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

Seventy-Sixth Session
March 11, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 12:06 p.m. on Friday, March 11, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, 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/76th2011/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).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Tick Segerblom, Clark County Assembly District No. 9

STAFF MEMBERS PRESENT:

Allison Combs, Committee Policy Analyst
Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Mitzi Nelson, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Bobbette Bond, representing Nevada Health Care Policy Group and Health Services Coalition
Bill M. Welch, President/CEO, Nevada Hospital Association
Christine Bosse, Chair, Data and Finance Committee; Nevada Hospital Association; and representing Renown Health
Robin Keith, Vice President, Government Relations, Nevada Rural Hospital Partners
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Mastroluca:
[Roll was called.] This afternoon we are going to hear Assembly Bill 160 sponsored by Assemblyman Segerblom, which revises provisions governing the financial reports of certain medical facilities.

Assembly Bill 160: Revises provisions governing the financial reports of certain medical facilities. (BDR 40-559)

Assemblyman Tick Segerblom, Clark County Assembly District No. 9:
I have a few brief comments to make about A.B. 160, and then I will turn the presentation over to Bobbette Bond, who will be joining us from southern Nevada by teleconference. A recent *Las Vegas Sun* investigative series on health care quality, titled "Do No Harm," just received the Goldsmith Prize for Investigative Reporting from the Joan Shorenstein Center on the Press, Politics and Public Policy at Harvard University. The series identified that Las Vegas has the highest concentration of for-profit hospitals of any city of its size or larger in the country, that patients and payors spend hundreds of millions of dollars at these hospitals every year, that the bill charges in Nevada are some

of the highest in the nation, and that most of Nevada's hospitals belong to three large out-of-state national chains. Many of our Las Vegas hospitals are the top earners for those chains. Even if an individual hospital has a bad year, the parent corporation still makes a substantial amount of money. Hospital Corporation of America (HCA), which just raised $3.79 billion in an initial public offering (IPO) of stock shares, is a good example of such a corporation.

In essence, a lot of Nevada's money is being sent to these out-of-state corporations. This bill tries to determine how much money is involved and if there is a way this money could be reinvested in Nevada. I know there is some concern that focus is being paid to a particular industry when other national corporations, such as Wal-Mart, Bank of America, and Union Pacific, are also doing business in our state. There are two issues that differentiate the hospital industry from other national corporations. First, a lot of our state Medicare and Medicaid dollars are going to these hospitals. How much these hospitals make is directly influenced by the state's legislative process to raise money and allocate it to health care. Second, the state budget is always tight and if the hospital system is not working for Nevadans, it would behoove us to try to identify ways to save money.

There are four sections to the bill. As you may know, hospitals are currently required to report their earnings to the state. Unless these earnings are reported on the state website, there is no way for the public to view the data. In addition, an ordinary person cannot immediately see how much profit a hospital took in because the reports are not very clear. Section 1 of the bill attempts to make the reporting process more transparent by putting the information directly on the state website.

Section 2 tries to identify how much money is made by a hospital doing business in Nevada. Each hospital pays overhead to their national operations and these payments are taken into account when the hospital reports their profits. So when the hospital reports how much money they made in Nevada, they also include expenses that are actually part of the national chain's home office expenditures. We are trying to separate out those home office allocation numbers, so that we can focus solely on Nevada. We are also asking that these corporations report their expenses based on Medicare guidelines, which use a different formula. You will hear testimony from the hospitals stating that changing to the Medicare method is unfair because Medicare does not allow them to include all their costs. Nevertheless, it is important for us to know how much these hospitals make in Nevada based upon Medicare principles. We would like this information to be reviewed by the interim Legislative Committee on Health Care so that we may come back in two years with better legislation.

This bill is simply designed to clearly identify how much money is made by the huge hospital chains that do business in Nevada, before they include their overhead, using Medicare principles rather than the formula they currently use.

Chair Mastroluca:
Are there any questions?

Assemblyman Goicoechea:
The two primary providers in northern Nevada, Northeastern Nevada Regional Hospital and Banner Churchill Community Hospital, are privately owned hospitals. There are no public hospitals in this area. If we make it hard for the private hospitals to do business in those communities, there is no alternative for care.

Assemblyman Segerblom:
We have an amendment, to be discussed later, that would exclude the smaller hospitals. This bill would only apply to the large multinational corporations like Renown Health in Reno and others that are primarily located in Las Vegas.

Chair Mastroluca:
Has the proposed amendment been uploaded into the Nevada Electronic Legislative Information System (NELIS)?

Assemblyman Segerblom:
Yes, and I believe a representative from the Nevada Hospital Association will speak about it later in the meeting.

Assemblyman Livermore:
Generally speaking, a large hospital chain has certain services housed primarily at their corporate location for cost efficiency. A corporate allocation charge is not uncommon, even in some smaller systems. The figures you are asking for need to include the corporate allocation cost.

Assemblyman Segerblom:
We are asking to have that corporate allocation cost separated out. This is not a matter of taxation. As you know, corporations do not pay taxes in Nevada. We are asking to be able to identify how much income these hospitals are receiving from Nevada. They can later attribute a portion of their corporate allocation to doing business in our state. For all we know, they are attributing their entire amount of national overhead even if they have three times as many hospitals in California. It is a policy decision for the Legislature to make.

Assemblyman Livermore:
The information you are requesting is available; I have seen it. There is a corporate hospital in Reno owned by Catholic Healthcare West (CHW). It is difficult to run a private business when you have to share your charges, costs, and how you operate your business with your competitors. I understand that you are trying to assess the hospitals' responsibility to the citizens who are paying the fees, but I think that is a separate issue. If you relate this to a business model, it can be compared to a bid where you would generally look at the bottom line. You do not look at every line item included in a bid. For instance, concrete and steel might be cheaper one place and more expensive somewhere else. I think separating out corporate allocations may not give you the information you want.

Assemblyman Segerblom:
That is the policy issue we are asking the Nevada Legislature to make. We are concerned that the hospitals may be over allocating their national expenses to Nevada because that number is not currently broken out.

Assemblyman Sherwood:
It sounded like you said one of the reasons for bringing this bill forward was that these hospitals make profit from Medicare. Is that the case?

Assemblyman Segerblom:
I apologize if I said "profit." I meant to say "income." Much of our taxpayers' money goes to these hospitals. I believe we have a right to question if that money is being spent appropriately. That is the purpose of the bill. I do not know if Medicare is a loss leader, but I am sure the hospitals would be happy to tell us.

Chair Mastroluca:
Are there any other questions for Assemblyman Segerblom? [There were none.]

Bobbette Bond, representing Nevada Health Care Policy Group and Health Services Coalition:
The Health Services Coalition is a group of 24 self-funded plans in southern Nevada that work on health care quality and affordability. We are here to support transparency in the reporting of financial information by our Nevada hospitals. Some of this information is currently provided. However, it is difficult to access and interpret the information and it is also easy to misunderstand the information. I appreciate Assemblyman Segerblom and the cosigners of the bill for bringing legislation forward to make progress on this issue.

We are primarily concerned with the hospitals in southern Nevada. Almost all of the hospitals in this area are part of a large national chain. Universal Health Services, Inc. (UHS) has five hospitals in southern Nevada; HCA and CHW both have three. North Vista Hospital also belongs to a large company called IASIS Healthcare. University Medical Center of Southern Nevada (UMC) is the only community hospital that, while it also takes resources from the community, returns all resources back to the community.

We would like to support pieces of this bill. We also have two suggestions that we would like to see added as an amendment. I do not have the amendment prepared today, but I am happy to have it prepared depending upon the Committee's findings.

I would like to now go through my presentation, (Exhibit C). Page 2 contains a slide that has been presented several times by the Nevada Hospital Association. This slide illustrates the problem that we are having with information communication. The chart on the bottom right of the page shows the total statewide hospital operating margins per year. However, the information is not broken out by hospital or even by hospital system. You also cannot see information regarding the parent company, even when local losses have been experienced. If one hospital has a very bad year, it can heavily impact this graph. For instance, UMC's loss of $60 million significantly pulled down the average hospital operating margin shown on this chart. Yet, this is the graph that has repeatedly been provided to both the Assembly and Senate Committees on Health and Human Services as a snapshot of how Nevada hospitals are doing financially. There was a lot of discussion during the interim regarding Medicaid income, the state budget shortage, and their impact on hospital reimbursement. We think it is very important to provide a more detailed picture on the Nevada Compare Care website, <http://nevadacomparecare.net/>, that is easily accessible to legislators and residents.

The slide on page 3 of the presentation deals with home office allocation. Hospitals in almost every state in the country are already required to report detailed data because of their heavy investment in public funding of Medicare and child health programs. The hospital industry has always been different from regular corporations because of the public funding streams flowing into them. The hospitals in Nevada are currently required to report home office allocation. However, while the report submitted to the state does include the formula they use to calculate this figure, there is no consistency between hospitals when reporting home office allocation. One hospital reports 6 percent of net revenue, while others report 2.5 percent, or as low as 1.85 percent. All of these percentages differ from what is reported to Medicare, which requires each hospital to use a specific formula to report their home office allocation number

and only allows certain expenses to be included. In addition, I believe these reports are audited. There is a federal system in place to capture home office allocation in a consistent way, but we are not currently requiring that system to be used in Nevada.

We created the slide on page 4 to give you a snapshot of the reports made by the hospitals, which compares net revenue income versus home office allocation amounts. This report is for 2009, but the information is reported quarterly. I wanted to you to understand how the numbers look and why we are trying to understand them better. The graph shows net income and home office allocation in millions of dollars by each hospital located in southern Nevada. The lighter shaded bars represent each hospital's home office allocation and the darker shaded bars represent their net income. The most dramatic piece on this chart is Sunrise Hospital and Medical Center, which reported $42 million net income loss and $30 million in home office allocation. We are trying to drill down and really understand how those numbers are created. It is difficult to see how a hospital can lose $42 million and still have a $30 million home office allocation paid to corporate headquarters in Tennessee. This may be valid, but we would like to understand these figures better.

The slide on page 5 of Exhibit C shows information from the Center for Health Information Analysis (CHIA), which is a University of Nevada, Las Vegas (UNLV) agency. This agency is under contract to track all hospital data that comes into the state through hard-copy reports, as well as electronic claims data that is used for the Nevada Compare Care website. This chart shows you what the reports posted to the website look like. While net revenue and operating expenses are reported, the data is complicated and there are dozens of reports to sift through. I am very sympathetic toward the hospitals that provide this information. Unfortunately, the information is not created in a way that makes it easy for either a legislator or a citizen to look at the numbers and figure out how the hospitals are doing and how much revenue remains in Nevada versus how much is being sent out of state. We are also unclear about how much of the currently reported data is audited. It is difficult to know if you are comparing apples to apples.

The final slide contains some information on how other states are handling this issue. Most states require hospitals to give more corporate, local, and state information than a regular corporation would be asked to report. This slide represents an incomplete sample; there are over 20 states that require detailed information. I would like to call your attention to the states of Florida and Indiana, which both have auditing functions built into their reports.

The Nevada Health Care Policy Group and the Health Services Coalition would like to see a bill that requires each hospital to clearly report their profits using the Medicare cost report formula, as well as how much money is sent out of state, so that these reports can be posted to the state transparency website. Additionally, we would like to see the total profits of each hospital's parent corporation. We would also like these numbers to be audited by the hospital or to see some documentation on how the auditing process was performed. Finally, we would like to see a cost-to-charge ratio based upon the Medicare formula. Hospitals already have to report this number; it is not a new reporting requirement. We are not really asking for anything new; we are asking for the way in which these numbers are reported to be restructured so that they are more useful. The cost-to-charge ratio shows how much of the charges billed by a hospital are representative of the actual cost of services provided. I would be happy to answer any questions.

Chair Mastroluca:
Are there any questions?

Assemblyman Goicoechea:
From your chart, it appears that other states require this information from every hospital. Is that correct?

Bobbette Bond:
They probably do and so does Nevada. Even the small rural hospitals report all of this information to the Nevada Hospital Quarterly Report (NHQR).

Assemblyman Goicoechea:
But it seems like the purpose of this bill is to focus on the private for-profit hospitals.

Bobbette Bond:
We support this amendment to focus on this detailed information so that we can do more comparison on the hospitals in southern Nevada.

Assemblyman Hambrick:
Referring back to the fourth slide you presented regarding home office allocation, to what end do you need this information? Why?

Bobbette Bond:
We would like the information so that we can promote hospital transparency. We also believe that the state has an interest in the information because of Medicare and Medicaid expenditures that go to these hospitals. Medicaid has a huge budget that is a major issue for the Legislature this session. We are

interested in making sure the money that is leaving the state for home office allocation is really going towards cost and is not extra revenue that we would prefer to see remain in the state.

Assemblyman Anderson:
Do you know if the hospital chains currently operating in Nevada do business in Florida and Indiana? Are they bound to do this type of reporting in those states?

Bobbette Bond:
Every one of the corporations I mentioned—HCA, UHS, CHW, and IASIS—have hospitals in other states. Some of these corporations have hospitals in a number of other states. I have a map that shows which states have which hospital chains. I would be happy to send that information to you to be included as part of the record. The specific reporting requirements vary state to state. Most states are requiring pretty good documentation about hospital funding, but there is not a lot of documentation about national corporate profits.

Assemblyman Sherwood:
As I understand the system, hospitals that take Medicaid payments are not making money off those payments. I think it is acceptable to be a for-profit hospital. My constituents are happy that we have more hospitals in Nevada than other areas. We need UMC to be healthy; we need everyone to be healthy. If the endgame is to have the State of Nevada regulate the hospitals and tell them what they should be doing with their profits, I would have a real concern with that idea. That practice has not worked in Clark County with UMC.

Bobbette Bond:
I would never dream of trying to regulate the private hospitals in southern Nevada. I think having good transparency and understanding where the money is going is not the same as regulating the hospitals. When the hospitals are continually trying to make sure that the state is well-educated about their profits and losses because they are worried about Medicaid cuts, the state should truly understand how much money the hospitals are losing or making. Some of these hospitals have had rotten years and you can see it when you look at the graph. It is not our intention to head toward regulating the hospital industry with this bill. It is our idea to head toward transparency and a thorough understanding of how much money leaves the state. For instance, while Renown Health in northern Nevada makes high profits, they do not send any of it out of the state. They reinvest their profits back into the community. When resources stay within a community, issues like indigent care can more easily be addressed. If a hospital is able to make it in other ways, they will not have to worry as much

about Medicaid reductions. The Coalition pays over $250 million per year to the hospitals. We are under a lot of pressure during contract negotiations to make sure hospitals can meet their bottom line, because we want them to stay in Nevada, too.

Assemblyman Sherwood:
I can appreciate the fact that we all want better rates on health insurance. The fundamental premise of this is that hospitals are buildings, but it is the doctors who get hurt when Medicaid reimbursements are too low. I have met with dozens of doctors and specialists, from anesthesiologists to general practitioners to pediatricians. These are the folks that are getting hurt. It is not all about the hospitals. The health care professionals who have privileges in many of these hospitals are the ones who perform the surgeries. That is a part of the equation that needs to be addressed. If we do not, we have missed the mark.

Bobbette Bond:
We are very sympathetic to what is going on with Medicaid physician reimbursement rates. We are also sympathetic to the hospitals, which are also paid by Medicaid. There is concern on both levels. We are not asking the doctors to do any piece of the reporting required by this bill. The doctors all live in Nevada and reinvest all of their resources as members of their communities.

Assemblyman Livermore:
Referring to page 4 of your presentation where you discuss home office allocation, it is difficult for me to understand which corporation owns what hospital. Is CHW, a 501(c)(3), included in this list?

Bobbette Bond:
Catholic Healthcare West owns three facilities in southern Nevada and one in northern Nevada. They own the St. Rose Dominican Hospitals system. They are headquartered in San Francisco and are classified as a not-for-profit hospital. They do generate quite a bit of revenue that leaves the state.

Assemblyman Livermore:
My point is, CHW came to northern Nevada and took over a failing hospital, St. Mary's Regional Medical Center, investing a huge amount on infrastructure. How does CHW get credit for what they have done for that community? Even if they have taken revenue out of the state in southern Nevada, look at what they have invested and continue to invest for the benefit of the patients in northern Nevada.

Bobbette Bond:
You make a very good point. I think a part of the bill that I did not address focuses on the community benefits that hospitals provide. There is a provision in the bill to try to more carefully track these benefits as a percent of revenue. I did not address that issue. There could be an entirely separate bill draft regarding how to make community benefit reports more useful. The hospitals in Nevada do a great job of making sure there is enough access to medical care; we just want to make sure that there is as much infrastructure and support of local Nevada as possible.

Chair Mastroluca:
How much of the information that you want to compile to create more transparency does not already exist? Is there anything that is particularly new? Are you trying to get the same information in a more concise, uniform manner on a hospital-by-hospital basis?

Bobbette Bond:
With your permission, I would like to speak to our interests rather than how the bill is currently written. I do not think that any of the information is brand new. I think all the requested information exists in a report somewhere inside the Division of Health Care Financing and Policy or can be found in the archives of the Nevada Legislature. It is difficult to find, however. While using the home office allocation formula provided by Medicare would be new to Nevada, these figures are already being reported at the federal level. The new issue would be requiring hospitals to report corporate profits. If you are a researcher and have time to analyze HCA's financial statements, you can get that data, but it is harder now that they are privatized. This information is not easily accessible in Nevada.

Chair Mastroluca:
Does anyone else have any questions for Ms. Bond?

Assemblyman Brooks:
I would like to go back to the third slide of your presentation that demonstrates net revenue income versus home allocation payments. Are you basically stating that the information on a graph like this, which depicts Sunrise Hospital and Medical Center losing $42 million dollars while contributing $30 million to their home office, is confusing because we do not know whether the $30 million is part of the $42 million? Do we think there was actually $72 million in revenue? Are you saying the current graphs are terribly confusing, you do not understand them, and you are looking for clarity?

Bobbette Bond:
That would definitely be helpful. I created this graph, so if it is confusing that would be my fault. From the data included in their report, it appears to us that Sunrise is reporting a $42 million loss after they sent $30 million in profit to their corporate headquarters. That is what we would like to clarify.

Chair Mastroluca:
Are there any other questions? [There was no response.] Ms. Bond, did you have anyone else that you intended to testify in support of this bill?

Bobbette Bond:
No, I am solo today. Thank you very much for all the time you allowed me to speak.

Chair Mastroluca:
Is there anyone else who would like to testify in support of A.B. 160? [There was no response.] Is there anyone who would like to testify in opposition to the bill?

Bill M. Welch, President/CEO, Nevada Hospital Association:
I have with me today, Christine Bosse, the Chair of the Nevada Hospital Association's Data Finance Committee. We asked that committee, which has much more technical expertise and understanding of these issues, to review the bill. With your permission, I will ask her to walk through the technical pieces of the proposed legislation.

I would like to make some opening comments prior to that presentation. Also, I would like to acknowledge that I did sign in both as opposed and as neutral to the bill. As has been testified and demonstrated today by the proponents of this legislation, much of this information is already available. It may not be available in the format in which the proponents would like to see it, but the information clearly is there. The proponents of the bill have been able to extract this information to demonstrate the points they wish to make. The question is, do we ask the Department of Health and Human Services (DHHS), or other appropriate agency within DHHS, to go through the information that is already being reported and ask them to extract and reformat the information in a manner that would meet everyone's needs?

I would also like to make a couple of comments. In the 1970s and 1980s, I served as Chief Executive Officer (CEO) of a hospital in Elko. At that point in time, there was a public hospital in almost every community in Nevada. Today, public hospitals operate in less than half of the communities in the state and there is only one public hospital in urban Nevada. The reason for this decrease

is the financial challenges and difficulties that have been faced by the hospital industry for many years. We can express concern over that fact that we have many private hospitals in Nevada, but I would suggest that we might not have any hospitals at all without our private hospitals. In fact, more than 85 percent of the beds in Nevada are associated with either a for-profit or not-for-profit private hospital. On the occasions when I or members of my family have had to utilize the hospital delivery system in Nevada, we have been appreciative that health care services were available.

My overall position with respect to this legislation is that the information is already there; Mr. Duarte and Ms. Bosse can both speak to this fact. We oppose the idea that the information already reported might be used to suggest that our hospitals' bottom lines or charges are different than what is reported. That is concerning to us. Medicare does not recognize much of our costs. For example, Medicare does not recognize the costs incurred by the hospital to ensure that there are physicians on call and available for services. Medicare sees that as a different cost center. Even though hospitals have to pay physicians to be on call and available to the patients that we serve, this is not acknowledged as a hospital cost because Medicare pays physicians directly for their services. We are concerned that any methodology Medicare would use to try to determine a bottom line is flawed because it is based upon reimbursement rather than cost accounting principles. We are also concerned as to what the use of the data is really aimed at. We do not know if the law allows the revenue generated by a for-profit Nevada hospital to actually be taxed in the state where their corporate headquarters are located. We are trying to clarify that issue; however, we see this as an issue with every industry doing business in Nevada, not just as an issue to be imposed solely upon the hospital industry. How much of the business in Nevada is foreign or based out of state? Most of it is. If we need to look at this issue, we also need to look at the resort, retail, and restaurant industries. There is not an industry in this state, other than local mom-and-pop services, that is Nevada based. If out-of-state corporations are an issue, every industry in the state should be included.

Home office allocations could also be termed "shared services." This information, though available, necessarily varies from system to system because each corporation shares different services. Some of the shared services could be business office functions, human resources, information technology, and legal expenses. There is not going to be one consistent percentage for all corporations. The percentage charged depends upon which systems are being shared in order to promote efficiency. There is absolutely a benefit involved when a corporation shares systems. Hospitals are not the only segment of the market using this method to support efficiency and reduce costs. Any industry in Nevada that is part of a national or multi-delivery service is sharing expenses.

The Culinary Union probably has shared expenses, because it makes sense to share costs whenever you can.

I have provided a slide for you on NELIS (Exhibit D) showing the average cost per adjusted inpatient day. You can see that these costs are less for system hospitals than for stand-alone hospitals, because they are able to work off of efficiencies. There is a fairly significant difference. Do we really want the hospitals to be less efficient? The Nevada Legislature is currently looking at ways the state can be more efficient by sharing services and functions more economically. It makes sense.

The second slide of the exhibit deals with earnings and capital investments made in Nevada. We went back four years, because the data is readily available from a community benefit report that is required as a result of the passage of Assembly Bill No. 146 of the 74th Session in 2007. You can see the net earnings of the hospitals represented in light blue. During that four-year period, there are stand-alone hospitals and hospital systems that made money. You can also see, represented in dark blue, the amount of money these hospitals have reinvested. There is not one hospital in Nevada that did not invest more money into the state than they have been able to generate in earnings. Even if we look back over the past 10 to 15 years, I believe this trend would be observed. How many new hospitals have been built in Clark County over this time period? We are not only investing the actual buildings of these hospitals into the community, I would suggest that there has also been hundreds of millions of dollars worth of jobs that have been contributed to Nevada's economy.

Another slide I would like to present deals with Medicaid (Exhibit E). I do not have any qualms about our hospitals being accountable. We do receive Medicaid payments. In fact, the total actual cost to provide services to Medicaid patients in 2009 was in excess of $443 million. Broken down, the federal government funds about $168 million, the state funds a little over $95 million, and the hospitals are funding almost $180 million of these uncompensated costs. I would suggest to you that hospitals are pretty good partners when it comes to ensuring that care is available for Medicaid recipients. The hospitals pick up a significant portion of these costs.

Going back to the slide, $25 million of the state's total available funding came from the Fund for Hospital Care to Indigent Persons, also known as the Indigent Accident Fund (IAF). The IAF was created as a collaboration between local counties and the hospitals over 20 years ago to help offset the cost of uninsured individuals with catastrophic medical conditions who were not eligible for any other social service program. That money was swept from the hospitals

during the 25th Special Session (2008) and has continued to be swept since. Due to this, hospitals now absorb more than 50 percent of the cost to cover the care of Medicaid patients. Again, I would suggest that the hospitals have been pretty good partners to the State of Nevada when it comes to addressing the needs of Medicaid recipients.

I have provided an additional slide dealing with unreimbursed care (Exhibit F) that includes data from the NHQR which can be extracted by individual hospital. I have been asked to do this report for many individual hospitals and I pull this information from the NHQR. While I gave you a summary of the hospital industry as a whole, I could provide the same information for each of the 33 short-term, full-service, acute care hospitals in Nevada. As you can see, Nevada hospitals are in a very difficult situation. Yes, we do have some hospitals that have a positive bottom line, and thank goodness that we do. However, 20 out of the 33 full-service acute care hospitals in the state are currently operating at a loss. I am very concerned with the trend of proposed legislation that will only increase our costs while our industry is also faced with proposed additional cuts on hospital funding. We read in the newspaper that UMC is in big trouble right now. That hospital provides critical services to the community and we need it to stay in business. There are a lot of other hospitals in trouble, as well.

I will close my comments and turn the discussion over to Ms. Bosse, who will go through the bill in detail showing you how the information requested by A.B. 160 is already available. Perhaps the solution is to direct the state on how to extract the information and make it readily available. I would like to make one final comment. I think that it is interesting that A.B. 160 references Assembly Bill No. 146 of the 74th Session, which created the transparency requirements. The Nevada Hospital Association worked with the sponsor of that bill back in 2007 and actually produced much of the data prior to the state having the ability to post it. We have made the information readily available and continue to expand and grow. We will be unveiling a significant enhancement to our website within the next 30 to 60 days and hopefully will have to opportunity to come back and show you what that looks like. However, it is interesting that the focus continues to be placed upon the hospital industry when other industries included in the referenced legislation have not posted any information toward becoming compliant with the transparency requirements. Perhaps we need to look at Assembly Bill No. 146 of the 74th Session and make sure all of the original intent is being met rather than just focusing on the hospital community. I will be happy to answer any questions.

Chair Mastroluca:
Are there any questions?

Assemblyman Livermore:
Can you talk about how the new health care reform will potentially affect acquisitions, mergers, and consolidations of hospitals throughout the country?

Bill M. Welch:
While there are many pieces of health care reform that we think have value, there are some pieces that concern us. Medicare does not recognize our full costs and we think that we can clearly demonstrate that concern. Medicare contributes to some of the negative operating margins currently experienced. Medicare is freezing hospital reimbursement rates for the next ten years. It would be nice if costs did not increase during that time period, but they will increase. Most costs are associated with the labor force: nurses, nurse assistants, technicians, housekeeping, and others. The hospital labor force is not going to be willing to continue working without some increases in compensation.

Hospitals will have to become even more efficient. The industry will see more centralization and coordination in an effort to continue to remain viable. I would predict that the stand-alone hospital is going to be hard-pressed to make it in the future without some type of assistance. If you look at rural Nevada, most individual hospitals there have had to look to an outside entity to ensure sustainability or have had to form taxing districts to maintain their hospitals. You will see this trend continue as a result of health care reform.

I can tell you that Nevada hospitals are doing the best they can to manage their costs. The national trend on hospital costs is currently running a little over 6 percent. Our hospitals have been managing cost increases to keep our costs in the range of 5 percent, which is a little better than the national average. Unfortunately this is not enough, because we are still operating at close to a 4 percent loss in Nevada, while hospitals nationally are making a 4 percent profit. One hospital is not driving that average. There are 20 hospitals in that category.

I did not touch on the many services that are impacted by operating at a net loss. The second page of the last handout I mentioned contains information on real services that affect real people which have had to be closed as a result of the economic environment our hospitals have been dealing with over the past two years. I will be providing information to the budget committees showing additional services that have been closed subsequent to this handout. I now actually have hospitals . . .

Chair Mastroluca:
We would like to stay focused on A.B. 160 and the issue of whether or not additional reporting is needed and necessary. I understand your concern and issues, but I do not want the discussion to cross into fiscal issues. We will move on to the next question.

Assemblyman Carrillo:
You mentioned transparency for other businesses, such as resorts. How many of those businesses accept federal money for services rendered?

Bill M. Welch:
I could not answer that question, but I can tell you that a high percentage of the population in Nevada relies on Medicaid, Medicare, or other social services. This population spends money in the state. While other businesses may not get direct federal funding, they get indirect benefit from doing business in Nevada and having that population utilize their services. There are some not-for-profit hospitals that do receive a fair amount of money and past legislative sessions have suggested that they should have some accountability, as well.

Assemblyman Carrillo:
I feel my constituents want to know where their tax money is going. Is it staying in the state? Will it provide more jobs? You spoke of construction jobs. I know of many people who are out of work because of the downturn in the construction industry. Overall, people want to know where the money is going.

Chair Mastroluca:
Are there any other questions?

Assemblyman Brooks:
You mentioned that you proposed much of the information that was requested in this bill. At one point you stated that the information is available and DHHS can decipher it. If you are already reporting this information to us, it seems you or the hospitals could decipher it. Why would we leave that incumbent upon DHHS?

Bill M. Welch:
I do not believe that we proposed collecting the information. I was trying to say that the information called for by the proposed legislation is already available. I am concerned with creating duplicative legislation. It might be easier to redesign the system so that we do not have to do duplicative reporting. Our concern is that, although some information may have to be extracted to be posted in the desired format, the information is already available. We should make sure that we do not create requirements to report the information in one

format in one location and then have to report the same information in another format in different location.

Assemblyman Brooks:
If that is the case, it would probably be best if we receive the information initially in a format that is understandable to the common person. My constituents want transparency too. Transparency is the term of the day with educational expenditures, taxes, Medicaid, and Medicare dollars. I would ask that you would carefully consider what you are asking us to do and then carefully consider what this bill is asking you to do. It is asking you to make the information more user friendly to laypeople.

Assemblywoman Pierce:
You asked us to refer to Assembly Bill No. 146 of the 74th Session. Was that from 2009?

Bill M. Welch:
That bill was from 2007.

Chair Mastroluca:
Are there any other questions? [There was no response.]

Christine Bosse, Chair; Data and Finance Committee; Nevada Hospital Association; and representing Renown Health:
We thought it might be best if someone went through the bill section by section (Exhibit G). Section 2, subsection 3 on page 4 of the bill basically adds reporting requirements for each hospital that has fewer than 100 beds. I know there is testimony that will be presented today to address this issue, so I will not discuss it. However, that section is of significant concern to us.

Section 2, subsection 3, paragraph (a) deals with the reporting of net revenue costs. This information is reported in the NHQR, filed 30 days after the end of each quarter, and aggregated at the end of the year. The state then provides the information on an annual basis by facility. The NHQR fiscal year aggregate is either directly tied to an audited financial statement or tied to our audit using agreed-upon procedures. A third party does audit the information that we provide in the NHQR. I wanted to make sure you understood this. We do not have any concern with the request under this section, because we already provide the information.

I am not clear that net revenue is the figure you want to consider; what you probably intend to look at is net income. However, I am not sure if it makes sense to look at net income and then add in the cost of shared services. Shared

services are costs that the hospital purchases from their corporate office and may include a centralized business office, finance, human resources, or other services. You would probably want to add it back to net income as opposed to net revenue, because it was never originally subtracted from net revenue.

This same section of the bill says, "The Director may prescribe the manner in which the net revenue of a hospital must be calculated for purposed of this paragraph." We are concerned that this language may be confusing. Currently, the method used to report our income is based upon generally accepted accounting principals and is audited. If side calculations are to be done, it may not be of service to create multiple ways to look at the data.

Section 2, subsection 3, paragraph (b), subparagraph (1) deals with reporting the amount of corporate home office allocation. That information is already reported in the NHQR; we are fine with that section. Subparagraph (2) requires us to provide the methodology used to calculate home office allocation. That information is also already provided by the NHQR. The NHQR and the home office allocation are audited every other year. Our home office allocation methods are audited biannually by a third party auditor hired by the state. I believe Chuck Duarte of DHHS has a sample report that shows the five or six elements that are audited, including the home office allocation methodology.

This subparagraph also requires that the home office allocation be reported using the same method allowed by the Medicaid and Medicare cost report. This is a different methodology which is used for a different purpose. The Medicare cost report is intended to line up our costs with how Medicare pays us. We do file our Medicare and Medicaid cost reports with the state and federal governments, so that information is available. However, this methodology does not include all of our costs, by any means. I will highlight a couple of differences. One of the key differences is that Medicare's methodologies can use allocations made after the fact. They might request a time study, square footage report, or actual number of bills produced. On the cost report, they might look back and ask, "How much of those shared services did you actually use?" Then they bring that information into the cost report. The allocation methodology we use is an estimate that, on average, is fairly accurate for the purpose of paying for shared services. Medicare's point is, "I only want to pay you for the piece you used."

Another quirky Medicare rule requires us to offset any revenues received on certain administrative expenses. They look at our costs netted after any revenue is received. For example, we really spent the money for cafeteria services, but the cost report requires us to net it down before we show net

costs. You can see this method reports the data differently and does not reflect the actual money spent by the hospital.

Section 2, subsection 3, paragraph (b), subparagraph (3) requires any amount of home office allocation that was disallowed by Medicare to be reported. Again, that information is already available by comparing the home office allocation included in the Medicare cost report to the share of home office allocation reported in the NHQR. The difference in the two amounts would equal the amount disallowed by Medicare.

Chair Mastroluca:
When you refer to the information being available in the Medicare and Medicaid report, is that the state report or the federal report?

Christine Bosse:
I believe we file both of those cost reports with the state; but at the very least the Medicaid report is filed with the state. The state has this information in their possession and it is available under the Freedom of Information Act (FOIA).

Chair Mastroluca:
Have you ever filed to receive information under the FOIA?

Christine Bosse:
Yes.

Chair Mastroluca:
Can you tell me approximately how long it takes to get the information?

Christine Bosse:
There is a specific time frame. Once an information request is made in writing, I believe the response time is 30 days.

Assemblyman Anderson:
The common refrain that I am hearing is that the information requested by this bill is already available. Maybe the part of the bill we should be talking about is section 2, subsection 7, paragraph (b), which states that the information "Must be in a form which is readily understandable by a member of the general public." Could you comment on that?

Christine Bosse:
I hear what you are saying. My intention was to go through this bill and highlight each section. We do not agree with reporting our home office

allocations using a method that does not represent all our costs. I hear what you are saying and agree. I think most of the information we already provide could be assimilated into such a report.

Assemblyman Anderson:
I just wanted to get that on the record.

Bill M. Welch:
I would like to state that we have met with Assemblyman Segerblom and have offered to sit down and try to work through the bill to figure out the easiest way to get this information without creating a duplicative process. Much of the information is already reported.

Chair Mastroluca:
Before you go on, Ms. Bosse, I do not see the point of going through the bill section by section. If would be helpful if you could speak only on the items you do not think should be reported or other issues that you believe are incorrect in the bill regarding the requested information.

Christine Bosse:
I do not believe it is appropriate to use the Medicare allowable costs for the purpose of defining hospital costs, because they are not all-inclusive of the actual costs of providing care. In addition, I am not clear that there are any taxes paid in another state that would be attributable to home office allocations in this state. These are shared services where expenses are actually incurred. That is a significant issue that we would want to work through. We believe the information requested by section 2, subsection 3, paragraph (b), subparagraph (5), which asks for the percentage of the corporate home office budget paid by the hospital in Nevada as well as every other hospital within the hospital chain, is not currently available. We also believe that it is the services provided by the hospitals doing business in this state which are truly relevant. Section 4 of the bill deals with studying home office costs and determining if a new hospital tax is appropriate. We would have significant concerns about this section because the home office allocation represents actual costs sustained by the hospital. We are trying to be more cost effective by utilizing shared services.

Chair Mastroluca:
Are there any questions? Is there anyone else who would like to speak in opposition to A.B. 160? [There was no response.] I would now like to hear from Robin Keith, from Nevada Rural Hospital Partners, regarding her proposed amendment.

Robin Keith, Vice President, Government Relations, Nevada Rural Hospital Partners:
I am here to present an amendment to A.B. 160 (Exhibit H), which is posted on NELIS. The amendment restores an existing exemption for small hospitals. As Assemblyman Segerblom indicated, he and I have discussed this issue and I would like to thank him for agreeing to this amendment. Under current law, hospitals with 100 beds or less are exempt from the reporting requirements outlined in *Nevada Revised Statutes* (NRS) 449.490, which among other things, currently includes a requirement to report community benefit. Assembly Bill 160 adds new reporting requirements. The accounting and administrative efforts associated with these reporting requirements are substantial. In the past, small hospitals were exempted because the benefits derived from their reports do not outweigh the cost of isolating, gathering, tracking, and reporting the information. Without the amendment, small hospitals would have to invest substantial effort and cost. We are asking that the exemption be restored through the mechanism indicated in the amendment. If it is of interest, I have additional testimony. However, given the discussion, I think what I have said is perhaps enough.

Chair Mastroluca:
Does anyone have any questions? [There was no response.]

Charles Duarte, **Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:**
I work for the agency that administers the Medicaid program. I will not dispute any of the information made in this meeting regarding Medicaid. I am not an expert in hospital accounting and the associated mechanisms thereof. I am here today to provide information on a fiscal note that DHHS has attached to this bill. We are requesting approximately $155,000 from the State General Fund to provide one staff person to help administer this program. This employee would consolidate the information that is already available, gather new information, and develop reporting formats with the hospitals to post the information on the website. The second part of the funding is associated with contract services for the Center for Health Information Analysis, the UNLV agency that would administer the transparency website.

I will add that today's discussion will significantly change this fiscal note. Some of it may reduce costs and other changes may add costs. Ultimately, any amendments or revisions accepted that include new auditing or reporting requirements may add to the cost of the bill. The elimination of reporting by hospitals having fewer than 100 beds may slightly reduce the cost. Nonetheless, there will be a fiscal note associated with this bill. Rather than dwell on the existing fiscal note, I would prefer to wait and see what

amendments are approved so that we can determine what the potential cost may be.

Chair Mastroluca:
Can you let me know when you submitted the fiscal note? A fiscal note is not currently associated with this bill.

Charles Duarte:
It was an unsolicited fiscal note and I am not sure if was posted in time.

Chair Mastroluca:
We do not have a copy of it, so we will make sure that the Committee gets a copy of what has already been submitted. If the fiscal note changes based on the conversation today, we will make sure any additional notes are also posted. Are there any questions for Mr. Duarte? [There was no response.]

Is there anyone else who would like to speak on A.B. 160? Are there any comments from the Committee? [There was no response.] I will close the hearing on A.B. 160. Is there anyone present for public comment? Seeing none, I will adjourn this meeting [at 1:28 p.m.].

RESPECTFULLY SUBMITTED:

_____
Mitzi Nelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: March 11, 2011 Time of Meeting: 12:07 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 160	C	Bobbette Bond	PowerPoint Presentation from Nevada Health Care Policy Group
A.B. 160	D	Bill M. Welch	Average Cost per Adjusted Inpatient Day
A.B. 160	E	Bill M. Welch	Nevada's Medicaid Story
A.B. 160	F	Bill M. Welch	Condition Critical
A.B. 160	G	Christine Bosse	Testimony from Bill M. Welch
A.B. 160	H	Robin Keith	Proposed amendment