

**MINUTES OF THE SUBCOMMITTEE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES**

**Seventy-Fourth Session
March 13, 2007**

The Subcommittee on Health and Human Services was called to order by Chair Sheila Leslie at 2:08 p.m., on Tuesday, March 13, 2007, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda ([Exhibit A](#)), the Attendance Roster ([Exhibit B](#)), and other substantive exhibits are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/74th/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

SUBCOMMITTEE MEMBERS PRESENT:

Assemblywoman Sheila Leslie, Chair
Assemblywoman Susan I. Gerhardt, Vice Chair
Assemblyman Joseph P. (Joe) Hardy

STAFF MEMBERS PRESENT:

Sarah J. Lutter, Committee Policy Analyst
Katrina Zach, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services, Carson City, Nevada
Alex Haartz, Administrator, Health Division, Department of Health and Human Services, Carson City, Nevada
Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada
Bobbette Bond, Legislative Liaison, Health Services Coalition, Las Vegas, Nevada

Minutes ID: 491



Chair Leslie:

This meeting is called to order. [Roll.] I would like to call the Subcommittee to work on Assembly Bill 146. Madam Secretary, please note that all three members of the Subcommittee are present. We heard the bill in a regular meeting, and enough issues and interest were raised that we decided to set a special time to work on Assembly Bill 146. You will see an interaction between the Subcommittee and people who have specific suggestions for the bill. We probably will not vote on a recommendation for the Committee today because I want the research staff to look up some things. The Subcommittee might meet one more time to discuss what recommendation we want to make to the Committee.

Assembly Bill 146 concerns a new program that establishes transparency around healthcare costs and quality indicators of healthcare facilities.

Assembly Bill 146: Requires the Department of Health and Human Services to establish a program to increase public awareness of health care information concerning the hospitals in this State. (BDR 40-687)

**Charles Duarte, Administrator, Division of Health Care Financing and Policy,
Department of Health and Human Services:**

I have some responsibility for data collection under Nevada Revised Statutes (NRS) 439B, which includes hospital in-patient data. We provided some data the last time Assembly Bill 146 was heard. We made specific suggestions on revisions to the bill language, which would still allow the development of a consumer-friendly website that offers cost and quality information to consumers.

Alex Haartz, Administrator for the Health Division, is with me today. The Health Division maintains a lot of this information, which is consistent with the presentations on Wisconsin's Price Point website. The information comes from separate morbidity and mortality reports or from the Center for Health Information and Analysis (CHIA) at the University of Nevada, Las Vegas. The Center for Health Information and Analysis collects data on hospital charges, and they aggregate the charges based on diagnostic-related groups (DRG). They publish the information for each hospital and provide an average DRG cost associated with a particular diagnosis for each hospital in Nevada. The document is called *Healthy Choices*, and it is available on the web. This is the data that is essentially presented on the Wisconsin Price Point website.

Chair Leslie:

I remember that document. I saw things that were interesting, but it is somewhat difficult to use. I agree that a lot of information we are seeking is in that document. Instead of publishing a document that is difficult to use, could we use CHIA to accomplish this purpose?

Charles Duarte:

The current resources we have can certainly enhance what we already offer. We have been talking with Joseph Greenway, the director of CHIA and an expert on health care data. Mr. Haartz has a technology improvement request in Governor Gibbon's budget to enhance their database.

Chair Leslie:

Is there a way we can combine the intent of Assembly Bill 146 with what you are already doing?

Charles Duarte:

There are sets of data we have divided between the Health Division and the Division on Health Care Financing and Policy that are the result of the old cost containment statutes. One was the hospital costs and reporting information, which previously included the publishing of charge masters. The Division on Health Care Financing and Policy maintains hospital cost reporting while the Health Division maintains the quality and utilization reporting. All this data comes from CHIA, although you probably get data from separate data sets. I just want to make sure you understand that there are ways of enhancing the CHIA contract to do both.

Chair Leslie:

In the past, under the cost containment statutes, did Medicaid get the charge master from the hospitals?

Charles Duarte:

That is correct.

Chair Leslie:

But you no longer do?

Charles Duarte:

That ended in 1997 or 1998, so we no longer collect that data.

Chair Leslie:

But you have the right to go to the hospital and look at it?

Charles Duarte:

Yes, under the laws that were passed in 2006, we have the right to look at it as does any citizen, I believe.

Chair Leslie:

Is there ever a need for you to look at the charge master?

Charles Duarte:

We really do not use the charge master data. The charge master is a tool for hospitals to generate a bill. We no longer have the responsibility to approve or authorize changes to the charge master.

Alex Haartz, Administrator, Health Division, Department of Health and Human Services:

The Health Division collects data that has been collected many times by others. If it involves vital records, the Health Division collects the data and puts together a simple analysis to make it useful for the general public. Regarding *Healthy Choices*, I agree there are aspects of the document that are very useful, and there are other aspects that are difficult to understand. The document is a starting point. We make the information available in a published and Internet-downloadable format. You cannot manipulate the data or move information around to draw different conclusions. As Mr. Duarte mentioned, we do have, in Governor Gibbon's recommended budget, a data warehouse that needs the flexibility that Assembly Bill 146 is requiring. This is a possible strategy to accomplish what Assembly Bill 146 intends to do. At this point, the Health Division's role is to make information available based on basic quantitative analysis without worrying if there is statistical significance. We let others draw conclusions from the data.

Chair Leslie:

It sounds like the Health Division has some resources, or will have, if Governor Gibbon's budget is approved, that could be used differently to help us accomplish this goal.

Alex Haartz:

I do not know if "differently" is correct.

Chair Leslie:

I was thinking of the CHIA report. What is the possibility of rewriting the CHIA contract?

Alex Haartz:

We prepare a report analysis based upon the CHIA contract.

Charles Duarte:

The Center for Health Information and Analysis has a contract. We have been talking with the director of CHIA about modifications to the contract that would meet the requirements of Assembly Bill 146. We prepared a fiscal note that we submitted to Mike Willden, the Director of the Department of Health and Human Services. There are some aspects of Assembly Bill 146 that will require additional staff resources, such as health professionals and auditors to accomplish the goals identified in the bill. In my previous testimony, I identified the sections that might be problematic. The CHIA director informed me that the Wisconsin Price Point website is totally doable. CHIA's data is more robust than the data Wisconsin provides through the Price Point website, and the director believes it is not a difficult project to implement.

Other aspects of Assembly Bill 146 are large projects. They are all feasible, but it is a matter of time and money. The out-patient claims data is possible depending on the time-frame and the completeness of the reports. The director's opinion is not comparable to data that is provided by, for example, an ambulatory surgical center. You cannot compare the information from the claims because there are different data elements, and frankly, different forms that are used for claims. It is feasible to do some sort of crossover between the two, but then again, you are trying to compare apples and oranges.

Chair Leslie:

But other states have done that. Wisconsin has done it, right?

Charles Duarte:

I do not know if Wisconsin has done it.

Chair Leslie:

What are other states doing? Does Wisconsin provide in-patient and out-patient data? Florida does it.

Charles Duarte:

The CHIA director believes it is feasible, but it becomes a matter of how long it takes and how many resources we want to invest in redesigning the system.

Chair Leslie:

Do you see a trend of more and more hospitals pushing out-patients into their own centers or into the communities?

Charles Duarte:

That has been a trend for more than a decade. As I told you before, the consumer should have that information available to them, but I think we have to

be cautious about what we are comparing, and also recognize the size and complexity of some of the projects. For example, posting the charge master electronically is very doable, but analysis on that data is time consuming.

Chair Leslie:

I am not proposing posting the charge masters.

Charles Duarte:

I thought that was included.

Chair Leslie:

That was not the intent. I agree that no one is going to understand a charge master.

Charles Duarte:

We can understand the general scope of it, and the scope seems to be quite doable. We can work with the CHIA director, the Health Division, and others to determine what we think are realistic costs. I hate to put out this fiscal note until we fully understand what we are doing. Again, when I saw your presentation, the scope seemed to involve fewer dollars than what was proposed in the draft. Another example deals with infection control monitoring, which requires a professional staff. There are not any standards that we are monitoring. Some terminology in Assembly Bill 146, such as "without limitation," needs to be honed down, because it could be a really big project or it could be as small as a bread basket and very feasible. It is those kinds of things that will drive the fiscal analysis.

Chair Leslie:

Mr. Duarte, will you hear the rest of the technical discussion? We should, as we start preparing our work session, consider your testimony that you gave us a couple weeks ago as a starting point.

Assemblywoman Gerhardt:

Are we collecting instances of infection in the hospital's data? I believe we are already getting that information.

Alex Haartz:

We are collecting that information in the context of a sentinel event. The sentinel event, if it is deemed to be an unexpected event, is collected.

Assemblywoman Gerhardt:

In the absence of any other data, at least we could start with something like that.

Alex Haartz:

The law that was passed regarding sentinel events requires the data to be aggregated and not hospital-specific.

Chair Leslie:

I think it is a very good point. Consumers would love to see that data. Let us move to the Nevada Hospital Association.

Bill Welch, President and CEO, Nevada Hospital Association:

[Submitted ([Exhibit C](#)).] We submitted proposed amendments to Assembly Bill 146. The Nevada Hospital Association is supportive of appropriate consumer-friendly transparency, and in fact, we have taken initiatives. In 2006, we heard the message during the 73rd Session and at the Interim Healthcare Committee, and we began to evaluate systems that would allow us to, in a pro-active manner, produce transparency. The Nevada Hospital Association purchased a model that was presented to the Committee on Health and Human Services a few weeks ago. We transferred the data from CHIA to Price Point so they can begin analysis and build a report, which we would be happy to share with the Committee. We anticipate a draft report in the next two or three weeks.

With respect to the amendments we are proposing, do you want me to walk through each one or do you want me to present highlights?

Chair Leslie:

Let us walk through it.

Bill Welch:

The charge master does not help you in what you are trying to accomplish, so we tried to reword that to coincide with the information that CHIA and Price Point collects. Section 3 of Assembly Bill 146 reads "the fifty most common diagnoses," but we clarified that based upon diagnosis-related groups for in-patients. We excluded the out-patients for reasons Mr. Duarte presented, as well as other concerns we have.

Chair Leslie:

Do you mean "average allowable charges"? Is it not the phrase that is often used?

Bill Welch:

We are looking at the forms that are required to be submitted for all billings on in-patient services. We take the full charges, and it would average those out.

Chair Leslie:

So it would be average allowable charges?

Bill Welch:

Yes.

Assemblyman Hardy:

Is there a difference between average charges and average allowable charges?

Bill Welch:

We are looking at the total amount that is billed. One of the reasons hospitals have a charge master is because we are required by law to ensure that every patient is charged the same price for the services provided. As we all know, depending on which health insurance plan the patient has, the patient might not pay those full bill charges, but we have to ensure that there is a system that bills the same amount for every service.

Chair Leslie:

Are average allowable charges and bill charges the same thing?

Bill Welch:

The bill charges are the same. This is the full amount the patient will be billed, but it might not be what the patient actually pays.

Assemblyman Hardy:

I am looking at the total charges versus the allowable charges. Are we not allowed to charge as much for some people as we are allowed to charge for others?

Bill Welch:

I understand your point. Medicaid only pays \$.79 cents on the \$1. This will be the full amount billed regardless of how much we are reimbursed.

Chair Leslie:

How should we word it? I think we are all in agreement of what the full amount should be.

Bill Welch:

We need to leave the word "allowable" out.

Chair Leslie:

It will be just average charges?

Bill Welch:

Yes.

Chair Leslie:

It is not really the average, though.

Assemblywoman Gerhardt:

If we are billing full fee per service, why would we need to average?

Bill Welch:

For example, if hospital A had 100 pregnancies last year, one could take the total charges billed for those 100 pregnancies, divide by 100, and the figure would be the average charge per delivery.

Assemblywoman Gerhardt:

If my daughter-in-law is pregnant, how is she able to compare hospitals if it is averaged?

Bill Welch:

Again, this is based upon the DRG. There will be a code for a normal delivery, a code for a cesarean delivery

Assemblywoman Gerhardt:

So you will group them together?

Bill Welch:

Yes. It is by DRG code. That would mean the treatment and medical condition have to be the same.

Chair Leslie:

I am going to ask Ms. Lutter to do more research. I think we understand what you mean by average charges.

Bill Welch:

On subsection 2 of Section 3, we tried to narrow the quality measurements that are consistently utilized throughout the hospital community. All hospitals are Centers for Medicare and Medicaid Services (CMS) certified. As we know, CMSs are doing a lot of quality measurements right now. CMS has a lot of information out there, so you may want to look at the information if you want to make it consumer-friendly. All urban hospitals and a number of the small rural hospitals in Nevada are Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited. The JCAHO also has quality measurements that are very consistent in how they are measured and reported. We believe

CMS and JCAHO are the most commonly used systems. There are many quality measurement programs out there, but they are voluntary, such as Leap Frog. Not all hospitals use Leap Frog.

Chair Leslie:

I do not know what that means. What is Leap Frog?

Bill Welch:

It is a voluntary quality measurement system that some hospitals have purchased, and there are other systems like it. We are trying to come up with systems that are consistent in measuring and reporting.

Chair Leslie:

I think the reason why we had four quality indicators in Assembly Bill 146 is to allow flexibility. We want to make sure the law we write can withstand the test of time, at least for a decade or two. The CMS and JCAHO are the systems that you are recommending, and the other two are ones that other states are using. I would like Ms. Lutter to find out what systems other states are using. You make a good point; the CMS system is probably the most popular. I want to make sure that we leave enough flexibility, and I do not want to limit the number of quality indicators.

Charles Duarte:

I understand the intent. The language of Assembly Bill 146 allows the consumer to request any type of quality measure. For example, the Agency for Healthcare Research and Quality maintains over 1,000 different quality measures, many of which are in-patient related. These measures are impossible to collect from claims, and require a medical records review. I suggest that you make sure the information can be provided by the hospital. I understand that you want to make sure that as measures develop and become commonly used, the State would be able to get that information. I want to make sure this is feasible, without adding a lot of cost to state or industry.

Chair Leslie:

I want to leave flexibility in so we can limit it to the quality measures that make the most sense. If we left those four quality measures in the bill, will that cause a lot of problems?

Charles Duarte:

Bill Welch recommends some language in his draft ([Exhibit C](#)), which states, ". . . to the extent the hospital currently reports the data and the data is publicly available." I think that helps narrow it a little bit. You might want to play with that language.

Chair Leslie:

Ohio gives the director discretion in choosing which quality measures that the hospitals should report. I agree with the sentence that the Nevada Hospital Association is recommending.

Bill Welch:

We moved Paragraph (c) of Section 3 (2) up to the prior section of A.B. 146. In Section 4 we want to assure consistency, so we want to say everybody "shall use these" rather than "may use these," otherwise the data will be inconsistent.

Chair Leslie:

Why did you scratch out the phrase "that are in addition to those"? It did read ". . . which may include charges imposed by hospitals and measures of quality for hospitals that are in addition to those"

Bill Welch:

That refers to subsection 2 of Section 3. That is where we placed the pricing information. We are talking about quality and charges, and we tried to make it flow consistently.

Chair Leslie:

If we get rid of that, it takes away the flexibility.

Bill Welch:

We were just trying to use appropriate words. In Section 5, we tried to define the function of the Department of Health and Human Services. We had some reservations on how some of the charge masters will be collected. We made Section 6 into Section 5, and we defined what the Department's responsibilities are, and how they would provide the information.

Chair Leslie:

You removed out-patient.

Bill Welch:

That is correct. Mr. Duarte presented reasons why we took it out. We feel it would be unfair for hospitals. The hospitals are required to maintain emergency rooms and all emergency services. The hospital sets up charges by spreading out uncompensated costs. When the hospital community reported for A.B. No. 342 of the 73rd Session, there were approximately \$455 million of uncompensated costs that were spread out. The ambulatory free-standing centers do not have uncompensated costs of care; they do not have the same mandates. They are in the position to pick and choose who they will do business with based upon their payer source. It is an unfair comparison.

A free-standing ambulatory surgery center can price services that are lower than hospital charges, but they simply do not have the same cost centers as hospitals.

Chair Leslie:

I wonder how other states have done it.

Bill Welch:

I will have to look into that. The states we looked at only compared hospitals, but again, that is our concern.

Assemblywoman Gerhardt:

Would it not be a good thing to let people know that going to the emergency room is the most expensive option? Would it not alleviate some burden on the hospitals?

Bill Welch:

That would be true if the ambulatory facilities were receptive to self-paying patients, Medicaid patients, and so on. These patients go to the hospital emergency rooms not because they want to, but because the emergency rooms are the only providers that are willing to accept them. You can give price comparisons, but that is not going to change one's inability or ability to access free-standing centers. People will access those services because of their payer status. Also, the free-standing facilities will know what the hospital charges and can make their charges lower.

Assemblywoman Gerhardt:

I understand, but I think the purpose of Assembly Bill 146 is to provide information to the consumer. Indigent people are not the only ones that go to emergency rooms. I understand that we do not want to create unfair comparisons, but we also want people to know that if the emergency room is the place they choose to go, it is the most expensive option.

Bill Welch:

We have our concerns. Most insured people are aware of their health plan benefit packages. I suspect insurance companies are trying to direct their enrollees to the most cost-effective setting.

Assemblyman Hardy:

I think the misnomer is the self-pay patient. It is actually the self-unpaid patient. The real problem is that the emergency rooms are filled with people who only have a cold, whereas an urgent care center makes sure they do not take the non-paid patient. There is an unfair advantage to the out-patient facility because

they can charge the same as an emergency room and still look really good. It would actually increase costs to the person with insurance because it is not only the person that pays, but the insurance company also pays. The hospitals are not only competing against urgent care, but it is also competing against a higher standard monetarily.

Assemblywoman Gerhardt:

I just do not think there are many urgent care centers available in Clark County.

Assemblyman Hardy:

Actually, there are quite a few urgent care centers. I am not going to speak about government entities competing against private entities because that is not the focus of our discussion.

Assemblywoman Gerhardt:

Can we get information on urgent cares? I do not think there is quite the same competition that we may think there is.

Chair Leslie:

Those of us with insurance do not have much choice; the insurance companies tell us where to go. With elective surgery, sometimes a patient can choose a hospital. Sometimes you do have some options. As a consumer, I would like know what my choices are. Ohio has an in-patient website set up, where they list 60 of the most common out-patient procedures. They must have grappled with the issue you are raising. I would like Ms. Lutter to further investigate what other states have done in terms of out-patient procedures. The Ohio Hospital Association strongly advocates the inclusion of ambulatory surgical centers. Perhaps this is something you could help us explore.

Bill Welch:

I would be happy to do that. Ohio advocates it because the hospitals are already being required to report that data. They wanted to make sure all the ambulatory surgical centers are reporting that data. They want to see if their prices changed immediately. If you are going to this, you will need to do it simultaneously.

Again, urgent care centers, as well as ambulatory out-patient surgery centers, are owned by physicians or other individuals. The same applies to radiological diagnostic centers. The hospital costs are much higher. I would like to point out that 2/3 of the patients who go to the hospital do not pay the costs for services. I do not mean bill charges, but the cost to provide that service. The patients that use Medicaid, Medicare, Indian Health Services, or the self-pay population, which is 2/3 of the patients that go to hospitals, do not cover the costs of services.

Chair Leslie:

I understand that, but that is not the intent of the bill. Consumers have to stretch their health care dollar. They just need to know where the best deal is.

Bill Welch:

We changed Section 6 to Section 5. We think it would be important to post on the website that this is historical information because even the data CHIA collects is several months old.

Chair Leslie:

So we should post some kind of disclaimer.

Bill Welch:

Under Section 7, because of the way we amended the bill, it would become Section 6. If CHIA is not utilized, and you need to choose another option, we feel it should be through a competitive selection process. The other changes include cleaning up the language to improve the flow. We want to add "average" so it clarifies what kind of charges we are putting up.

Chair Leslie:

In Section 8, you have an issue where . . .

Bill Welch:

We interpreted that to mean the charge master. When A.B. No. 342 of the 73rd Session passed, all patients had access to the charge master, that is what Section 8 is referring to.

Chair Leslie:

As I understand it, you want to keep it the way it is now. If anyone from the state health agencies, like Mr. Duarte, wants to look at the charge master, they can, like any other person.

Bill Welch:

Most of our hospitals have it electronically, but not all of them do. There are 30,000 to 40,000 separate line item charges.

Chair Leslie:

What is the secret behind the charge master?

Bill Welch:

Each hospital is structured differently, so you would have to do a thorough analysis. When Mr. Duarte was trying to compare charge master to charge master, they had two staffs working full time. Hospital A may have their pricing structure in one format while hospital B has it in a different manner.

Chair Leslie:

Will people misuse the information because they have not done the analysis to know what they are looking at?

Bill Welch:

I do not know if an individual will know that. The most important thing is the cost for a certain type of service.

Chair Leslie:

I would like to know what shop A is charging versus shop B.

Assemblywoman Gerhardt:

There has to be some standardization because how will insurance companies be billed properly? There is a corresponding insurance code for each procedure and service. There has to be standards.

Bill Welch:

It depends on how the hospital structures their charges. One hospital may have service costs bundled into a flat charge while others may break it down to individual line items. Unless you understand those little nuances, you will not be able to compare them. The insurance companies negotiate a contract with the hospitals, and they evaluate those charges.

Assemblywoman Gerhardt:

Not necessarily, because a lot of insurance companies are paying a percentage of the total cost. It is not all contracted. If all these insurance companies are figuring these fees, it cannot be that mysterious.

Bill Welch:

If the insurance companies have a bill from the hospital, they have the ability to review the charge master.

Chair Leslie:

Do they do it?

Bill Welch:

I am not aware of any insurance company or any self-funded plan that has done that. I have talked with others from other states, and they report access to the charge master is minimal.

Chair Leslie:

I think most consumers have a hard enough time figuring out their bill. Section 10 is now Section 9.

Bill Welch:

That corresponds to the changes we made. We did not make any changes in that section until you get to subsection 5. Again, we added average charges to clarify the charges.

Chair Leslie:

The blue section is yours or ours?

Bill Welch:

That is yours. The only changes we made in Section 10 are the cross-references. The same also applies to Section 12.

Chair Leslie:

What if we gave you a year to help us figure out how we could do out-patient on a limited basis?

Bill Welch:

I would hate to have a set date, and not know what challenges and obstacles we would run into. I would be happy to work with the state agencies, and come back for the 75th Session. The Florida model is something that has evolved over a number of years. We asked for a copy of their history, of how they started and where they are today, and we also have a copy of the report on their entire system. The same applies for Price Point; it has evolved over a number years. All these systems have their little nuances.

Chair Leslie:

I remember the bill on hospital emergency rooms that the Committee passed, and nothing happened.

Bill Welch:

The hospital industry did step forward on that ambulance bill, and with respect to transparency, we have purchased Price Point. It is very much our intention to have this information. We have also utilized the sentinel event process that was passed in 2002, and codified it in the 72nd Session. The Nevada Hospital

Association has a committee that meets on a regular basis, and they have been evaluating CMS and JCAHO quality measurements, and identifying any other standards that are consistently used, reported, and measured. The Nevada Hospital Association will have a quality and pricing transparency system by the summer of 2007.

Charles Duarte:

I just want to make sure the Committee understands that we certainly do not oppose collection of out-patient data. Like I have said before, it would be good for a consumer to see. The issue at hand is a technical issue. Folks that are collecting the data, such as the CHIA director, should have the opportunity to review the scope. We might get some information back in the next few weeks.

Chair Leslie:

We have some time, and that is why we started on this bill early in the session. I would rather get it right the first time than not. There is no rush at this point. If you could explore that and get back to the Committee with some options, that would be very helpful.

Charles Duarte:

The CHIA director understands that the intent is to build a more robust, consumer-friendly interface for in-patient data, and he did not want out-patient data using up resources and frustrating the effort.

Chair Leslie:

Thank you.

Robin Keith, President, Nevada Rural Hospital Partners:

[Submitted ([Exhibit D](#)).] My comments will build on Mr. Welch's comments. Nevada Rural Hospital Partners had the opportunity to participate with the Nevada Hospital Association as they developed their recommendations.

In light of the discussion that has taken place, I would like to comment on subsection 2 of Section 3 of Assembly Bill 146. As we read the section, we were concerned that we would need to comply with literally hundreds, potentially thousands, of quality indicators. I am relieved to hear that is not the intent, and that we will craft this language so we can select indicators that are useful and applicable to the appropriate setting. We would appreciate it if you took the rural setting into account as the indicators that apply to urban Nevada may be different. We think flexibility in this section is important.

In subsection 2 of Section 3, I had some heartburn about this language because it is so broad and immeasurable. As Mr. Duarte pointed out, there are no current

standards related to infections in hospitals because it is such a difficult thing to quantify. As I read this, I feel like we need to prove the fire department did everything they could do to eliminate fires in Washoe County. You cannot get your arms around it. I would value the Committee's attention and discussion on this issue before enacting a law that asks, "How consistently did each hospital follow recognized practices to prevent infection, the speed of recovery, and to avoid complications."

Chair Leslie:

But that phrase was left in Mr. Welch's mock-up ([Exhibit C](#)).

Robin Keith:

They did leave it in, and that is why I am here. Although we participated in that discussion, we missed this until I went back and read the bill again.

Chair Leslie:

Are you saying that Mr. Welch would also like it removed?

Robin Keith:

Could we ask?

Chair Leslie:

We could ask. Are there quality indicators about the infection rates?

Robin Keith:

I cannot say no, but to my knowledge there is no standard that establishes acceptable levels. What is the acceptable range? Frankly, in my opinion, there will never be an expectation that the hospitals will be infection-free.

Chair Leslie:

That is not what it says. As I read it, it says, "Each hospital in the state follows recognized practices to prevent the infection of patients." Those exist.

Robin Keith:

Yes, they do. One of those recognized practices would be hand washing. Hand washing is probably the best thing to do to avoid infection. How would we measure that? Would we go around and count how many people

Assemblywoman Gerhardt:

We are talking about DRG, the diagnostic-related groups. Is there such a thing for treating infection? If we took an average of that, maybe we could get a sense of how often it is occurring.

Robin Keith:

There are codes for complications. For example, if a patient has diabetes and an infection, in addition to the DRG for diabetes, there would be a code applied to the infection. But what is the source of the infection? Do we capture that? I do not know if we do. It is so difficult to measure. Did the patient come to the hospital with an infection? Or did the patient acquire it in the hospital? This is what we are trying to get at here in terms of the quality of care.

Assemblywoman Gerhardt:

But if we are taking an average, and we use the same formula for each hospital, would it really make a difference?

Chair Leslie:

Do some hospitals require their workers to wash their hands more than workers at other hospitals? As a consumer, I would like to know that.

Robin Keith:

I do not know how we could measure that without having an extensive and costly apparatus to track who is washing their hands, how often, and how well.

Chair Leslie:

Do the hospitals report this data through the JCAHO inspections?

Robin Keith:

Yes, there is a component in JCAHO about infection control.

Bill Welch:

The hospitals track infection controls, and run analyses to evaluate them. It is discussed in patient committees and medical staff committees. The data is utilized to measure what is happening, and to develop solutions to ensure those situations do not happen again. Currently, the data is protected by confidentiality. Making patient information public would be a concern to us.

Chair Leslie:

Do you find this paragraph objectionable?

Bill Welch:

I talked with Ms. Keith, and I understand her concerns. They are difficult to monitor. We initially did not have a concern with that, but how do you monitor them?

Chair Leslie:

No, that is not what we are talking about. I will ask Ms. Lutter to look at what other states are doing, and what quality indicators other states use. I think this information is important to consumers.

Assemblyman Hardy:

We focused on the infection part, but there is also the issue of health care workers believing the sooner they get the patient out, the better they look on the report. I have problems with that. The phrase "avoid medical complications of patients" is the same kind of thing. It is not just hand washing. Studies show the tie the doctor wears carries germs. Hand washing is problematic in its implementation.

Chair Leslie:

Let us look at what other states have done.

Bill Welch:

We have been looking at this in our committee, and we have been trying to evaluate the appropriate quality measurements. One of the challenges is figuring out what infections the patient comes to the hospital with. Would we have to do lab procedures to measure every patient?

Chair Leslie:

No, we are not talking about that. Let us not get carried away.

Bill Welch:

When you start measuring it, you have to measure it from point A to point B, and those are some of the challenges we have been looking at.

Assemblyman Hardy:

Some infections rise to the level of a sentinel event, and that can be tracked and reported. I do not know if you are going to find anyone who can figure out this conundrum.

Chair Leslie:

We will take a look at that paragraph. Give me an example of a quality indicator that we would use for a rural hospital but not use for an urban hospital.

Robin Keith:

For example, if we want to find the survival rate for quadruple bypass surgeries, rural hospitals do not do those. On the other end, there may be indicators for basic trauma care, for example, that would occur in a rural emergency room. That would be appropriate to look at.

Chair Leslie:

If it is a procedure a rural hospital does not do or does very few of, then as a consumer, you might want to consider not going there for that procedure. I am not yet convinced of the argument that there are indicators that exist in urban hospitals, but not in rural hospitals.

Robin Keith:

I am asking that we not ask the rural hospitals to collect meaningless data. The data becomes meaningless because they do not do enough of it to make it significant.

Chair Leslie:

I see what you are saying.

Robin Keith:

They have to collect it to show that they do not do enough and that is just additional work.

Chair Leslie:

We will take a look at that. We are not trying to overburden any hospital with more work than they need. Again, these are procedures the consumers are most worried about, and they need to know.

Robin Keith:

I agree. I do not want rural hospitals to not show the quality of care they provide.

Bill Welch:

Data has to be measured on a standardized basis. I used to be a CEO for a rural hospital, and my counterpart from Ely told me to look at the most current American Hospital Association report. There was a patient with a rare disease, a non-resident of Nevada, who died at a Nevada hospital. The report stated the death rate of that hospital was 100 percent without any data adjustment or factoring. We show paranoia because we have been down this path in a number of other scenarios. Unless it is quality data that has basic standards, is consistently reported, and has volumes to allow comparative measurements, the data does not mean much.

Chair Leslie:

I appreciate that. We certainly do not want to mislead the public. There are ways, I think, to note that. Is there anyone else who would like to comment?

Bobbette Bond, Legislative Liaison, Health Services Coalition:

The Health Services Coalition has 22 organizations that provide healthcare benefits in southern Nevada. One of the platforms of the Health Services Coalition is quality. We work with hospitals and national groups on quality, and our quality expert will be able to provide input and suggestions.

All of our clients have insurance, and there is a large problem with emergency rooms. We have seen a real decline in urgent care, and all people are trying to figure out how much it costs to get care. This is still an issue for people with insurance. I think a website that handles both the insured and uninsured, and uses allowable charges rather than the bill charges, would be most helpful. The urgent care situation in southern Nevada is not working. If you seek care after 7 p.m. there are no quick care facilities available.

Chair Leslie:

Do you think it should be average charges, average allowable charges, or bill charges in the bill?

Bobbette Bond:

I will have our experts help us, but when we rate our physicians and our hospitals, we take the average cost that Health Services Coalition pays, not the average bill charges. I am confused that Mr. Welch wants bill charges; what is the difference between bill charges and average bill charges?

Chair Leslie:

Mr. Welch submitted average charges.

Bobbette Bond:

That is a bill charge. However, on the other side, he said he did not want to use bill charges. We use allowable charges, which is what the insurance company will pay the hospital. The hospitals take all those averages from every payer, come up with an average for a certain procedure, and report that to the State.

Assemblywoman Gerhardt:

But that does not mean anything to anyone without insurance.

Bobbette Bond:

The person without insurance will be stuck with the bill charges. I think if we had a vote, we would want both reported.

Assemblywoman Gerhardt:

I think you would have to start with full fee for service. What if there is a situation where an insured patient cannot go to a hospital that does not carry their insurance so they have to go to a different hospital.

Bobbette Bond:

I am not sure it would mean as much to the insured as an allowable charge. What you are saying is that anything would be a good start, and as the years go by, we can build the website to hit every population group.

Assemblywoman Gerhardt:

Allowable charges will mean something else for each insurance contract, and as for your members, you could show how the information from the website relates to their particular insurance policy.

Bobbette Bond:

I think every insurance company tries to explain to their participants what the participants will be responsible for. Maybe our next step is to talk about what the insurance company is responsible for so the participant understands the cost of care. Either way, getting information about the cost of care is progress.

Chair Leslie:

Thank you. We will appreciate any outside expertise you can lend to us.

Robin Keith:

The Nevada Hospital Association is talking about average bill charges. We need to fix this so we have definitions in the bill.

Chair Leslie:

We need to be very clear if it is average bill charges. What I have from them right now is average charges.

Robin Keith:

The source of confusion is there are two definitions of an allowable charge. One definition is a charge allowed by the insurance carrier. Another definition is what Medicaid allows a hospital or provider to include in the charge. For example, the cost of a television set in a patient's room is not an allowable charge.

Assemblywoman Gerhardt:

But the charge master is full fee for service. That is where everyone starts before all the contracts, before all the insurance . . .

Chair Leslie:

That is why those costs are the highest.

Bill Welch:

What we are talking about through the entire bill is the full bill charges, the average of what the full cost would be. I want to emphasize that.

Chair Leslie:

Ms. Keith brings up a good point. There are so many different definitions that we need to be very careful.

Bill Welch:

The payers have the most complete data on what a patient's liability will be. Assemblywoman Gerhardt was going in that direction. They know who the providers are that their enrollees utilize, and they know what they are being billed for by all providers. They also know the allowable reimbursements for those services. An insurance company, as Ms. Bonds suggested, might need some transparency to help the consumer.

Chair Leslie:

Are there any more questions? Thank you, it has been very helpful. This meeting is adjourned. [3:29 p.m.]

RESPECTFULLY SUBMITTED:

Katrina Zach
Committee Secretary

APPROVED BY:

Assemblywoman Sheila Leslie, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 13, 2007

Time of Meeting: 2:00 p.m.

Bill	Exhibit	Witness / Agency	Description
	A	Committee on Health and Human Services	Agenda
	B	Committee on Health and Human Services	Attendance Roster
AB 146	C	Bill Welch, Nevada Hospital Association	Document titled <i>NHA Draft</i>
AB 146	D	Robin Keith, Nevada Rural Hospital Partners	Document titled <i>Memo to Assemblywoman Sheila Leslie</i>