ORAL ARGUMENT NOT YET SCHEDULED

No. 20-5193

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA

THE AMERICAN HOSPITAL ASSOCIATION, *et al.*,
Appellants,

v.

ALEX M. AZAR II, in his official capacity as Secretary of Health and Human Services,
Appellee,

On Appeal from the United States District Court for the District of Columbia,
(No. 19-3619, Honorable Carl J. Nichols)

CORRECTED BRIEF OF *AMICI CURIAE* FORTY (40) STATE HOSPITAL ASSOCIATIONS IN SUPPORT OF APPELLANTS

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CERTIFICATE AS TO PARTIES, RULINGS AND RELATED CASES

A. Parties and *amici*

All parties, intervenors, and amici are listed in the Certificates as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 3, 2020.

B. Rulings under review

References to the rulings at issue appear in the Certificate as to Parties, Rulings Under Review, and Related Cases filed in this Court on July 3, 2020.

C. Related cases

Amici are not aware of any cases related to this appeal.

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CORPORATE DISCLOSURE STATEMENT

Amici curiae are non-profit organizations. They have no parent corporations and do not issue stock.

STATEMENT REGARDING CONSENT TO FILE AND SEPARATE BRIEFING

All Parties have consented to the filing of this brief. *Amici curiae* filed their notice of intent to participate as *amici curiae* on July 24, 2020.

Counsel for *amici curiae* certify that it is not practicable to file a joint *amicus curiae* brief with other potential *amici* in support of Appellants and that it is necessary to file a separate brief.

Counsel reached out to potential *amici* and was able to put together the present coalition of organizations, thereby reducing the number of potential *amicus curiae* filings.

INTEREST OF AMICI CURIAE[1]

Amici curiae are forty state and regional hospital associations.[2] It is no exaggeration to say that *amici*'s member hospitals will be *most* directly and adversely impacted by the Department of Health and Human Services' (HHS) Final Rule, entitled "Price Transparency Requirements for Hospitals to Make Standard Charges Public."[3] *Amici*'s members provide care to patients, negotiate complex contracts with insurers, mail out the bills, and will be the hospitals that are required to disclose millions of lines of data under the regulation at issue here. As such, *amici* have the strongest possible interest in how HHS regulates the disclosure of privately-negotiated contracts in the Final Rule. They respectfully submit this brief to provide information directly relevant to the Court's consideration of this appeal.

[1] In accordance with Federal Rule of Appellate Procedure 29(a)(4)(E), *amici* certify that this brief was authored entirely by counsel for *amici curiae* and not by counsel for any party, in whole or part; no party or counsel for any party contributed money to fund preparing or submitting this brief; and apart from *amici curiae* and their counsel, no other person contributed money to fund preparing or submitting this brief.

[2] The individual associations are described in Appendix A to *amici*'s notice of intent to file.

[3] 84 Fed. Reg. 65,524-01 (Nov. 27, 2019).

INTRODUCTION

Amici's member hospitals know better than anyone how important it is for patients to make informed health care choices. For that reason, *amici* strongly support meaningful price transparency. Like HHS, *amici* "believe that transparency in healthcare pricing is critical to enabling patients to become active consumers so that they can lead the drive towards value."[4]

But this Court need not decide whether the Final Rule is "sound polic[y]." *Department of Homeland Security v. Regents of Univ. of Cal.*, No. 18-587 2020 WL 3271746 *17 (U.S. June 18, 2020). The only question for this Court is one of administrative law, *i.e*. "whether the agency appreciated the scope of its discretion or exercised that discretion in a reasonable manner." *Id*. HHS did not do so here. It instead chose to achieve its laudable goals in unlawful ways.

To make matters worse, HHS's Final Rule will impose inordinate burdens on health systems across the United States without a corresponding benefit to consumers. *Amici*'s member hospitals are experiencing those burdens today—in the midst of a global pandemic.[5] Right now, they are required to spend precious dollars

[4] *Id*. at 65,526.

[5] *See* Ron Shinkman, *Ratings agencies issue foreboding reports on hospital finances as AHA seeks $100B to respond to COVID-19*, Health Care Dive (March 20, 2020), https://www.healthcaredive.com/news/ratings-agencies-issue-foreboding-reports-on-hospital-finances-as-aha-seeks/574541/ ("Most U.S. hospitals typically operate on thin margins," and recent financial reporting indicates that "the fiscal fortunes of the nation's hospitals are apparently shrinking."); American Hospital Association,

and staff-hours to comply with a rule that far exceeds HHS's statutory authority and still does not advance the ultimate goal of price transparency: to allow consumers to determine their out-of-pocket payment obligations for health care services.

Appellants have persuasively explained why the district court erred in upholding the Final Rule. Rather than repeating those arguments, *amici* seek to provide this Court with background information about how hospital charges and reimbursement work in the real world. This brief describes the history of hospital charging in the United States and how we have ended up where we are today—a system in which hospitals maintain a single list of standard charges (the "chargemaster" list), which is used as the "starting point" for individualized negotiations with private insurers. Memorandum Opinion ("Opinion") at 3 (June 23, 2020), ECF No. 35. The result of these complex, ongoing negotiations is a myriad of discounts and deviations from the "chargemaster's" standard pricing list.

Today, hospitals typically contract with dozens of private insurers, covering multiple types of plans, each of which has different payment rates and reimbursement methodologies. None of these thousands of different rates, which

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Letter on Proposed Rulemaking (June 29, 2020) at 1-2 ("The last several months have required all hospitals and health systems to dedicate significant resources to managing the COVID-19-surge and adapting to new ways of caring for patients.… Even attempting to comply with the rule will require a significant diversion of financial resources and staff time that hospitals and health systems cannot afford to spare as they prepare to or care for patients with COVID-19.").

are discounted from the "chargemaster" starting point, can be reasonably described as "standard." Strikingly, the district court misunderstood this argument and essentially read the word "standard" out of the statute. That misunderstanding caused the court to reject Appellants' argument under *Chevron* Step One and choose incorrectly when making what it described as a "close call" under *Chevron* Step Two.

The district court's misunderstanding of this argument hits especially close to home to *amici* because the district court misconstrued *amici*'s brief below, which it cited in support of its erroneous reading of "standard charges." Specifically, the district court cited *amici*'s brief as evidence for its assertion that Appellants and *amici* believe there is only "one set of charges: those reflected in their chargemasters." Opinion at 17 (quoting Br. of Amici Curiae Thirty-Seven State Hospital Associations at 15, ECF No. 25-1 ("[T]he chargemaster remains a hospital's *only* universal list of charges for services.")). Nobody disputes that the chargemaster contains *the only* uniform set of charges. Nevertheless, the district court ignored the word "universal" in the sentence quoted from *amici*'s brief.

Let us be clear: *amici* do not dispute that patients often ultimately pay rates that are different from what is on a hospital's "chargemaster" list. In fact, *amici* agree that there are thousands of different final, individualized payment rates, and most do not match the standard "starting point." But therein lies the problem with

the district court's and HHS's interpretation of "standard charge." When every charge is so different and there are thousands of different charges, how can the agency reasonably call *all* of those charges "standard"?

By contrast, there is only one "universal" list—the "chargemaster"—and only that list can be reasonably called "standard." Everything else is a *non*-standard discount. The district court and HHS, however, would treat *every* single charge, for *every* different individual patient or insurer, as "standard." This distorts "standard" beyond both its common meaning *and* the realities of the current hospital payment system. It should be rejected under both steps of the *Chevron* test.

The district court's "close call" under *Chevron* Step Two is further undercut by its failure to seriously grapple with the statute's use of the word "list." Despite Appellants and *amici* having devoted considerable attention to this statutory term, the district court relegated its analysis of the phrase "a list" to a brief footnote. *See* Opinion at 24 n.16. This Court should not ignore that key phrase.

As an initial matter, Appellants have convincingly explained that the Final Rule requires hospitals to disclose *two* lists: both the machine-readable file and the shoppable-services list. Appellants' Br. at 37-39. More fundamentally, in giving short shrift to the term "a list," the district court stated that "a list can contain multiple categories" that are combined into a single "data file." *Id.* But that, too, stretches the concept of a "list" far beyond any reasonable understanding. An electronic data

file containing innumerable variations of separately-negotiated rates will contain an unintelligible mish-mash that no patient, doctor, hospital administrator, or legislator would ever reasonably call "*a* list," even one with "multiple categories."

Finally, given the sheer amount of information that hospitals must disclose, it is incontestable that the Final Rule will inflict immense burdens on hospitals. One *amicus* captured it well during the rulemaking process:

> Contrary to CMS's assumption that the requested data and information is already stored in hospital chargemasters and could be easily produced, compiling this information would require a *significant manual* effort.… *Hospitals would need to iterate literally thousands of different service bundle and other code combinations in order to develop the proposed data*. This would require hospitals to commit hundreds of staff hours across administration, finance, managed care, patient accounts, public relations, and information technology departments to compile the information.[6]

Another amicus explained:

> This proposal, if finalized, would pose excessive burden on hospitals and health systems…. Cursory math indicates that CMS's proposed mandate would require hospitals to sort, compile and make public millions of lines of data. Moreover, the information CMS intends to make public is not neatly grouped into categories because plans reimburse hospitals based on different formulas.[7]

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[6] Greater New York Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3206) (Sept. 27, 2019) at 5-6, https://www.regulations.gov/document?D=CMS-2019-0109-3206 (emphasis in original).

[7] Texas Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-2398) (Sept. 26, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-2398.

In other words, to achieve what the Final Rule requires, already-overstretched hospital staff will have to manually scour every insurance contract (some of which have hundreds of variations of payment rates), combine millions of lines of data into a massive new electronic file, and ensure that it is scrubbed appropriately for public consumption.

Contrary to HHS's back-of-the-envelope assertion, this is not an "$11,898.60 per hospital" job.[8] To take just one example, a single hospital system in Washington, D.C. explained that it would cost more than $500,000 to build a database to track the required information, and it would likely need to hire a consultant to do so. The same hospital system believes it will cost more than $300,000 to maintain this database each year, which includes hiring at least three additional staff members. Similarly, one Ohio hospital system estimated that the cost of compliance with the Final Rule could be as high as $2,000,000 annually, based on the analysis to produce and update the data, potential use of outside vendors, and increased support staff.

Comment after comment explained these burdens to HHS. Some of those comments are collected in footnote 44 of this brief. *See also* Appellants' Br. at 17-19 (citing similar comments from individual hospitals). Regrettably, the district court considered these burdens only in connection with Appellants' arbitrary-and-capriciousness claim. But as the Supreme Court indicated in *Utility Air Regulatory*

[8] 84 Fed. Reg. at 65,525.

Group v. Environmental Protection Agency, 573 U.S. 302, 323 (2014), regulatory burdens are relevant to the *Chevron* Step Two analysis—perhaps even more so. Here, the regulatory burdens demonstrate just how far HHS has stretched the statutory language to achieve its policy preferences. The terms "standard charge" and "a list" cannot bear the enormous costs that HHS seeks to inflict on hospitals.

In the past, this Court has considered regulatory burdens based on an *amicus* brief. Indeed, this Court looked to those costs to when considering whether Congress was hiding an elephant in a statutory mousehole.[9] *Amici* respectfully submit that this Court should do the same here. The information *amici* provide regarding regulatory burdens reveals a prominent pachyderm.

At bottom, the district court's conclusion that HHS's interpretation survives *Chevron* review cannot withstand scrutiny. The Final Rule bends the key statutory terms "standard" and "a list" far past their breaking points, and it imposes extreme

[9] *See NACS v. Board of Governors of Federal Reserve System*, 746 F.3d 474, 494 (D.C. Cir. 2014) ("[W]e think it quite implausible that Congress engaged in a high-stakes game of hide-and-seek with the Board, writing a provision that seems to require one thing but embedding a substantially different *and, according to financial services* amici, *much more costly requirement* in the statute's definitions section. [*See*] *Whitman v. American Trucking Associations*, 531 U.S. 457, 468 (2001) ("Congress ... does not ... hide elephants in mouseholes.")" (emphasis added)); *see* Brief of Amici Curiae at *31, No. 13-5270 (D.C. Cir. Oct. 21, 2013), 2013 WL 5720157 ("Developing and implementing the solutions necessary to satisfy the court's decision would raise a long list of complex and costly challenges. Moreover, any such change would likely require years to develop and implement - again, at considerable cost, none of which would be recoverable under the district court's construction of the statute.").

burdens on hospitals. These multiple errors make plain that HHS's interpretation is, at worst, incorrect under *Chevron* Step One, and, at best, unreasonable such that the district court's *close* call under *Chevron* Step Two was the *wrong* call. Accordingly, *amici* respectfully request that the Court reverse the district court's decision.

I. HHS'S INTERPRETATIONS OF "STANDARD CHARGE" AND "A LIST" CANNOT BE RECONCILED WITH HOW HOSPITALS OPERATE IN THE REAL WORLD

To understand why the Final Rule exceeds HHS's authority under 42 U.S.C. § 300gg-18(e), it is necessary to understand (1) the history of hospital charges in the United States; (2) the central role that the "chargemaster" list has played throughout the past century and continues to play today; and (3) the innumerable variations in rates that hospitals negotiate with private insurers. With this background in mind, it quickly becomes clear that a hospital's "chargemaster" is the *only* realistic list of its "standard charges," and that the Final Rule's definition of "*a* list" impermissibly shatters that singular statutory term into thousands of different lists.

Early American Hospital Payment and the Advent of Private Insurance. For much of American history, private insurance did not pay for hospital services. In fact, before World War II, "most hospital care was either free or very

inexpensive."[10] In the 19th and early 20th centuries, hospitals "were primarily philanthropic organizations" that "hous[ed] the poor and insane who were sick."[11]

This began to change in the 1920s. At that time, "the ability of hospitals to improve the health status of patients increased dramatically."[12] As a result, "[f]or the first time, rich and poor Americans sought out hospital care when they became seriously ill."[13]

As demand for hospital services increased in the 1920s, hospitals began to charge patients for care. In addition, developments in medical science provided physicians with "a wider range of services to provide to hospitalized patients." New drugs and equipment—including anesthesia and antibiotics—became available, and "more highly trained personnel" were needed to provide these services.[14] Together, these increases in cost and demand led to an entirely new model for hospital charges.

As hospitals began to charge patients for their services, they developed a so-called "chargemaster" list. A "chargemaster" is "a document maintained by each

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[10] A Review of Hospital Billing and Collections Practices: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 108th Cong. (2004) (Statement of Dr. Gerard Anderson) ("Anderson Testimony").

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.*

hospital that contains a list of prices for each [individual] item and procedure offered."[15] "Initially there were only a few items on the list."[16] Over time, that list grew to reflect the many different types of services, products, medicines, and devices provided during a hospital stay. Today, as the Final Rule observed, the chargemaster list "can include tens of thousands of line items, depending on the type of facility."[17]

Shortly after hospitals began developing their "chargemaster" lists, the Great Depression began to make it "difficult for hospitals to get paid for services."[18] In response, the modern health insurance system emerged. "Blue Cross was formed in 1932 under the auspices of the American Hospital Association (AHA), and Blue Shield was established by medical societies in 1939."[19] Insurance programs like these "proliferated," with insurers paying hospitals based upon the "chargemaster" list.[20] This private insurance system accelerated after World War II, particularly as

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[15] Opinion at 3; *see* Christopher P. Tomkins et al., *The Precarious Pricing System for Hospital Services*, 25 Health Affairs 45, 48 (2006) ("Each hospital maintains a file system known as the chargemaster, which contains all billable procedure codes performed at the hospital, along with descriptions of those codes and the hospitals' own list prices."); *see also Maldonado v. Ochsner Clinic Foundation*, 493 F.3d 521, 523 n.1 (5th Cir. 2007) ("The 'chargemaster' is an exhaustive and detailed price list for each of the thousands of services and items provided.").

[16] Anderson Testimony.

[17] 84 Fed. Reg. at 65,533.

[18] Tomkins et al, *The Precarious Pricing System* at 46.

[19] *Id*.

[20] Anderson Testimony.

Congress made health insurance tax exempt.[21] By 1948, for example, Blue Cross and Blue Shield accounted for approximately 9 percent of total hospital expenses; by 1958, those insurers accounted for 27 percent of total hospital expenses, and "nearly one-third of the U.S. population was enrolled in Blue Cross."[22]

In these early years of health insurance, hospital charges were based on the cost of providing services plus a small (*i.e.*, less than 10 percent) allowance.[23] In other words, the "chargemaster" list, which largely tracked the cost of services, dictated an insurer's cost of care. Critically, during this period, "[t]here were no discounts; everyone paid the same rates."[24]

Medicare and the DRG. The next several decades experienced important changes with the enactment of Medicare and Medicaid.[25] The one feature of Medicare that is relevant to the Final Rule and the text of Section 300gg-18(e) is how Medicare reimburses hospitals—especially given the government's misplaced emphasis on statutory language referencing diagnosis-related groups (DRGs).

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[21] *Id.*

[22] Tomkins et al, *The Precarious Pricing System* at 46.

[23] Anderson Testimony.

[24] *Id*.

[25] *See* Anderson Testimony; *see also* Centers for Medicare & Medicaid Services, *Acute Inpatient PPS*, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

The DRG is at the heart of how Medicare pays hospitals. Specifically, "Medicare uses what is known as the 'case base' system for paying hospitals for inpatient care, which means that hospitals receive one single payment for an entire inpatient episode of a given type. To implement this system, Medicare categorizes all hospital inpatient care into [761] distinct 'medical-severity adjusted, diagnosis-related groupings,' known in the trade as MS-DRGs."[26] Once grouped, "Medicare pays hospitals one single, bundled payment to cover the cost of all the supplies and services that a hospital with average efficiency would use in managing that particular case."[27] Significantly, the Medicare payment system is "fully transparent."[28] Indeed, this year's list of DRG reimbursement rates can be found in the Federal Register at 84 Fed. Reg. 42,044.

As such, HHS's expansive reading of Section 300gg-18(e) is incorrect. There is no indication whatsoever in Section 300gg-18(e) that, by referring to DRGs

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[26] Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*, N.Y. Times Economix Blog (Nov. 26, 2010, 6:00 AM), http://economix.blogs.nytimes.com/2010/11/26/how-medicare-sets-hospital-prices-a-primer/; *see* Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, (Mar. 2019), http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf ("To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system classifies each patient case into 1 of 761 groups, which reflect similar principal diagnoses, procedures, and severity levels.").

[27] Uwe E. Reinhardt, *How Medicare Sets Hospital Prices: A Primer*.

[28] *Id*.

"established under *section 1395ww(d)(4)* of this title," Congress *also* intended to require hospitals to publish dozens of individually-negotiated lists of what private insurers may pay for DRGs. This single statutory phrase—which expressly refers to *Medicare* DRGs[29]—does not remotely suggest that Congress intended to authorize the Final Rule's sweeping disclosure requirements. "To give the [DRG language] the controlling weight that is claimed for [it] … would allow the tail to wag the dog." *United States v. Zacks*, 375 U.S. 59, 70 (1963).

As *amici* explained below, there is an easy explanation for why Section 300gg-18(e) refers to "diagnosis-related groups established under section 1395ww(d)(4) of this title."[30] That language was included to ensure that hospitals *still* made information about DRGs publicly available under the already-transparent system of Medicare payments, and that the new provisions for disclosure in Section 300gg-18(e) were not misread as superseding existing transparency measures. *See Spectrum Health--Kent Community Campus v. NLRB*, 647 F.3d 341, 346 (D.C. Cir. 2011) ("[D]rafters of legislation … sometimes take a belt-and-suspenders approach in order 'to make assurance doubly sure.'" (quoting *United States v. Hansen*, 772 F.2d 940, 947 (D.C. Cir. 1985)). Far from "odd," as the district court described it (at 23), this belt-and-suspenders approach makes good sense when Congress was

[29] Opinion at 19 ("[S]ection 2718(e) references the DRGs established *by* Medicare.").

[30] The district court acknowledged this explanation (at 19 n.12), but did not respond to it.

imposing new *private* transparency requirements that may have been misunderstood as supplanting preexisting *Medicare*-related ones. At a minimum, the DRG language cannot overcome the combined effect of the many other unreasonable aspects of HHS' interpretation—from its misreading of "standard" to its distortion of "a list" to the massive burdens it imposes on hospitals.

Growth of Payer-Negotiated Hospital Charges. The next major relevant change in the hospital payment system occurred in the 1980s and 1990s. Managed care plans began to increase in popularity and "wanted discounts off of charges in return for placing the hospital in their network."[31] These managed care plans began to "negotiate with hospitals" over pricing and payments.[32] The plans had distinct advantages through their volume, and their negotiating clout increased.[33] Consequently, managed care plans were able to "successfully negotiate[] sizeable discounts with hospitals."[34] Other private insurers, which competed with managed

[31] Anderson Testimony.

[32] *Id.*

[33] Tomkins et al, *The Precarious Pricing System* at 47; *see* Anderson Testimony ("Managed care expanded rapidly using their market power to negotiate discounts off of charges with hospitals."); *see* Michael E. Porter and Elizabeth Olmstead Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* 37-38 (2006) (same).

[34] Anderson Testimony.

care plans, quickly caught up. "Soon commercial insurers asked for similar discounts"[35]—and they received them.

By the end of the 20th century, nearly all private insurers and managed care plans negotiated payment contracts directly with hospitals. Hospitals now separately negotiate their charges with each insurance company, often across a variety of product lines. This means that a single hospital typically has a huge variety of reimbursement structures depending on the number of insurers with which it contracts and the type of contracts it negotiates. And even with a single insurer, a hospital often has multiple contracts because that insurer offers a variety of plans.

The experience of *amici*'s member-hospitals reflects this reality. In connection with this brief, *amici* surveyed their members about how many charge-related contracts they have with insurers. The following responses reveal just some of the complexity and variability of modern hospital charges:

- One Ohio hospital responded: "In total, our organization has over 74 contracts it negotiates with the various payors, including commercial plans, Medicaid managed care plans, Medicare Advantage plans, Affordable Care Act Marketplace Eligible Plans, and other niche products."

[35] Anderson Testimony.

- One New York hospital stated: "We have 200 contracts when we consider product lines and payer organizations. On average, the time to negotiate our contracts is 4 to 6 months. It is fair to say that an additional ten to twelve individuals are engaged in one way or another with negotiations [at any given time]."
- An Oregon hospital explained: "We have about 16 contracts that cover approximately 30 lines of business, resulting in over 200 'contracts' in our system."
- A Washington, D.C. hospital answered: "We have approximately 35 contract/products for the facility and approximately 40 different contracts on the professional side."
- The North Carolina Healthcare Association provided aggregate responses for its many hospitals. It explained: "Our largest health systems have several hundred payer contracts representing over 50+ payors with multiple product lines. Negotiation of the actual contract documents, including rate schedules, may take several months to several years depending on the scope and complexity of the contract and the size of the hospital. Negotiation with insurers is a continuous ongoing effort. … Each of the changes requires a review by managed care professionals, legal and operational staff."

These survey responses indicate that HHS got at least one thing right in the Final Rule: "some hospitals may have negotiated charges with many payers representing *hundreds* of plans."[36]

Despite this variability in payment structures, the "chargemaster" list remains the central component of the hospital charging system. A century or so after it was first developed, the "chargemaster" continues to be a hospital's *only* **universal** list of charges for services. *Contra* Opinion at 17 (ignoring the word "universal"). With the exception of Medicare and Medicaid, which have their own cost and price databases, a hospital's "chargemaster" list still drives price for most health care consumers. "[F]or most insurance companies, the price is simply a 'discounted' chargemaster price."[37] As one court explained, "[m]ost hospitals have a 'chargemaster,' an itemized list of prices, similar to a restaurant menu," which serves as a "starting point for ensuing closed-door bargaining with different commercial insurers."[38]

This history of hospital pricing undercuts the Final Rule's attempts to: (1) require hospitals to publish multiple "lists" of payer-specific negotiated charges; and

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[36] 84 Fed. Reg. at 65,551 (emphasis added).

[37] *Id*. at 12.

[38] *O'Connell v. Springfield Hospital, Inc*., No. 5:16-cv-289, 2018 WL 4699312, at *2 (D.Vt. July 17, 2018) (quoting AMA Journal of Ethics, Nov. 2015, Vol. 17, No. 11).

(2) subdivide the statutory term "standard charge" into more than thousands of different "standard charges." As to the statutory phrase "*a* list," the real-world operation of hospital pricing makes plain that hospitals across America have hundreds or thousands of *different* lists of charges. Indeed, as indicated by *amici*'s members and as acknowledged by HHS itself, hospitals in some cases have many different lists for a single insurer depending on the variety of plans that insurer offers. HHS has nonetheless required hospitals to publish *each and every* list, for *each and every* insurer, for *each and every* plan offered by every insurer, and for *each and every* service provided by the hospital—not to mention various additional lists such as "de-identified minimum and maximum negotiated charges."[39] Given the sheer amount and variety of data involved in real-world hospital pricing, requiring hospitals to publish *each* of these individualized lists for *each* insurance payer cannot be reconciled with Section 300gg-18(e)'s use of the *singular* term "a list." *See Hertz Corp. v. Friend*, 559 U.S. 77, 93 (2010) (emphasizing Congress' use of "the singular, not the plural"). And at a minimum, as Appellants have explained, this Rule requires two lists under any conceivable understanding of the term: the unwieldy machine-readable spreadsheet and the shoppable-services list. Appellants' Br. at 37-39.

The district court's short-shrift answer, which it included in a four-sentence footnote, cannot rehabilitate HHS's unreasonable interpretation of "a list." The

[39] 84 Fed. Reg. at 65,567.

district court all but concedes that the Rule requires hospitals to take these thousands of individualized lists, reformulate them into something new, and create a "data file" with "multiple categories." What the district court failed to recognize, however, is that this data file is not anything close to "a list." It is a sprawling electronic record containing millions of lines and dozens of columns of individualized payment rates that cannot be reasonably understood as "a list" within the meaning of the statute. Put simply, the district court's and HHS's "multiple-category-data-file" reading of "a list" exceeds "the bounds of reasonable interpretation." *Arlington, Texas v. FCC*, 569 U.S. 290, 296 (2013).

In addition, HHS's definition—or really, its multiple definitions—of "standard" cannot be squared with on-the-ground realities of contemporary hospital charging practices. The district court rightly concluded that hospitals use the "chargemaster" as the "starting point" for negotiations with insurers. Opinion at 3. The Final Rule appears to do so as well. It states that "for the insured population, hospitals charge amounts reflect *discounts* to the chargemaster rates that the hospital has negotiated with third party payers."[40] Commonsense therefore suggests that the only conceivable "standard" charge is the "chargemaster," and the many discounted variations are *non*-standard discounted charges from the "chargemaster's" "standard

[40] 84 Fed. Reg. at 65,537 (emphasis added); *see id*. 65,540 ("[H]ospitals routinely use gross charges as a starting point for negotiating discounted rates.").

charge." Accordingly, HHS's attempt to fractionate each insurer's negotiated rate into hundreds of different per-insurer "standards" does not reflect the real-world way in which hospital pricing works. Congress was well aware of that real-world system when it enacted the term "standard charge" in Section 300gg-18(e).[41] HHS cannot now creatively redefine that statutory language to conjure its own new reality.

II. HHS'S INTERPRETATIONS OF "STANDARD CHARGE" AND "A LIST" WILL IMPOSE SEVERE BURDENS ON HOSPITALS

The reason why the Final Rule inflicts such severe burdens on hospitals should come as no surprise. By requiring hospitals to disclose millions of lines of data across dozens of spreadsheet columns, hospitals will have to devote substantial resources to manually create and maintain the new electronic files required under the Final Rule. They also will have to update these files every time new rates are negotiated, making this a never-ending task given how frequently rates change.[42]

Amici support meaningful transparency in health care pricing. But transparency can be accomplished through far less burdensome initiatives that are

[41] What is more, if there were any indication at the time of enactment that Congress intended to impose such a sweeping and onerous disclosure requirement on hospitals, hospitals would have objected vociferously to that "sea change," just as they did during the comment period here. *Maine Community Health Options v. United States*, 140 S. Ct. 1308, 1324-25 (2020); *id*. at 1321 n.6. They did not.

[42] Critically, this year-round negotiation with insurers conflicts with the statutory phrase "each year," 42 U.S.C. § 300gg-18(e). Only the "chargemaster" is determined annually.

more useful for consumers. Hospital financial navigators, online tools from hospitals and insurers, and other resources would provide consumers the information they *actually* are looking for: their expected out-of-pocket cost of care for a treatment or procedure—not an enormous "data file" containing "multiple categories" of unintelligible information.[43] For all the data that the Final Rule requires to be disclosed, it ignores the information patients actually want. In that respect, it is as unhelpful as it is unlawful.

HHS was well aware of these burdens. Numerous *amici* identified them during the rulemaking process,[44] as did many individual hospitals, *see* Appellants'

[43] *E.g.*, 84 Fed. Reg. at 65,526; California Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3038) (Sept. 27, 2019) at 3, https://www.regulations.gov/document?D=CMS-2019-0109-3038 (explaining that the rule requires disclosure of information that will be "indecipherable" to patients, and that by contrast "California hospitals have developed ways to provide potential patients information on estimated out-of-pocket costs from hospital charges associated with a procedure."); Texas Hospital Association, *Price Transparency*, https://www.tha.org/PriceTransparency ("Through online tools like PricePoint and conversations with patients ahead of elective and scheduled procedures, Texas hospitals have long empowered health care consumers to make informed decisions about their medical care."); Minnesota Hospital Association, *Cost and Quality Transparency* (June 1, 2019), https://www.mnhospitals.org/newsroom/news/id/2180/cost-and-quality-transparency (describing price transparency tools used in Minnesota); Consumers for Affordable Health Care, *New Maine Website Gives Patients Tools to Compare Hospital Costs* (Nov. 2, 2015), https://www.mainecahc.org/new-maine-website-gives-patients-tools-to-compare-hospital-costs/ (same for Maine).

[44] *E.g.*, California Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3038) (Sept. 27, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-3038 ("CMS' proposal does not account for the

many different payment methodologies that are negotiated between hospitals and payers, such as capitated rates, value-based purchasing payments, shared savings arrangements, etc. For example, a single hospital contracts with many different insurers and individual and group health plans that offer many different benefit packages. The proposed rule does not accurately account for the amount and scope of hospital resources required to gather the relevant data, to prepare for its electronic availability, to prepare for its display in what the agency describes as a user-friendly platform, and to regularly update that information."); Wisconsin Hospital Association, Comment Letter on Proposed Rulemaking, (CMS-2019-0109-3247) (Sept. 27, 2019) at 2, https://www.regulations.gov/document?D=CMS-2019-0109-3247 ("CMS's approach in the proposed rule will add to the burden that already drives up costs and creates obstacles for hospitals trying to deliver nation-leading care…. The new regulations would require hospitals to determine negotiated rates for hundreds of different services, with multiple different contracts. In a state like Wisconsin that has a very competitive insurance market, this is even more burdensome as hospitals would have to constantly update data covering hundreds of service items for multiple insurers. On top of that, many insurers offer slightly different products that each may have different negotiated payments to go with them."); HANYS, Comment Letter on Proposed Rulemaking (CMS-2019-0109-0002) (Sept. 26, 2019) at 4, https://www.regulations.gov/document?D=CMS-2019-0109-1980 ("HANYS agrees with AHA that this proposal, if finalized, would pose excessive burden on hospitals and health systems — far exceeding CMS' estimate of 12 hours. Compiling, standardizing and issuing this information online in a machine-readable format would require staff time reallocations and new hires (executive, finance, IT, legal, and patient relations). These resources would not only be required to aggregate the information and build web interfaces, but also keep the information and technology up to date and to respond to patient inquiries.") (emphasis omitted); Oregon Association of Hospitals and Health Systems, Comment Letter on Proposed Rulemaking (CMS-2019-0109-0002) (Sept. 27, 2019) at 3, https://www.regulations.gov/document?D=CMS-2019-0109-3302 ("To prepare for the January 2019 deadline to post all standard charges in a machine-readable format, hospitals and health systems often spent more than 100 hours manually creating the files and updating their websites. The file CMS would require under the proposed rule would be exponentially larger…. This could introduce thousands or even hundreds of thousands of additional rows to the required spreadsheet.

CMS's proposal also would require hundreds to thousands of columns. In addition to descriptions, codes, and gross charges, the spreadsheet would need to include separate columns for each health plan issuer contract. Many hospitals and health systems have over 100 contracts with different health plan issuers, often with

Br. at 17-19. While dense, the burdens these comments described demand far more attention than the district court and HHS gave them.

To the extent there is any doubt about these burdens, *amici*'s survey of member hospitals further elucidates them:

- One hospital system in Washington, D.C. and Maryland stated: "We do not have the data in one system in the way it has been requested. We would have to manually pull information or try to build a new tool with algorithms to try and meet the standards.… This will create a substantial amount of staff time to build and maintain." This hospital system estimated that it would cost more than $500,000 to build a database to track the required information, and it would likely need to hire a consultant to do so. In addition, the hospital system believes it will cost more than $300,000 to maintain this database each year, which includes hiring at least three additional staff members.
- A hospital in Illinois responded: "[T]he burden of complying with this rule is significant." This hospital stated that it will need to spend at least $214,000

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multiple contracted rates depending on the type of health plan (e.g., Medicare Advantage, individual market health maintenance organization (HMO), individual market preferred provider organization (PPO), each self-insured plan). Hospitals and health systems report that a file of this size could easily crash most standard computer systems, and some members worry about the ability of their websites to function at all with such a large file.").

to get a system up and running, and it "will require us to divert several FTE's for several months to meet this requirement." In particular, the hospital explained, "[t]his will impact not just staff directly involved with pricing, but also our communications staff who need to assist posting the data on line in a readable format and with scripting responses for speaking with patients about this data." In short, this Illinois hospital has concluded that the Final Rule will "diver[t] attention away from focusing on the patient experience," and prevent it from "being able to focus more on meeting the individual needs of the community and our patients."

- A Kansas hospital explained that "gathering the data required by the new HHS price transparency rule will be extremely time consuming and taxing on facilities who already have limited resources for day to day operations." Specifically, "[a]ll information required under the new HHS price transparency rule must be compiled 'manually' using a combination of both facility and professional historical claims data, definitions of shoppable services defined by HHS, chargemaster files and current contract/reimbursement documents for all 34 product lines across all plans (therefore, up to 34 unique negotiated rates for EACH of our thousands of services)." This hospital estimates that the cost of compliance will exceed

$100,000, which will "delay the purchase of new, high tech equipment" for patient care.

- One Ohio hospital system stated that "based on the analysis to produce and update the data, potential use of outside vendors, and increased support staff, the cost could be as high as $2,000,000 annually." This system "estimates that we have 3,000 contracted rate schedules across the system. Further, our chargemaster reflects over 70,000 lines – just for technical (hospital inpatient and outpatient) charges. Thus, the number of data points that would need to be posted would exceed 210 million just for hospital services."
- A Washington hospital called the burdens "a nightmare." The hospital's administrator stated: "I don't have the resources to do it, I don't have the staff, and I know it can't all be done by me. The time estimate by HHS is absurd. I've already spent more time learning about what we need to do than their estimate." This hospital anticipates having to hire an outside consultant, which will cost more than $100,000, to assist with initial compliance, and then a full-time employee to keep up with regulatory requirements. As a result, this hospital explained, "we will be slashing staff until we can get into the black. It's the last thing we want to do, but we aren't really left with many options."

The massive burdens that the Final Rule imposes on hospitals across the United States demonstrate the unreasonableness of HHS's radical interpretation of "standard charge" and "a list." *E.g.*, *Utility Air Regulatory Group*, 573 U.S. at 322-323 ("Start with the PSD program, which imposes numerous and costly requirements on those sources that are required to apply for permits.… Not surprisingly, EPA acknowledges that PSD review is a 'complicated, resource-intensive, time-consuming, and sometimes contentious process' suitable for 'hundreds of larger sources,' not 'tens of thousands of smaller sources.'") (citation omitted). Those burdens—on their own—are enough to defeat HHS's interpretation. *Id*. at 323-324 ("The fact that EPA's greenhouse-gas-inclusive interpretation of the PSD and Title V triggers would place plainly excessive demands on limited governmental resources is alone a good reason for rejecting it."); *United States v. Zazove*, 334 U.S. 602, 616-17 (1948) ("Yet Congress nowhere specified that the United States would bear the huge cost of the enhanced liability that it would necessarily have anticipated had it impressed upon s 602(h)(2) the meaning that respondent finds there; and that striking omission is persuasive, in the absence of cogent considerations to the contrary, that no generosity of this magnitude was contemplated."). Unfortunately, the district court only considered these burdens in its consideration of whether the Final Rule is arbitrary and capricious. *See* Opinion at 41-42. But these burdens *also* are relevant to the *Chevron* Step Two analysis. When piled on top of HHS's

unreasonably aggressive readings of "standard" and "a list," these burdens cinch the conclusion that the Final Rule is *not* "based on a permissible construction of the statute." *Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

CONCLUSION

This Court should reverse the district court's opinion and vacate the Final Rule.

Dated: July 24, 2020

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CERTIFICATE OF COMPLIANCE

1. This document complies with the word limit of Fed. R. App. P. 32(a)(7) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 6492 words, according to the word-processing program used to prepare it.

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Dated: July 24, 2020

/s/ Chad I. Golder
Chad I. Golder

CERTIFICATE OF SERVICE

I hereby certify that on July 24, 2020, I caused a true and correct copy of the foregoing to be served on all counsel of record through the Court's CM/ECF system.

Dated: July 24, 2020

/s/ Chad I. Golder
Chad I. Golder

DESCRIPTION AND INTERESTS OF INDIVIDUAL *AMICI*

The Alaska State Hospital & Nursing Home Association (ASHNHA) is a non-profit trade association established in 1953. We represent more than 65 hospitals, nursing homes, and other healthcare organizations who employ over 10,000 Alaskans. Our membership spans geographically from PeaceHealth Ketchikan Medical Center to Samuel Simmonds Memorial Hospital in Utqiagvik.

The Arizona Hospital and Healthcare Association (AzHHA) is Arizona's largest statewide trade association for hospitals, health systems, and affiliated healthcare organizations. Its hospital members are united with the common goal of improving healthcare delivery in Arizona. AzHHA is a powerful advocate for issues that impact the quality, affordability, and accessibility of healthcare for the patients, people, and communities of Arizona. AzHHA's long-term vision is simply stated, but difficult to achieve: to make Arizona the healthiest state in the nation. AzHHA files this brief as amicus curiae in furtherance of its goal and vision, and because it is uniquely situated to provide information on the severe burden this rule imposes on hospitals.

The Arkansas Hospital Association (ArHA) is a trade association representing over 100 hospitals and related institutions and the more than 41,000 dedicated individuals serving patients within these organizations. For 90 years, ArHA has supported its members in the delivery of high quality, efficient, and accessible health care throughout Arkansas. As the state's most trusted authority on health care, ArHA is committed to improving the health system to enhance individual patient care and safeguard the well-being of Arkansas hospitals and the communities they serve.

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's members include all types of hospitals and health systems: non-profit; children's hospitals; those owned by various public entities, including cities/counties, local health care districts, the University of California, and the Department of Veterans Affairs; as well as investor-owned. The vision of CHA is an "optimally healthy society," and its goal is for every Californian to have equitable access to affordable, safe, high-quality, medically necessary health care. To help achieve this goal, 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. CHA promotes its objectives, in part, by participating as *amicus curiae* in important cases like this one.

The Connecticut Hospital Association (CHA) in a not-for-profit membership organization that represents hospitals and health-related organizations. With more than 140 members, CHA's mission is to advance the health of individuals and communities by leading, representing, and serving hospitals and healthcare providers across the continuum of care that are accountable to the community and committed to health improvement.

The District of Columbia Hospital Association (DCHA) is a trade association representing 13 hospitals and the more than 27,000 individuals employed by these facilities in the District of Columbia. DCHA is the unifying voice for its members and works to advance health policy to strengthen the District's world-class health care system to ensure that it is equitable and accessible to all.

The Florida Hospital Association (FHA) is the leading voice of Florida's hospital community. Founded in 1927, FHA's membership is comprised of more than 200 hospitals. FHA supports the mission of its members to provide the highest quality of care to the patients they serve. To that end, FHA advocates proactively on behalf of hospitals at the state and federal levels on issues that will assist members in their mission of community service and care to patients.

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 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 Association represents its members in legislative matters, as well as in filing *amicus curiae* briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens.

The Healthcare Association of Hawaii (HAH), established in 1939, is a trade association which serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the healthcare continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate affordable, high quality care to all of Hawaii's resident and visitors, our members contribute significantly to Hawaii's economy by employing over 30,000 people statewide. HAH promotes its objectives through a variety of means, including participating as amicus curiae in matters of importance such as this.

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. As the representative of virtually every hospital in the state, the IHA has a profound interest in this case. The IHA respectfully offers this *amicus curiae* brief in hopes of providing information not addressed by the litigants that will help the Court evaluate the litigants' arguments more thoroughly.

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 not-for-profit voluntary state organization located in Topeka, Kansas that represents and serves 127 community hospitals, including 85 Critical Access Hospitals. Its mission is to provide education and information and be the leading advocate for its members on the state and national level.

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 our 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. Its acute-care hospitals are non-profit, community-governed organizations with more than 800 volunteer community leaders serving on the boards of Maine's hospitals. Maine is one of only a handful of states in which all of its acute-care hospitals are non-profit.

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. Of those, 134 are community hospitals providing inpatient, outpatient and emergency care 24 hours a day, seven days a week, 365 days a year. MHA membership encompasses large urban trauma centers and teaching hospitals, mid-size community hospitals, and rural Critical Access 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 mission of the MHA is to advance the health of individuals and communities. Through its leadership and support of hospitals, health systems and the full care continuum, the MHA is committed to achieving better care for individuals, better health for populations and lower per-capital costs. In addition, the association provides members with essential information and analysis of health care policy and offers relevant education to keep hospital administrators and their staff current on statewide issues affecting their facilities. Using its collective voice, the MHA advocates for its members before the legislature, government agencies, the media and the public.

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 Missouri Hospital Association (MHA) members include every acute-care hospital in the state, as well as most of the federal and state hospitals and rehabilitation and psychiatric care facilities. MHA actively serves its members' needs through representation and advocacy on behalf of its members, continuing education programs on current health care topics, and education of the public and media as well as legislative representatives about health care issues.

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 Nebraska Hospital Association (NHA) is a statewide trade association representing Nebraska's hospitals and health systems since 1927. The hospital and health system field is the only sector of Nebraska's economy that touches every citizen and business of Nebraska. Not only do hospitals support a healthy Nebraska and provide essential health care services, they are also among the largest employers and economic drivers in most regions of the state. Hospitals and health care are the foundation upon which communities in Nebraska are built.

The Nevada Hospital Association (NHA) represents all of 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, the NHA serves as an advocate for its members to lead in the provision of high quality, affordable and accessible healthcare services, resulting in healthier Nevada communities.

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. In furtherance of this mission, NJHA undertakes research and health care policy development initiatives, fosters public understanding of health care issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems.

The New Mexico Hospital Association (NMHA) is the trade association for acute-care hospitals in New Mexico. It advocates for the interests of its members at the state and federal level in the legislative and regulatory arenas. The NMHA represents 45 not-for-profit, investor-owned, and governmental hospitals and health systems from around the state.

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' members range from rural Critical Access Hospitals to large, urban Academic Medical Centers and other Medicaid and safety net providers. 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. NCHA is an advocate before the legislative bodies, the courts, and administrative agencies on issues of interest to hospitals and health systems and the patients they serve.

The North Dakota Hospital Association (NDHA) has been representing hospitals and health-related member organizations for over 80 years. The NDHA is a voluntary, not-for-profit organization comprised of hospitals and health systems, related organizations, and other members with a common interest in promoting the health of the people of North Dakota.

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 236 hospitals and 14 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 OHA's mission is to collaborate with member hospitals and health systems to ensure a healthy Ohio.

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 South Carolina Hospital Association is a private, not-for-profit organization founded in 1921 to serve as the collective voice of the state's hospital community. Today, it comprises approximately 100 member hospitals and health systems and 900 personal members. It advocates for sound healthcare policies and legislation, facilitates collaboration to tackle problems that none of us could solve alone, finds and shares innovations and best practices, and provides data, education and business solutions to help its members better serve their patients and communities.

The South Dakota Association of Healthcare Organizations (SDAHO) is the professional/trade association representing and serving health care organizations

across the state in advancing healthy communities. The association has a not-for-profit mission and is funded principally through membership dues. Membership spans various types of category, geographic location, size and complexity of services and includes 54 hospitals, 3 health care systems, 32 nursing facilities, home health agencies, assisted living centers, and hospice organizations.

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 Texas Hospital Association (THA) is a non-profit trade association representing Texas hospitals. THA advocates for legislative, regulatory, and judicial means to obtain accessible, cost-effective, high-quality health care. THA opposes reductions to 340B Program reimbursement that increase costs for uninsured or low-income patients and reduce hospitals' ability to provide expanded services to patients.

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 outcomes.

The Wisconsin Hospital Association (WHA) is a statewide non-profit association with a membership of more than 130 Wisconsin hospitals and health systems. For 100 years, the Wisconsin Hospital Association has advocated for the ability of its members to lead in the provision of high-quality, affordable, and accessible health care services, resulting in healthier Wisconsin communities.

The Wyoming Hospital Association (WHA) is a member-owned non-profit organization representing Wyoming hospitals. WHA serves as the voice of Wyoming hospitals before local, state, regional and national legislative and

regulatory bodies, the media and the general public. WHA also promotes information and education that enables Wyoming hospitals to deliver high quality, adequately financed/cost-effective health care that is universally accessible to all Wyoming citizens.