursing home beds established under KRS 216B.015, 216B.020, 216B.330, and 216B.332;

b. Need and accessibility. The proposal shall meet an identified need in a defined geographic area and be accessible to all residents of the area. A defined geographic area shall be defined as the area the proposal seeks to serve, including its demographics, and shall not be limited to geographical boundaries;

c. Interrelationships and linkages. The proposal shall serve to accomplish appropriate and effective linkages with other services, facilities, and elements of the health care system in the region and state, accompanied by assurance of effort to achieve comprehensive care, proper utilization of services, and efficient functioning of the health care system;

d. Costs, economic feasibility, and resources availability. The proposal, when measured against the cost of alternatives for meeting needs, shall be judged to be an effective and economical use of resources, not only of capital investment, but also ongoing requirements for health manpower and operational financing;

e. Quality of services. The applicant shall be prepared to and capable of undertaking and carrying out the responsibilities involved in the proposal in a manner consistent with appropriate standards and requirements assuring the provision of quality health care services, as established by the cabinet;

f. Hospital-based skilled nursing, intermediate care, and personal care beds shall be considered by the cabinet in determining the need for freestanding long-term care beds.

(b) Conduct public hearings, as requested, in respect to certificate-of-need applications, revocations of certificates of need, and denials, suspensions, modifications, or revocations of licenses.

(3) The cabinet may:

(a) Issue other administrative regulations necessary for the proper administration of this chapter;

(b) Administer oaths, issue subpoenas, subpoenas duces tecum, and all necessary process in proceedings brought before or initiated by the cabinet, and the process shall extend to all parts of the Commonwealth. Service of process in all proceedings brought before or initiated by the cabinet may be made by certified mail, or in the same manner as other process in civil cases, as the cabinet directs;

(c) Establish by promulgation of administrative regulation under KRS Chapter 13A reasonable application fees for certificates of need;

(d) Establish a mechanism for issuing advisory opinions to prospective applicants for certificates of need regarding the requirements of a certificate of need; and

(e) Establish a mechanism for biennial review of projects for compliance with the terms of the certificate of need.