North Dakota Legislative Council

Prepared for the Health Care Committee
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CONTRACT NURSING AGENCIES STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

Section 1 of House Bill No. 1476 (2023) (Appendix A) directs the Legislative Management to study the impact of entities that receive Medicaid and Medicaid Expansion funding utilizing contract nursing agencies.

As introduced, House Bill No. 1476 would have placed a moratorium on contract nursing services for providers accepting reimbursement for medical assistance services under North Dakota Century Code Chapter 50-24.1 if the maximum hours of contract nursing services in a month exceed the monthly average hours of contract nursing services the provider used in calendar year 2021. In response to concerns from stakeholders that rely on contract nursing services to provide critical patient care, the bill was amended in the House to provide for this study.

BACKGROUND

Contract nursing agencies provide temporary, immediate assistance to hospitals and other health care facilities seeking short-term, nurse staffing solutions. Contract nurses, also known as travel nurses, often are employed by an independent staffing agency and may need to travel across state or international borders to fulfill a contract. Contract nurses typically earn higher wages than traditional full-time nurses, which places a greater financial burden on hospitals and other health care providers that rely heavily on these services. Data from Prolucent Health indicates the advertised pay rate for contract nurses increased by 67 percent from January 2020 to January 2022, and hospitals are billed an additional 28 to 32 percent over those pay rates by staffing firms.

The health care industry has been impacted by a decades-long shortage of health care professionals, with the shortage in nurses being the most pronounced. Nurses are a critical component of the health care system and make up a majority of the industry's workforce. Contributing factors to the nursing shortage include an aging population, a lack of educators, and turnover rates from 8.8 to 37 percent, depending on geographic location and specialty.[1] Rural communities are disproportionately impacted by the shortage of nurses, due to older populations, fewer resources, and low staff retention.[2] The COVID-19 pandemic further exacerbated nursing shortages, requiring health care facilities to contract with nursing agencies to keep facilities staffed during periods of increased demand. In 2020, travel nursing increased nationally by 35 percent from the previous, pre-pandemic year and the industry continues to grow.[3]

CONTRACT NURSING IN NORTH DAKOTA

Hospitals and long-term care facilities in the state depend on contract nurses to provide essential health care services. According to the North Dakota Long Term Care Association, contract nursing expenditures for long-term care facilities in North Dakota have increased steadily, costing $19.9 million in 2019, $24.2 million in 2020, $28.8 million in 2021, and $63.8 million in 2022. Of the 77 long-term care facilities in the state, 91 percent, or 70 facilities, utilize contract nursing services. The Bureau of Labor Statistics reports a traditional registered nurse in North Dakota makes an average hourly wage of $34.23 while a contract nurse makes an average hourly wage of $80.67. North Dakota does not have any statutory provisions that pertain to contract nursing. Further, North Dakota is 1 of 13 states that have not enacted price gouging protection statutes (Appendix B).

CONTRACT NURSING IN OTHER STATES

Many states have proposed and enacted legislation to regulate contract nurses and nursing staff agencies. While some states regulated contract nursing before the COVID-19 pandemic, state regulation efforts increased overall

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[1] Haddad, Lisa M.; Annamaraju, Pavan; Toney-Butler, Tammy J. *Nursing Shortage,* National Library of Medicine, 2023.
[2] Id.
[3] Yang, Tony Y.; Mason, Diana J. *Covid-19's Impact on Nursing Shortages, The Rise of Travel Nurses, and Price Gouging*, Health Affairs, (2022).

in response to the pandemic. Few states have directly tied reform efforts to Medicaid. Most state legislation has been broad in nature. During the 2021-23 biennium, 14 states introduced legislation (Appendix C) regulating health care staffing agencies. Regulation approaches have included:

- Nurse wage caps for staffing agencies, which address pay inequities between full-time nurses and contract nurses, who often make three to four times more per hour and receive additional stipends. Most states have price gouging laws to prevent "unconscionable prices during a declared state of emergency" which may apply to nurse staffing agencies, but do not cover all nurse compensation.
- Agency administrative fee caps, which decrease indirect costs associated with obtaining contract nurses by regulating the administrative fees that can be charged by staffing agencies.
- Agency licensing and registration, which requires a nurse staffing agency to obtain a license in the state in which the agency is operating and to meet minimum qualifications as determined by the licensing entity.
- Non-compete agreements, which regulate or prohibit legal agreements that dictate whether an employee can enter competition with an employer after the employee's employment period has ended.
- Limitations tied to Medicaid, which impose certain requirements a nurse staffing agency must meet if the agency contracts with Medicare or Medicaid participating entities. Only two states, Iowa and Ohio, have introduced legislation directly impacting Medicaid. Iowa's legislation requires health care employment agencies that contract with Medicare or Medicaid participating entities to submit quarterly reports to the Department of Inspections and Appeals, which include a detailed list of the average amount charged to the health care entity for each individual agency worker category and the average amount paid by the agency to agency workers in each individual agency worker category. Ohio's introduced legislation, while more comprehensive in nature, failed to pass.

Minnesota

In 2001, Minnesota passed legislation regulating supplemental nursing service agencies (SNSA) mainly through licensing and registration requirements that include wage and administrative fee caps. A SNSA is defined as any business that provides or procures temporary employment in health care facilities for licensed health professionals. Supplemental nursing service agencies shall register with the Minnesota Department of Health each year and submit an application fee. Each employee working in a Minnesota facility must undergo a criminal background check, provide documentation certifying educational compliance, and maintain state health requirements. If requested by a facility, a contracted SNSA shall provide staffing for at least 30 percent of the total personnel hours on the night, weekend, and holiday shifts. The legislation requires the Minnesota Department of Health to submit to the legislature an annual report on the hours and wages paid to supplemental nursing services and maintain a list of registered SNSAs on the Department of Health's website.

The legislation also capped payments from nursing homes at 150 percent of the average wage for an employee classification, as determined annually by the Commissioner of Human Services. Maximum rates include all charges for administrative and contract fees. In addition to the maximum rates, a nursing home may reimburse actual travel and housing costs, either directly or indirectly. Minnesota has some of the most comprehensive laws relating to contract nursing agencies, which were implemented well before the COVID-19 pandemic.

Iowa

Iowa is the only state that passed legislation related to contract nursing agencies with a provision tied directly to Medicaid. Enacted in 2022, the legislation requires health care employment agencies to register with the Department of Health annually, pay a fee, and abide by certain minimum requirements and recordkeeping. The bill also prohibits non-compete clauses in health care employment agency contracts. An employment agency that contracts with facilities that participate in Medicare or Medicaid shall submit a quarterly report to the Department of Health which includes the average amount charged by the agency to the health care entity and the average amount paid by the agency to employees, each broken down by employee category.

FEDERAL ACTION IMPACTING CONTRACT NURSING

Federal action related to contract nursing and health-care professions generally has been limited to the regulation of non-compete agreements. These actions have included:

- An executive order issued by the Biden Administration in July 2021 ordering the Federal Trade Commission to ban or limit "non-compete agreements and unnecessary, cumbersome occupational licensing requirements that impede economic mobility."

- A letter sent by more than 200 members of the House of Representatives in January 2022 to the White House's COVID-19 Response Team Coordinator urging federal agencies to investigate the conduct of nurse-staffing agencies and determine if the conduct rises to the level of anticompetitive activity or violates consumer protection laws.
- A statement by the American Hospital Association in February 2022 expressing concern over staffing agencies exploiting the nursing shortage to driving up costs for providers and urging the Federal Trade Commission and Congress to investigate reports of anticompetitive conduct from staffing agencies.

STUDY APPROACH

In conducting this study, the committee may wish to receive testimony from:

- North Dakota hospitals, long-term care facilities, nurses, and other health care providers regarding concerns associated with contract nursing agencies;
- The North Dakota Department of Health and Human Services, and the State Board of Higher Education;
- Nursing contract agencies operating in the state, including information on pay rates, administrative costs, and regulatory practices; and
- The National Conference of State Legislatures and other interested parties regarding what other states have done to address contract nursing expenditures and health care shortages.

ATTACH:3