No. 26-473

In The Supreme Court of the United States

SLIGO CREEK CENTER,
Petitioner,
v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF THE AMERICAN HEALTH CARE ASSOCIATION AND THE NATIONAL CENTER FOR ASSISTED LIVING AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF AMICUS CURIAE[1]

Amicus curiae, the American Health Care Association and the National Center for Assisted Living ("AHCA"), is the largest association in the United States representing long-term and post-acute care providers, with more than 15,000 individual member facilities. AHCA is also comprised of 51 state affiliate members, which are local associations that represent facilities in all 50 states and the District of Columbia. AHCA's diverse membership includes skilled nursing centers, assisted living communities, sub-acute centers, and homes for individuals with intellectual and developmental disabilities. By delivering solutions for quality care, AHCA aims to improve the lives of the millions of frail elderly and individuals living with disabilities who receive long-term or post-acute care in member facilities each day. As healthcare providers, AHCA's member facilities are committed to providing quality nursing home care and support systems for their patients and residents.

In addition, as participants in the Medicare and Medicaid programs, AHCA's member facilities are subject to the survey and enforcement system at issue in this case, including the imposition of civil monetary penalties. For this reason, AHCA and its

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[1] Pursuant to Rule 37.6, *amicus* affirms that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* and their counsel has made any monetary contributions intended to fund the preparation or submission of this brief. *Amicus* also confirms that it has provided timely notice to the counsel of record for all parties of its intention to file this *amicus curiae* brief, as required by Rule 37.2.

members have an interest in a constitutionally sound system through which facilities can appeal determinations of noncompliance and associated penalties. As this case illustrates, the current review process can and does subject facilities to multiple constitutional harms.

SUMMARY OF THE ARGUMENT

To participate in Medicare and Medicaid, skilled nursing facilities ("SNFs") must adhere to requirements of participation, certain of which are analogous to common law standards of care. When the Centers for Medicare & Medicaid Services ("CMS") take enforcement action against SNFs for failing to fulfill those duties, including by imposing a civil monetary penalty ("CMP") and other legal remedies, providers are constitutionally guaranteed an opportunity to challenge that action before an independent factfinder in an Article III court. Relegating Medicare- and Medicaid-participating SNFs, including Sligo Creek, to the administrative appeals scheme designed and administered by the U.S. Department of Health and Human Services ("HHS"), runs afoul of the Seventh Amendment. That conclusion ends the inquiry, and the Fourth Circuit's decision cannot stand.

The practical realities of this administrative scheme underscore the significance of the constitutional protections at stake and the need for this Court's intervention. Administrative adjudication through the HHS Departmental Appeals Board ("DAB") takes many years, is designed to favor the agency, and requires providers to place in escrow the penalty funds, subject to DAB adjudication, raising additional due process

concerns. The administrative appeals process is a costly, lengthy exercise in near futility that healthcare providers should not be compelled to use.

Nor can these constitutional protections be withheld on the theory that SNFs voluntarily subject themselves to this regime by electing to participate in Medicare and Medicaid. That reasoning fails twice over: it both gives dispositive weight to the regulatory context in which the right arises, contrary to this Court's instruction, and rests on an inaccurate premise about the voluntariness of SNF participation. When considering whether a matter must be adjudicated in an Article III court, this Court has issued a clear mandate that the statutory and regulatory origins of the cause of action are not dispositive; if the action concerns private rights, "adjudication by an Article III court is mandatory." *SEC v. Jarkesy*, 603 U.S. 109, 128, 134–35 (2024). Even if this Court was to deviate from its prior instruction, the Fourth Circuit's analysis hinged on a factually inaccurate distinction: Sligo Creek's participation in the public benefits programs is not functionally voluntary. Whether providing short-term post-acute care or long-term care services, SNFs are overwhelmingly reliant on funding from Medicare and Medicaid to operate. If society desires that healthcare providers deliver this essential care, the government cannot condition providers' participation in these constructively involuntary programs on a purported waiver of their constitutional rights. This Court must intervene to correct the Fourth Circuit's decision.

ARGUMENT

I. FUNDAMENTAL DEFECTS IN THE ADMINISTRATIVE APPEALS PROCESS UNDERSCORE THE IMPORTANCE OF PROTECTING SKILLED NURSING FACILITIES' SEVENTH AMENDMENT RIGHT TO INDEPENDENT FACTFINDER ADJUDICATION.

Leaving the decision below undisturbed would relegate providers to a woefully deficient administrative process as their only means of pursuing factfinder adjudication. SNFs responsible for caring for society's most vulnerable populations will be forced to continue to litigate adverse compliance determinations and attendant penalties in a system designed to their disadvantage—marred by delay and bias. As argued by the Petitioner, the Seventh Amendment requires that facilities be able to challenge CMS's CMPs not through the administrative appeals process, but by electing a jury trial in an Article III court. *See* U.S. Const. amend. VII; *Jarkesy*, 603 U.S. at 122–23, 127. By summarily carving out these CMPs from Article III adjudication, the Fourth Circuit condemns these healthcare providers to pursuing review of agency action through a structurally and constitutionally unsound administrative process.

A. SNFs must navigate CMS's multi-step internal appeals process to challenge this type of CMP.

Put simply, in order to be reimbursed for

Medicare and Medicaid services[2] provided to enrolled beneficiaries, a healthcare provider must meet certain requirements of participation and receive approval from CMS to operate as a "participating provider" in the programs. To maintain its enrollment, a provider must continuously satisfy these requirements. Many of the requirements specific to SNFs are codified in the Federal Nursing Home Reform Act ("FNHRA") and its implementing regulations, enacted by CMS. *See*, *e.g.*, 42 U.S.C. § 1395i-3 (Medicare); 42 U.S.C. § 1396r (Medicaid); 42 C.F.R. Part 483. FNHRA authorizes the Secretary of HHS (the "Secretary") to take certain actions to ensure compliance with these requirements; the Secretary has, in turn, delegated that enforcement authority to CMS.

To monitor compliance, CMS contracts with state agencies to survey SNFs. *See*, *e.g.*, 42 C.F.R. § 488.305. If surveyors determine that a SNF is out of "substantial compliance" (called a "deficiency"), CMS can take a number of actions, including imposing sanctions on the facility, such as CMPs. *See*, *e.g.*, 42 U.S.C. § 1395i-3(h)(2); 42 C.F.R. §§ 488.406, 488.430 (civil monetary penalties).

If a facility seeks to challenge sanctions assessed under the FNHRA, it may pursue independent informal dispute resolution ("IIDR")

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[2] Although the CMP at issue arose from an alleged violation of a Medicare requirement of participation, 42 C.F.R. § 483.65 (2016) (revised 42 C.F.R. § 483.80), Part 483 regulates providers' participation in both Medicare *and* Medicaid. *See* 42 C.F.R. § 483.1(b). Allowing the Fourth Circuit's opinion to stand would also infringe upon the constitutional protections afforded to Medicaid-participating healthcare providers.

within thirty days of the imposition of the penalty. 42 U.S.C. § 1395i-3(h)(2)(B)(ii)(IV)(aa); 42 C.F.R. § 488.431.[3] Simultaneous to the IIDR process—and potentially before resolution of that process—a provider may appeal the sanctions through the two-step administrative appeals process before the DAB.[4] *See* 42 CFR Part 498. The process proceeds in two parts: First, the provider may request a hearing before a DAB administrative law judge ("ALJ"). 42 C.F.R. § 498.40. DAB ALJs are HHS employees that are supposed to provide "impartial, independent review of disputed decisions in a wide range of [HHS] programs." U.S. Dep't of Health & Human Servs., Organizational Overview, https://www.hhs.gov/about/agencies/dab/about-dab/organizational-overview/index.html (last reviewed May 19, 2021).

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[3] The IIDR process is distinct from the informal dispute resolution ("IDR") process, which a SNF may opt to pursue "to dispute survey finds upon the facility's receipt of the official statement of deficiencies," before a penalty has been imposed. 42 C.F.R. § 488.331.

[4] This is the same administrative adjudication process found to be unconstitutional by the Fifth Circuit in June 2026. *See Texas Tobacco Barn, LLC v. HHS*, 180 F.4th 229 (5th Cir. 2026) (holding that ALJ and DAB Appellate Division adjudication of alleged Food, Drug & Cosmetic Act violations, which resulted in CMPs imposed by FDA, violated the regulated entity's Seventh Amendment right to a jury). The U.S. Department of Justice declined to file a petition for a writ of certiorari, explaining that the Fifth Circuit correctly rejected arguments that the agency action fell within the public rights exception. *See* Letter from U.S. Solicitor General to Hon. Mike Johnson, Speaker of the U.S. House of Representatives, *Texas Tobacco Barn, LLC v. HHS*, No. 25-60200 (5th Cir.) (Aug. 25, 2026), available at: https://www.justice.gov/oip/media/1459066/dl?inline.

Second, the provider can appeal any adverse ALJ decision to a three-member panel of the DAB Appellate Division. 42 C.F.R. §§ 498.80, 498.82–83. As occurred in this case, once that process is exhausted, DAB final decisions regarding CMPs may be appealed directly to a United States Court of Appeals,[5] 42 C.F.R. § 498.90, where they are reviewed under the Administrative Procedure Act ("APA"). *See* 42 U.S.C. § 1320a-7a(e); 5 U.S.C. § 706.

B. The administrative appeals system is procedurally flawed and constitutionally deficient.

Under the current regulatory scheme, a SNF challenging the type of CMP at issue in this case is unable to seek adjudication by an Article III factfinder and is instead improperly relegated to a one-side administrative appeals process that raises material due process concerns.

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[5] Regulated entities' ability to appeal a final DAB decision to a Federal Court of Appeal *after* exhaustion does not cure this administrative process of its constitutional defect. *Cf. Jarkesy,* 603 U.S. at 117, 140 (finding that even when appeal of a final agency decision was available, a "defendant facing a fraud suit has the right to be tried by a jury of his peers before a neutral adjudicator"). The Federal Courts of Appeal do not provide an opportunity for independent factfinding: When they review this type of CMP, the "findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive." *See* 42 U.S.C. § 1320a-7a(e).

1. The DAB lacks the capacity to process cases efficiently, leading to delays.

The DAB is notoriously backlogged and slow-moving, depriving healthcare providers of efficient resolution and delaying their access to federal court review. The DAB's jurisdiction is broad; it is tasked with reviewing disputes involving more than 60 statutory provisions. HHS, DAB, Organizational Overview, *supra*. And it lacks the resources to adequately and efficiently adjudicate the cases brought before it. As of March 2025, the DAB faced a backlog of 11,000 cases. Yeji Lee & Dan McKay, *HHS Cuts Hit Attys Tackling Medicare Appeals Backlog* (Mar. 4, 2025), https://www.law360.com/health/articles/2305847?nl_pk=f777bea7-8342-4260-9c2c-738b0972956d&utm_source=newsletter&utm_medium=email&utm_campaign=health&utm_content=2025-03-05&read_main=1&nlsidx=0&nlaidx=0&detected=1. It is likely that the backlog has only grown following HHS decisions to terminate more than a dozen DAB attorneys. *Id.*[6]

As a result, the volume of ALJ and DAB Appellate Division decisions on the merits in SNF appeals has plummeted from fifty or more annually

[6] These statistics and termination decisions pertain to the DAB as a whole, including divisions that review the substantial volume of payment appeals. There is little publicly available information about case backlog specific to the Civil Remedies Division, the DAB subpart that adjudicates CMP appeals; however, as a component of the DAB, that Division suffers from the same inefficiencies and institutional shortcomings as the larger body.

to only a handful in recent years. *See* Am. Health Care Ass'n, Comment Letter Responding to HHS RFI: Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again (July 14, 2025), at 13 (PDF p. 16), https://www.regulations.gov/comment/AHRQ-2025-0001-0877 [hereinafter "AHCA Response to HHS RFI"]. In 2024, the DAB Appellate Division issued just 44 decisions, only six of which involved SNFs. U.S. Dep't of Health & Human Servs. Departmental Appeals Bd., 2024 Board Decisions, https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2024/index.html (last visited Oct. 8, 2026); *see also* U.S. Dep't of Health & Human Servs. Departmental Appeals Bd., 2025 Board Decisions, https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2025/index.html (only 11 of the 66 DAB Appellate Division decisions issued in 2025 involved SNFs, including the DAB decision that precipitated the instant case).

As *amicus* has submitted to CMS in formal comment, DAB cases regularly pend without decision for multiple years. *See* AHCA Response to HHS RFI, at 13 (PDF p. 16). Here, more than eight years passed between Sligo Creek's initiation of the administrative review process and the DAB's final decision. These inefficiencies persist despite regulatory timetables intended to ensure prompt adjudication. Pursuant to CMS's own regulations, ALJ decisions are to be issued "as soon as practical after the close of the hearing," 42 C.F.R. § 498.74(a), and DAB Appellate Division decisions must be issued "as appropriate, no later than 180 days after the appeal was received by the Board," 42 C.F.R. § 498.88(g).

The DAB's broad jurisdiction, coupled with inadequate agency resources and a lack of adherence to deadlines imposed by regulation, means that the DAB is persistently and systemically overwhelmed, depriving regulated facilities of efficient process. Even with an opportunity to seek judicial review of a DAB final decision, 42 CFR § 498.90, facilities must first exhaust the protracted, lengthy administrative process.

2. The DAB operates with procedural bias towards CMS.

Unsurprisingly, the administrative appeal process is designed to favor the agency's enforcement decision. As an initial matter, the ALJs and members of the DAB are employees of HHS, raising concerns about real independence. As Justice Gorsuch recognized in his *Jarkesy* concurrence:

> ALJs enjoy some measure of independence as a matter of regulation and statute from the lawyers who pursue charges on behalf of the agency. But they remain servants of the same master—the very agency tasked with prosecuting individuals. This close relationship, . . . can make it extremely difficult, if not impossible for the ALJ to convey the image of being an impartial fact finder. . . . And with a jury out of the picture, the ALJ decides not just the law but the facts as well.

Jarkesy, 603 U.S. at 142 (Gorsuch, J., concurring) (internal quotations, citations, and modifications omitted).

Second, the standards of review written by CMS to govern the DAB appeals procedure create structural advantages for the agency. For example, when an ALJ reviews a CMP, "CMS's determination as to the level of noncompliance of a SNF . . . must be upheld [by an ALJ] unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). Likewise, when reviewing a CMP, as long as the ALJ or higher administrative review authority "finds that the basis for imposing a civil money penalty exists," they may not "[r]eview the exercise of discretion by CMS . . . to impose a civil money penalty." 42 C.F.R. § 488.438(e)(2). In contrast to the "oversight role of a federal court reviewing agency decisions to determine if an adequate basis is articulated" to substantiate the amount of a CMP, the DAB has "consistently rejected provider arguments that the ALJ should review CMS's internal decision-making process." *Cal Turner Extended Care Pavilion v. CMS*, DAB No. 2030, 2006 WL 1726481, at *4 (May 25, 2006). As one would expect, in 2019, about half of the ALJ decisions on the merits of nursing facility appeals were "decide[d] by 'summary judgment' in favor of CMS (that is, without a hearing)." Joseph L. Bianculli, *Nursing Facility Enforcement Before the Department of Health and Human Service Appeals Board - The Breakdown of Administrative Procedure Act Standards, and Modest Proposals to Accommodate Agency Prerogatives with Fundamental Fairness*, 13 Liberty U. L. Rev. 223, 239 (2019), https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=1264&context=lu_law_review.[7]

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[7] *Amicus* notes that the use of summary judgment to

Moreover, ALJs regularly shift to providers the burden of proof that properly rests with CMS, in contravention of the APA. Pursuant to the APA, "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof" in an administrative hearing. 5 U.S.C. § 556(d). In that same section, the APA dictates that "[a] sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence." *Id.* *Amicus* has not found statutory language setting out an independent burden of proof, and thus the APA controls in these DAB proceedings. As courts have recognized, it is the administrative agency that has imposed a sanction that is the "proponent of the . . . order," 5 U.S.C. § 556(d), and, therefore, bears the burden of proof. *See Bosma v. USDA*, 754 F.2d 804, 810 (9th Cir. 1984) (identifying the agency as the "proponent of the order" when it assessed a CMP); *Hazardous Waste Treatment Council v. EPA*, 886 F.2d 355, 366–67 (D.C. Cir. 1989) (explaining that the agency has "the initial burden of going forward with a prima facie case of unlawful conduct" under 5 U.S.C. § 556(d)); *cf. Steadman v. SEC*, 450 U.S. 91, 98 (1981) (interpreting 5 U.S.C. § 556(d) to permit an agency to impose sanctions "only when they are in accordance with substantial evidence" (internal modifications omitted)). The DAB has fundamentally misconstrued this standard, stating that it is the

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resolve DAB appeals on CMPs may contravene providers' rights to a hearing, guaranteed by statute. See 42 U.S.C. § 1320a-7a(c)(2).

facility seeking an order of compliance that is the "proponent of an order," and not CMS, who has taken final agency action. *Batavia Nursing & Convalescent Ctr. v. CMS*, DAB No. 1904, 2004 WL 230864, at *9 (Jan. 14, 2004) (discussing *Hillman Rehab. Ctr. v. Health Care Fin. Admin.*, DAB No. 1611, 1997 WL 123708 (Feb. 28, 1997)).

Likewise, the DAB Appellate Division applies a mixed standard of review of its own making when reviewing ALJ decisions. Although a disputed issue of law is reviewed de novo, factual findings are reviewed for substantial evidence on the whole record, affording the ALJ below substantial deference. U.S. Dep't of Health & Human Servs., *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Program* (last reviewed Oct. 1, 2014), https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html. When it benefits the government, however, the DAB Appellate Division reweighs evidence, introduces new interpretations, and effectively rewrites the basis for CMS's actions. *See*, *e.g.*, *Sheridan Health Care Ctr. v. CMS*, DAB No. 2178, 2008 WL 2625670 (June 2, 2008) (reversing ALJ's decision, holding in favor of CMS after independently making factual findings). The DAB's overly expansive view of its authority effectively transforms it from a neutral adjudicator into a long-arm of CMS's enforcement authority.

Within this context, the DAB Appellate Division customarily affords CMS inappropriate deference. As one example, when considering whether a CMP amount was reasonable, the DAB

Appellate Division "presume[d]" that CMS properly considered the "regulatory factors in choosing the CMP amount and that those factors support the penalty imposed." *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703, 2016 WL 3574655, at *10 (May 20, 2016). The DAB Appellate Division stated that the burden therefore fell on the "SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26–27 (2011)). That burden shifting was not grounded in any identifiable statutory or regulatory authority.

It is no surprise that the outcomes of the DAB review process are overwhelmingly one-sided. Independent analyses of the DAB's decisions in recent years found that CMS prevailed in more than 95% of appeals from ALJ decisions involving SNF deficiency citations and civil money penalties. *See* Center for Medicare Advocacy, *Nursing Homes Lose Almost All Formal Appeals of Deficiencies and Civil Money Penalties* (Feb. 24, 2022), https://medicareadvocacy.org/nursing-homes-lose-almost-all-formal-appeals-of-deficiencies-and-civil-money-penalties/ (finding that in 2020, "ALJs upheld deficiencies and civil money penalties . . . in 48 decisions (96%); ALJs ruled for the facility in two decisions (4%)"); Kimberly Marselas, *Logjam at Top Appeals Board Stymies Efforts to Overturn Steep Nursing Home Penalties*, McKnight's Long-Term Care News (Feb. 27, 2025), https://www.mcknights.com/news/logjam-at-top-appeals-board-stymies-efforts-to-overturn-steep-nursing-home-penalties/ (explaining that ALJs "found for CMS 46 out of 47 times in 2023"). And at

the DAB Appellate Division stage, the DAB "rarely entertains even oral argument, almost always upholds CMS sanctions, and almost always reverses every ALJ [d]ecision in favor of a facility." Bianculli, *supra*, at 239 & n.63 (explaining that between 2010-2019, the DAB Appellate Division "reversed every ALJ decision in favor of a facility that CMS . . . appealed" (emphasis in original)); *see also* AHCA Response to HHS RFI, at 14 (PDF p. 17).

3. Mandatory escrow of disputed funds raises due process concerns and incentivizes providers to forgo challenges.

While this lengthy DAB process proceeds, CMS collects and holds in escrow funds in the amount of the unreviewed CMPs. 42 C.F.R. § 488.431(b). Such a deprivation raises due process concerns because it is undertaken prior to an opportunity for a hearing. *See Fuentes v. Shevin*, 407 U.S. 67, 82 (1972) ("The right to a prior hearing has long been recognized by this Court under the Fourteenth and Fifth Amendments."). CMS's collection and holding of facilities' funds without access to proper adjudication could constitute a taking. U.S. Const. amends. V, XIV; *Fuentes*, 407 U.S. at 84–85 ("[I]t is now well settled that a temporary, nonfinal deprivation of property is nonetheless a 'deprivation' in the terms of the Fourteenth Amendment."). These concerns are heightened when considering that about half of the ALJ decisions decided in 2019 were issued in favor of CMS without a hearing. Bianculli, *supra*, at 239.

CMS dismissed similar concerns raised by commenters when it promulgated section 42 C.F.R. § 488.431(b) by pointing to the IIDR process as an

interim review step before the funds are collected. *See* 76 Fed. Reg. 15106, 15108 (Mar. 18, 2011). CMS stated that "[t]he new independent informal dispute resolution process is an option available for facilities to contest surveys findings prior to the collection of civil money penalties to be placed in escrow and should reduce the chances of erroneous deprivation." *Id.*

In practice, IIDR serves as another layer of agency review, not a truly independent dispute resolution process. The IIDR process, whether operated by CMS or a state agency, "is not intended to be a formal or evidentiary hearing"; CMS retains authority to adjust the process unilaterally. *See* Ctrs. for Medicare & Medicaid Servs., State Operations Manual, ch. 7, §§ 7213.4, 7213.7 (Rev. 244, issued June 26, 2026), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf. And the completion of IIDR does not provide a binding, appealable decision for the facility, even if it results in their favor. The reviewer merely issues "recommendations" that are subject to CMS's approval or rejection. *See id.* § 7213.4. As CMS states in its regulation setting forth this process, "CMS retains ultimate authority for the survey findings and imposition of civil money penalties." 42 C.F.R. § 488.431(a).

In fact, CMS "routinely disregards or rejects" independent informal dispute resolution results that come out in favor of facilities. Bianculli, *supra*, at 243; *cf.* Ctrs. for Medicare & Medicaid Servs., QSO-23-05-NH, Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measures Based on Erroneous Schizophrenia Coding, and Posting

Citations Under Dispute 3 (Jan. 18, 2023), https://www.cms.gov/files/document/qso-23-05-nh-adjusting-quality-measure-ratings-based-erroneous-schizophrenia-coding-and-posting.pdf (explaining that approximately 75% of deficiency citations reviewed in the IIDR or IDR process are not changed after review). And while regulatory text requires that funds in escrow be returned, with interest, to facilities if a deficiency finding is reversed by a "final administrative decision," 42 C.F.R. § 488.431(d)(2), the compounding errors and structural unfairness in the DAB system may effectively discourage SNFs from challenging penalties.

Moreover, the regulatory scheme creates strong incentives for providers not to contest CMPs. CMS regulations provide a 35 percent reduction in the CMP amount if the facility waives its right to an ALJ hearing. 42 C.F.R. § 488.436(b). If a provider decides to pursue ALJ review, it forfeits that reduction, and the unreviewed funds are placed into escrow. *Id.* The combination of this incentive, the burdens of navigating the administrative process, and the likelihood of defeat in a biased review scheme operates to deter SNFs from exercising their rights to challenge CMPs levied against them.

II. HEALTHCARE PROVIDERS CANNOT BE REQUIRED TO RELINQUISH THEIR CONSTITUTIONAL RIGHT AS THE PRICE FOR FUNCTIONALLY MANDATORY PARTICIPATION IN FEDERAL BENEFIT PROGRAMS.

The decision below rests on a mistaken premise: that a healthcare provider's participation in Medicare is sufficiently voluntary to transform

conditions of participation equivalent to common law duties of care into modern regulatory requirements shielded from constitutional protections.[8] The Fourth Circuit found that the instant CMPs stemmed from Petitioner's alleged failure to fulfill a duty of care that "arose from petitioner's choice to participate in a voluntary government program (Medicare) where public funds are spent to achieve public benefits"—and, therefore, not from a failure to fulfill a "common law duty of care that applies to all people or those who participate in a particular type of activity."[9] *Sligo Creek Ctr. v. HHS*, 177 F.4th 556,

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[8] The Fourth Circuit also erred in distinguishing the alleged violations of infection control requirements at issue in this case from common law torts on the basis that the regulatory violations are "untethered to any injury." Pet.App. 11a. To support this reasoning, the Fourth Circuit relied exclusively on a footnote in a recent Fourth Circuit decision stating that "[s]uits at common law to vindicate private rights required both injuria (a legal wrong) and damnum (actual, concrete harm)." *Id.* (citing *In re: Express Scripts, Inc.*, 176 F.4th 301, 310 n.8 (4th Cir. 2026)). But this Court has explained that although "early courts" at common law required "injuria & damnum [injury and damage]," "[l]ater courts . . . reasoned that every legal injury necessarily causes damage." *Uzuegbunam v. Preczewski*, 592 U.S. 279, 286 (2021). Thus, the Fourth Circuit grounded its holding in a statement of law that this Court has rejected, and its reasoning cannot defeat the analogy to a common law tort.

[9] The infection control regulatory obligations at issue also bear a close relationship to traditional common law contract obligations. In order to participate in the Medicare and Medicaid programs, facilities execute a Provider Agreement, which includes terms incorporating statutory and regulatory obligations, including those under 42 C.F.R. Part 483. Thus, an alleged regulatory violation, like the one at issue here, may simultaneously constitute a failure to satisfy the facility's

561 (4th Cir. 2026). That type of analysis directly contravenes this Court's instruction that the context in which the legal right arises is not determinative: "[I]f the action resembles a traditional legal claim, its statutory origins are not dispositive." *Jarkesy*, 603 U.S. at 135 (explaining that the fact that the action "originated in a newly fashioned regulatory scheme" does not "permit Congress to siphon this action away from an Article III court" (internal quotations and modifications omitted)).

But even if this Court were to now permit consideration of the regulatory origins that gave rise to the enforcement action, the Fourth Circuit's rationale for distinguishing the federal program requirements at issue from mandatory tort obligations is based on a fundamentally inaccurate understanding of the Medicare program.

SNFs, such as Sligo Creek, must participate in Medicare and Medicaid—not as a voluntary choice, but as a practical necessity. The vast majority of frail elderly and individuals living with disabilities

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contractual obligations. The Fourth Circuit incorrectly concluded that this contractual duty lacks a common law analogue because CMS may impose penalties without proving that it has "incurr[ed] any actual damages as a non-breaching party." Pet.App. 12a. As this Court has recognized, it is "decisively settled" and "well established at common law" that a "party whose rights are invaded can always recover nominal damages without furnishing any evidence of actual damage." *Uzuegbunam*, 592 U.S. at 286–89 (citing common law breach of contract cases); *see also Attias v. CareFirst, Inc.*, 346 F.R.D. 1, 10 (D.D.C. 2024) ("History shows that parties long have been able to sue in Anglo-American courts based on an alleged contractual breach, regardless of whether they have suffered actual damages as a result.").

are insured by these public benefit programs. A facility that wishes to serve those patient populations, therefore, has little practical choice but to participate in Medicare and Medicaid. Financial realities likewise make participation functionally compulsory. These facilities operate with tight margins and would cease to function without Medicare and Medicaid reimbursement, leaving their patients without access to critical care. There is therefore no meaningful difference between the mandatory nature of a common law tort obligation—i.e., negligence and the standard of care governing the conduct of medical professionals—and of the infection control regulatory obligations that attach to Medicare- and Medicaid-enrolled providers at issue in this case. If society expects healthcare providers to deliver this essential care, the government cannot condition providers' participation in these constructively involuntary programs on waiver of their constitutional rights.

A. SNFs play a critical role in the public health system, providing care to vulnerable populations.

SNFs largely provide care to two groups of patients:[10] One group receives short-term and high-

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[10] "Nursing facilities" is a statutorily-defined term used to refer to facilities that provide this type of care and are certified in Medicaid, *see* 42 U.S.C. § 1396r(a), whereas "SNF" is used to define those facilities certified in Medicare, *see* 42 U.S.C. § 1395i-3(a). The vast majority of facilities that provide qualifying nursing care are certified in both Medicare and Medicaid, and only a small portion are certified exclusively in Medicaid. *See* Varun Saraswathula & Jenny M. Markell, Cong.

level care following an acute hospital stay. This care involves intensive rehabilitation services necessary to support recovery from strokes, heart attacks, and orthopedic procedures, and is an essential part of the continuum between an inpatient hospital stay and a patient's return to independent living. In the face of persistent hospital and in-patient facility bed shortages, SNFs have developed to provide post-acute care unavailable or inaccessible in a hospital setting. These services typically require higher staffing levels, with more registered nurses and other skilled professionals, capable of providing a very high level of transitional care.

The second group of patients served by certified SNFs receives long-term care based upon, among other things, their inability to manage activities of daily living in a safe manner. These long-term care facilities, referred to colloquially as "nursing homes," provide on-going clinical care and assistance with daily tasks as patients' capabilities decline over time. These patients often have chronic conditions and behavioral health needs, including progressing dementia or psychological disorders. Indeed, over 41% of SNF residents in 2022 had an Alzheimer's or other dementia diagnosis. *FastStats: Alzheimer Disease*, Ctr. for Disease Control & Prevention: Nat'l

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Rsch. Serv., IF11545, *Overview of Federally Certified Long-Term Care Facilities* (Sep. 10, 2026), https://www.congress.gov/crs_external_products/IF/PDF/IF11545/IF11545.2.pdf (explaining that 1.7% of long-term care facilities were exclusively certified in Medicare). Thus, *amicus* uses "SNFs" throughout this brief to refer to nursing facilities certified in Medicare and/or Medicaid.

Ctr. for Health Stats. (last reviewed Feb. 18, 2026), https://www.cdc.gov/nchs/fastats/alzheimers.htm

The care provided by these facilities is in high demand. In 2025, about 1.24 million residents lived in 14,742 SNFs certified by CMS to participate in the Medicare and Medicaid programs. Priya Chidambaram & Alice Burns, *A Look at Nursing Facility Characteristics in 2025*, KFF (Dec. 17, 2025), https://www.kff.org/medicaid/a-look-at-nursing-facility-characteristics/. And the median occupancy rate in 2025 was 83%, with one quarter of facilities operating at an occupancy rate higher than 91%. *See* Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment Policy, Chapter 7: Skilled Nursing Facility Services 223 (Mar. 2026), https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch7_MedPAC_Report_To_Congress_SEC.pdf [hereinafter MedPAC Ch. 7].

B. SNFs practically must participate in Medicare and Medicaid.

The patient populations with the greatest need of nursing care—typically elderly or people living with a disability—are overwhelmingly insured by Medicare and Medicaid.[11] Medicaid, in particular, is the primary payor for long-term care.[12] Though

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[11] Providers who do not participate in Medicare and Medicaid do not receive any payment from the public payors for services; the responsibility for payment rests entirely with the patient or, if applicable, their third-party private payor.

[12] It makes sense that Medicaid pays for more long-term care than Medicare. Medicare coverage is limited to 100 days of SNF care per spell of illness after qualifying conditions, and to

Medicaid accounts for one-fifth of total national healthcare spending, it accounts for more than half of spending for long-term care. Alice Burns et al., *10 Things to Know About Medicaid,* KFF (Feb. 18, 2025), https://www.kff.org/medicaid/10-things-to-know-about-medicaid/; Abby Wolk et al., *A Profile of Dual-Eligible Individuals*, KFF (July 15, 2026), https://www.kff.org/medicare/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/. These trends define SNFs' payment sources, more specifically: Medicare and Medicaid are the primary payors for 14% and 63% of SNF residents, respectively. *See* Chidambaram & Burns, *supra*. That means that in 2025, Medicare and Medicaid were the primary payors for 77% of SNF residents.[13]

These percentages of revenue translate to large dollar amounts. Medicaid accounted for nearly $66.5 billion in SNF spending in 2019, and Medicare Fee-for-Service reimbursed $31 billion to SNFs in 2024. Medicaid & CHIP Payment & Access Comm'n, Estimates of Medicaid Nursing Facility Payments Relative to Costs 2 (Jan. 2023), https://www.macpac.gov/wp-content/uploads/2023/01/Estimates-of-Medicaid-Nursing-Facility-

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qualify for SNF care, beneficiaries must have had a three-day in-patient hospital stay and require daily skilled nursing or rehabilitation services. *See* MedPAC Ch. 7, at 219.

[13] "Dual eligibles" are individuals who receive their primary health insurance coverage through Medicare, supplemented by Medicaid. "Dual-eligible individuals are more likely than Medicare beneficiaries without Medicaid to live in a long-term care nursing home or other institutional facility." Wolk et al., *supra*.

Payments-Relative-to-Costs-1-6-23.pdf; MedPAC Ch. 7, at 219.

SNFs operate with very slim margins. In 2024, freestanding SNFs had an estimated all-payor total margin of 2.1%—an improvement over 0.4% in 2023. *See* MedPAC Ch. 7, at 230. Even still, 40% of SNFs operated in 2024 with a negative all-payor total margin—meaning they operated at a loss; that percentage was even higher in 2023, when 46% of SNFs operated with a negative all-payor margin. *Id.*; *see also* Charlene Harrington, Richard Mollot, Robert Tyler Braun & Dunc Williams Jr., United States' Nursing Home Finances: Spending, Profitability, and Capital Structure, 54 Int'l J. Soc. Determinants of Health & Health Servs. 131, 131, 137 (2024), https://journals.sagepub.com/doi/pdf/10.1177/27551938231221509 (reporting the total net profit margin in 2019 for the 11,752 SNFs analyzed was 0.58%, with 45% reporting a net loss).

Importantly, payment by public payors, even though it does not cover 100% reimbursement for all services, is critical to offset significant operational losses. As stated above, in 2024, 40% of SNFs had a negative all-payor total margin. *See* MedPAC Ch. 7, at 230. When isolated to Medicare Fee-for-Service payments, those SNFs had an estimated margin of 24%. *Id.* at 231. Together, these data suggest that Medicare reimbursement plays a critical role in offsetting lower margins generated by other payors. Without Medicare and Medicaid reimbursement, it is likely that the vast majority of SNFs would not be financially viable.

The SNF profession is unique in its near-total reliance on government funding, but these are far

from the only healthcare providers dependent on Medicare and Medicaid participation to sustain their operations. Hospitals are a particularly strong comparison. In 2024, Medicare and Medicaid paid for at least 50% of inpatient days at 96% of community hospitals in the United States. Fact Sheet: Medicare and Medicaid Constitute Majority of Hospital Payments, Am. Hosp. Ass'n (Mar. 16, 2026), https://www.aha.org/fact-sheets/2022-05-25-fact-sheet-majority-hospital-payments-dependent-medicare-or-medicaid. Other providers' ability to serve patients should also not be conditioned on a waiver of their Seventh Amendment rights.

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In sum, SNFs occupy a critical place in the Nation's healthcare infrastructure, providing care to some of the most vulnerable populations—and they are able to do so only by participating in Medicare and Medicaid. The practical necessity of participating in those programs underscores why providers should not be forced to waive constitutional protections as the price of serving Medicare and Medicaid beneficiaries.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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