HB3843, HB3844, HB1008, SB557

TESTIMONY IN OPPOSTION TO:
MANDATORY NURSE STAFFING RATIOS/
CAPS ON OPERATING MARGINS & COMPENSATION

Joint Committee on Health Care Financing

March 24, 2014

The Massachusetts Hospital Association (MHA), on behalf of its member hospitals and health systems, appreciates this opportunity to register our strong opposition to **HB3843**, **HB3844 HB1008, and SB557**. MHA urges the committee to act in the best interest of every patient in the Commonwealth, all members of the full caregiving team who work by the bedside and communities across the state that depend upon access to high quality and affordable healthcare, by rejecting all four proposals.

Three of these proposals (**HB3843**, **HB1008**, and **SB557**) would mandate the use of one-size-fits-all mandatory nurse staffing ratios at all times in every hospital. They each fail the basic principle of starting all hospital care decisions with a focus on the needs of individual patients and instead substitute a focus on one group within the staffing team. **HB3843** spells out the specific ratios that would be required in each unit of the hospital and policed by the Health Policy Commission (HPC). **HB1008** and **SB557** direct the Department of Public Health (DPH) to develop and impose mandated ratios. While the wording among the proposals may vary, the impact of all three remains identical to bills that have been filed – and rejected – every legislative session since 1998: forced compliance at all times, by all hospitals, with artificial, one-size-fits-all mandatory staffing ratios for registered nurses (RNs).

Despite the fact that no scientific universal ideal number of patients-per-RN has ever been identified, or could be, all three of these bills ignore staffing based on patient need and patient outcomes, and instead equate patient care decisions with an assembly-line-like process. This approach ignores the best interests of the patient because it ignores staffing based on the actual needs of patients, ignores the invaluable contributions of other professionals on the care giving team, and ignores the fact that neither all patients nor all nurses are the same.

These three bills also claim to propose that all hospitals be required to implement a "patient acuity system". But actually, under the proposal, hospitals and the caregiving team would be prohibited from fully using such a system. The patient acuity system could be used to "adjust" the ratio, *but only to* require additional registered nurses – if the acuity system indicated that fewer registered nurses were needed to meet the care needs of a patient, the proposal would not allow that adjustment to be made. If the patient acuity system called for by the legislation is in

fact a valid tool for developing nurse staffing plans, then it should be the standard for all patient care staffing decisions; no artificial "limit" is needed. This scheme is an example of how the legislation focuses on staffing, not patient care needs.

Patient care is best determined by the caregiving team at the bedside, not by a fixed formula mandated by the government. The number of patients a nurse should care for at any one time must be based on the sickness or acuity of the patient (which can vary from hour to hour), the education, skills and experience of the nurse, the technology available in the hospital, and the specialized team available to care for a patient's needs. *Every patient, every nurse, and every hospital is different.* A patient in need of an appendix removal is not the same as a patient having an appendix removed who also has several other complex comorbidities. A registered nurse with one year's experience is not the same as a nurse with 20 years of experience. An intensive care unit in an academic medical center is not the same as one in a small critical access hospital. An arbitrary fixed number per unit that must be followed at all times, by all hospitals, cannot account for these differences. Nurse leaders and other RNs must have the flexibility to work together to use all members of the caregiving team in a manner that best meets the needs of each patient.

The true measuring stick for hospital care must be based on the quality of care received by patients, not an arbitrary fixed formula focused solely one professional member of the caregiving team. These teams vary in their composition but include professionals such as registered nurses, licensed practical nurses, nurse assistants, resident physicians, physician hospitalists, radiologists, pharmacists, laboratory and diagnostic specialists, dietitians, transporters, and many more. That full team must make frequent adjustments to meet the changing needs of each patient.

As the state and the nation have moved forward with healthcare reform, the effort has been advanced through increased coordination of patient care and enhanced transparency and accountability for all facets of healthcare delivery. There are a multitude of state and federal reports focused on the quality of care received by patients at each hospital. Through this openness and transparency, healthcare providers are now directly rewarded and penalized for the quality of care that they provide. The outdated assembly-line notion of mandatory nurse staffing ratios directly conflicts with this transition to an integrated, accountable, care delivery model. In fact, if any one of these three proposals were enacted, the many years of progressive system change that began with the enactment of Chapter 58, and the numerous successes we have collectively achieved since, would all be imperiled.

And when it comes to measures of patient care staffing and quality care, the Commonwealth's hospitals have gone beyond any public reporting required by state and federal authorities. In 2006, Massachusetts hospitals implemented a first-in-the-nation effort to provide public transparency about patient care staffing – www.patientcarelink.org. This public website provides a hospital-by-hospital account of staffing levels and measures of the quality of care.

When the Massachusetts Senate pursued a compromise approach on staffing legislation in 2008, it engrossed legislation that would have moved the collection and reporting of patient care staffing and nurse-sensitive patient outcomes to DPH and empowered the department to take action in instances of poor patient outcomes. The hospital community embraced the proposal as a

reasoned resolution to the unfounded rhetoric surrounding the call for mandated staffing ratios. The bill failed enactment however because it was rejected by the nurses' union even though it offered transparency, accountability, and a remedy if a problem was discovered. So, instead of a resolution, there is continued charged political rhetoric.

The hospital community is proud of the Commonwealth's highly skilled nursing workforce. RNs in Massachusetts are among the most highly compensated nurses in the country – second only to California. And Massachusetts hospitals fully supported legislation ensuring that nurses are not required to work mandatory overtime except in instances when the wellbeing of the patient requires it. Obviously, registered nurses are essential members of the caregiving team. But they are not the only members. Effective patient care is dependent on a full team of competent, qualified healthcare professionals and assistive staff. That is why care decisions must remain at the bedside, where staffing decisions are made by nursing leaders based on the needs of each and every patient.

One of the core goals of the Massachusetts healthcare reform laws is to ensure universal access to healthcare that is both of the highest quality and affordable. Increased transparency and accountability, integrated and coordinated care delivery models, and reimbursing providers on the basis of patient satisfaction and quality medical outcomes are among the means the reform laws promote to achieve those goals. The public supports those goals, yet the bills listed above are in conflict with those goals. If the legislature mandates the staffing decisions for every patient, at all times, in every unit, and in all hospitals across the state, then it removes those decisions from the hands of the hospital caregiving team and places it in the hands of the legislature. The legislature is then responsible for the access, patient care, and healthcare cost implications of those decisions.

If the legislature mandates the staffing levels of registered nurses, what are the implications for others who provide care or support care? If the proposed legislation's provisions are to be believed, then virtually no one else working in hospitals can have their positions affected by the staffing mandate. If this is legal, then the cost of healthcare will rise precipitously, or hospital services will be closed or restricted. That outcome would be detrimental to access, care quality, and affordability of care. If those provisions are not legal, then important members of the caregiving team and those who support the caregiving team will be subject to job insecurity or worse. That outcome would also be detrimental to access, care quality, and affordability of care. Neither outcome should be considered acceptable.

California remains the only state to enact legislation that mandates nurse staffing ratios, having done so in 1999. After more than 15 years, not one single state has followed the lead of California. This is largely because numerous studies of the California experience show that the imposition of ratios had no discernible benefit to the quality of care received by patients. While the science of quality measurement continues to evolve, Massachusetts currently equals or outpaces California on a variety of hospital quality measures, perhaps most importantly bettering California common measures of inpatient hospital mortality prevention and patient satisfaction.

Each patient expects that care decisions affecting them are based on a professional assessment of their particular medical needs, needs that change over time. Each family in the Commonwealth

expects that the same approach to care decisions will be used for their family members. For hospitals, it is more than an expectation. Hospitals believe that the professional judgment of each member of the caregiving team should be respected and utilized to benefit their patients. And, hospitals believe that healthcare resources should be used efficiently and effectively to ensure access to quality and affordable care for all. **For all of these important reasons, MHA respectfully urges the committee to reject HB3843, HB1008, and SB557.**

MHA also urges the committee to reject **HB3844**. This legislation proposes to place caps on the operating margins of certain hospitals and CEO compensation at all hospitals. It also purports to call for further transparency of hospital financials. The hospital community opposes this proposal both for matters of principle and practical reasons.

Hospitals share a common mission to care for their patients, their workforce, and their local communities. Far too many hospitals struggle these days to find the resources to fulfill that mission – illustrated by the fact that the median operating margin of hospitals in the commonwealth stands at 1.6% and a third of hospitals have negative operating margins. Yet this bill would have government arbitrarily limit certain hospital operating margins at a time that each hospital must spend millions of dollars to implement government mandated electronic medical records, adopt new coding criteria, and numerous other mandates. At the same time, this proposal would directly impede the ability of hospitals to appropriately update technologies and aging facilities.

The proponent of this legislation says that state government has a right to limit hospital operating margins because it pays hospitals to provide care for those enrolled in public healthcare programs. But what they don't acknowledge is that every hospital subsidizes those government programs with hundreds of millions of dollars each year because government only pays part of the cost of providing that care. Whether a hospital receives 60% of its revenues from government healthcare programs, or 55%, or 45%, every hospital experiences underpayment from state and federal government programs and every hospital pays an assessment to help fund the Health Safety Net Trust Fund (HSN). Every year, the state assess hospitals hundreds of millions of dollars to support the HSN and its annual shortfall – those assessments also generate federal Medicaid matching dollars that are deposited into the commonwealth's General Fund and used for non-healthcare purposes.

Imposing arbitrary caps on operating margins is a misguided effort driven by two key assumptions: that the financial health of a hospital can be assessed using its operating margin alone, and that after a certain threshold, a higher margin is "undesirable" and "unnecessary" and should be capped, with the 'excess' recouped by the state and redirected to other hospitals. Both assumptions are completely wrong. Margins are inadequate measures of hospital financial well-being when considered alone and generally have to be supplemented by additional indicators.

This legislation's undue focus on operating margins and its underlying assumption that a hospital with a higher margin is "too" financially healthy and can afford to be penalized demonstrates not only an ignorance of finance, but a lack of concern for one of the state's biggest employment sectors. Publicly reported margins such as those calculated and published by the Center for Health Information and Analysis (CHIA) reflect individual hospitals, but our health care delivery

system is evolving into integrated health systems which include hospitals, as well as outpatient clinics, surgery centers, home health agencies, hospices, physician practices, and even insurance components. In order for the entire integrated health system to remain a going concern, cross subsidization is an essential factor. Penalizing a hospital for high margins while ignoring the performance of the system as a whole demonstrates a lack of understanding of the structure and functioning of the healthcare delivery system in the commonwealth. Further, hospital margins vary widely from year to year so a hospital could be over this arbitrary 'cap' one year and under the next year—and thus could ill-afford to be penalized for any temporary improvement in its margins.

The so-called "transparency" provision of **HB3844** is yet another red herring. Massachusetts hospitals do not object to reasonable examination, transparency and oversight. The commonwealth already has in place numerous financial reporting requirements, including annual filings of cost reports, audited financials and charge books that are filed with CHIA. Hospitals are also required to submit quarterly financial data as well as hospital case mix and discharge data. In fact, the state already requires the uniform reporting of inpatient and outpatient costs, including direct and indirect costs, despite the duplicative call to do the same found in HB3844.

The proposed legislation would also cap the compensation of hospital chief executives whose compensation is set by hospital boards of trustees or directors who follow federal criteria and national standards. The compensation is publicly reported at the state and federal levels for all to see.

On what basis should state government limit CEO compensation, or physician compensation, or nurse compensation? The challenges that hospitals confront in these transformational times are extraordinary. No one could credibly argue with that statement. Hospitals are complex institutions that are affiliated with other providers and they are often the largest employer in their communities. Some hospital CEOs who oversee smaller hospitals wear multiple hats and must find ways to compensate for government underpayment, find investment funds to meet the demands of the competitive market and government mandates, fund community benefits and uncompensated care, and cover the cost of a workforce that comprises70% of its budget. CEOs who lead larger hospitals and health systems may be responsible for operating multiple hospitals, fulfilling a medical teaching function, and carrying out cutting edge medical research. Collectively the hospital community provides healthcare to our state while also serving as the state's economic engine.

The Massachusetts Attorney General, the Federal Internal Revenue Service, and the Massachusetts Center for Health Information Analysis all have oversight authority to examine the appropriateness of CEO salaries. Given the public reporting requirements and oversight by government regarding the setting of CEO compensation, **HB3844** certainly appears to be more about politics than sound public policy.

The hospital community's opposition to a proposed cap on CEO compensation is not based on a particular number or formula, it is based on principle. There is already sufficient transparency and accountability regarding CEO compensation and hospitals need to be able to pick leaders they believe can direct them through these tumultuous times. Government is making tremendous

demands upon hospitals and government should not impose arbitrary barriers on hospitals that will make it more difficult for them to serve patients, employees, and local communities.

For all of these reasons, MHA urges the committee to strongly oppose HB3844.
Thank you for the opportunity to comment on these matters. If you have any questions or need further information, please contact Michael Sroczynski, MHA's Vice President of Government Advocacy, at 781-262-6055.