FISCAL IMPACT REPORT

SPONSOR Chavez/Chasey/Szczepanski **LAST UPDATED** **ORIGINAL DATE** 02/05/2024

SHORT TITLE Nursing Staff Ratio Requirements **BILL NUMBER** House Bill 145/ec

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

	FY24**	FY25	FY26	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
DOH/HCA staff costs, recurring	$241.2	$964.7	$964.7	$2,170.6	Recurring	General Fund
DOH/HCA staff costs, recurring	$241.2	$964.7	$964.7	$2,170.6	Recurring	Federal funds
DOH/HCA IT costs, non-recurring	$23.8			$23.8	Nonrecurring	General Fund
DOH/HCA IT costs, non-recurring	$23.8			$23.8	Nonrecurring	Federal funds
DOH/HCA IT costs, recurring	$8.1	$24.4	$24.4	$56.9	Recurring	General fund
DOH/HCA IT costs, recurring	$8.1	$24.4	$24.4	$56.9	Recurring	Federal funds
DOH/HCA costs, promulgation costs, nonrecurring	$161.2			$161.2	Nonrecurring	General Fund
DOH/HCA rule promulgation costs, nonrecurring	$161.2			$161.2	Nonrecurring	Federal funds
Total General Fund	$434.3	$981.9	$981.9	$2,398.1	Mixed	General Fund
Total Federal Funds	$434.3	$981.9	$981.9	$2,398.1	Mixed	Federal funds

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent version of this legislation.
See below for reason for split between DOH and HCA.
** Although the emergency clause indicates the provisions in the bill would begin during FY24, it is uncertain whether DOH would use all of the nonrecurring funds during FY24 before the division is transferred to HCA.

Sources of Information

LFC Files

Responses Received From the Following Regarding
University of New Mexico Health Sciences Center (UNM-HSC)
Health Care Authority (HCA)

SUMMARY

Synopsis of House Bill 145

House Bill 145 (HB145) would amend the Public Health Act to create a hospital staffing ratio committee to advise the Department of Health (DOH) (and subsequently the Health Care Authority, see below) in setting minimum staffing ratios for nursing units in the state's hospitals and requires the DOH to enforce those requirements, by court action if necessary.

HB145 creates a 10-member "staffing advisory committee" consisting of hospital administrators, nonmanagerial caregivers in public and in private hospitals, and union representatives, and would be appointed by the department for staggered four-year terms, with mechanisms of replacement given. They would not be paid but would receive per diem and mileage compensation.

Under HB145, the department's would be required to enforce its staffing ratio rules, could waive rules for rural general hospitals if safe, and could enjoin hospitals not following the guidelines. General units, critical care units, and emergency departments would be covered by ratios specific to each. The rules and ratios would be reported to the Legislature before being issued.

The bill also requires hospitals to employ sufficient staff to meet the ratios required and to adopt rules on the training of direct patient care personnel, whether they are permanently or temporarily employed. Hospitals are prohibited from assigning unlicensed personnel to perform duties that require a licensed nurse or require specialized knowledge, but licensed and registered nurses could work within their scope of practice.

HB145 establishes a cause of action for the department, individuals, or organizations for injunctive relief if that entity felt the act's provisions or the department's regulations were being ignored.

This bill contains an emergency clause and would become effective immediately on signature by the governor.

The Division of Health Improvement of DOH oversees health facility licensing and certification, and while HB145 does not name it specifically, it can be assumed the responsibilities assigned to the department are intended for the division. The division will be transferred from DOH to the Health Care Authority (HCA) on July 1, 2024, after the bill would be enacted if signed into law.

FISCAL IMPLICATIONS

There is no appropriation in HB145. Because the Division of Health Improvement will be transferred to HCA in FY25, HCA has estimated its expenses in carrying out the mandates of HB145. HCA estimates its expenses as follows, and as indicated in the table above:

1. HCA estimates it would take 4 FTE healthcare surveyors to survey 50 hospitals annually for compliance with the act and posted staffing for each hospital unit,
2. While the number of complaints of violations of HB145 requirements is unknown, the HCA bases FTE estimates on 200 complaint investigations, including necessary follow-ups, per year. HCA estimates it would take an additional 11 FTE nurse surveyors to investigate complaints annually,

3. HCA estimates it would take a 0.5 FTE attorney to participate in or respond to court filings for injunctive relief,
4. HCA estimates it would take 0.5 FTE annually to develop and maintain the HCA website for posting hospital reports. For these 16 FTE positions listed as numbers 1-4 here, HCA estimates an annual cost of $1,929.4 thousand per full year.
5. Computer hardware for each additional FTE,
6. Phone services for each additional FTE,
7. IT services and enterprise applications and subscriptions for each additional FTE. For items 5-7 listed here, HCA estimates $47.5 thousand in non-recurring costs and $48.8 thousand in recurring costs per full year.
8. Office space for each additional FTE (no cost figure given)
9. Rule promulgation and hearing costs. HCA estimates $161.2 thousand in non-recurring costs at the beginning of the project.

Because of the emergency clause, it is estimated that three months of recurring costs (salary, IT) will fall within FY24. Nonrecurring costs are noted in the table above as being needed in FY24 during the first three months, but some part of those costs may be carried over into FY25. In addition, the estimates in the table assume a 50 percent match from federal Medicaid funds.

In addition to the state and federal costs, the University of New Mexico Hospital (UNMH) and its satellite hospital, Sandoval Regional Medical Center (SRMC), assume additional costs of nearly $100 million between those two hospitals, based on their assumptions as to what staffing levels would be recommended by the committee.

SIGNIFICANT ISSUES

Healthcare providers in New Mexico and throughout the United States are experiencing nursing shortages, which affects patient care. High patient-staff ratios likely increase unsafe conditions for patients and burnout for nurses.

The Board of Nursing (BON), in analysis of similar legislation in 2023, documents considerable evidence in the medical/nursing literature that attests to high ratios leading to burnout. BON also points to one preliminary study indicating that better staffing ratios could result in cost savings for hospitals.[1]

The University of New Mexico Health Sciences Center points out concerns regarding increasing costs for hospitals, especially regarding costs for contract labor ("traveling nurses"):

> Hospitals currently have the flexibility under the direction of their chief nursing officer to staff nurses and unlicensed personnel as appropriate and needed based on the hospital's census, acuity, and staffing availability. By mandating staffing ratios with less flexibility, hospitals may be forced to bring in additional nursing and unlicensed personnel, including more expensive contract labor to fill the required positions, even if the chief nursing officer and nurse leaders did not find that the hospital's census and acuity

[1] Lasater, K. B., Aiken, L. H., Sloane, D., French, R., M. B., Alexander, M., & McHugh, M. D. (2021). Patient outcomes and cost saving associated with hospital safe nurse staffing legislation: an observational study. *BMJ Open*, 11:e052899. doi: 10.1136/bmjopen-2021-052899.

> necessitated that level of staffing. Regarding workforce availability, the New Mexico Health Care Workforce Report (2022) notes the number of [registered nurses] and [clinical nurse specialists] practicing in New Mexico remains nearly 6,000 nurses below national benchmarks. Mandating staffing and removing the autonomy of hospital nursing leaders to make decisions in the best interest of patient care will contribute to higher levels of moral distress and burnout among nursing leaders, at a time when the nursing workforce is struggling to recover from the impacts of the Covid-19 pandemic.
>
> An unfunded ongoing additional expense of nearly $100 million per year cannot be funded by UNMH and SRMC. This means that UNMH and SRMC would have to close hospital beds. The closing of those beds means fewer New Mexicans have access to hospital care, including care at New Mexico's only level one trauma center. However, since the Emergency Medical Treatment and Labor Act (EMTALA) requires that hospitals evaluate all patients who arrive at the hospitals' emergency rooms, the very busy emergency rooms of UNMH and SRMC would be overwhelmed with patients who could not be admitted into hospital beds because the beds were closed. This bill places UNM hospitals in an impossible position where we would be unable to reconcile obligations related to healthcare access and patient care, workforce availability limitations, and federal law.

UNM implies that other hospitals in the state would be similarly affected.

DOH in 2023 analysis of legislation made note of a likely conflict between staffing levels recommended by the committee and requirements from the federals Centers for Medicaid and Medicare Services (CMS), and the difficult position DOH would be in if forced to choose one or the other. HCA echoes that concern in 2024:

> This may also put hospitals in an impossible position if CMS denies either Medicaid or Medicare payments or both based on state hospitals' noncompliance with CMS regulations, which require the nurse executive to decide staffing patterns. CMS standards state, in part, "the nurse executive [at each hospital] establishes guidelines for the delivery of nursing care, treatment and services." Among four enumerated items that the nurse executive must write and approve is "nurse staffing plans."

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB145 is identical to 2023 House Bill 236

HB145 is also related to 2019 House Bill 178 (not enacted), which specified that each hospital be required to set up a "safe staffing council" to determine the ratio of nurses to patients in each unit, and 2018 Senate Bill 82, the enacted Safe Harbor for Nurses Act, which required healthcare facilities to develop processes by which nurses may invoke safe harbor when given an assignment where the nurse believes they lack the knowledge, skills, or abilities to deliver the minimum standard of care, or which may violate the Nurse Practice Act.

TECHNICAL ISSUES

Only rural general hospitals could have nursing staff ratios waived; urban or nongeneral hospitals might also need to have a waiver in case of a public health emergency or other unanticipated patient load increases.

The Board of Nursing in 2023, commenting on the identical 2023 HB236, pointed out the following, which it felt may need adjustment:

- On page three, lines seven to 12 refer to advisory committee non-supervisory members who is involved in direct patient care. These lines imply that unlicensed assistive personnel (UAP) could be on the advisory committee. In most hospital settings registered nurses are the largest sector of the workforce. If the intention was to assure that a nurse involved in direct patient care is on the committee, this legislation might benefit by specifying a registered nurse for this role.
- Also of note, there is some confusion about the current scope of practice of unlicensed assistive personnel (see page eight, lines six to 25). This includes nurse aides, nurse technicians, nurse interns, nurse externs, and others that are not listed, who currently and for years have performed some of the duties that would not be permitted, such as nurse techs who perform venipuncture, insert urinary catheters, and basic wound care, among many other tasks. Certified medication aides in long-term care facilities, excluded here it appears, are assistive personnel who administer medications.
- Additionally, facilities differ in other types of patient care supports. Some organizations have lifting teams, transport teams to diagnostics, rapid response teams, vascular access/PICC teams, on-unit lactation nurses on women's units, on-unit physical therapy techs orthopedic units, wound care teams, in-unit care management and/or social work, and telemonitor staff that may have been depleted during the recent pandemic surge. How does this bill interfere with these roles?

LAC/al/hg/ss