Legislative Analysis

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MINIMUM NURSE-TO-PATIENT RATIOS

House Bill 4550 as introduced
Sponsor: Rep. Stephanie A. Young

House Bill 4552 as introduced
Sponsor: Rep. Carrie Rheingans

Committee: Health Policy
Complete to 11-8-23

SUMMARY:

House Bills 4550 and 4552 would amend the Public Health Code to require hospitals to implement specified minimum ratios of direct care registered professional nurses (RNs) to patients in different hospital units, provide administrative fines and sanctions for a violation, require records to be kept, provide for notice and a complaint process, and create a fund through which fines imposed for violation of the bills can be used to support their administration.

House Bill 4550 would amend Part 215 (Hospitals) of the Public Health Code to require hospitals to implement the minimum direct care registered professional nurse-to-patient ratios described below within one year after the date the bill takes effect or, for hospitals located in a ***rural area***, within two years after that date.[1] However, if a collective bargaining agreement that prevents compliance with the bill is in effect for hospital employees when the bill takes effect, the bill would not apply until after that agreement expires.

Ratio requirements
Under the bill, a hospital could not assign more patients per direct care RN than indicated by the ratios shown in the table below for each of the corresponding hospital units.

Acute rehabilitation		One RN to four patients (1:4)
Behavioral health/psychiatric		One RN to four patients (1:4)
Emergency department	Nontrauma or noncritical care	One RN to three patients, plus one RN for triage duties (1:3, +1)
	Trauma or critical care	One RN to one patient, plus one RN for triage duties (1:1, +1)
Intensive/critical care	Includes coronary care, acute respiratory care, medical, burn, pediatric, or neonatal intensive care patients	One RN to one patient (1:1)

[1] ***Rural area*** would mean an area that is located either outside of a metropolitan statistical area as defined by the U.S. Office of Management or Budget or in a city, village, or township with a population of 12,000 or less that is in a county with a population of 110,000 or less (using the most recent federal decennial census).

Labor and delivery	Antepartum	One RN to three pregnant patients (1:3)
	Antepartum (if continuous fetal monitoring is required)	One RN to two pregnant patients (1:2)
	Active labor	One RN to each birthing patient (1:1)
	During birth	One RN to each birthing patient and one RN to each baby (1:1,1:1)
	Immediate postpartum (within two hours after birth)	One RN to each birthing patient/baby couplet plus one RN for each additional baby (1:1[2], 1:1)
	Unstable newborn	One RN to one newborn (1:1)
	Intermediate care newborn	One RN to two newborns (1:2)
	Postpartum/postsurgical	One RN to two birthing patient/baby couplets (1:2[2])
	Medical/obstetric complications in labor and delivery (including an epidural or a C-section)	One RN to one patient (1:1)
	Postpartum birthing patient or well-baby care	One RN to four patients (1:4)
	Patient receiving conscious sedation	One RN to one patient (1:1)
	Postanesthesia care	One RN to one patient (1:1)
Medical/surgical		One RN to four patients (1:4)
Operating room		One RN to one patient, as long as at least one additional person serves as a ***scrub assistant***[2] in the unit (1:1, +1)
Pediatrics		One RN to three patients (1:3)
Stepdown or intermediate intensive care unit		One RN to three patients (1:3)
Telemetry		One RN to three patients (1:3)

[2] ***Scrub assistant*** would mean an individual functioning in a role that is also known as a surgical technician, operating room technician, surgical tech, first assistant, scrub tech, or scrub. A scrub assistant could be a direct care registered professional nurse.

All of the following would apply to the requirements described above:

- If a unit not listed above provides a level of care to patients whose needs are similar to those in a unit that is listed, the hospital would have to apply that listed minimum ratio.
- The required minimum RN-to-patient ratios would have to be in effect at all times, including during breaks, meals, and other routine and expected absences from a unit.
- A hospital could increase the number of RNs above a required minimum ratio at any time before or during a shift and for any reason.
- The minimum direct care RN-to-patient ratio established for each unit under the bill would not limit, reduce, or otherwise affect the need for other licensed or unlicensed health care professionals, assistants, or support personnel necessary to provide safe patient care within the unit.

Prohibitions

A hospital could not do any of the following:

- In computing a required minimum direct care RN-to-patient ratio, include an RN who is not assigned to provide direct patient care in that unit or is not oriented, qualified, and competent to provide safe patient care in that unit.
- Average the number of patients and the total number of direct care RNs assigned to patients in a unit during a single shift or over a period of time to meet a required minimum direct care RN-to-patient ratio.
- Except during a ***declared state of emergency***, impose ***mandatory overtime*** to meet a required minimum direct care RN-to-patient ratio.

  Declared state of emergency would mean an emergency declared by a person authorized by the state, the federal government, or a local government that is related to an unpredictable or unavoidable circumstance that affects the delivery of medical care and requires an immediate or exceptional level of emergency or other medical services at the hospital. It would not include an emergency that results from a labor dispute in the health care industry or consistent understaffing in the hospital.

  Mandatory overtime would mean a mandated assignment for a direct care RN to work more than their regularly scheduled hours according to their predetermined work schedule.

Notification and complaints

A hospital would have to post in each unit, in a visible and conspicuous location accessible to hospital staff, patients, and the public, a notice in a form approved by the Department of Licensing and Regulatory Affairs (LARA) that contains all of the following information:

- The requirements of the bill.
- An explanation of the rights of direct care RNs, patients, and other individuals under the bill.
- A statement that a direct care RN, patient, or other individual may file a complaint with LARA against a hospital they believe to have violated the bill.
- Instructions on how to file a complaint with LARA for a violation of the bill.

LARA would have to establish and maintain a toll-free telephone number to provide information regarding the required minimum direct care RN-to-patient ratios and to receive complaints alleging violations of the bill. A hospital would have to provide the number to each

patient admitted for inpatient care and inform each patient that the number may be used to file a complaint alleging a violation of the bill.

A direct care RN, a patient, or another individual could file a complaint with LARA against a hospital they believe to have violated the bill. LARA would have to investigate each complaint received and notify the complainant in writing of the results of a review or investigation of the complaint and any action proposed to be taken.[3]

Violations and fines

A hospital that does not comply with a minimum direct care RN-to-patient ratio required under the bill would be in violation of the bill. Each shift that does not comply with a required minimum ratio for that shift would be a separate violation. If LARA determines that a hospital has not complied with the minimum direct care RN-to-patient ratio required for each unit during each shift under the bill, it would have to require the hospital to establish a corrective action plan to prevent a recurrence of the violation. LARA would have to consider each violation of the bill by a hospital when making licensure decisions.

A hospital that violates the bill would be subject to an administrative fine of $10,000 to $25,000 for each violation or, if hospital has shown a *pattern of violations* (a finding by LARA of two or more violations in one calendar year), an administrative fine of $25,000 to $50,000 for each violation. LARA would have to publish on its website the names of hospitals it imposes an administrative fine on under these provisions, the violation the fine is imposed for, and any additional information it considers appropriate.

Other provisions

The bill would create the Nurse-to-Patient Ratio Regulatory Fund in the state treasury, and the state treasurer would have to credit to the fund the administrative fines described above. The state treasurer would direct the investment of money in the fund and credit to it interest and earnings from those investments. LARA would be the administrator of the fund for auditing purposes. LARA could expend money from the fund, upon appropriation, only to administer the bill.

LARA would have to develop and issue rules to implement the bill.

Proposed MCL 333.21525 and 333.21525a

House Bill 4552 would amend the Public Health Code to require hospitals to create an accurate record of actual direct care RN-to-patient ratios in each unit for each shift and maintain that record for at least three years. The record would have to include the number of patients in each unit and the identity and duty hours of each direct care RN assigned to each patient in each unit for each shift. The record would have to be made available to LARA, RNs and their collective bargaining representatives, and the public under rules promulgated by LARA.

Proposed MCL 333.21525a

Each bill would take effect 90 days after it is enacted.

[3] For provisions concerning confidentiality and appeals, see http://legislature.mi.gov/doc.aspx?mcl-333-20176

FISCAL IMPACT:

House Bills 4550 and 4552 would have an indeterminate fiscal impact on the Department of Licensing and Regulatory Affairs and publicly owned hospitals.

House Bill 4550 would require LARA to establish and maintain a toll-free telephone number, conduct complaint investigations related to nurse-to-patient ratio violations, publish information regarding administrative fine assessments, and promulgate rules. The magnitude of these costs is currently indeterminate, as it is unclear whether a new system would be required for the toll-free phone line and because the costs related to any complaint investigations would depend on the volume of complaints. In addition to the existing resources appropriated for the department, funding could be appropriated in the future from the Nurse-To-Patient Ratio Regulatory Fund created under the bill. It is unclear at present whether revenue from that fund would be sufficient to offset LARA's incurred costs under the bill.

If publicly owned hospitals are not currently in compliance with the staffing requirements established under House Bill 4550, those hospitals could incur staffing costs in order to achieve compliance. The cost of compliance would vary by facility, based on each facility's staffing situation, and the cost is therefore indeterminate. If a hospital was in violation of nurse-to-patient staffing ratios, the hospital would be subject to an administrative fine of between $10,000 and $25,000 for each violation, but if a pattern of violations exists, the fine would be between $25,000 and $50,000.

As mentioned previously, House Bill 4550 would create the Nurse-To-Patient Ratio Regulatory Fund, which would be a state restricted fund that would receive the administrative fines for nurse-to-patient ratio violations. Funding could only be used, on appropriation, for administration of nurse-to-patient ratio regulation. The amount of revenue that would be deposited into the fund would depend on the volume of administrative fines assessed, and is therefore indeterminate.

In addition, the bills would have an indeterminate, but possibly significant, fiscal impact on the state Medicaid program. The primary fiscal cost driver would be any overall hospital cost increases based in the hiring of additional nurses in order to meet the mandatory patient to nurse ratios and the degree in which Medicaid provides reimbursements for the overall hospital cost increase. For fiscal year 2023-24, any fiscal impact related to Medicaid reimbursements would be financed with federal and state funds at 64.94% and 35.06%, respectively.

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