

H Fundamental Transformation of the Hospital Field

At a time when hospital revenues already are strained, hospitals must respond to rapidly changing market forces, including: (1) reimbursement reductions and changes; (2) an increasing necessity to implement robust electronic health records (EHR) systems; and (3) limited access to capital. These market forces are driving an urgent need for hospitals to make significant capital investments and achieve greater economies of scale, both of which are critical to hospitals' future ability to compete.

Effective delivery of high-quality care to a community depends on the hospital's ability to succeed in an increasingly competitive environment. For many hospitals – particularly stand-alone hospitals – merging with another hospital or system may be the only hope for remaining competitive. Indeed, changes in the field are prompting a “national explosion of consolidation” in the health care sector (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Without the ability to merge, many hospitals' ability to provide the kinds of services and care their patients and community depend on would be deeply impacted.

“The healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed.”

Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012

H Current Market Trends are Transforming the Health Care Field, Driving an Urgent Need for Capital Investments and Economies of Scale

In the health care field, “actual market realities” demonstrate that hospitals' past performance often reveals little about their future ability to compete. Many hospitals are struggling to make ends meet, and three major trends have created further pressure: reimbursement reductions and changes, EHR requirements and difficulty accessing capital. To remain competitive, hospitals must have the capability to adapt to these trends by making significant capital investments and achieving economies of scale.

Reimbursement Reductions and Changes are Constraining Revenues and Will Require Hospitals to Alter Methods of Delivering Care.

In light of the challenges facing hospitals and the uncertainty surrounding the future of health care, analysts have reported an “unequivocally negative” outlook for hospitals “for at least the next several years” (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012). Hospital reimbursement rates have declined in recent years, and

they are expected to undergo further cuts. Meanwhile, commercial and government payers have implemented dramatic reimbursement changes that will fundamentally alter the manner in which hospitals provide care. Together, these changes will require hospitals to make significant investments in technology, as well as develop greater economies of scale.

Recent Reimbursement Pressures. Hospital reimbursements are declining, resulting in an “unprecedented threat to revenues.” According to industry analysts, “the median hospital revenue growth rate is the lowest in two decades” at 4.0 percent (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011). Revenue is expected to continue to decline in 2012 and “reach a low point in 2013” (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).



Hospital reimbursement rates under Medicare and Medicaid – which account for more than half of hospital revenues – have been constrained, and these revenue sources are very likely to suffer deeper cuts (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011). Medicare payment rates increased every year from 1999 to 2010, but rates were effectively cut in federal fiscal year 2011. Changes in reimbursement methods will not only transform the way in which hospitals deliver care, but will also lead to cuts of \$150 billion in Medicare payments over the next 10 years. And further Medicare cuts are likely as legislators struggle to reduce the federal deficit (Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow*, Aug. 10, 2011).

Medicaid reimbursement rates also are under fire. Financially strapped states have cut Medicaid reimbursement rates in an effort to balance their budgets. Currently, average Medicaid rates are only 72 percent of Medicare rates. Deeper Medicaid cuts loom: Over the next five years, \$14 billion dollars will be cut from Medicaid Disproportionate Share Hospital payments, which provide additional assistance to hospitals caring for a high number of Medicaid and uninsured patients. These cuts will be felt acutely by hospitals in states that elect not to expand Medicaid coverage under the *Patient Protection and Affordable Care Act* because they will not be offset by revenues from newly eligible Medicaid patients.

These reimbursement pressures are compounded by a decrease in inpatient admissions and a shift toward outpatient treatment. This shift is significant because reimbursement for observation stays and same-day visits “is much lower than for a comparable inpatient day” (Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012).

Hospitals have implemented “aggressive cost reduction strategies across the board” to match decreased revenues with decreased costs, including by cutting salaries and

benefits (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011). But these cost-cutting measures only go so far. “While managing costs is an effective near- to medium-term strategy, . . . its effectiveness is limited in the long term as it is hard to find new cost-cutting initiatives year after year, unless the broader business model also changes” (Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012). “[A]s many providers are forced to hold down or lower costs year after year to maintain operating margins” in the face of reimbursement pressure, “it remains unclear how hospitals can come up with additional reductions.” As a result, “[a]dditional expense reductions will now involve deeper and more difficult strategies in order to both gain efficiencies and fundamentally change how hospitals deliver care” (Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).

Changes in Reimbursement Methods Threaten Revenues and Alter the Metrics for Success, Requiring Hospitals to Reduce Costs as They Improve Quality.

As hospitals struggle to reduce costs in line with reimbursement reductions, they also must adapt to groundbreaking changes in reimbursement methods. To maximize value, hospitals must improve the quality of care while finding new ways to gain efficiencies.

The Shift from Volume to Value. “Of the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value.” Both government and private payers are moving away from the traditional fee-for-service model, which assigns a reimbursement amount for each particular service. Instead, payers are implementing “value-based” reimbursement, which ties payment to the quality and cost-effectiveness of care.

Value-based programs – sometimes called “pay-for-performance” programs – take on various forms. Some commercial insurers tie hospital payments to performance goals such as clinical outcomes and cost per case. Other programs incorporate additional measures of value, including adoption of information technology (IT) and patient satisfaction. Even Medicare has joined the trend toward value-based reimbursement; the Hospital Value-Based Purchasing Program marks “the beginning of an historic change in how Medicare pays health care providers.” The program will withhold a portion of Medicare reimbursement each year and redistribute it as “incentive” payments based on hospitals’ achievement of various quality outcomes.

Payers are also measuring hospital “readmission” rates, the rates at which patients are readmitted to a hospital after initial discharge. For example, hospitals now face penalties for having disproportionately high readmission rates, which could cost a hospital up to 3 percent of its total Medicare reimbursements.

Bundled payment systems also illustrate this shift. Under a new pilot program, the government will make a flat (bundled) payment for a package of services, which may include hospital, physician and post-acute care costs. Bundled payment systems “are currently being more widely tested by commercial payers” (Moody’s Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012), and they “driv[e] the need for greater efficiencies” (Moody’s Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012).

Adapting to Reimbursement Changes Requires Investments in IT and Economies of Scale. The focus on value is “driving a fundamental reorientation of the healthcare system” to maximize quality and cost-effectiveness. As the health care field evolves, hospitals’ relevant “success factors” “will change from what we know today.” In a value-based field, these “success” factors include making immediate capital investments in IT and achieving economies of scale.

Investments in IT. Value-based reimbursement methods demand that hospitals make significant investments in IT to achieve a variety of performance-based goals. Enhanced IT is “essential if providers are to comply with new quality standards and pay-for-performance initiatives being imposed by Medicare and private insurers.” To qualify for value-based payments, providers must have IT that permits them to “[a]ccurately and consistently report data on appropriate metrics,” share information throughout the organization, and measure quality results against benchmarks to monitor progress. Such systems enable providers to “link quality and financial metrics to quantify the value of care provided.” IT also may help hospitals improve quality of care by developing clinical protocols to promote consistent practices (Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals*, May 16, 2012). Moreover, IT will enable providers to “improve processes and allocate resources in a highly efficient way, resulting in an efficient cost structure.” These systems require large upfront investments, which may be particularly difficult for smaller providers with limited resources.

Economies of Scale. Another “success factor” is the ability of hospitals to gain “sufficient size to achieve economies of scale in all their operations.” Economies of scale allow providers to reduce costs, as well as provide comprehensive care for a community or population “by deploying the right resources in the appropriate setting.” More comprehensive care is likely to result in better clinical outcomes and fewer readmissions, which in turn lead to higher value-based payments.

To Remain Competitive In The Future, Hospitals Must Adopt Electronic Health Records.

Another trend transforming the health care field is the movement toward electronic health records (EHRs). Not only are EHRs necessary for hospitals to succeed in a value-based reimbursement model, but a portion of Medicare and Medicaid reimbursements are now conditioned on hospitals’ adoption of EHRs that meet various objectives. The costs of HER systems are staggering, however, making it difficult for already-struggling hospitals to keep up.



EHRs have the potential to improve efficiency and clinical outcomes – both of which are essential in value-based purchasing. Federal “meaningful use” requirements encourage hospitals to reap these benefits by awarding Medicare and Medicaid “incentive payments” to hospitals that are “meaningful users” of EHRs. A hospital is deemed a “meaningful user” if it implements certified technology that meets various standards – for example, the technology must have the ability to conduct drug-drug and drug-allergy interaction checks. Hospitals that have not achieved targeted “meaningful use” standards by 2013 or early 2014 will face penalties in the form of decreased Medicare reimbursements. To maintain revenues, it is imperative that hospitals implement certified EHRs that pass muster under “meaningful use” requirements.

Despite this imperative, hospitals’ overall rate of EHR adoption remains low, with a long way to go before they reach full implementation. Indeed, more than 80 percent of hospitals have not met the government’s “meaningful use” Criteria. In the meantime, the digital divide is widening. Large, urban teaching hospitals are more likely to adopt EHR systems than their smaller, rural nonacademic counterparts. Smaller hospitals may continue to fall further behind as other hospitals reap the eventual cost-saving benefits of EHRs.

Hospitals that have not adopted EHRs cite financial concerns – including capital and maintenance costs – as the primary barrier to implementation. EHR systems require significant “upfront costs to initiate” the technology. In addition to evaluating and purchasing the technology itself, a hospital may need to hire additional staff or outsource the conversion of paper charts to electronic charts; train its staff members on the systems; and adapt the hospital infrastructure to house the technology. EHRs also require ongoing maintenance costs, such as implementing system

updates. One expert estimates that implementing EHRs will cost between \$20 million and \$200 million, depending on the size of the hospital. Even those hospitals that already have EHRs may face high costs – \$10 million in one hospital’s estimate – to upgrade their systems to meet federal requirements. Although hospitals eventually will receive “incentive payments,” those payments are available only *after* hospitals have made significant investments. Hospitals’ ability to make these investments is an important measure of their future ability to compete.

The Capital Crisis: Despite Hospitals’ Need For Significant Capital Investments, They Continue To Suffer From Limited Access To Capital.

Despite hospitals’ strong need to invest in EHRs and other technology, it is increasingly difficult for hospitals to access the capital necessary to do so. A hospital’s ability to access capital is a critical “indicator[] of future ability to compete” in the changing field of health care.

The Need for Capital. Hospitals’ need for capital is greater now than ever. The trend toward value-based purchasing will require hospitals to adopt sophisticated IT, including EHRs, to compete in the health care market. Meanwhile, hospitals must continue to update their plant, property and equipment to maintain quality care.

“Hospitals are very capital intensive. Hospitals must spend money on capital to maintain their equipment, to provide new systems, and to avoid decline.” Hospitals that do not consistently invest in buildings, equipment and IT cannot effectively compete in the future market of health care. “Years of thin or deferred capital spending can place hospitals at a significant competitive disadvantage with patients, payers, physicians, and employees.” Hospital quality – and, as a result, patients’ clinical outcomes – could suffer.

The Process of Accessing Capital. Hospitals rely on various sources of capital, including investment income, philanthropy and tax-exempt bonds. For not-for-profit hospitals, tax-exempt bonds are the traditional and primary means of financing future projects. A hospital's ability to finance projects through tax-exempt bonds depends primarily on its credit rating, which is shorthand for its ability to access capital and the price at which it can borrow money. Ratings agencies, including Moody's and Standard and Poor's, evaluate and rate the creditworthiness of hospitals. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on the bonds. In other words, the higher the bond rating, the lower the cost of capital. Even the slightest drop in a bond rating – resulting in a slightly higher interest rate – may cost a hospital significantly more over the lifetime of a bond issue.

Hospitals' Difficulties Accessing Capital. The health care sector “is becoming increasingly bifurcated into ‘haves’ and ‘have nots’” (HFMA, *How Are Hospitals Financing the Future?: The Future of Capital Access*, May 2004). The “haves” are those hospitals with broad access to capital, while the “have-nots” suffer from limited access. In 2009, 88 percent of hospitals reported that it was “more difficult or impossible to access capital from tax-exempt bonds” since the 2008 recession.

Difficulties obtaining access to tax-exempt bonds have led hospitals to “quickly scale[] back” their capital projects. “In order to preserve liquidity, some healthcare systems delayed major projects that were not already started, halted projects already begun, postponed new equipment purchases and/or re-prioritized projects” (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012). The median growth rate of capital investment

has declined for two consecutive years. And the median average age of plant has increased for three straight years, indicating that hospitals are delaying capital spending, and that they will have an even greater need for capital spending in the future.

Without capital expenditures, hospitals are unable to invest in new technology and equipment that benefit patients, and hospitals may find it more difficult to recruit top physicians. Continued deferment of capital expenditures is not sustainable. “[G]iven the pace of change in the industry . . . , hospitals may not be able to reign in capital expenditures and remain competitive.” As a result, consolidation activity has continued “as resource strapped hospitals seek partners to help them invest in these areas.”

To the extent that hospitals have made capital expenditures, they are increasingly funding projects with cash holdings, as opposed to debt borrowings. “While this strategy protects current debt service coverage requirements, it reduces the balance sheet cushion and may reduce liquidity, weakening cash to debt measures” (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012).

The Downward Spiral. Because a hospital's access to capital is closely tied to its financial health and ability to invest in the future, trends in capital spending reveal “the potential for a downward spiral.” The spiral involves the following sequence:

- “Hospitals increasingly struggle with their financial health . . .
- [T]heir deteriorating financial health makes them less creditworthy . . .
- [T]heir ability to access capital becomes limited . . .
- [T]hey must devote a larger proportion of their capital to keeping up with the demands of today . . .
- [T]hey are decreasingly able to invest in the future . . .
- [A]s a result, their financial health drops significantly.”



As “[s]truggling hospitals” experience this “very slow downward spiral,” they become “unable to meet consumer and competitive needs.” The outlook can be particularly bleak for smaller hospitals that enter the spiral with lower credit ratings and less access to capital (see Moody’s Investors Service, U.S. *Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011).

Unless hospitals short-circuit the downward spiral by improving their access to capital, they will continue to fall behind and may never regain their footing. “[E]ventually, if they are not acquired, they wind down and close.” As a result, “more hospital closures are likely.”

The results could be devastating for both patients and the community. The financial unraveling of a hospital has the potential to impact the community more profoundly than the unplanned closure of nearly any other institution. Patients will suffer as hospitals struggle to survive and slowly

deteriorate. Prices will rise, equipment will wear down without being replaced, and physicians will leave for greener pastures. Ultimately, the health of the community will suffer. Furthermore, closure may result in reduced specialty services and overcrowding in other hospital emergency departments, while patients may delay treatment due to confusion regarding where to obtain appropriate care.

The Impact of these Trends Impact the Likely Competitive Effects of a Merger. These three trends – reimbursement reductions and changes, EHRs and limited access to capital – are changing the landscape of health care, and they speak “directly to the question of whether future lessening of competition [i]s probable.” Hospitals’ past performance is no longer a “conclusive indicator[] of anticompetitive effects.” Rather, hospitals’ ability to compete turns on their ability to keep pace with these trends, which requires significant capital investments and economies of scale.



Current market forces “have ignited the national explosion of consolidation” in the health care field. Moody’s Consolidation Report at 1. For a field that has a depressed ratings outlook, consolidation often offers a glimmer of hope (Moody’s Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012). Mergers arm hospitals with two critical “success factors” that will enable them to adapt to recent health care trends: economies of scale and improved access to capital.

Mergers Enable Hospitals to Become More Competitive Through Economies of Scale. Even the most vigilant cost-cutting efforts cannot carry already-struggling hospitals through this period of transformation. Mergers present hospitals with a unique opportunity to achieve deeper cost reductions and greater economies of scale with the promise of becoming more competitive.

Now more than ever, “size and scale are . . . a more important means to gaining greater efficiencies and driving waste and costs out of the delivery systems” (Moody’s Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Through consolidation, hospitals can gain the “size and scale” necessary to diversify their revenue sources, spread costs over a larger base, and “allocat[e] . . . resources to better withstand likely future reductions in funding” (Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders*, July 6, 2012).

For example, mergers allow hospitals to reduce excess capacity, the number of available hospital beds that go unoccupied. Unused beds – as well as the staff and buildings necessary to maintain those beds – “represent fixed costs that must still be paid and thus spread over a dwindling number of patients and . . . over all other services at that particular facility.” Reducing excess capacity results in significant cost savings, which can then be captured and reinvested to fill community needs, such as a pro-competitive expansion of services.

Mergers also allow hospitals to eliminate duplicative services and technology, which “could save money without compromising access to care.” Eliminating these expenses may result in lower prices. **Consolidation efforts short of a merger do not typically result in the same degree of**

success in eliminating excess capacity and duplicative resources. By establishing common ownership of facilities and equipment, mergers allow hospitals a clearer path to achieve these critical improvements, which are relevant to the “probable anticompetitive effect of the merger.”

Mergers Provide Hospitals with Greater Access to Capital, Allowing them to Make Necessary Investments to Remain Competitive in the Future. Access to capital is critical to hospitals’ ability to make capital investments – and to effectively compete in the future. Mergers allow hospitals to improve their access to capital by increasing their size and, in many cases, by joining a hospital system.

Hospital size is closely tied to a hospital’s bond rating; larger hospitals tend to have higher bond ratings, in part due to their greater “scope and acuity of services” and “ability to gain greater efficiencies” (Moody’s Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook*, Aug. 30, 2011). Smaller providers, on the other hand, are subject to greater ratings pressure. By increasing size, hospitals may improve their ability to access capital.

Through a merger, the acquired hospital frequently joins a larger hospital system, which provides even greater access to capital. In general, hospitals that are part of systems tend to have better access to capital. Rating agencies may allow systems to achieve higher credit ratings with some lower thresholds – such as days cash on hand – because they generally see less risk in a system than a stand-alone hospital. A hospital system disperses risk among a variety of facilities, services, and even geographic locations. In addition, hospitals frequently obtain “[g]reater synergies as a larger system with critical mass, particularly if in same or adjacent markets” (Moody’s Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). Furthermore, hospitals that become part of a system may also join that system’s obligated group, which is a group of organizations that act as a single entity for credit purposes and that are obligated on the collective debt of the group. Membership in an obligated group will increase the security of the acquired hospital’s debt and likely lead to higher credit ratings.



In light of the benefits of size and system membership, it is unsurprising that hospital mergers have a positive impact on a hospital's credit – and corresponding ability to access capital (see Standard & Poor's, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012, discussing “two mult notch upgrades” that occurred as a result of mergers). “Access to capital . . . almost certainly will improve as a result of consolidation.” Greater access to capital allows hospitals to make critical capital expenditures.

Particularly for Stand-Alone Hospitals, Mergers may be the only Means of Remaining Competitive in the Future. In the rapidly changing field of health care, many stand-alone hospitals – those hospitals that are not part of a system – are facing a crossroads: Will they merge with a partner hospital to ensure that they remain competitive, or will they remain independent and hope to find other means to weather the storms? As analysts have recognized, “[l]ong term structural change in the sector has favored a minority of larger, well managed hospitals and systems, while creating ever tighter competitive conditions for the majority of smaller, especially freestanding, hospitals” (Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012*, Jan. 25, 2012).

Stand-alone hospitals are particularly vulnerable to the threat of the downward spiral. There is a “longstanding credit quality gap between . . . systems and stand-alone providers,” and market changes threaten to widen the gap (Standard & Poors, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012*, Jan. 25, 2012). Recent downgrades in hospital credit ratings “were disproportionately weighted toward stand-alone hospitals.” In the future, stand-alone hospitals “with weaker ratings will be greatly constrained in obtaining the capital they need for facility improvements, product line development, IT improvements, or physician alignment strategies.” This pressure “may push them over the edge to seek a merger partner or acquisition.”

Indeed, experts are advising the boards and management of stand-alone hospitals to consider consolidation. “[Given

the ever-growing pressures [facing hospitals,] it is imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone.” Although many not-for-profit boards and CEOs “have a bias toward independence,” they are advised to carefully consider “whether independence continues to be in the hospital's best interest.” Various indicators – “[a] weakening in key financial metrics, a softening market share, or an inability to keep pace with facility and technology upgrades” – “may point to the need for affiliation or merger.” Many stand-alone hospitals have followed this advice; in 2009, 85 percent of hospital mergers and acquisitions involved stand-alone hospitals.

Hospitals that are “left out of consolidations, especially smaller stand-alone hospitals . . . , will face greater negative rating pressure going forward” (Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation*, Mar. 8, 2012). This pressure will make it harder for hospitals to access capital and to remain competitive. Those hospitals that do survive are likely to “evaluate their service offerings [and] may downsize their footprints,” which will further reduce competition. Therefore, many acquisitions of stand-alone hospitals will result in more competition, rather than less.

Policy Makers Should Consider these Market Realities when Assessing the Probable Effect of Hospital Mergers. During this period of rapid market transformation, many smaller hospitals – especially stand-alone hospitals – will struggle to remain competitive unless they find a partner that can help improve their access to capital and provide greater economies of scale. This “market realit[y],” is highly relevant to any “assessment of what will likely happen if a merger proceeds as compared to what will likely happen if it does not.”

Hospitals should not be forced to wait to merge until they are in imminent danger of closing their doors. If hospitals must tumble through the downward spiral, both patients and the community will suffer from disruptions in the quality and consistency of care as hospital services slowly deteriorate. . . In many cases, “the public interest would best be served by allowing the hospitals to proceed with the merger.”

This paper has been adapted from an AHA amicus brief filed on Sept. 24, 2012 in the Sixth Circuit Court of Appeals. For a complete list of references, go to: <http://www.aha.org/advocacy-issues/legal/legal-amicus-briefs.shtml>.

