

# States fight back against managed care, hospital asset-stripping

Dozens of states are now taking action—mostly procedure by procedure, and disease by disease—against various of the harmful practices of all aspects of “managed care,” ranging from health maintenance organizations, to for-profit companies that asset-strip community health facilities and staff.

For example, this year alone, 16 states have adopted laws to nullify efforts by HMOs to limit what doctors can tell their patients. States adopting such “anti-gag” laws against HMOs include California, Colorado, Delaware, Georgia, Indiana, Maine, Maryland, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, and Washington. In Oklahoma, the Board of Health decided this year to administratively enforce the anti-gag policy through licensing of HMOs; the New Jersey Health Department has proposed similar rules.

In 33 states, various other kinds of actions to control managed-care cost cutting have been enacted for specific diseases and procedures. For example, many states have passed laws to prohibit “drive-through” childbirth—the practice of many HMOs to refuse to pay for a woman’s stay in the hospital, or restrict it to one day.

In September, federal legislation was enacted mandating health care insurers to cover 48 hours of hospitalization for the woman giving birth. Now federal action is being drawn up by U.S. Rep. Rosa DeLauro (D-Conn.) to require insurers to pay for a minimum 48-hour stay for a mastectomy, and one-day for a lymph node removal. This comes in response to at least two Connecticut HMOs (CIGNA HealthCare and ConnectiCare) saying they will not pay for an overnight stay for breast removal surgery (unless the doctor insists, but the doctor is under pressure not to).

These examples show that fighting managed care/HMO practices procedure by procedure, and disease by disease, involves long lists of targets, and never-ending battles. In recognition of this, Connecticut State Sen. Edith Prague is working on legislation to compel insurers to cover hospitalization, whenever it is deemed medically necessary by a physician.

The following are selections from recent initiatives in three states: Nebraska, Pennsylvania, and Massachusetts.

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## Nebraska: The Non-Profit Hospital Sale Act

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This spring, the Nebraska legislature passed the Non-Profit Hospital Sale Act, which Governor Branstad signed into law. The intent of the Act is to provide safeguards so that a large, for-profit hospital conglomerate cannot enter Nebraska and begin gobbling up community nonprofit hospitals, and then start slashing hospital staff and closing down all or part of the hospital, denying hospital care to the community.

According to the official summary of the Non-Profit Hospital Sale Act:

“The bill provides that no person shall engage in the acquisition of a hospital owned by a nonprofit corporation, without having applied for, and received, the approval of the Department of Health and the Attorney General (if the Attorney General determines to review the application). . . . For purposes of this act, acquisition is a transaction which results in 20% or more ownership or control, or a cumulative 50% of ownership or control. . . .

“The application is made jointly to the Department of Health and the Attorney General. It shall include the names of the seller and purchaser, the terms of the proposed agreement, the sale price, a copy of the acquisition agreement, a financial and economic analysis and report from an independent expert or consultant as to the effect of the acquisition in meeting the criteria set forth in the bill, and other related documents. The application and all related documents shall be considered public records. . . . Public notice and a public hearing are required as part of the review. Intervenors with a distinct interest are allowed. . . .

“The review criteria for the Department of Health is set out in Section 8. . . .

“The decision on the acquisition is to be made within sixty days. . . . A procedure is provided for a hearing to determine whether the acquisition is being carried out according to the approved application. The license of the hospital may be revoked or denied when the acquisition of the hospital does not meet the terms of this act. . . .



*Pennsylvania nurse Laura Gasparis Vonfrolio speaks at a demonstration in Washington, D.C. on May 10.*

## Section 8: Criteria

"In making a decision whether to approve or disapprove an application, the Department of Health shall consider:

"Subsection 1: whether sufficient safeguards are included to assure the affected community continued access to affordable care; a right of first refusal to repurchase the assets by successor nonprofit corporation or foundation if the seller is subsequently sold to, or merged with, another entity, including an assurance [that] financing necessary to accomplish the repurchase is reasonably available shall be considered evidence of access to continued care.

"Subsection 2: whether a purchaser has made a commitment to provide care to the disadvantaged, the uninsured, and the underinsured to promote improved health care."

## Pennsylvania's House Resolution 368

*This resolution was the subject of hearings of the Pennsylvania House Committee on Human Services on Sept. 12.*

*Resolved, That the Health and Human Services Committee shall:*

1. Examine the extent of enforcement and violation of current regulations and standards of nursing practice.
2. Examine the extent to which the hospital accreditation process adequately considers the "downskilling" of acute care providers.
3. Examine the adverse effect of this practice on the capac-

ity of physicians to render quality acute care.

4. Examine nurse/patient ratios and their significance for medical care;

and be it further

*Resolved, That the Department of Health, the State Board of Nursing and all other agencies of the Commonwealth shall provide assistance upon request as the Health and Human Services Committee may deem appropriate; and be it further*

*Resolved, That the Health and Human Services Committee may hold hearings, take testimony and make its investigations at such places as it deems necessary in this Commonwealth. Each member of the committee shall have the power to administer oaths and affirmations to witnesses appearing before the committee; and be it further*

*Resolved, That the Health and Human Services Committee make a report of its findings and recommendations to the House of Representatives on or before November 30, 1996.*

## Legislation presented in Massachusetts

*The Massachusetts Nurses Association (MNA), the largest professional health care organization in the state (18,000 members), has introduced a package of legislation to the state legislature, including five bills that address a variety of problems. The bills call for legislative and regulatory changes that would expand the scope of the Patient's Bill of Rights to include information about the amount and type of nursing care provided, provide a more specific definition and formula for determining "sufficient" levels of nursing care in every health care setting, and regulations that would mandate the collection of patient outcomes data reflecting the impact of nursing interventions on the quality of care.*

*According to MNA President Margaret Barry, "This legislation is an attempt to solve a number of problems caused by the health care industry's dramatic attempts to restructure health care without proper concern for the quality of care delivered."*

*The following summaries of the proposed legislation were prepared by the MNA.*

### **H. 5871: An Act to Identify Health Care Providers**

Patients have the right to know who is caring for them.

This bill adds an amendment to the Patient's Bill of Rights that all licensed persons must identify themselves by a name tag before caring for individuals. The tag must indicate their licensure status, not their job/position/role.

There is a trend in the country and in Massachusetts to identify health care workers as "patient care associates" or "multi-skilled workers." Homogenizing the providers of health care leaves the public without accurate information about who is at their bedside. This bill would assure the public

of factual information about who is caring for them.

#### **H. 5872: An Act Furthering Patients' and Residents' Rights**

The public has the right to know who is caring for them and the nature and amount of nursing care they should receive in any given health care delivery setting.

This bill amends the Patient's Bill of Rights to:

1. Include "sufficient nursing care" requiring adequate available qualified nurses to meet both the routine care and unplanned care needs of patients based on recognized professional standards of practice, the patient's or resident's acuity level, and functional capacity for self care.

2. Upon request, to provide consumers with information about the nature and amount of nursing care they will receive. This information should include, but not be limited to:

- the ratio of patients to RNs, LPNs, and unlicensed personnel;
- the incidence of infections and pressure sores;
- the incidence of medication errors and patient injuries;
- data regarding patient satisfaction;
- data on the educational level and experience of nursing staff.

3. Requires all health care providers to identify their licensure status to the patient before rendering care.

#### **S. 2183: An Act to Ensure Sufficient Nursing Care**

Significant studies over more than a decade indicate that patients' outcomes are improved when they have direct access to professional nursing care. Every institution that provides health care is responsible for providing "sufficient nursing care." Yet, there is no definition of "sufficiency" except in critical care units and out-patient dialysis units. Nurses are expected to care for patients competently, no matter how many they care for and no matter the amount of resources available to them. They are also held accountable for the care they direct to other licensed and unlicensed personnel.

This bill defines "Sufficient Nursing Care" based upon:

- the patient's acuity of illness;
- the patient's functional level; and
- the standards of nursing practice to which the individual licensed nurse is held accountable.

A commission, under the direction of the Department of Public Health, with representation and consultation from the Board or Registration in Nursing, Nursing Associations and Specialties would define *guidelines to establish minimal acceptable levels of nursing staff for "sufficient" nursing care.*

This bill would mandate "flexible" guidelines that would assure appropriate nursing resources for the patients.

*This is not a ratio bill, but does clearly outline that there must be safety limits on the number of patients any one nurse can care for at any one time, in order to secure sufficient, competent nursing care.*

There would be a requirement for a Registered Nurse to

be designated by the facility for the overall quality assurance for nursing care provided by the facility.

The public would have a mechanism to measure the sufficiency of care provided and a mechanism to seek corrective action with the Department of Public Health.

#### **H. 5863: An Act to Establish Licensing for Nursing Clinics**

This bill creates an opportunity to license clinics for the delivery of nursing care alone. Only one such clinic currently exists, the Pine Street Inn Nurses' Clinic, which cares for homeless guests.

The public would have the option to utilize nursing care services in clinics as adjunct to medical care. Nursing clinics could provide a wide range of services, for example:

- Hypertension/Health Maintenance Clinic
- Elder Services Support Clinic
- Adolescent Health Care/Education Clinic
- Maternal/Newborn Health Information Clinic

#### **H. 5864: An Act Relative to Public Access to Comparative Nursing Care Data**

Nearly all outcomes data is generated by claims data. Nursing is most frequently categorized with the cost of room and board. Therefore, there is no systematic collection or mandate to collect data about the interventions of nursing and subsequent outcomes of patient care.

This bill creates a mechanism to collect and report the data about the influence nursing care has on patient outcomes in a systematic way in "hospitals, nursing homes, chronic-care and rehabilitation hospitals, specialty hospitals, clinics . . . and health maintenance organizations." Further, it provides information to the public for their review in making judgments about the services they seek.

The indicators to be measured would include, but not be limited to:

*Outcome Indicators*—those which focus on how patients and their conditions are affected by their interaction with nursing staff: mortality rate, length of stay, readmission rates, adverse incidents, complications. . . .

*Process of Care Indicators*—which focus on the nature, amount, and quality of care nurses provide to patients. This includes: assessment and implementation of patient care plans, pain management, skin integrity, patient education, discharge planning, patient safety responsiveness to unplanned patient care needs, and patient/family satisfaction with nursing care.

*Structure of Care Indicators*—which focus on the nature of staffing patterns expected to affect quantity and quality of care provided by nursing, including ratio of RN, LPN to patient.

This information would be made available annually so the public and purchasers of groups health insurance policies could use it to consciously choose health care with nursing services in mind.