ENGLEWOOD HOSPITAL & MEDICAL CENTER, HUDSON HOSPITAL OPCO, LLC D/B/A CHRIST HOSPITAL, IJKG OPCO, LLC D/B/A BAYONNE MEDICAL CENTER, HUMC OPCO, LLC D/B/A HOBOKEN UNIVERSITY MEDICAL CENTER, CAPITAL HEALTH REGIONAL MEDICAL CENTER, CAPITAL HEALTH MEDICAL CENTER – HOPEWELL, HACKENSACK MERIDIAN HEALTH PASCAK VALLEY MEDICAL CENTER, JFK MEDICAL CENTER, ST. FRANCIS MEDICAL CENTER, HACKENSACK MERIDIAN HEALTH – MOUNTAINSIDE MEDICAL CENTER, AND PRIME HEALTHCARE SERVICES – ST. MARY'S PASSAIC, LLC D/B/A ST. MARY'S GENERAL HOSPITAL,

Appellants,

V.

THE STATE OF NEW JERSEY, THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES, CAROLE JOHNSON IN HER CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES, STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, MEGHAN DAVEY IN HER CAPACITY AS DIRECTOR OF THE DIVISION OF

SUPREME COURT OF NEW JERSEY
DOCKET NO. 089696

Civil Action

ON APPEAL FROM A FINAL JUDGMENT OF THE SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

DOCKET NO.: A-2767-21

SAT BELOW:
Hon. Lisa Rose, J.A.D.
Hon. Morris G. Smith, J.A.D.
Hon. Lisa Perez Friscia, J.A.D.

MEDICAL ASSISTANCE AND HEALTH SERVICES, STATE OF NEW JERSEY DEPARTMENT OF HEALTH, AND SHEREEF M. ELNAHAL IN HIS CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HEALTH,

Respondents.

SUPPLEMENTAL BRIEF OF RESPONDENTS
Date Submitted: February 14, 2025

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PRELIMINARY STATEMENT

New Jersey, like other States, has long prohibited licensed hospitals from turning away patients simply because they are indigent, while providing subsidies directly from the public fisc to offset the cost of providing such care. This system, known as "charity care," ensures that patients are not denied critical care simply because they are unable to afford the cost of hospitalization or because a hospital is unsure about a patient's financial resources. While Petitioners, a group of eight hospitals, argue that this statutory scheme effects a per se taking of private property, the Appellate Division correctly rejected their claims. This Court should do the same.

As a threshold matter, most if not all Petitioners cannot assert a takings claim in the first place, because they acquired their respective ownership interests after charity care's enactment. Thus, like the tort claimant who "came to the nuisance," they cannot complain of an encumbrance that they voluntarily assumed. In any event, Petitioners' per se theory—that charity care deprives them of their right to exclude indigent patients from their property, and relatedly commandeers hospital supplies and services—is erroneous. Per se takings occur when a government either appropriates or extinguishes a property interest, but as the U.S. Supreme Court confirmed four years ago in the case on which Petitioners principally rely, no such appropriation can occur when the regulation

complained of is "consistent with longstanding background restrictions on property rights." That exception is dispositive here, because an owner who purchases a hospital is charged with knowing that hospitals are heavily regulated public accommodations, with limitations on their ability to exclude others and to charge whatever they like. (Indeed, both this Court and the Third Circuit have rejected similar takings challenges to New Jersey statutes limiting hospital rates and restricting nursing homes from denying service based on a senior's ability to pay.) The same result obtains here: just as precedent teaches that a law firm cannot complain that this Court's pro bono requirement effects a per se taking of their associates' time or printer ink, a policy that places reasonable restrictions on hospitals' ability to deny service to indigent patients does not work a per se taking either.

Petitioners' theory is better analyzed under the rubric of a "regulatory taking," though it cannot ultimately succeed on these facts, and it is unclear if Petitioners even still press it in this Court. The governing inquiry—a flexible, context-specific test grounded in the three factors drawn from the U.S. Supreme Court's Penn Central decision—weighs heavily in the State's favor, because while Petitioners have shown that charity care has some economic impact on their businesses, they have not shown that the impact is extreme, and the challenged government action reflects no more than a standard regulatory

concern that does not run afoul of any reasonable, investment-backed expectations, given the highly regulated nature of the hospital industry.

Finally, Petitioners' focus on the distinction between facial and as-applied relief is not germane. Their central claim is that charity care works a per se taking—a categorical question of pure law, separate from any fact-specific questions that turn on how charity care operates as to a particular hospital. In that sense, it is facial, but whether styled as facial or as-applied, the answer is the same: New Jersey's charity care system does not effect a per se (or regulatory) taking, and therefore no remand is necessary to consider whether the State's subsidy program is "just" as applied to each individual hospital. This Court should affirm.

PROCEDURAL HISTORY AND COUNTERSTATEMENT OF FACTS[1]

A. The Charity Care Statutes.

In order to more effectively "ensure access to and the provision of high quality and cost-effective hospital care to its citizens," N.J.S.A. 26:2H-18.51(a), the Health Care Reform Act of 1992 (the Act) provides that no hospital may deny admission or appropriate service based on a patient's "ability to pay or source of payment," N.J.S.A. 26:2H-18.64, and creates a charity-care subsidy to support hospitals that disproportionately serve patients who are unable to afford

[1] These related sections are presented together for the Court's convenience.

needed care, see N.J.S.A. 26:2H-18.51 to -18.64. The prohibition on denying service based on ability to pay applies to every licensed acute-care hospital, N.J.S.A. 26:2H-18.52; see N.J.A.C. 8:33-4.9(c), -4.10(a)(6) (requiring hospitals to commit to providing such charity care to become licensed), and violators are liable for a civil penalty of $10,000 per violation, N.J.S.A. 26:2H-18.64.

The State disburses charity-care subsidies from a larger dedicated, nonlapsing fund, the Health Care Subsidy Fund (HCSF), which also supports Medicaid and other subsidized-healthcare programs. See N.J.S.A. 26:2H-18.58 to -18.62. The amount allocated to a hospital is correlated with its overall charity care costs and the ratio of its charity care costs to overall revenue. See N.J.S.A. 26:2H-18.59i. For instance, the statutory formula directs DOH to rank each hospital "in order of its hospital-specific, relative charity care percentage ... by dividing the amount of hospital-specific gross revenue for charity care patients by the hospital's total gross revenue for all patients," N.J.S.A. 26:2H-18.59i(b)(1). The statute then instructs DOH to apportion to the ten hospitals at the top of that ranking a subsidy "equal to 96 percent of each hospital's hospital-specific reimbursed documented charity care," with the hospital ranked in eleventh place receiving a 94-percent subsidy and each hospital ranked thereafter receiving a subsidy two percentage points lower than the previous hospital on the list. N.J.S.A. 26:2H-18.59i(b)(2). And regardless of its

placement in that overall ranking, the hospital that provides the most charity care in each of the ten poorest municipalities in the State also receives a subsidy equivalent to 96 percent of its charity care costs. See N.J.S.A. 26:2H-18.59i(b)(3).[2] The Legislature in each year's Appropriations Act appropriates funds for the subsidy; interest earnings and assessments on health care providers, including hospitals, also help to fund it. Ibid. Once the aggregate amount is determined in light of that year's appropriation, the Department of Health (DOH) allocates the subsidy for the current fiscal year according to the statutory formula, N.J.S.A. 26:2H-18.59i, accounting for any instructions in that year's Appropriations Act regarding the calculation of the subsidy paid to each hospital, N.J.S.A. 26:2H-18.55.

The Act also addresses the valuation for charity care. Most relevantly, in quantifying the amount of charity care an eligible hospital provided, that care is "valued not at its usual and customary charges but rather on the amount

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[2] The Act further provides that "no hospital shall receive reimbursement for less than 43 percent of" its qualifying care. N.J.S.A. 26:2H-18.59i(b)(4). While the Legislature has included provisions in subsequent Appropriations Acts that have lowered that reimbursement floor and/or the allocation formula for particular fiscal years, see, e.g., N.J. Dep't of Treasury, Appropriations Handbook: Fiscal Year 2024-2025, at B-98, available at: https://tinyurl.com/2zxkjt64 (last accessed February 14, 2025), the constitutional question before this Court is whether the charity care regime can qualify as a taking in the first place, and chiefly whether it effects a per se taking—a question that does not turn on the quantum of the subsidy.

Medicaid would pay for such services ('documented charity care')."[3] Univ. of Med. & Dentistry v. Grant, 343 N.J. Super. 162, 165 (App. Div. 2001) (citing N.J.S.A. 26:2H-18.59e(a)(1)); see N.J.S.A. 26:2H-18.59i(a)(1) (governing such valuations during and after 2004). In other words, the input to calculating each hospital's subsidy is the "Medicaid-priced" value of the charity care provided by each hospital. See ibid. A hospital that is dissatisfied with its share of the HCSF may challenge the amount of its subsidy through an administrative appeal, N.J.A.C. 10:52-13.4(f)(1)-(2) (providing for challenges based both on "a calculation error" and "reasons other than a calculation error"), or may petition the Division of Medical Assistance and Health Services within the Department of Human Services to adjust its Medicaid rate, N.J.A.C. 10:52-14.17(c).[4]

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[3] Specifically, the Act instructs the State to "maintain the charity care subsidy at an amount not less than 75 percent of the Medicaid-priced amounts of charity care provided by hospitals in the State." N.J.S.A. 26:2H-18.59i(c).

[4] New Jersey's law is hardly unusual: a number of States have similar laws requiring hospitals and other providers to provide some level of care regardless of ability to pay, some of which also provide for a subsidy to offset the costs of such care. See, e.g., CAL. HEALTH & SAFETY CODE § 1317; DEL. CODE ANN. tit. 16, § 9311; GA. CODE ANN. § 31-6-40; IOWA CODE § 347.16; KY. REV. STAT. ANN. § 205.640; MD. CODE ANN., HEALTH-GEN. § 19-214.1; ME. REV. STAT. ANN. tit. 22, §§ 1715-16; MONT. CODE ANN. § 50-5-121; NEV. REV. STAT. ANN. § 439B.320; OHIO REV. CODE ANN. § 5168.14; 35 PA. STAT. ANN. §§ 449.8; R.I. GEN. LAWS ANN. §§ 23-17-43, 40-6-3.2; S.C. CODE ANN. § 44-7-260.

B. Proceedings Below.

Petitioners, a group of hospitals, commenced this action in the Law Division in 2017, suing the State and multiple state agencies and officials involved in administering charity care (collectively, the State).[5] In March 2022, following the close of discovery and cross-motions for summary judgment, the trial court granted summary judgment to the State dismissing certain takings claims, and dismissing in part the remaining takings claims for failure to exhaust administrative remedies. Petitioners appealed.

The Appellate Division affirmed, "for slightly different reasons" than the trial court. (Op. 4).[6] The panel first considered whether the trial court erred in dismissing a portion of the claims on exhaustion grounds—i.e., whether the trial court correctly found that Petitioners' claims were as-applied challenges. (Op. 15). The panel noted that Petitioners "challenge the Legislature's reimbursement system, including N.J.S.A. 26:2H-18.64, in its entirety," and that

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[5] Many of these Petitioners had previously challenged the charity care statute on takings grounds in separate administrative appeals from the determinations of their charity care subsidies and Medicaid rates for various years. See (Op. 8-10). The Appellate Division affirmed the agency decisions in both matters without passing on the merits of the taking claims, ibid., instead directing Petitioners to bring those claims in a Law Division filing. This suit followed.

[6] "Op." refers to the Appellate Division's published June 27, 2024, opinion, reproduced in Petitioners' certification appendix. "Pcb" refers to Petitioners' certification brief. "Psb" refers to Petitioners' supplemental brief in this Court.

if they succeeded, such an outcome would "affect all hospitals, even though the claim was not brought on behalf of all hospitals licensed to operate in the state." (Op. 15-16). The panel thus held that Petitioners' claims "represent a facial constitutional attack on the charity care statute," such that they should not have been dismissed for failure to "first obtain individual decisions under the rate appeal process." (Op. 16.).

On the merits of the takings claim, the Appellate Division held that neither a per se nor a regulatory taking had occurred. The court found that there was no per se taking because "the charity care statute's operation does not lead to physical invasion of the hospitals' property." (Op. 20). It further concluded that the statute "does not require a transfer of ownership of medical supplies or equipment into the government's or a third party's hands." (Op. 21).

The Appellate Division also found that no regulatory taking had occurred, applying the test outlined in Penn Central Transportation Co. v. New York City, 438 U.S. 104, 124 (1978). (Op. 21-26). As to economic impact, the panel noted that while Petitioners had provided sufficient evidence "that N.J.S.A. 26:2H-18.64 has had an adverse impact on their profitability, ... [a] takings claim cannot be sustained on the sole ground that [the Hospitals] fail to financially perform on par with industry-wide norms." (Op. 22-23). And Petitioners had not shown that the statute "deprives them of economic use of their properties as

a whole." (Op. 23). As to reasonable investment-backed expectations, the panel emphasized that "[h]ospital investors in the highly regulated health care industry should expect that use of their property, in all its forms, is likely to be regulated by the state, and that such government regulation may diminish investment-backed expectations without resulting in an unconstitutional taking." (Op. 24). Given Petitioners' choice to do business in this field, "it is reasonable that they should expect such license conditions to affect business profits." (Op. 25). The panel thus concluded that "it is not reasonable for the hospitals to expect an at-cost reimbursement for the medical services the Legislature has required them to provide as a condition of doing business in our state." (Ibid.)

Finally, as to the character of the government action (the final component of the Penn Central analysis), the panel observed that "the character of public health and healthcare regulations typically weighs against the conclusion that a law acts as a taking," citing precedent of this Court upholding an analogous requirement that nursing homes make available a "reasonable number" of beds to indigent persons as a condition of licensure. (Op. 25) (citing In re Health Care Admin Bd., 83 N.J. 67, 81 (1980)). Consistent with those principles, the court found that the charity-care mandate and accompanying subsidy "are specific to its aims—to ensure equal access to healthcare for indigent patients[.]" (Ibid.) Accordingly, the Appellate Division concluded that "the character of the

government action reflects a reasonable adjustment to the benefits and burdens of economic life for the common good and weighs strongly against finding a taking." (Op. 26).[7]

This Court granted certification and permitted both parties to file supplemental briefs. This brief follows.

ARGUMENT

Petitioners' Takings Clause challenges fail. The Takings Clause provides: "private property [shall not] be taken for public use, without just compensation." U.S. Const. amend. V.[8] In the past century, courts have divided takings doctrine into two categories: per se and regulatory takings. See Cedar Point Nursery v. Hassid, 594 U.S. 139, 147-48 (2021). Per se takings involve an absolute appropriation or extinguishing of an owner's property rights, and fall into "two relatively narrow categories" of action, Lingle v. Chevron U.S.A. Inc., 544 U.S.

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[7] While the Appellate Division appeal was pending, multiple plaintiff-hospitals withdrew from the case (but still appear in the caption). The eight Petitioners still in this case are Englewood Hospital & Medical Center; Hudson Hospital OPCO, LLC, d/b/a Christ Hospital; IJKG OPCO, LLC, d/b/a Bayonne Medical Center; HUMC OPCO, LLC, d/b/a Hoboken University Medical Center; Capital Health Regional Medical Center; Capital Health Medical Center–Hopewell; St. Francis Medical Center; and Prime Healthcare Services–St. Mary's Passaic, LLC, d/b/a St. Mary's General Hospital.

[8] Because the New Jersey Constitution provides "coextensive" protection against takings, Mansoldo v. State, 187 N.J. 50, 58 (2006), this brief discusses state and federal takings doctrine together.

528, 538 (2005): scenarios where the government has undertaken or authorized "a permanent physical occupation of property," Ark. Game & Fish Comm'n v. United States, 568 U.S. 23, 31 (2012), or taken action "that completely deprive[s] an owner of 'all economically beneficial us[e]' of her property," Lingle, 544 U.S. at 538 (quoting Lucas v. S. Carolina Coastal Council, 505 U.S. 1003, 1019 (1992)). Regulatory takings can occur, by contrast, when the government does not appropriate or extinguish rights, but instead "imposes regulations that restrict an owner's ability to use his own property." Cedar Point, 594 U.S. at 148.

Petitioners' various theories fail. First, no matter whether styled as a per se or regulatory takings challenge, most if not all of the Petitioners run into a dispositive threshold problem: because they acquired or established their hospitals after the State adopted the challenged charity-care provisions, Petitioners are entitled to no compensation for these pre-existing statutory requirements. Second, beyond that threshold problem, Petitioners' per se takings claim fails: the challenged charity-care provisions neither appropriate nor extinguish Petitioners' property rights given the historical tradition of medical regulation that itself cabins those rights. Third, the challenge equally fails when framed as a regulatory takings claim: the governing Penn Central

factors—economic impact, interference with reasonable investment-backed expectations, and the character of the government action—all foreclose it.

POINT I

PETITIONERS' TAKINGS CHALLENGES TO PREEXISTING STATUTORY REQUIREMENTS NECESSARILY FAIL.

The takings claims brought by at least most of these Petitioners can be disposed of for threshold reason: most of if not all Petitioners acquired their respective hospitals after charity care was enacted. Takings law serves to protect "owners who can demonstrate that they bought their property in reliance on the non-existence of the challenged regulation." Good v. United States, 189 F.3d 1355, 1360 (Fed. Cir. 1999). The doctrine is thus concerned with impositions on the "bundle of rights" an owner acquired when it obtained title, Lucas, 505 U.S. at 1027, which requires examining "the regulatory environment at the time" of acquisition. Love Terminal Partners, L.P. v. United States, 889 F.3d 1331, 1345 (Fed. Cir. 2018); see, e.g., 74 Pinehurst LLC v. New York, 59 F.4th 557, 567 (2d Cir. 2023) (noting recovery should be limited to those who "bought their property in reliance on a state of affairs that did not include the challenged regulatory regime"). Courts thus regularly deny recovery to owners who challenge pre-existing regulations as a taking. See, e.g., 74 Pinehurst LLC, 59 F.4th at 567-68; Anaheim Gardens, L.P. v. United States, 953 F.3d 1344, 1349-

51 (Fed. Cir. 2020); see also Ruckelshaus v. Monsanto Co., 467 U.S. 986, 1006-07 (1984) (rejecting claim based on trade secrets submitted to federal agency after the challenged disclosure statute took effect). As Lucas put it, takings law "assuredly would permit the government to assert a permanent easement that was a pre-existing limitation upon the land owner's title"—in contrast to one that was "decree[d] ... anew." Lucas, 505 U.S. at 1029.

There are good reasons for this rule—consistent with the logic animating the Takings Clause itself. For one, owners "who bought" a particular property "with knowledge of the restraint" can hardly claim to have relied on possessing property rights free from such regulation, and thus are instead better understood as having "assumed the risk of any economic loss" from a preexisting regulation. Good, 189 F.3d at 1361. For another, beyond simply assuming the risk of that preexisting regulation, "it is common sense" that such owners "presumably paid a discounted price for the property," because the market would have naturally baked in the preexisting restriction. See ibid. Indeed, on that same logic, allowing a plaintiff to bring a takings claim regarding a law that predates their ownership interest is not only unnecessary, but unfair: providing additional money to such an owner would "confer a windfall" given those market forces. Ibid.; see also Murr v. Wisconsin, 582 U.S. 383, 398 (2017) (agreeing a "reasonable restriction that predates a landowner's acquisition ... can be one of

the objective factors that most landowners would reasonably consider in forming fair expectations about their property"). Just as tort law limits those who "come to the nuisance" from complaining of pre-existing activity, so too does takings jurisprudence bar claims that the government "took" property before the owner ever possessed it. The Takings Clause, after all, does not "turn the Government into an involuntary guarantor of the property owner's gamble that he could develop the land as he wished despite the existing regulatory structure." Mehaffy v. United States, 102 Fed. Cl. 755, 756 (2012), aff'd, 499 F. App'x 18 (Fed. Cir. 2012).

This principle applies regardless of whether a challenger styles its claim as a per se or regulatory takings challenge. See Lucas, 505 U.S. at 1029 (in reviewing per se claim, observing that courts "assuredly would permit the government to assert a permanent easement that was a pre-existing limitation upon the land owner's title"); Monsanto, 467 U.S. at 1006-07 (same principle for regulatory claim). Were it otherwise, a plaintiff could simply recast its claim under the "per se" label rather than the "regulatory" one, given the overlap between the two. See Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 126-29 (1st Cir. 2009) (rejecting challenge to substantially similar charity-care law that was litigated as a regulatory taking). But that is the opposite of what the text of the Takings Clause and precedent teaches: that per se and regulatory arguments

are simply two frames for making the same core claim, i.e., that the government has taken private property and thus is required to pay just compensation. See Yee v. City of Escondido, 503 U.S. 519, 535 (1992). Someone who bought a property already encumbered by the government cannot claim that the government subsequently took that encumbrance, whether by calling it appropriation or regulation.

That is a bar to recovery for most if not all Petitioners. The charity-care regime that Petitioners challenge was established decades ago—in 1992. See L. 1992, c. 160. Prime Healthcare Services–St. Mary's Passaic, LLC, d/b/a St. Mary's General Hospital was acquired in 2014.[9] St. Francis Medical Center was purchased by Capital Health Systems in 2022.[10] Hudson Hospital OPCO, LLC, d/b/a Christ Hospital; HUMC OPCO, LLC, d/b/a Hoboken University Medical Center; and IJKG OPCO, LLC, d/b/a Bayonne Medical Center were all purchased in 2023.[11] And the physical hospital Capital Health Medical Center–

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[9] Letter from Comm'r Mary O'Dowd to Edward J. Condit, President/CEO (June 13, 2014), available at: https://tinyurl.com/u25bznb4 (last accessed February 14, 2025).

[10] Letter from Comm'r Judith Persichilli to Al Maghazehe, President & CEO (Nov. 30, 2022), available at: https://tinyurl.com/nhcyb9hb (last accessed February 14, 2025).

[11] Letter from Comm'r Judith Persichilli to Achintya Moulick, President & CEO (April 17, 2023) (Christ Hospital), available at: https://tinyurl.com/4mzpw6w3 (last

Hopewell was not opened until 2011.[12] While the State presently remains unaware of the dates the relevant owner-claimants acquired Englewood Hospital & Medical Center and Capital Health Regional Medical Center, it is working to ascertain whether their acquisition predated the charity care statute's enactment as well. At the very least, the six Petitioners whose hospitals' physical locations or ownership structures postdate the enactment of charity care—and possibly all eight Petitioners—cannot now use the Takings Clause to recover a windfall by challenging preexisting laws in effect before they acquired the property. See Good, 189 F.3d at 1361.

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accessed February 14, 2025); Letter from Comm'r Judith Persichilli to Achintya Moulick, President & CEO (March 20, 2023) (Bayonne Med. Ctr.), https://tinyurl.com/3u67pe7w (last accessed February 14, 2025); Letter from Comm'r Judith Persichilli to Achintya Moulick, President & CEO (March 20, 2023) (Hoboken Univ. Med. Ctr.), https://tinyurl.com/4n8m4w4b (last accessed February 14, 2025).

[12] Erin Duffy, New Hopewell Capital Health Campus Opens Doors, NJ.com (Nov. 7, 2011), available at: https://tinyurl.com/5cr7nzsv (last accessed February 14, 2025). This Court can take judicial notice of this article's content for its existence. See N.J.R.E. 201(b)(3); Cohen v. Cmty. Med. Ctr., 386 N.J. Super. 387, 396 n.4 (App. Div. 2006); Gen. Motors Corp. v. Linden City, 22 N.J. Tax 95, 156 (2005).

POINT II

CHARITY CARE DOES NOT EFFECT A PER SE TAKING.

Even assuming that any Petitioners can overcome that threshold defect, their per se takings theory is mistaken. While Petitioners contend that the charity-care regime "deprives the Hospitals of their right to exclude others from their property" and amounts to a "physical appropriation" of hospitals' property, (Psb14), their arguments conflict with both precedent and longstanding tradition in regulation of health care facilities in general and hospitals specifically.

Charity care does not fit either of the two paradigmatic examples of a per se taking. Most obviously, it does not "remove all economically beneficial uses of the property." See Franklin Mem'l Hosp., 575 F.3d at 126. While Petitioners argue that their financial outlook would be better without this regime, they have never argued (nor could they) that charity care extinguishes their property's value altogether. More to the point, charity care does not authorize a "permanent physical occupation" of hospitals' property, Ark. Game & Fish Comm'n, 568 U.S. at 31—rather, it simply "regulates how the [hospitals] can use their property" with respect to indigent patients who require care, Sierra Med. Servs. All. v. Kent, 883 F.3d 1216, 1225 (9th Cir. 2018) (rejecting similar challenge); see also Franklin Mem'l Hosp., 575 F.3d at 126 (same).

To be sure, charity care means that there are some patients whom hospitals will have to admit to their premises whom they otherwise would prefer not to admit, and some medical supplies that the hospitals will have to use to treat those patients whose costs will not be completely offset by the government subsidy. But that is true of a host of regulations that govern when certain types of highly regulated, public-facing businesses must admit customers whom they would prefer not to serve, e.g., Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241, 261 (1964) (rejecting claim that prohibition on racial discrimination in public accommodations effects a taking), and that govern how much those businesses can charge, e.g., Loretto v. Teleprompter Manhattan CATV Corp., 458 U.S. 419, 440 (1982) (noting that the Court "has consistently affirmed" that rent-control statutes do not effect a taking). But just as an apartment complex could not bring a successful per se takings challenge simply because it is prevented from discriminating against poorer applicants who can still afford a rent-controlled price (even if it would prefer to charge more and thus house only more affluent tenants), cf. N.J.S.A. 10:5-12(g), these Petitioners cannot properly claim that the government has effected a per se taking simply by requiring them to serve all patients, including indigent patients—and even less so when the State itself provides a subsidy program, albeit one that the hospitals argue is inadequate. See (Psb26). The proper rubric for such a claim (though it fails

here) is a regulatory takings analysis. See Yee, 503 U.S. at 527 (explaining why challenge to regulations affecting mobile home parks, "while perhaps within the scope of" regulatory-takings precedent, could not "be squared easily with" per se takings case law); Qwest Corp. v. United States, 48 Fed. Cl. 672, 681 (2001) (explaining that whether a "rate set by the competent government authority" for a public utility is too "low" is a classic type of "regulatory takings" challenge); City of Scranton v. Pub. Serv. Comm'n, 80 Pa. Super. 549, 558 (1923) ("The legislature ... has power of supervision over corporations exercising quasi-public functions, which in general includes the right to regulate rates and charges of common carriers."); see also infra Point III (explaining why these Petitioners' regulatory-takings challenge fails on these facts).

History and precedent confirm that hospitals fall well within the class of quasi-public entities whose property rights are subject to such longstanding economic restrictions that preclude Petitioners' per se theory. For one, hospitals are a classic public accommodation. See N.J.S.A. 10:5-5(l) (defining them as such under the Law Against Discrimination). They "open their premises to the general public in the pursuit of their own property interests," Uston v. Resorts Int'l Hotel, Inc., 89 N.J. 163, 173 (1982), and are "devoted to a use in which the public has an interest and are subject to control for the common good," as their "basic purpose is to make available hospital facilities for the care and treatment

of the public," Doe v. Bridgeton Hosp. Ass'n, 71 N.J. 478, 487, 490 (1976); see also Greisman v. Newcomb Hosp., 40 N.J. 389, 403-04 (1963) (finding "hospitals are operated not for private ends but for the benefit of the public, and [] their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public."); J. Singer, No Right to Exclude: Public Accommodations and Private Property, 90 Nw. U. L. Rev. 1283, 1321-23, 1462-63 (1996) (including hospitals within the class of "quasi-public corporations and nonprofit charitable institutions" subject to distinct legal regimes). In this sense, they are no different from the common carriers and innkeepers of old, long obligated "to receive and lodge all comers in the absence of a reasonable ground of refusal." Doe, 71 N.J. at 487-88; see also Biden v. Knight First Amend. Inst., 141 S. Ct. 1220, 1223 (2021) (Thomas, J., concurring) (noting "regulations like those placed on common carriers may be justified, even for industries not historically recognized as common carriers, when 'a business, by circumstances and its nature ... rise[s] from private to be of public concern.'"). And, of course, such businesses' property rights never included absolute rights to exclude, e.g., Heart of Atlanta Motel, 379 U.S. at 261—much as this Court has long been clear that hospitals do not, see Uston, 89 N.J. at 173; Doe, 71 N.J. at 487; see also, e.g., Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557, 559 (7th Cir. 1999) (under the Americans with Disabilities

Act, a dentist's office "open to the public cannot exclude disabled persons from entering the facility and, once in, from using the facility in the same way that the nondisabled do."); (Psb18) (Petitioners acknowledging that "members of the public can and do receive services at their facilities, if medically appropriate").

This Court's decision in Doe is illustrative. There, pregnant women and their doctors sued nonsectarian, private hospitals to compel them to make their facilities available to conduct elective abortions to which the hospitals objected. The Court relied on the hospitals' common-law duty to "serve the public without discrimination" to hold that they could not deny access to women seeking elective abortions which the hospitals had the facilities and capacity to perform. 71 N.J. at 487, 489-90. The Court rejected the hospitals' defense that they would suffer financial losses as a result (in the form of lower donations from donors opposed to abortion), reasoning that their position "conflicts with and ignores the underlying principle of a nonsectarian hospital, whose basic purpose is to make available hospital facilities for the care and treatment of the public." Id. at 489-90. Indeed, in addition to making clear that state law has long restricted hospitals' rights to exclude given their status as quasi-public institutions, Doe highlights that a sick person's ability-to-pay would be an especially perverse basis on which to exclude, given that hospitals were initially "designed to serve as a place for the custodial care of the dying poor." Id. at 486 n.2.

Like other health care facilities (and other businesses traditionally bound up with the public good), hospitals are also historically subject to price controls and similar restrictions that do not offend the Takings Clause. This Court, for instance, rejected a takings challenge to a state law that required nursing homes "to make available a reasonable number" of beds to indigent seniors, explaining that such restrictions are permissible "even though they may result in some economic disadvantage," and identifying "rent control" as a "prime" analogy. In re Health Care Admin. Bd., 83 N.J. at 80-81. And the Third Circuit similarly rejected a takings challenge to the State's precursor statutory scheme for setting hospital rates, explaining that the regime did not cause a physical invasion or permanent appropriation, but rather "adjust[ed] the benefits and burdens of economic life to promote the common good." United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp., 995 F. 2d 1179, 1190-91 (3d Cir. 1991) (quoting Connolly v. Pension Benefit Guaranty Corp., 475 U.S. 211, 225 (1986)). Indeed, as that court emphasized, such restrictions were particularly hard to fault, "given the historically heavy and constant regulation of health care in New Jersey." Id. at 1191; Sierra Med. Servs. All., 883 F.3d at 1225 (rejecting similar challenge to California law); Franklin Mem'l Hosp., 575 F.3d at 126-29 (same for Maine law); cf. Desai v. St. Barnabas Med. Ctr., 103 N.J. 79, 88 (1986) (discussing ways in which "the State exerts extensive

supervisory and regulatory control over hospital functions"). The same logic applies here: if it is not a per se taking to prevent a hospital from charging more than 75 cents for a Band-aid (even if the hospital would prefer to cater only to wealthy patrons whom it could charge ten dollars), it cannot be a per se taking to enact a charity care regime that accomplishes the same essential result, albeit through a more mathematically complicated set of subsidy formulas. See supra at 4-6 (explaining reimbursement system).

Petitioners' theories, which would upend this history, are unavailing. To start, Cedar Point, 594 U.S. 139, is not to the contrary. Contra (Psb14-18). In Cedar Point, the U.S. Supreme Court reviewed a state law requiring agricultural employers to permit union organizers on their property to organize workers, for up to three hours per day, 120 days a year. 594 U.S. at 144. The Court held that the law effected a per se taking, reasoning that the law appropriated "a right to physically invade the growers' property," depriving them of their physical right to exclude, id. at 149-50, 152, and explained that the temporary or intermittent nature of the physical invasion did not change the result, id. at 153. But the fact that the growers enjoyed a right to exclude was essential to the holding; the Court stressed that "without the access regulation, the growers would have had the right under California law to exclude union organizers from their property." Id. at 155. The Court thus distinguished PruneYard Shopping Center v. Robins,

447 U.S. 74 (1980), which found no taking resulted when a shopping center was barred from excluding political activists from the property. Id. at 82-84. As Cedar Point noted, "[u]nlike the growers' properties, the PruneYard was open to the public, welcoming some 25,000 patrons a day," and limits on "a business generally open to the public" are "readily distinguishable from regulations granting a right to invade property closed to the public." 594 U.S. at 156-57; id. at 157 (noting that Horne, a case involving raisin-growers, was distinct from PruneYard for the same reason—it did not "involv[e] 'an already publicly accessible' business"). But here, as just discussed, hospitals are a classic public accommodation—so they take their property rights subject to traditional encumbrances, including limitations on their right to exclude. Private farms and raisin growers are not subject to that same tradition.

Indeed, Cedar Point expressly identified this very caveat to its holding, explaining that "many government-authorized physical invasions will not amount to takings because they are consistent with longstanding background restrictions on property rights." Id. at 160. And as just explained, such a "longstanding background restriction" does exist here, see ibid.: a hospital is not like a private agricultural business, for which the common law backdrop recognizes a stronger right to exclude, but rather a modern public accommodation whose right to exclude is notably cabined by traditions around

public availability, price regulation, and ensuring medical care that serves the public good (including for the indigent specifically). See Uston, 89 N.J. at 173; Doe, 71 N.J. at 486-87 & n.2. And to be clear, charity care does not disturb hospitals' right to exclude for reasons unrelated to nonpayment, e.g., where the patient interferes with "essential" hospital operations or poses a security risk, Uston, 89 N.J. at 173, or because his medical "progress warranted discharge," 40A Am. Jur. Hospitals and Asylums § 14. Cf. Doe, 71 N.J. at 488 (at common law, "reasonable ground[s]" for a common carrier to refuse service included "lack of space"). So Petitioners' quarrel with charity care and the extent of the State's subsidy program at most raises a regulatory takings argument (albeit an unavailing one here) that this particular regime goes "too far." Yee, 503 U.S. at 529 (citation omitted). It cannot support the per se theory on which Petitioners focus in this Court. See (Psb6-26); (Pcb4-5).[13]

Petitioners' reliance on Horne is also misplaced. See (Psb11-14). Horne involved an unusual government regime that required raisin growers to hand over to the government a significant percentage of their annual crop—to literally

[13] This tradition also provides the limiting principle that forecloses Petitioners' parade of horribles, such as compelling restaurants "to provide food and beverage to members of the public without compensation" or hotels "to provide lodging without payment." (Psb18-19). And even in contexts where such a tradition exists, as-applied regulatory takings challenges are always possible—which likely explains why no rent-control ordinance caps rents at $50.

transfer title to the raisins. 576 U.S. at 355. But there was no background property-law principle that supported the raisin-specific regime at issue in Horne, in contrast to the property-law backdrop for hospitals. Indeed, Horne emphasized that the set-aside regulation was distinct from a law granting rights of access to "an already publicly accessible" business. Id. at 364; see also Cedar Point, 594 U.S. at 157 (reaffirming that a limited grant of access to "a business generally open to the public" is "readily distinguishable from regulations granting a right to invade property closed to the public"). So Horne, like Cedar Point, in no way upends the tradition that laws like New Jersey's charity care statute reflect, much less renders it a per se taking.

Petitioners misunderstand the import of this legal backdrop, incorrectly focusing on the fact that one case that illustrates this principle—the dispute involving the mall in PruneYard—involved a modern "public square[]" that thus served as a forum for speech. (Psb15-16). But while that distinction is often relevant for First Amendment purposes, it is not relevant for the purposes at hand, because this case is not about whether Petitioners may exclude certain types of speech, but rather whether they can deny medical care based on a patient's ability to pay. For those purposes, what matters is that hospitals are a public accommodation whose rate-making decisions have long been subject to public regulation, see supra at 3-6—the legal tradition with which charity care

accords. To be sure, Petitioners would have a very different claim if the State sought to grant all individuals the right to conduct public parades throughout hospitals, see (Psb16), because the State is aware of no background property-law tradition that recognizes such a privilege—much the same way the shoppers in PruneYard did not have access to every back-office and storage room in the 21 acres comprising the PruneYard complex. See 447 U.S. at 83 (noting that the mall, though generally open to the public, had the right to enforce time, place, and manner restrictions to "minimize any interference with its commercial functions"). But that is not this case.

Petitioners' related claim that charity care works a per se taking by commandeering their "supplies[] and professional services for use by charity care patients" likewise fails. See (Psb12). It is true that equal-service obligations, and price controls, often incidentally encompass goods and services: the hotel that has to accept guests from a protected class will inevitably have to provide those guests with non-reusable goods like soap, water, ice, and at least temporarily with reusable goods like towels and sheets, cf. Heart of Atlanta Motel, 379 U.S. at 261, much as the leasing office and maintenance team for the landlord who would prefer to charge more and house only affluent renters will still have to dedicate professional services to tenants who can afford the rent-controlled price, cf. N.J.S.A. 10:5-12(g). But as this Court confirmed in

Doe, a hospital's duty to "serve the public without discrimination" is not vitiated merely by the prospect that it will suffer a financial loss from admitting the patient in question. See 71 N.J. at 489-90.

As these examples underscore, Petitioners' premise—that a taking occurs because they must devote employee time and supplies to complying with the state law—risks proving far too much. Myriad laws requires owners to buy and use particular items of property (including single-use items) to comply with reasonable regulations: property owners are regularly required to install smoke detectors and fire extinguishers, e.g., N.J.S.A. 52:27D-198.1; restaurants are typically required to use "single-use gloves" in the preparation of food, e.g., N.J.A.C. 8:24-3.3(a)(2); and plant owners are sometimes required to install particular devices on smokestacks to remove pollutants from emissions, see N.J.A.C. 7:27-8.12. None of these reasonable regulations "requisition" property, as Petitioners contend, (Psb12). See Cedar Point, 594 U.S. at 160-61.

Consider one final example, from another, closer-to-home professional context: pro bono and other bar-related requirements. Courts and other governmental bodies often require attorneys to spend some of their time serving the poor or the public interest in some related way. See, e.g., R. 1:21-12; R.P.C. 6.1. In Scheehle v. Justices of Supreme Ct. of Ariz., 508 F.3d 887 (9th Cir. 2007), for example, an Arizona tax attorney argued that a county court rule him

to serve two days a year as an arbitrator for limited compensation worked a per se taking because it deprived him and other attorneys of "time and effort [that] can never be recovered." Id. at 889, 893. The Ninth Circuit easily rejected that argument, explaining that "viewing any imposition by a state on an attorney's time as a discrete deprivation of property" requiring compensation "is foreclosed" by precedent holding that pro bono requirements do not work a taking. Id. at 894 (citing, inter alia, United States v. Dillon, 346 F.2d 633, 635 (9th Cir. 1965)). After all, courts "have long recognized that attorneys, because of their profession, owe some duty to the court and to the public to serve without compensation when called on." Id. at 894-95 (internal citation omitted). Put differently, that duty is the condition of receiving "the benefits conferred by admission to the bar," such that entry to the bar with no attendant duties was "not part of [the attorney's] title to begin with." Id. at 896.

Petitioners' theory cannot be squared with that precedent, either. Indeed, if Petitioners were right that the mere loss of consumable items needed to comply with a statute works a taking, then even if pro bono requirements were not per se takings for consuming an attorney's time, they would work takings by requiring attorneys to consume printer ink, legal pads, or gasoline to travel to court. Nothing in takings law compels that extraordinary result, and this Court should reject Petitioners' novel per se takings theory.

POINT III

CHARITY CARE ALSO DOES NOT EFFECT A REGULATORY TAKING.

While Petitioners' takings claim is instead properly reviewed (though ultimately rejected) under the regulatory-takings framework, they appear to have largely abandoned that claim. See (Psb6-26) (lodging only a per se takings challenge to charity care).[14] In any event, any regulatory taking claim fails. To determine whether a regulatory taking occurs, courts apply the Penn Central factors: (1) the economic effect of the regulation on the claimant, (2) the extent to which the regulation interferes with distinct investment-backed expectations, and (3) the character of the government action. Lingle, 544 U.S. at 538-39 (citing Penn Central, 438 U.S. at 124). Those factors clearly dispose of any regulatory takings claim on these facts.

Even in their petition for certification, Petitioners appear not to dispute the Appellate Division's findings on the first or third factors. See (Pcb15-18). As to the first, the court acknowledged that charity care results in some financial loss, but correctly found that Petitioners made no showing that the statute "deprives them of economic use of their properties as a whole, in effect, as

[14] For instance, in the one place where Petitioners mention Penn Central in their supplemental brief, they do so only to criticize its test and to argue that courts have shifted away from it—not to apply it to these facts. See (Psb8-10). But see (Pcb15-18) (discussing Penn Central in their certification petition).

hospitals." (Op. 23 (citing Yee, 503 U.S. at 522-23)); see also Gardner v. New Jersey Pinelands Comm'n, 125 N.J. 193, 210-11 (1991) ("[R]estrictions on uses do not necessarily result in takings even though they reduce income or profits."). As to the third factor, the panel emphasized that "the requirements of the charity care statute and its subsidy scheme are specific to its aims" which "fits squarely within the police power" of the State. (Op. 25-26); see also In re Health Care Admin. Bd., 83 N.J. at 81 (noting similar charity-care regime applied to nursing homes is "directed at an acute social problem affecting the health and welfare of the needy aged and infirm" in rejecting similar takings claim).

As to the second factor (investment-backed expectations), the Appellate Division did not err in concluding that "it is not reasonable for the hospitals to expect an at-cost reimbursement for the medical services the Legislature has required them to provide as a condition of doing business in our state." (Op. 25). "Regulation may, consistently with the Constitution, limit stringently the return recovered on investment, for investors' interests provide only one of the variables in the constitutional calculus of reasonableness." Permian Basin Area Rate Cases, 390 U.S. 747, 769 (1968) (citation omitted). Thus, interference with distinct investment backed expectations must be evaluated with respect to the owner's expectations for the use of its property as a whole and the character of the industry in which it operates. Connolly, 475 U.S. at 227. In the highly

regulated context of the health care industry (and hospital industry specifically), that context is critical: owners and investors must necessarily expect that uses of their property may be regulated by the State, and such regulation may diminish their profits without resulting in a taking. See, e.g., United Wire, 995 F. 2d at 1191; Franklin Mem'l, 575 F.3d at 128; cf. Desai, 103 N.J. at 88 (noting that "the breadth and depth" of the State's regulatory oversight of hospitals "reflect and illustrate the State's profound concern with public health care").

Petitioners' previous responses also lack merit. At the certification stage, for instance, Petitioners noted that businesses in other highly regulated industries "are not required to provide their goods and services without compensation," (Pcb16)—but that is not true as to pro bono requirements, and in any event, charity care includes a public subsidy, just not one that Petitioners believe is adequate, as applied to their hospitals, see (Psb26); see also infra at 36 & n.18 (discussing why the adequacy of this subsidy as applied to each specific hospital's facts would be a question for remand only if this Court finds that charity care does or could qualify as a taking at all, which it should not). Petitioners also argued that "[u]nder the Appellate Division's opinion, the State could require a licensed hospital to provide an unlimited amount of care without any obligation to make any payment for these services and use of the hospital property," (Pcb17), but that slippery-slope argument is unavailing: the

Appellate Division did not rule that such a strawman policy would pass muster, only that this reasonable and longstanding requirement did. And while Petitioners are correct insofar as they argue that the line of cases regarding voluntary participation in a government program are no longer dispositive of issues currently on appeal, (Psb28; Pcb17),[15] the larger concepts regardless remain relevant, since Petitioners choose to operate in this industry, knowing and accepting the regulatory risk—even if it turns out that, as remains unclear, two of their ownership interests predate this specific statute. See supra Point I; Good, 189 F.3d at 1360 ("[t]he requirement of investment-backed expectations 'limits recovery to owners who can demonstrate that they bought their property in reliance on the non-existence of the challenged regulation.'"); see also Concrete Pipe, 508 U.S. at 645-46.[16]

Finally, assuming that this argument likewise goes to the second Penn Central factor, Petitioners also err in contending that the Appellate Division

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[15] At the trial court level, Appellants argued that the rates they receive for Medicaid reimbursement also effected a taking. (Op. at 11, 12). Appellants abandoned this argument at the Appellate Division and do not raise it here.

[16] And to the extent a hospital owner's property interest predates the enactment of charity care, it still bears emphasizing that the regime has been in place since 1992; the predecessor rate-setting statute (upheld against a takings challenge in United Wire, see supra at 21) dates to 1971; and Petitioners did not commence this litigation until 2017, (Pcb1)—some 25 years after charity care was enacted. Cf., e.g., State v. Buckner, 223 N.J. 1, 34 (2015) (noting that decades of uniform acquiescence can undercut a constitutional challenge).

failed to "recognize the applicable and impact of the unconstitutional conditions doctrine," and that the State is impermissibly requiring the relinquishment of constitutional rights. (Psb31); see (Pcb17) (arguing that "to abandon one's status as a licensed or regulated business or professional is an existential choice"). The provision of charity care is not a condition of licensure; as Petitioners concede and the law's text confirms, the consequence of failing to comply with the charity care statute is not a license revocation or suspension, but rather a fine. (Psb33-34); N.J.S.A. 26:2H-18.64. Nor is the State arguing that Petitioners' claim fails simply because they could cease operating as hospitals. The point, rather, is that by virtue of entering the highly regulated hospital field, any regulatory takings claim is subject to the distinct investment-backed expectations that attend that field. See Penn Central, 438 U.S. at 124. Such expectations are profoundly cabined by the highly regulated nature of that field and its pricing structures, see supra at 19-22, and this factor thus weighs heavily against Petitioners' claim under a regulatory-takings analysis—much as it forecloses the claims of all Petitioners who acquired their hospitals after enactment of the charity care law, see supra Point I, and defeats their per se theory, see supra Point II; Cedar Point, 594 U.S. at 160. Coupled with the first and third factors, the result is overwhelming.

POINT IV

WHETHER PETITIONERS' CLAIM IS FACIAL OR AS-APPLIED, THE RESULT IS THE SAME.

Petitioners conclude their supplemental brief by chiding the Appellate Division for characterizing their claim as facial, (Psb35-38), but their critiques are mistaken and in any event beside the point. Petitioners framed their principal question presented as whether, in light of Horne and Cedar Point, charity care effects an unconstitutional physical taking. (Pcb4).[17] But whether charity care effects a physical taking at all is a facial question in the sense that it presents a question of law that a court can resolve by looking to the face of the statute, rather than finding specific facts about a particular claimant. See, e.g., United States v. Marcavage, 609 F.3d 264, 273 (3d Cir. 2010) ("A facial attack tests a law's constitutionality based on its text alone and does not consider the facts or circumstances of a particular case."). Thus, if Petitioners' theory were correct (which it is not), it would follow necessarily that all applications of the charity care statute effect a physical, per se taking. See (Op. 15-16). And the Appellate Division credited Petitioners for the purely legal nature of that question,

[17] This brief has already explained why Petitioners' theory on its second question presented (conditioning licensure on "surrender" of a business's Fifth Amendment rights) is wide of the mark, see supra at 32-34, and Petitioners' third question presented focuses on the facial/as-applied distinction discussed here.

explaining that they therefore did not need to exhaust their remedies and instead could precede directly in that judicial forum. (Ibid.)

Petitioners have quarreled with this reasoning, arguing that it is factually erroneous because there have been and could be instances in which hospitals receive "100 percent of their costs," (Pcb18), but the objection is misguided. On Petitioners' theory, those would all still be takings—just takings with undisputedly just compensation, as where the government condemns a house but pays a price that everyone agrees is fair. See U.S. Const. amend V. But the question of whether charity care effects a taking in the first place is the central legal question here; if it does, the quantum of compensation that is "just" would be a question for remand, not one for this Court to parcel out on a hospital-by-hospital basis.[18] And the answer to the core, legal question for this Court is the

[18] In that event, the answer surely would vary hospital to hospital—based not only on when the hospital's owners acquired the property, see supra Point I, but also on questions of valuation and traceability, such as the total quantum of payments from the State's fisc that Petitioners have received to cover uncompensated care to patients, including indigent patients, whether Petitioners' assessment of their own costs is the proper one, and how much of whatever costs they incurred independently flowed from other, voluntary obligations, such as Petitioners' participation in Medicare and Medicaid, or any care correspondingly mandated under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), see generally Virginia Hosp. & Healthcare Ass'n v. Roberts, 671 F. Supp. 3d 633, 644, 665-67 (E.D. Va. 2023) (detailing EMTALA's requirement that all Medicare-enrolled hospitals provide screening and stabilizing care to all patients, "regardless of ability to pay" and rejecting takings challenge to EMTALA).

same regardless of whether Plaintiffs styled their claims as facial or as-applied: New Jersey's charity care statute does not effect a taking.

CONCLUSION

This Court should affirm.

Respectfully submitted,

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