No. 19-840

IN THE
Supreme Court of the United States

THE STATES OF CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, HAWAII, ILLINOIS, IOWA, MASSACHUSETTS, MICHIGAN, MINNESOTA, NEVADA, NEW JERSEY, NEW YORK, NORTH CAROLINA, OREGON, RHODE ISLAND, VERMONT, VIRGINIA, AND WASHINGTON, ANDY BESHEAR, THE GOVERNOR OF KENTUCKY, AND THE DISTRICT OF COLUMBIA,

Petitioners,

v.

THE STATE OF TEXAS, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

MOTION FOR LEAVE TO FILE *AMICI CURIAE* BRIEF AND *AMICI CURIAE* BRIEF OF 33 STATE HOSPITAL ASSOCIATIONS IN SUPPORT OF PETITIONERS

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January 15, 2020

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Petitioners,

v.

THE STATE OF TEXAS, et al.,

Respondents.

MOTION FOR LEAVE TO FILE BRIEF OF AMICI CURIAE 33 STATE HOSPITAL ASSOCIATIONS

Thirty-three state hospital associations, representing over 5,000 hospitals and health systems (together, "proposed amici"), respectfully move under Supreme Court Rule 37.2(b) for leave to file a brief as amici curiae in support of Petitioners.

All parties were timely notified of proposed amici's intention to file this brief. The Petitioner States, Respondent States, and Respondent U.S.

House of Representatives have all consented. The Individual Respondents did not object, and the Federal Respondents are considering the consent request. Given the potentially accelerated briefing schedule, proposed amici have chosen to submit this brief with a motion for leave to file rather than await additional consents. Notably, all five parties consented to the filing of an amici curiae brief on behalf of 24 state hospital associations (most of whom are the same as proposed amici) when the case was before the U.S. Court of Appeals for the Fifth Circuit.

This case presents issues of monumental importance to proposed amici. As described in greater detail in the accompanying brief, proposed amici share an interest in delivering quality, affordable health care, and thus in the preservation of the Patient Protection and Affordable Care Act (ACA). Since enactment of the ACA, amici have spent considerable resources adopting the law's reforms that have resulted in the delivery of higher-quality, more coordinated care at a lower cost. Proposed amici are submitting this brief because they wish to ensure that the ACA's reforms remain in effect and because reverting back to old delivery models would significantly disrupt proposed amici's operations and patient care.

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INTEREST OF AMICI CURIAE

This brief[1] is filed on behalf of 33 state hospital associations,[2] which represent over 5,000 hospitals and health systems that treat tens of millions of patients every year. Amici and their members (hereafter "amici") share an interest in delivering quality, affordable health care, and therefore in the preservation of the Patient Protection and Affordable Care Act (ACA). Since enactment of the ACA, amici have spent substantial resources embracing the law's reforms that have resulted in the delivery of higher-quality, more coordinated care at a lower cost. Amici are submitting this brief because they are committed to ensuring that the ACA's reforms remain in effect and because reverting back to old delivery models would significantly disrupt amici's operations and patient care.

Although this brief focuses on the adverse impact of the Fifth Circuit's decision on the delivery of health care services in this country, amici endorse the constitutional and severability arguments presented by petitioners, which demonstrate that the Fifth

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to its preparation or submission.

[2] The individual associations are described in an Appendix to this brief.

Circuit's opinion was wrongly decided.[3] Amici agree with petitioners that the ACA's minimum coverage provision, as amended, is constitutional. But if this Court decides otherwise, amici concur that this Court should reach the question of severability and hold that the rest of the ACA must remain intact—including the delivery reforms described in this brief.

INTRODUCTION

A specter of uncertainty now looms over health care delivery and financing in this country. After nearly a decade of lawsuits seeking to invalidate the ACA, the Fifth Circuit struck down the minimum coverage provision, as amended, and left unanswered whether anywhere from zero to one hundred percent of the remainder of the law should survive. Pet'r App. 51a-68a. The Fifth Circuit's deferred decision is remarkable given the panel majority's acknowledgment that the ACA "is a monumental piece of healthcare legislation that regulates a huge swath of the nation's economy and affects the healthcare decisions of millions of Americans." *Id.* at 2a.

Underscoring the ACA's importance is the fact that even its lesser-known but equally important provisions have foundationally changed the U.S. health care system. The ACA's "delivery reforms," which the Fifth Circuit and the district court did not mention in their opinions, transformed the way hospitals and health systems deliver and are paid for health care. These reforms make fundamental improvements in the quality and coordination of care and have become

[3] *See* Pet'r U.S. House of Representatives Br. at 17-34; Pet'r States Br. at 19-26.

integral to the delivery of health care services in the United States during the almost ten years since the ACA was enacted.

Unless this Court grants certiorari and resolves the constitutionality and severability questions presented here, the valuable reforms designed to improve health care and lower cost will hang in limbo for several years. A delayed resolution may force hospitals to postpone or abandon the adoption of innovative models, such as Accountable Care Organizations, that are designed to improve health care and lower costs. Moreover, hospitals will almost certainly encounter increased difficulty raising money to finance the investments necessary to adopt these changes. Because ACA uncertainty results in bond rating downgrades, hospitals' access to capital will be adversely affected and thus expenses associated with necessary facility upgrades and other projects aimed at enhancing access to care will increase. Prompt and final resolution of these questions is necessary to settle how hospitals and health systems will continue to deliver care.

ARGUMENT

THE FIFTH CIRCUIT DECIDED IMPORTANT QUESTIONS OF FEDERAL LAW WHICH UNLESS OVERTURNED WILL PROFOUNDLY AFFECT THE AVAILABILITY AND QUALITY OF HEALTH CARE FOR MILLIONS OF AMERICANS AND WHICH SHOULD THEREFORE BE DECIDED BY THIS COURT.

The Patient Protection and Affordable Care Act[4] made health care available to more than 20 million individuals through insurance subsidies and expansion of the federal Medicaid program. The ACA is best known for its provisions that reformed the individual market for private health insurance, including the minimum coverage provision. The law created Health Insurance Marketplaces where individuals may purchase insurance, provided subsidies to help individuals buy insurance on the Marketplaces, required that insurance policies permit young adults up to age 26 to remain on their parents' health insurance plans, and prohibited insurers from denying coverage ("guaranteed issue") or charging drastically higher rates because of an individual's health status ("community rating"). It also included provisions that expand Medicaid coverage to millions of Americans.

Often omitted in descriptions of the ACA are its landmark provisions that have made a sea change in health care delivery, coordination, and payment. These reforms have modernized the way hospitals and

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[4] Pub. L. 111-148, 124 Stat. 119-1045 (2010). All citations to the law are styled as ACA § ___.

health systems deliver services. The law also invested in the health care workforce, prioritized wellness and prevention, and launched new initiatives to study and compare health care quality. All of these important innovations were jeopardized when the district court struck down the entire ACA and their future remains in doubt after the Fifth Circuit's decision.

A. The ACA Made Fundamental Changes to the Delivery of Health Care in the United States, Improving Patients' Lives and Saving Tens of Billions of Dollars.

The ACA's reforms include pioneering new models of care that foster better coordination between health care professionals, and payments to health systems, based on the quality of care provided to Medicare beneficiaries, with less reliance on reimbursement based on each separate hospital and doctor's visit, test, and service provided (the "fee-for-service" model). These paradigm shifts have had ripple effects on hospitals and health systems both because the federal government is the largest payer for health care in the United States and because private insurers often mirror the federal government's policies with respect to payment.[5]

As part of these reform efforts, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) and gave it authority to test innovative

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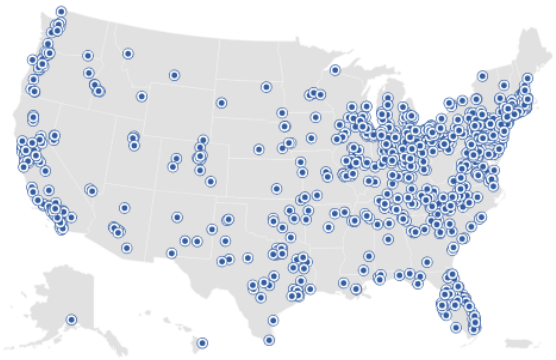
[5] *E.g.*, American Health Policy Institute, *How the Government as a Payer Shapes the Health Care Marketplace* (2015), *available at* http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf.

payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children's Health Insurance Program expenditures while preserving or enhancing the quality of care for beneficiaries.[6] CMMI has launched over 40 new payment and health care service delivery models, involving more than 18 million patients and 200,000 health care providers across the country.[7] The map below from the Centers for Medicare & Medicaid Services (CMS) shows where in the country health care providers are working with CMMI to test methods for improving the delivery and coordination of care at a lower cost.



Source: Centers for Medicare & Medicaid Services

According to a September 2016 report issued by the Congressional Budget Office, CMMI's programs are expected to reduce federal spending by roughly $34 billion from 2017 through 2026.[8]

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[6] ACA §§ 3021 & 10306; *see* CMS, *Innovation Models*, http://innovation.cms.gov.

[7] CMS, *CMS Innovation Center: Report to Congress* 1-2 (Dec. 2016).

[8] *CBO's Estimates of the Budgetary Effects of the Center for Medicare & Medicaid Innovation: Hearing Before the H. Comm. on the Budget*, 114th Cong. 3 (2016) (testimony of Mark Hadley,

Better care coordination was always a key objective of health reform. As Senator Max Baucus, Chairman of the Senate Finance Committee and one of the principal architects of the ACA, wrote in a 2008 white paper outlining the goals for what would become the law:

> Ensuring access to meaningful health coverage is a fundamental goal of health care reform, ***but there are also other vital priorities we must pursue***. Among them is ***the critical need to improve the value of care provided in our health care system***. We must take steps to ensure patients receive higher quality care, and do so in a way that reduces costs over the long-run. In short, the U.S. must get better value for the substantial dollars spent on health care.

(Emphasis added).[9]

A CMMI initiative that has had a particularly significant impact on the way hospitals provide care to patients is the Medicare Shared Savings Program for Accountable Care Organizations (ACOs). The Shared Savings Program provides financial incentives

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Deputy Director of the Congressional Budget Office). This is the most recent report on the subject available from CBO.

[9] Sen. Max Baucus, *Call To Action: Health Reform 2009*, at 36 (Nov. 12, 2008), *available at* https://www.finance.senate.gov/imo/media/doc/finalwhitepaper1.pdf.

to health care providers, including hospitals, primary care physicians, and nursing homes, to join together in ACOs.[10] The ACO members agree to coordinate and take collective responsibility for the quality and total costs of care for a specified patient population. In treating that population, if an ACO meets health care quality thresholds and provides care below a target budget, the provider network splits the savings 50/50 with Medicare. Alternatively, ACOs may split the savings 60/40 if the providers agree in advance to share excess costs with the government in the event their spending exceeds the target budget. A 2017 Office of the Inspector General report found that in the first three years of the program: 428 participating Shared Savings Program ACOs served 9.7 million beneficiaries; most of the ACOs reduced Medicare spending compared to their benchmarks, achieving a net spending reduction of nearly $1 billion; and ACOs generally improved the quality of care they provided.[11]

The ACA also established a pilot project to test Medicare bundled payment models called Bundled Payments for Care Improvement (BPCI).[12] Bundling

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[10] ACA §§ 3022 & 10307; *see* CMS, *Shared Savings Program*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html.

[11] HHS Office of the Inspector General, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality*, OEI-02-15-00450 (Aug. 2017), *available at* https://oig.hhs.gov/oei/reports/oei-02-15-00450.pdf.

[12] ACA §§ 3023 & 10308; *see* CMS, *Bundled Payments for Care Improvement (BPCI) Initiative*, https://innovation.cms.gov/initiatives/bundled-payments/.

links payments for the multiple services that Medicare beneficiaries receive during a specific episode of care across different settings (including hospitals, physician's offices, and post-acute care providers). Under the initiative, hospitals and other health care providers may enter into payment arrangements that include financial and performance accountability for episodes of care. For example, one model bundles payments for all inpatient hospital services, physician services, post-acute services, and hospital readmission care that a patient receives during and after a hip or knee replacement.[13] As one Senator described it during Congress's consideration of the ACA, "[i]n effect, instead of paying for each specific service, under bundling there is essentially one payment to reward trying to deliver care in an integrated fashion."[14]

Research has shown that bundled payments can align incentives for providers, allowing them to deliver higher-quality, more coordinated care across all specialties and settings. A 2018 report found that participants have responded to the initiative's incentives by reducing Medicare payments while maintaining quality of care.[15] In October 2018, CMMI

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[13] As a follow-on to BPCI, in 2016 CMMI launched a bundled payment program for hip and knee replacements that is mandatory for hospitals in certain geographic markets. *See* CMS, *Comprehensive Care for Joint Replacement Model*, https://innovation.cms.gov/initiatives/CJR.

[14] 155 CONG. REC. S11910 (daily ed. Nov. 21, 2009) (statement of Sen. Wyden).

[15] The Lewin Group, *CMS Bundled Payments for Care Improvement Initiative Models: Year 5 Evaluation & Monitoring Annual Report* (Oct. 2018), *available at*

launched BPCI Advanced, an initiative to test bundling models for 32 additional episodes of care, with nearly 1,300 health systems signed up to participate.[16]

Other ACA "pay-for-performance" reforms tethered Medicare payments to the quality of care delivered. A value-based purchasing (VBP) system now pays hospitals for their performance based on quality criteria while treating Medicare beneficiaries, instead of on the quantity of procedures performed.[17] Under the VBP program, CMS makes payments to hospitals based on how closely clinical best practices are followed and how well hospitals enhance patients' experience of care during hospital stays over a relevant time period.

The Hospital Readmissions Reduction Program reduces Medicare payments to hospitals with "excessive" readmissions in order to incentivize patient safety and education.[18] Research indicates

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https://downloads.cms.gov/files/cmmi/bpci-models2-4yr5evalrpt.pdf.

[16] Press Release, CMS, *CMS Announces Participants in New Value-Based Bundled Payment Model* (Oct. 9, 2018), *available at* https://www.cms.gov/newsroom/press-releases/cms-announces-participants-new-value-based-bundled-payment-model.

[17] ACA §§ 3001 & 10335; *see* CMS, *The Hospital Value-Based Purchasing Program*, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/hvbp/hospital-value-based-purchasing.html.

[18] ACA § 3025; *see* CMS, *Hospital Readmissions Reductions Program*, https://www.cms.gov/medicare/medicare-fee-for-servicepayment/acuteinpatientpps/readmissions-reduction-program.html.

that the law's incentives are working as intended, as readmissions for certain health conditions decreased more rapidly after passage, and improvement was most significant for hospitals with the worst pre-ACA performance.[19] Finally, the ACA established the Hospital-Acquired Condition Reduction Program.[20] The program addresses patient safety by reducing Medicare payments for hospitals that rank in the lowest-performing quartile of hospital-acquired conditions, based on recent statistics.

Together, these reforms represent the most significant changes to the health care delivery and payment systems in more than 50 years.[21] Some of

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[19] *See* Jason H. Wasfy *et al.*, *Readmission Rates After Passage of the Hospital Readmissions Reduction Program: A Pre–Post Analysis*, ANNALS OF INTERNAL MEDICINE (Mar. 7, 2017).

[20] ACA § 3008; *see* CMS, *Hospital-Acquired Condition Reduction Program*, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/hac-reduction-program.html.

[21] The ACA's reshaping of health care delivery went beyond changing service and payment models. The law made substantial investments in the health care workforce and in graduate medical education, refocused health systems on wellness and prevention, and launched a number of measures intended to study and improve health care quality. *See, e.g.*, ACA §§ 5201-10 (establishing flexible loan repayment programs and public health workforce loan repayment programs that have increased the size of the public health workforce); ACA § 4401 (creating the National Prevention, Health Promotion and Public Health Council to coordinate and lead federal strategy with respect to wellness, prevention, and health promotion practices); ACA §§ 3011 & 10302-05 (providing for a national quality improvement strategy to elevate priorities that have the greatest potential to improve patient outcomes, patient-centeredness and efficiency).

these health care delivery reform programs have already achieved improvements across a range of measures. Although we expect these programs will continue to be evaluated and improved, they have already spurred a significant amount of investment and innovation among hospitals.

B. The Fifth Circuit's Decision Introduces Substantial Uncertainty for Hospitals and Health Systems.

Hospitals and health systems' decade of investments to reimagine the way they deliver care has been called into doubt by the decisions below. By abdicating its responsibility to address the purely legal question of severability and instead remanding to the district court to re-conduct its own analysis "with a finer-toothed comb," the Fifth Circuit raised more questions than answers. As the decision stated:

> It may still be that none of the ACA is severable from the individual mandate, even after [the district court's inquiry on remand] is concluded. It may be that all of the ACA is severable from the individual mandate. It may also be that some of the ACA is severable from the individual mandate and some is not.

Pet'r App. 68a-69a. Practically speaking, absent review in this Court, the district court and Fifth Circuit will spend at least two years determining whether none, some, or all of the reforms described above should remain.

Such uncertainty has real-world consequences for hospitals and health systems, and, most importantly, the patients they serve. Predictability is critical in making investment and capital decisions. The ACA's Medicaid expansion (for the 37 states that have opted in) and delivery reforms (for all states) have made a substantial financial impact on hospitals and greatly enhanced access to care for patients. Taken together, these provisions have transformed the way care is delivered, resulted in fewer hospital closures, and provided greater economic confidence to lenders and boards of trustees who have taken on new projects. The expanded ACA insured population has also contributed to closing the uninsured gap, which has improved health systems' financial viability and allowed underserved populations to receive preventive and other services in more appropriate care settings. ACA uncertainty often comes up in hospital bond rating evaluations, and many health systems would face bond rating downgrades that adversely impact their access to capital and increase expenses associated with necessary facility upgrades and other projects aimed at enhancing access to care.

Given their widespread adoption across the country, the risk of losing the CMMI payment models may slow the shift to value-based payments and risk reversion to a fee-for-service model, from which Congress intended to evolve.[22] Hospitals and health systems have already invested hundreds of millions of dollars in labor, technology, and other capital to

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[22] *E.g.*, 155 CONG. REC. S11922 (daily ed. Nov. 21, 2009) (statement of Sen. Cantwell) ("What we need to do, which is what exactly this bill sets us on a course and path to do, is to pay for value not for volume . . .").

advance these new delivery models, with many such investments featuring multi-year service contracts. Hospitals and health systems considering whether to join or form an accountable care organization, for example, may now hesitate to do so given the current state of limbo and the risk that the underlying statutory authority to create ACO's and to grant waiver protections from the Stark and anti-kickback laws, which enable the care coordination activities essential to their success, could disappear.

Although this brief has focused primarily on the importance of the delivery system and payment reforms, it bears noting that the widespread coverage loss resulting from an invalidation of the ACA would itself have a significant impact on states, hospitals, and consumers. To understand the magnitude of uncertainty facing the nation's health systems, it is informative to drill down on Montana, one of our least populous states. The Montana Hospital Association estimates that judicial invalidation of the entire ACA would put the state at risk of: losing more than $1 billion in federal funding; adding $356 million in uncompensated care costs to health care providers; and over 140,000 Montana residents losing health insurance coverage (which amounts to almost 15% of the state's population and would result in a 176% increase in the uninsured rate).[23] Extrapolate those numbers nationwide, and it is no surprise that "judicial repeal of the ACA would have potentially devastating effects on the national healthcare system and the economy at large." Pet'r App. 106a (King, J., dissenting).

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[23] Similarly, Maine estimates that $200 to $300 million is at risk for its health systems.

CONCLUSION

The petition for a writ of certiorari should be granted.

RESPECTFULLY submitted.

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APPENDIX

DESCRIPTION OF INDIVIDUAL AMICI

Arizona Hospital and Healthcare Association (AzHHA) is Arizona's largest statewide trade association for hospitals, health systems, and affiliated health care organizations. Its hospital members are united with the common goal of improving health care delivery in Arizona.

The Arkansas Hospital Association (ArHA) is a statewide, non-profit trade association that represents 102 member hospitals and health systems and the more-than 41,000 individuals they employ. For 80 years now, ArHA has advocated for initiatives that protect and improve the health of Arkansans by ensuring access to effective, efficient health care. By jeopardizing access to care for approximately 300,000 individuals in the state, the elimination of the Affordable Care Act would have a detrimental impact on the health of Arkansans, on the economic health of the state, and on the continued viability of its hospitals.

The California Hospital Association (CHA) is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the general acute care and psychiatric acute patient beds in California. CHA is committed to establishing and maintaining a financial and regulatory environment within which hospitals, health care systems, and other health care providers can offer high-quality patient care.

Colorado Hospital Association (CHA) represents more than 100 member hospitals and health systems throughout Colorado, including urban, rural, critical access and specialty hospitals; and academic, non-profit and tax-paying systems. The Affordable Care Act's provisions impact all Coloradans – nearly six million Americans – and its elimination would have a detrimental impact on their health, on the economic health of the state, and on the continued viability of its hospitals.

The Georgia Hospital Association is a non-profit trade association made up of member hospitals and individuals in administrative and decision-making positions within those institutions. Founded in 1929, the Association serves nearly 161 hospitals and health systems in Georgia. Its purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia's citizens.

The Healthcare Association of Hawaii (HAH), established in 1939, is a not-for-profit association that serves as the leading voice of health care on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. HAH's organizational goal to is to support a healthy Hawaii where every resident of every age has convenient access to appropriate, affordable, high quality care, and where health care providers are reimbursed adequately to deliver that care.

The Illinois Health and Hospital Association (IHA) is a statewide not-for-profit

association with a membership of over 200 hospitals and nearly 50 health systems. For over 90 years, the IHA has served as a representative and advocate for its members, addressing the social, economic, political, and legal issues affecting the delivery of high-quality health care in Illinois.

The Iowa Hospital Association (IHA) is a voluntary, not-for-profit membership organization representing all of Iowa's 118 community hospitals, including 82 critical access hospitals. IHA's mission is to support Iowa hospitals in achieving their mission and goals by advocating for member interests at the state and national level, and providing members with valuable education and information resources.

The Kansas Hospital Association (KHA) is a voluntary, non-profit organization existing to be the leading advocate and resource for its members. KHA membership includes 219 facilities, of which 123 are full-service, community hospitals. Founded in 1910, KHA's vision is: "Optimal Health for Kansans."

The Kentucky Hospital Association (KHA) is a non-profit state association of hospitals, related health care organizations, and integrated health care systems statewide. Membership in KHA is voluntary, and its member entities include 120 hospitals in the Commonwealth of Kentucky. KHA engages in advocacy and representation efforts on behalf of their member hospitals that promote safety, quality, and efficiency in health care. The mission of KHA is to be the leading voice for Kentucky health systems in improving the health of their communities.

The Louisiana Hospital Association (LHA) is a non-profit organization founded in 1926 and incorporated in 1966 for the purpose of promoting the public welfare of the State of Louisiana. The Association's membership is composed of over 150 member institutions, with more than a thousand individual members. Membership consists of hospitals of all kinds, including public, private, non-profit, for-profit, federal, municipal, hospital service district, religious, general, specialty, acute-care, psychiatric, and rehabilitation classifications.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals in Maine including 33 non-profit general acute-care hospitals, two private psychiatric hospitals, and one acute rehabilitation hospital. In addition to acute care hospital facilities, it also represents 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices.

The Massachusetts Health and Hospital Association (MHA) is a voluntary, not-for-profit organization composed of hospitals and health systems, related providers, and other members with a common interest in promoting the good health of the people of the Commonwealth of Massachusetts. Through leadership in public advocacy, education, and information, MHA represents and advocates for the collective interests of hospitals and health care providers, and it supports their efforts to provide high-quality, cost-effective, and accessible care.

The Michigan Health & Hospital Association (MHA) is a statewide advocacy organization representing over 170 Michigan health care facilities providing inpatient care including long-term acute care and rehabilitation facilities as well as other specialty hospitals. The MHA represents *all* nonprofit and several for-profit hospitals in the state, advocating on behalf of them and the nearly 10 million people they serve. Established in 1919, the MHA represents the interests of its member hospitals and health systems on key issues and supports their efforts to provide quality, cost-effective and accessible care.

The Minnesota Hospital Association (MHA) is a Minnesota non-profit corporation that represents hospitals in the State of Minnesota, including 142 community-based hospitals and health systems and the physicians employed at those hospitals and health systems. MHA assists Minnesota hospitals in carrying out their responsibility to provide quality health care services to their communities; promote universal health care coverage, access, and value; and coordinate the development of innovative health care delivery systems.

The Mississippi Hospital Association (MHA) is a statewide trade association which serves the public by assisting its Members in the promotion of excellence in health through education, public information, advocacy, and service.

The Montana Hospital Association (MHA) is the principal advocate for the state's health care providers and the communities they serve. MHA's

diverse membership includes organizations that provide hospital, nursing home, physician, home health, hospice and other health services. The MHA Board serves voluntarily as Trustees of the not-for-profit organization and determines the association's public policy agenda based on input from member representatives through MHA councils, committees and task forces.

The Nevada Hospital Association (NHA) is a not-for-profit, statewide trade association representing Nevada's acute care hospitals along with psychiatric, rehabilitation and other specialty hospitals, as well as health-related agencies and organizations throughout the state. Formally established in 1960 and incorporated in 1971, the NHA was created by hospital administrators to provide a unified forum for various types of hospitals to address issues including reimbursement, worker's compensation, professional liability, and continuing education, among others.

The New Hampshire Hospital Association (NHHA) is the leading and respected voice for hospitals and health care delivery systems in New Hampshire, working together to deliver compassionate, accessible, high-quality, and financially sustainable health care to the patients and communities served by its member hospitals. NHHA represents 31 member hospitals, including a large academic medical center, 13 critical access hospitals, two specialty rehabilitation hospitals, one state psychiatric hospital, one private behavioral health hospital, and one VA Medical Center.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier health care association since its inception in 1918. NJHA currently has members across the health care continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible and affordable health care in New Jersey.

The New Mexico Hospital Association (NMHA) is a membership organization representing 46 New Mexico hospitals, health networks, ambulatory facilities, home health agencies and a variety of affiliate groups throughout the state on legislative, regulatory and public policy issues. For over seven decades, the NMHA has advocated for the common good and collective interests of its members in an ever-changing health care environment.

The Healthcare Association of New York State (HANYS) is New York's statewide hospital and health system association representing over 500 not-for-profit and public hospitals and hospital based skilled nursing facilities, home health agencies, and hospices. HANYS seeks to advance the health of individuals and communities by providing leadership, representation, and service to health providers and systems across the entire continuum of care.

The Greater New York Hospital Association (GNYHA) is a Section 501(c)(6) organization that represents the interests of nearly 150 hospitals located throughout New York State, New Jersey, Connecticut, and Rhode Island, all of

which are not-for-profit, charitable organizations or publicly-sponsored institutions. GNYHA engages in advocacy, education, research, and extensive analysis of health care finance and reimbursement policy.

The North Carolina Healthcare Association (NCHA) is a statewide trade association representing 136 hospitals and health systems in North Carolina, with the mission of uniting hospitals, health systems, and care providers for healthier communities.

The North Dakota Hospital Association (NDHA), comprised of 47 hospital members, is a non-profit, voluntary trade association established in 1934 which represents hospitals, health systems, health-related organizations, and other members with a common interest in promoting the health of the people of North Dakota. The NDHA is the advocate for North Dakota's hospitals, health systems, communities, and patients before legislative and regulatory bodies.

The Ohio Hospital Association (OHA) is a private non-profit trade association established in 1915 as the first state-level hospital association in the United States. For decades the OHA has provided a forum for hospitals to come together to pursue health care policy and quality improvement opportunities in the best interest of hospitals and their communities. The OHA is comprised of 220 hospitals and 13 health systems, all located in Ohio, and works with its member hospitals across the state to improve the quality, safety, and affordability of health care for all Ohioans.

The Oklahoma Hospital Association was established in 1919 to represent the interests and views of more than 130 member hospitals and health systems across the state of Oklahoma. OHA's primary objective is to promote the health and welfare of all Oklahomans by leading and assisting member organizations in providing high quality, safe, and valued health care services to their communities.

The Oregon Association of Hospitals and Health Systems (OAHHS), founded in 1934, is a statewide, non-profit trade association that works closely with local and national government leaders, business and citizen coalitions, and other professional health care organizations to enhance and promote community health and to continue improving Oregon's innovative health care community. Representing all 62 hospitals in Oregon, OAHHS provides leadership in health policy, advocacy, and comprehensive member services that strengthen the quality, viability, and capacity of Oregon hospitals to best serve their communities.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is a statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

The Tennessee Hospital Association (THA) was established in 1938 as a not-for-profit membership association to serve as an advocate for hospitals, health systems, and other health care

organizations and the patients they serve. The Association also provides education and information for its members, and informs the public about hospitals and health care issues at the state and national levels.

The Vermont Association of Hospitals and Health Systems (VAHHS) is a statewide non-profit member organization comprised of Vermont's network of not-for-profit hospitals. Working with partners and stakeholders locally and nationally, VAHHS supports and contributes to policies that meet the association's core principles of making health care more affordable, maintaining high quality care, providing universal access, and preserving the individual's ability to choose their doctor and hospital.

The Washington State Hospital Association (WSHA) is a non-profit membership organization that represents 107 member hospitals. WSHA works to improve the health of the people of the State by advocating on matters affecting the delivery, quality, accessibility, affordability, and continuity of health care.

The West Virginia Hospital Association (WVHA) is a not-for-profit statewide organization representing 63 hospitals and health systems across the continuum of care. The WVHA supports its members in achieving a strong, healthy West Virginia by providing leadership in health care advocacy, education, information, and technical assistance, and by being a catalyst for effective change through collaboration, consensus building, and a focus on desired outcome.