MINUTES

ASSEMBLY COMMITTEE ON HEALTH AND WELFARE
SUBCOMMITTEE ON SENATE BILL 194
MARCH 24, 1977
2:45 p.m.

Members Present: Mr. Robinson, Chairman
Mr. Ross
Mr. Weise

Guests Present: David R. Brandsness, Administrator
Sunrise Hospital
Fred Hillerby, Executive Director
Nevada Hospital Association
Gene Leverty, Chief Deputy
Insurance Commissioner
Dave Nicholas
Health Insurance Administrator
Dick Rottman
Insurance Commissioner
Roger Trounday, Director
Department of Human Resources
Orville A. Wahrenbrock, Chief Assistant
Department of Human Resources
Franklin M. Holzhauer, Chief of Planning
Department of Human Resources
Myrl Nygren, Administrator
Office of Health Planning and Resource Developmen

Robinson: Now getting to the main jist of why the subcommittee was appointed. It was the concern that we had and some of the things that have been brought to our attention by the two directors of the Health Systems Agencies, plus representatives of the hospitals, and others, regarding the budget of the Health Planning and Resources for the contracting of the certificates of need. The feeling of the HSAs was that if health planning is going to be health planning, it should be done entirely in the health planning agency. The two HSAs felt that the state agency which they will pass their information to after they have done their groundwork should be the one that will review the information. The number of certificates of need that were being done, roughly 15 a year, was putting a pretty high price tag on what was being done. We just denied them a bill to give them data collecting ability. This is why I wanted to have the meeting to find out if an in-house system can be just as desirable or perhaps more desirable and might leave some money left in Health Planning and Resources to use for the other health statistical studies that we are hoping to get. The bill as it passed the last session authorizes you to go in and get the financial disclosure of hospitals and nursing homes - health care facilities.

Nicholas: There is an annual report required by the financial disclosure. Since this law came into effect on April 1, 1976, its first full year of operation will not be over until April 1, 1977.

The facts and figures available for the October 1 report requested in that bill would not have been a first full year of activity.

Rottman: One other thing, Dr. Robinson, is that in trying to put that together, we have had some difficulty in getting the data, quite frankly, so it would be comparable.

Robinson: But whatever data are gathered as public information, it should be available anyway. Yet, if you are not on a contract to be paid to review, it appears to me you are using the money from the Health Planning agency to finance something that is mandated to you by something else - by the other bill. Do you need all this money to do the little bit of extra work you would be required to do?

Trounday: I don't think this is a very small task.

Holzhauer: Could we demonstrate the rationale in making the decision to go into a contract with another state agency? I think it will clarify it somewhat because it is a complicated issue. I thought it could best be described graphically by giving you a chart (Exhibit A) to show the steps that we took and the thinking that went into the reason we went into a contract. We had a state agency that had some of the responsibilities that we had and rather than having them do part of it and we do part of it, it made sense to have one state agency provide the information and the activity that was needed. This chart takes the mandates of 449.440 which is the S.B. 388 that was passed last session. The CON means certificate of need, and 1122 is the federally mandated oversight and the spending of Title money. All of these three activities require, and is the first statement in all of them, cost containment. They may be worded slightly different, but the main purpose is cost containment. The Federal Act under 1122, any state act under the old CHP agency, certificate of need and the new Health Planning Act, and this bill here today - all of them say cost containment. The basic difference between the three is that the certificate of need and the 1122 are only done upon request or application. The other under insurance activity is an annual requirement of State law. Because of that, we feel that they are doing things that when we go in a second time, it's infringement; it's duplication; it's information that has already been gathered. We don't need to go in and do it twice. On the second page - advantages - just one agency gathering financial information. If they have got all the financial information, why do we have to go out and do it again. They are mandated to do it. No matter if you take it away from them or not, they are still going to have to do it, and we are going to have to do it. They have legal authority - much, more firm legal authority than we do.

They can actually go in and fine people for not giving information. The concentration of expertise in financial analysis is related to the fact that this particular agency in health planning does not have this kind of staff. It does not have its own lawyer. We can only have one person qualified in this office to do fiscal analysis. They are in this business. They know what they are doing, and they are experts at it. Number five is the possible elimination of duplicate reporting under the Hill-Burton Act. Under this, the new Health Planning function for the federal government, the Hill-Burton, is combined with the old CHP agency. The next side is just a further explanation of what I have in the briefer formats and basically says the same thing. We are contracting with the insurance division to carry out the functions as recommended. The contract is pretty tight. It takes all of this and then lays out all kinds of different functions that have to be formed in accordance with the law. It comes back to the State Health Planning Agency to see that it coincides with the health plan as their recommendations which were double checked. The approval or disapproval or denial is made by Mr. Trounday as the director of the department who is the designated agency by the federal government.

Weise: I think that some of the problems that we have had were right here too. One is your initial statement is that they have got all the information. I think the concern that we have here is to what degree is the insurance division the recommending authority in health care instead of the Health Service Agency. Obviously, concern has been expressed by people involved in HSA and providers who are also under a different set of guidelines in the Insurance Division from a commerce standpoint rather than a health care standpoint. I think some of their concerns are that it is a mix.

Holzhauer: I don't think it is a mix. I think it is a real cooperation and coordinated effort. We work together so that we don't have to do duplicative work.

Trounday: They made some of the analysis on the fiscal and the need basis along with the economic sense, and they provide that information. But we also over here have been gathering information on the client and at that point we put it all together. If we already have an agency that is going out gathering a lot of financial information, and if we can work an arrangement with them and give them some additional bucks to expand on what are specific needs, why should we have to send our people back and retrace all the steps that are necessary.

Robinson: Perhaps you don't understand. In looking at this chart, if these things are all required and they are already doing them, and that was mandated, what additional things are you asking for

here that they are not doing that would justify say $6,000 or $7,000 a year? You must be asking them for more information than they are getting in this column.

Trounday: Well, we are asking for additional information, but we are also giving them. We need to do this as a State. I think this is physically impossible for the Insurance Division to adequately go out and do an annual report for every hospital in this State and then also have some other agency go out and do the other thing without giving them some financial support.

Robinson: Let's go back to when this thing was passed. Did we appropriate the money for you to do these things?

Rottman: It is woefully inadequate to do a decent job to make a decision with regard to significant capital expenditures. If we had to do in effect all of that with the limited budget that you gave us last time, there is just no way we can do it with any kind of thoroughness.

Robinson: In your budget this year, do you have anything inside of your budget to help with this?

Rottman: No, we have got basically a carryover of the previous equivalence built into the budget.

Trounday: We think we have a good working relationship and a good arrangement to accomplish our overall goal which is to carry out the federal law.

Weise: I have removed myself from the dollar figure because that is up to them to get the money from the money committees. Initially that was an interest of mine, but that's not my problem. My only concern is to what extent the regulative function of the Insurance Division is.

Robinson: Go ahead and turn the tape off because Ian (Ross) does have some questions that we want off the record. (tape off)

Leverty: I think we should understand that the Insurance Division is a regulatory body and with regard to the particular law that we enforce in gathering the information, we deal with it in a regulatory fasion trying to enforce the laws as we see it.

Weise: Being familiar with what is involved with the certificate of need, what additional information above and beyond what Dick's office does now would be necessary?

Hillerby: There are a lot of things that are necessary to good health planning. You must know that size and growth of a community that's going to be served and those kind of projections that are made that this does not address. You have to know the location and types of services that are available, and obviously, you can extrapolate that from that data they have. You have got to know some utilization statistics - that's also data that is not necessarily available just through financial data. Financial data about existing hospitals is not enough information, and that isn't going to answer the question. It's only a part.

Nicholas: It's only supposed to be a part. You know that, Fred.

Hillerby: That's what I'm saying. We're looking at more than just hospitals. It seems to me though that a lot of this money is given to collect data about existing facilities and it's not going to do us a lot of good when you start looking at a new type of delivery system, not just in the hospital, but a new type of system.

Rottman: It really dovetails in here in exploring ways of trying to develop health care services at perhaps a lower cost.

Hillerby: We need to address the needs of the areas as to what the health planners are really solving. I am very disturbed about the statement I just heard a minute ago, and I'll get to it in a second. There is additional data that's needed, and yet a significant portion of the money that's available to do this whole process is going to develop just one segment of that data, and that's financial data.

Ross: Where's the money coming from.

Trounday: We are talking about a $289,000 budget, and we are contracting out $63,000. The balance of that money is going to be getting a lot of the other kinds of activities on through our health planning organization. But we don't have to be duplicating what to me appears is being done by another agency.

Hillerby: The statute says that the stuff is available to you and I as a citizen as well as your agency.

Trounday: But the fact is, we don't feel after sitting down and discussing it, they were going to have to shore up in order to do their job adequately.

Hillerby: At first, I heard the comment there might be some need to provide some money to buy the data from them. But it appears to me that it's going well and that perhaps what you just said is

that you would have to subsidize them so they could even do more than what they were doing at the time.

Trounday: Not out of health planning. The same money would have to be used or probably even a little more money would have to be used if we were collecting this financial data.

Hillerby: I would hope we would not duplicate what they were doing even if it was in your shop.

Rottman: Fred, I'm a little bit confused. I'm kind of getting the impression that you people are suggesting it's a sort of a real hazy thing out there.

Hillerby: If the two health planning agencies are so underfunded that they need all the help they can get from the State.

Weise: (Excused himself to attend the Labor and Management Committee meeting.)

Brandsness: I cannot envision going in for a certificate of need and not now having to deal with both agencies because if health planning is going to exist, there are multiple factors that are not listed on your check sheet here which your agency is going to analyze. There a multitude of other issues that have to be looked at. So now you are asking me as an administrator of a hospital to deal with. You are going to be transferring information to him, and I can't imagine him issuing a certificate of need for a recommendation back to you without my being involved with him. Now once again, you are forcing hospitals to deal with multiple agencies, and we have too much of this right now.

Trounday: Well, in reality that isn't the functioning that you would end up having because if you have it all in one office, you certainly are not going to have a planning and regulatory deal with the same people in the same situation. They're either going to be dealing with certificate of need at a given process that deals with the application itself and then it's up to us to mash that wish the information that we've already established through our planning function. So I think in the everyday situation, it isn't going to work in the way that you're referring to.

Brandsness: Roger, planning without certificate of need is like going to the movies with your sister.

Trounday: Well, I can't agree with that. That's been one of the problems we've had in this State all along. We've had the regulatory and planning being in the same shop and so what basically comes along is that we have had zero planning basically because

the regulatory immediate situation gets into the picture, and it's dominated it in this State.

Hillerby: But is the implementation chart of the federal law in this agency.

Trounday: Certainly, it is.

Holzhauer: It says specifically in the federal law two distinct staffs - one for planning and one for regulatory.

Hillerby: But this states that if there is duplication if we go to the HSA as a hospital, that's our fault. We should only come to you.

Holzhauer: You don't have to go to the HSA. Your application from the hospital need only come to the state agency. If the HSA feels that the application is incomplete for the HSA area for 1122 or certificate of need, they can come and ask you for additional information.

Hillerby: We don't have to give it to them. They're not granting the certificate.

Holzhauer: That's right. And it says so in the law you do not have to give it to them.

Hillerby: But yet the HSA reviews and comments on the application.

Holzhauer: Yes - on the application. That's the word, and if we don't supply the HSA with adequate information, it is our problem.

Hillerby: So we're playing a game then, aren't we? We're going to go through all this process at the local level to help develop a plan that can be made the State plan. We have no control over the thing whatsoever.

Nygren: What kind of control are you looking for?

Hillerby: I want to have some of the input. What's the use if they don't even have to come to me as a planning agency, as a local agency?

Holzhauer: And they are a planning agency. They are no longer a regulatory agency.

Hillerby: Except from the standpoint of grants.

Holzhauer: Yes, but still grants come to the fact of what they've done. They've given the locals authority over $8,000,000 of federal grant money that normally used to be the State's responsibility to oversee. Now that's the responsibility of the HSA. But they took away from the HSA that authority to regulate the certificate of need.

Robinson: Well, isn't that an awful lot of waste of money?

Holzhauer: That's in program implementation like Crippled Children's Services and that kind of thing, not construction or new equipment.

Robinson: We talk about these certificates of need so much that we forget all the other things.

Holzhauer: We are talking about financial feasibility and the whole cost containment business. That's a fiscal matter. The matter regarding the contract, in my personal opinion, is a matter of budget and administration and is given to the state agency to contract with any place they want to in the Administrative Procedures Act, if the Governor and the Budget Office so agree. We can contract with anybody as long as it's approved by the Board of Examiners or the Attorney General.

Ross: It seems the conversation is evolving around are we talking about what is going to be more convenient for the State, or are we going to talk about what is more convenient for the hospital?

Holzhauer: I don't know if we need to talk about convenience; we need to talk about what is more efficient.

Rottman: We ought to keep in mind people's interest rather than special interests. It's really the poor guy on the street that you've got to ultimately be concerned with because he's the ultimate guy that's participating in the health care programs.

Robinson: Well, I think my primary concern on the thing was the amount of money that they're putting over to you. If we didn't have the certificates of need required, you would still have to be doing everything in that first column, and you'd have to be getting money some place to do it.

Rottman: It would be done in a much, much more general way and not nearly as a specific way as you have to do in the certificate of need program.

Robinson: Had you started any of this activity in here prior to the first certificate of need?

Rottman: Yes, we just started.

Robinson: Just by coincidence?

Rottman: Not by coincidence. You have two functions. If they wanted to do this, they could have kept it over there for that matter. But the thing of it is, these two functions really go hand in glove, and they complement each other. I think ultimately we're going to see a real benefit to the people.

Robinson: One final question - how do you determine the amount of a contract?

Nicholas: First of all, it's not really enough.

Robinson: Well, the contract expires the first of July, and was the contract over the last year the same amount here, or is this an increase?

Holzhauer: The contract for the current year is shown here.

Ross: (Excused himself to attend the Environment and Public Resources Committee meeting.)

Leverty: Our duty under the law with regard to the Insurance Division is to do a study in comparison with other states regarding health care costs, and we're not as specific as need be for this particular law. We have a very limited staff to do that.

Robinson: When you go into Sunrise Hospital, is it in response for the request for the certificate of need, or are you going in there to do your regular thing.

Leverty: Initially probably to do our original thing under 488. They when we want to update the report with regard to certificate of need, we go back and get additional information.

Robinson: If you get a certificate of need request or application from, let's say, Woman's Hospital, do you go back to Sunrise Hospital and check them again to see what they're doing in obstetrics?

Nicholas: Under certificate of need, you mean?

Robinson: Yes.

Nicholas: For comparative statistics, possibly yes.

Robinson: In areas where there may be an overlap into another state, do you have any authority to go across state lines.

Nicholas: Only the ability to utilize our best liaison techniques. There is no authority in going past the line.

Holzhauer: There is a current move to do something in that area with one or two of the federal agencies. They are trying to encourage some kind of movement in that area.

Nicholas: There are good reasons for cooperation. For example, if we were to ask Utah for something very reasonable, I'm sure they would probably go along with it understanding that at some future time they might want the same type of information from us. I have utilized this technique with the State of Arizona very successfully.

Robinson: What percent of fair return is involved here? Who determines what is a good percent of fair return?

Nicholas: Most of the guidelines are coming from the feds.

Robinson: If one hospital say is running more efficiently in their percent of return, it would be better than the hospital down the street that was not being run as efficiently. What effect would that have on the certificate of need?

Nicholas: What sort of a question is being considered for a certificate of need?

Robinson: Let's say that the hospital is running very efficiently and not showing any profit at all. Or they could run a tight ship and show a fair return. Then say they applied for ten more beds, and so did the guy down the street. It would seem to me you would say the first guy is making too much profit; we'll give the beds to the other guy.

Nygren: The converse could be true. The facility that's operating most efficiently and could show that through their financial figures would be the one that you would consider giving the certificate of need to because, essentially, their patient charges are going to be less. Could I make a point on the data gathering and how it's helpful. They get it because we don't have the authority to get it. One of our requirements is to provide technical assistance to anyone who needs it in the health planning and health and physical matters. I could just cite an example. In the last two weeks, we've been out in the rural areas looking at a small hospital that is having financial problems. The facility

had a management administration expenditure compared to the total expenditure of about 16%. Is that high or low for a rural hospital? We don't know. If we did know, we could go out to that hospital and say their percent of expenditures for administration is right on target, or it is too high, or it is too low.

Robinson: Well, I think the thing that most of the members of the Committee are concerned about was the fact that money was flowing out of Health Planning. I think maybe their conscience was bothering them a little bit about killing the other bill. What I would like to know is if an audit would show that you were being paid more from Health Planning than what it cost you to gather the information than was needed, what would happen.

Rottman: We would renegotiate the contract.

Holzhauer: They would have to pay it back.

Nygren: And we would get caught with an exception for not administering.

Holzhauer: And the other thing is that their expenditures must lie within the agreed-upon contract.

Robinson: Well, it's obvious to all of us that you are supplying to the Insurance Division money to pay for something that had already been mandated by law that he obtain anyway.

Nygren: Not necessarily.

Robinson: I am going on the premises that the bill that required you to supply this information -

Rottman: It's a very simple bill.

Robinson: Did it come from Health Planning?

Rottman: What, the bill?

Holzhauer: It was the last session - A.B. 388 of the last session.

Robinson: It wasn't a Health Planning bill?

Trounday: It was introduced by Al Whittenburg.

Hillerby: I have been involved with the Health Planning Agency in the North, and we've got some real concerns about the fact that good health planning is still not going to be accomplished. We don't have the money to collect good data. Financial data is nec-

essary, but it's available to anyone who needs it. You can request Medicare cost reports, Medicaid cost reports.

Trounday: I think we are going around and around, and I appreciate the legislators' concern and interest. When this responsibility was transferred to our office, I analyzed it very carefully and discussed it with a lot of people including the Governor, and I had a conversation with Fred. Fred's been opposed to this from the day one. But still overall, I felt that we would get more going for us if we went under the contract arrangement. And I get confused about why the issue of the contract seems to be a controversial one. I didn't arbitrarily make it without getting some input from some people including people out in the field and the industry who were involved. I have been one of the biggest critics of the fact that this State has never done health planning - good, adequate health planning, and that's one of the things when I hired Myrl. I told her that her primary responsibility would be to get a health plan. I tried administratively to take care of those differences, and I still think we are going to get a better situation by getting some of the information from another agency who has to go out and do this. They have to go out in the health planning area and get a lot of other additional data which Fred states, and I agree with that. But I think it's different from the kind of information we need to get from these people for 1122 and certificate of need.

Robinson: It isn't going to cut health costs. If he has to get an attorney to go into Sunrise Hospital, and Sunrise Hospital has to get an attorney to fight him, you guys are going to be auditing him six months from now and see a lot of attorney's fees there. We legislators will be looking at the Assistant DA's fees or whatever they have to - there has got to be some better rapport about how this is done.

Rottman: Dr. Robinson, you're coming down to a point here. I think the Legislature last session said go get some of this financial data and make some studies and let's see how we're faring here in Nevada in terms of health care costs. We are trying to do that.

Robinson: Well, this all hasn't come out of hospitals. It came out of our Health System Agencies. I directed a question right to Myrl and Frank about whether they could do it or not. They did not say they would rather not do it or that they would rather do it; they just said they could do it. So I think the thing that we have to do - you people - not you - but you people are going to have to get with these HSA directors because you're going to be working with them.

Holzhauer: We are attempting on a state-wide basis to set down an index that will be consistent North and South and state-wide for these so-called health plans and also the criteria for the type of data that's going to be in there.

Rottman: I think Dr. Robinson, in one of your answers or one of Fred's answers here in terms of getting additional information, if they'll be happy to sit down with us and sort of outline some of this stuff, it may be very well that some of this additional information we could probably get even though it's not strictly within the financial jurisdiction. Right now, we have to get with the insurance companies for most of this stuff.

Hillerby: We are supposed to agree with you. You don't agree with us that maybe we ought to spend some of that money for other data collection.

Robinson: To get back to this, I think we have got enough information on it, other than I do know that the people in Ways and Means are looking at it, and I don't know what they're planning on doing with it.

Trounday: I think the real question here is the bill itself and how we can administer the program. I think the bill itself can stand on its own merit, and it can really go through. But it's going to cost the State some money.

Robinson: Well, I think that they realize that it's money being spent that if they were doing it themselves they would have to spend anyway like you said, maybe $20,000 to boot. The feeling we all got yesterday was that what you were doing was going to have to be done anyway whether you had this contract or not.

Rottman: There was some money in an appropriation, but not enough. We dealt for a long time in just trying to get some uniform agreement on the uniform accounting standards.

Robinson: Dick, do you feel that this is getting you away from your primary scope as Insurance Commissioner?

Rottman: Realistically, I think that's a very legitimate question and it's one that we grappled with last summer when we originally talked about this thing. I think all of us really are interested in trying to figure out some way that we can slow the rising health care costs. If we can do something or make some inroads in it, I think the cost-benefit relationship will be outstanding.

Robinson: Fred, one other question. Have you had any complaints from any of the hospitals? Does the system seem to be working all right?

Hillerby: Yes.

Nicholas?: For a comment on that, I've just come back from visiting two hospitals and their administrators and gaining financial information - up in White Pine County and Lincoln County. Both of these visits were mutually advantageous - there is no question at all in the information we requested. I think our relationship generally is a good one quite seriously a good one, and we'll, of course, try and continue it.

Nygren: When the State Insurance Commissioner makes recommendations or comments, they have to be based on the State Health Plan and the two State Health Systems Agencies and based on the criteria put forth from his planners.

Robinson: One thing I would appreciate is you getting off a letter to Mr. Luce; he's a constituent of mine. Give him a copy of that information and that he has nothing to be concerned about this bill.

Respectfully submitted,

Carl R. Ruthstrom Jr.

Carl R. Ruthstrom, Jr.
Assembly Attache

EXHIBIT A

1122	CON	NRS 449.440 - 449.530	ACTIVITY
✓	✓	✓	COST CONTAINMENT
✓	✓	✓	CAPITAL EXPEND. & DEPRECIATION
✓	✓	✓	INDEBTEDNESS & RELATED COSTS
✓	✓	✓	OPERATING EXPENSES
✓		✓	PARTIAL PAYMENTS FOR CARE
✓		✓	COST OF RESEARCH
✓	✓	✓	NEED FOR INCURRING CAPITAL INVEST.
✓	✓	✓	PERCENT OF FAIR RETURN

ONLY UPON APPLICATION BY SPECIFIC FACILITY

ANNUALLY

ADVANTAGES OF CONTRACT	WHY?
1. One agency gathering financial information.	1. Provides greater capability to assess the impact of large expenditures and/or change in services on the cost of care to the patient.
2. Legal authority.	2. Regular access to financial information on unit cost of services enhances capability of State Health Planning and Development Agency (SHPDA) in providing technical assistance to financially troubled facilities.
3. Concentration of expertise in financial analysis.	3. Separation of planning function from regulatory function assures more objective planning and more objective regulatory decisions.
4. Annual collection of fiscal information.	
5. Possible elimination of duplicate reporting by hospitals regarding Hill-Burton.	
6. Totally separates the planning function from the regulatory function.	

CON/1122 PROCESS