Executive Summary

Following sharp increases in the costs for temporary staffing during the COVID-19 pandemic, Senate Bill 1549 was passed by the 2022 Oregon Legislature to explore policy that would regulate staffing agencies that provide temporary staffing to health care facilities. Oregon and the nation are experiencing a workforce shortage crisis. The workforce shortage is a major contributor to the recent increases in the use of temporary staffing services and the costs of using temporary staffing. The attached report was mandated by Section 15 of this bill, requiring the Oregon Health Authority (OHA) to recommend a process for how to set maximum rates that temporary staffing agencies could charge health care facilities.

Recommended factors to be considered when setting rates include:

- Basic mechanism for setting maximum rates
- Categories of temporary health care workers
- Additional staff qualifications that impact maximum rates
- Workplace setting
- Geographic variation
- Holiday rates
- Shift differentials
- Modifying maximum rates outside of the regular annual cycle

These recommended factors are described in more detail on the next page.

Process Overview

Interested parties in Oregon were convened for seven meetings from July to December of 2022, to understand their perspectives on setting maximum rates for temporary staffing agencies, and to gather input for a recommended process for setting rates. In addition, a survey was conducted to ask about specific factors that could be included in a process for setting maximum rates. Participants in this engagement process included representatives of temporary staffing agencies, the health care workforce, long term care facilities, hospitals, and other health care facilities. OHA contracted with Mercer to engage the interested parties, conduct research, and develop this report.

Other States with Rate Caps on Temporary Staffing Agencies

Two states, Massachusetts and Minnesota, currently have statutes that require setting maximum rates that temporary staffing agencies can charge. However, the methods/considerations each state incorporates in setting maximum rates differ. Key differences in considerations are indicated in the Venn diagram below. During the pandemic, Massachusetts increased the maximum allowed rates and Minnesota allowed temporary waivers of the maximum rates.

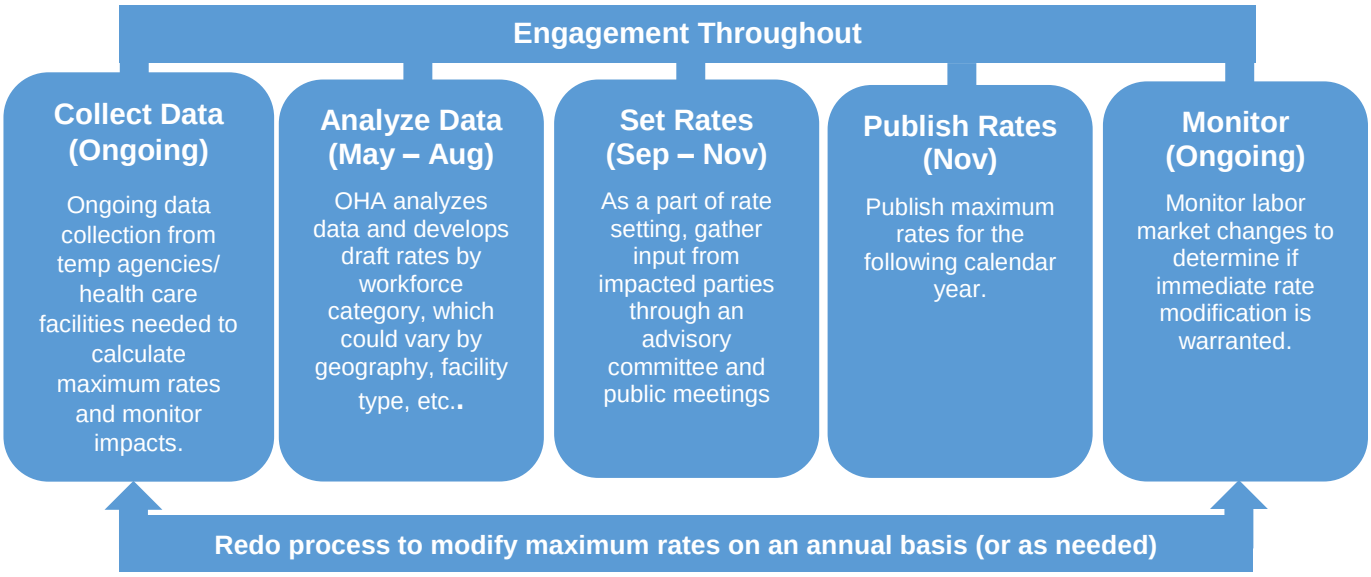
Factors Considered When Setting Rates	Massachusetts	Minnesota
Workforce covered by maximum rates	Nursing workforce, rates vary by licensure	Nursing workforce, rates vary by licensure
Facility setting	Rates vary by facility setting	Apply only to nursing facilities
Includes increased rates for holidays	Yes	Yes
Rates vary by shift (day-part, weekends)	Yes	No
Rates vary by region or are statewide	By region	Statewide

Other Policy Options

Discussions with the interested parties considered other options that could meet the policy goal of constraining sharp increases in the costs of temporary staffing. One of those options considered, was using a price gouging regulation that would not allow unjustified price increases. There was no consensus on whether a price gouging law would be effective. Kentucky recently amended their price gouging statute so that it now applies to health care services agencies.

Recommended Process for Setting Maximum Rates that Temporary Staffing Agencies Can Charge

Annual Process Framework



Recommendations for Setting Rates - Key Considerations

Factor	Recommendation	Explanation
Basic Mechanism for Setting Maximum Rates	Use wages for permanent staff as a baseline for the calculation of maximum rates for temporary staff.	Under the requirements and constraints of the current economic situation, using permanent workers' wages as the baseline for the maximum rate calculation may be the best option. The full report compares the potential impacts of using wages for permanent staff, wages for temporary staff, or both.
Categories of Temporary Health Care Workers	Set maximum rates for a limited number of categories of workers and include the most common temporary staffing categories.	The maximum rates in Massachusetts and Minnesota apply only to the nursing workforce, and Oregon could also include direct care workers and physician categories.
Workplace Setting	Differentiate maximum rates across facility type. More data are needed before determining which facilities should be subject to the maximum rates.	There was near consensus that maximum rates should vary by facility type.
Geographic Variation	Vary rates by geographic regions, making a final determination of regions based on the wage data collected.	Economic conditions vary by geography across the state. There was near consensus that the maximum rates for temporary staff should vary by geography, and a desire was expressed for a small number of regions.
Holiday Rates	Set a 50% higher maximum rate for holidays.	A 50% increase in pay is fairly standard for holidays, and the other two states increase the maximum rates for holidays.
Shift Differentials	Vary maximum rates by work shift, including looking at day-parts and weekends.	There was widespread support for shift differentials; higher rates are needed to fill less desirable shifts. Massachusetts differentiates 3 shifts per day and weekdays versus weekends.
Modifying Maximum Rates Outside of the Regular Annual Cycle	Allow the regulating authority to modify maximum rates when the labor market changes abruptly and consider other policy options for specific circumstances.	Massachusetts and Minnesota modified maximum rates outside of the annual process, during the COVID-19 pandemic. Other policy options include allowing temp staffing agencies to apply for waivers so facilities can charge more than the maximum rates. Such policy options should be limited to special circumstances (i.e., workforce shortage for a specific profession, or labor market conditions limited to a geographic area).

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Government Human Services Consulting

Potential Rate Caps for Temporary Nursing Staff

Produced for the Oregon Health Authority

December 31, 2022

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Section 1

Introduction

Background Regarding Potential Rate Caps for Temporary Staffing Agencies in Oregon

Senate Bill (SB) 1549 (2022) passed in the 81st Oregon Legislative Assembly and requires the Oregon Health Authority (OHA) to issue temporary staffing agency licenses to qualified applicants in conjunction with adopting rules to regulate temporary staffing agencies. SB1549, Section 15 (2) requires OHA to create and submit a report to an interim committee of the Legislative Assembly related to health care.[1] This report must include:

(a) a policy proposal and recommendations to establish a process to determine annual rates that a temporary staffing agency may charge to or receive from an entity that engages the temporary staffing agency.
(b) prioritization of the compensation of personnel, quality care outcomes for clients, patients, and residents of an entity that engages a temporary staffing agency and the fiscal viability of care providers based in the state.

OHA engaged Mercer to facilitate collaborator meetings during which the benefits and consequences of setting maximum rates that temporary staffing agencies can charge health care facilities (rate caps) were discussed, and to determine factors that should be considered when setting rates. Mercer and OHA held seven virtual meetings over six months, from July to December 2022, with interested parties, including individuals from the following organizations and groups:

- Service Employees International Union (SEIU)
- Oregon Association of Hospitals and Health Systems (OAHHS)
- Oregon Health Care Association (OHCA)
- Oregon Primary Care Association (OPCA)
- LeadingAge Oregon (not-for-profit advocacy association for elderly and disabled)
- American Staffing Association (ASA)
- Express Healthcare Professionals Staffing Agency
- Oregon Health and Sciences University (OHSU)
- Providence Health and Services
- Marquis Companies (assisted living and senior care facilities)
- Maryville Care (rehabilitative and intermediate care facility)

[1] Senator LIEBER, Representative NOSSE; Representative HIEB (Precession filed.). (2022, March). Oregon SB1549: 2022: Regular session. LegiScan, available at https://legiscan.com/OR/text/SB1549/id/2539339/Oregon-2022-SB1549-Enrolled.pdf

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Additionally, Mercer analyzed the processes of instituting rate caps used by Massachusetts and Minnesota to help shape the analysis and recommendations related to potentially setting rate caps for temporary staffing agencies in Oregon.

Workforce Crisis

Even before the coronavirus disease 2019 (COVID-19) pandemic, the National Academy of Medicine discovered that burnout had reached "crisis levels" in the United States' (U.S.) health workforce, with 35%-54% of nurses and physicians reporting symptoms of burnout, and 45%-60% of medical students and residents reporting similar symptoms.[2] Burnout is a work-related syndrome marked by a high level of emotional exhaustion and depersonalization (i.e., cynicism) as well as a low sense of personal accomplishment and is associated with an increased risk of mental health issues such as anxiety and depression.[3]

Currently, burnout among health workers has negative consequences for patient care and safety, including decreased time spent between provider and patient, an increase in medical errors and hospital-acquired infections among patients, and staffing shortages. Furthermore, health worker burnout can have a significant financial impact on the health care system, For example, a 2013 study used data from 472 physicians who completed a quality improvement survey conducted at two Stanford University affiliated hospitals to assess physician wellness, 26% of physicians reported experiencing burnout. Using results of multiple results of published research findings and industry reports, researchers computed a base-case model to estimate the costs related to physician annual burnout-related turnover costs, which ranged from $2.6 billion to $6.3 billion at the national level.[4] At the organizational level, the annual economic cost of burnout is roughly $7,600 per employed physician per year. This cost is tied to turnover and reduced clinical hours due to burnout.

In February 2022, Incredible Health analyzed data from more than 400,000 Incredible Health nurses profiles and surveyed more than 2,500 Registered Nurses (RNs) in the U.S. Results of the survey showed 34% of nurses are “very likely” to leave their current roles by the end of 2022, and 44% cited burnout and high-stress environment as the reason for their desire to leave.[5] Burnout among healthcare staff has exacerbated the existing nursing shortages in healthcare facilities. In order serve continuing patient admissions in facilities, there have been reports of hospitals and other facilities using short-term deployments of federal or state emergency resources (such as federal military or U.S. Public Health Service personnel and state national guard) or moving staff within hospitals to deal with acute shortages in

[2] National Academies of Sciences, Engineering, and Medicine, Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being. (2019). Taking Action against Clinician Burnout: A Systems Approach to Professional Well-Being. National Academies Press, available at https://nam.edu/systems-approaches-toimprove-patient-care-by-supporting-clinician-well-being/

[3] Trockel, M. T., Menon, N. K., Rowe, S. G., et al. (2020). Assessment of physician sleep and wellness, burnout, and clinically significant medical errors. JAMA Network Open, 3(12), available at https://doi.org/10.1001/jamanetworkopen.2020.28111

[4] Han, S., Shanafelt, T. D., Sinsky, C. A., Awad, K. M., Dyrbye, L. N., Fiscus, L. C., Trockel, M., & Goh, J. (2019). Estimating the attributable cost of physician burnout in the United States. Annals of Internal Medicine, 170(11), 784, available at https://doi.org/10.7326/m18-1422

[5] Landi, H. (2022, March 22). Third of nurses plan to leave their jobs in 2022, survey finds. Fierce Healthcare, available at https://www.fiercehealthcare.com/providers/third-nurses-plan-leave-their-jobs-2022-survey-finds

emergency departments and intensive care units (ICU).[6,7] One of the concerns presented by the increased use of travel nurses is the significantly higher wages temporary staff earn compared to permanent staff nurses. Nationally, wages for travel nurses rose 25% during the early months of the pandemic. A study conducted by IncredibleHealth evaluated salaries for permanent, experienced nurses at the beginning and end of 2020, and showed a roughly 8% increase in average salaries.[8] Prior to the start of the pandemic, temporary staff nurses at hospitals earned approximately $1,400 a week on average, compared to during the pandemic where wages paid were between $5,000 and $20,000 a week.[9]

Hospitals responding to the 2021 Office of Inspector General (OIG) survey reported facing increased labor market competition from staffing agencies, particularly for nurses, and that they were unable to compete with the salaries being provided through staffing agencies. Small and rural hospitals also reported that it was challenging for them to compete with larger and urban hospitals for staff, and although this has been a longstanding concern for rural hospitals, they reported that the situation had gotten more challenging during the pandemic.[10] The use of travel nurses may also negatively affect the morale of permanent staff nurses who receive lower levels of compensation, yet have the responsibility to train temporary staff on how a unit operates and technology protocols.[7]

Growing and diversifying the health care workforce is necessary to ensure access to culturally and linguistically appropriate health care for all Oregon residents (see the biennial healthcare workforce needs assessment). The use of temporary staff can expand the current pool of health care workers but does not increase the size or diversity of the permanent workforce.

History of SB1549

Oregon's health care facilities reported severe strain on health care services during multiple waves of COVID-19 virus infections due to heavy caseloads, testing demands, burned out employees, infections among staff, and staffing shortages. In response, the Oregon National Guard deployed 1,200 members to assist hospitals with administrative and non-clinical support in January 2022. The increased demand on health care facilities also necessitated the state's use of temporary staffing agencies to deploy health care workers from outside the state, such as clinicians to support hospitals, temporary staff to support long-term care facilities, and traveling nurses. In an effort to ease challenges being faced by Oregon's health care industry, SB 1549 establishes license requirements, but temporary staffing agencies will not be subject to any new regulation, licensure or quality standards until July 1, 2023. The bill

[6] American Academy of PAs . (2020, May 19). COVID-19 and the PA Workforce Trends and implications for PAs. 2020 AAPA PA Pulse Survey, available at https://www.aapa.org/

[7] Assistant Secretary for Planning and Evaluation. (2022, May 3). Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce: Challenges and Policy Responses. HP-2022-13 Issue Brief, available at https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf

[8] Study: 186% pandemic spike in nurse demand worsens turnover and stress. Incredible Health. (2022, July 13), available at https://www.incrediblehealth.com/blog/study-covid-19-anniversary-nurse-impact/

[9] COVID-19's Impact On Nursing Shortages, The Rise Of Travel Nurses, And Price Gouging", Health Affairs Forefront, January 28, 2022, available at https://www.healthaffairs.org/do/10.1377/forefront.20220125.695159/

[10] Yang YT, Mason DJ. COVID-19's impact on nursing shortage, the rise of travel nurses, and price gouging. Health Affairs Forefront. January 28, 2022, available at https://www.healthaffairs.org/do/10.1377/forefront.20220125.695159/

also requires OHA to recommend a process for how maximum rates could be developed for temporary staffing agencies that provide workers for health care services or personal care assistance.[11] SB 1549 does not set rates or caps on health care personnel wages.

Workforce Development Efforts in Oregon

The impact of COVID-19 on the health care workforce across the country exacerbated the existing health care worker shortage in Oregon. Current information on Oregon's health care workforce can be found in OHA's biennial assessment of the health care workforce which is currently available in draft form, and the final report will be submitted to the legislature by February 1, 2023.

In recent years the legislature has passed a number of bills related to the health care workforce development. For example, HB 4003 (2022) requires the Healthcare Workforce Advisory Committee to study the Oregon nursing workforce shortage, identify and describe the challenges in addressing staffing shortages in the nursing field, and submit the final report to the legislature by November 15, 2022. The bill also allows the state to issue nursing intern licenses to students who meet certain qualifications and allow them to practice under the supervision of a registered nurse. Nursing students may receive compensation and school credit if their intuition allows, and this will expand programs supporting the mental health and overall wellness of Oregon nurses and health care workers.[12] The bill also creates a wellness program fund to assist nonprofit organizations that promote the well-being of Oregon health professionals.

The legislature has also provided funding to the Oregon Department of Human Services (ODHS) to address the workforce crisis in long-term care. In 2021, the Oregon legislature passed a Long-Term Care Investment Package that included funds to increase wages for community-based care facility and skilled nursing facility workers, as well as a $12.2 million budget note to enhance workforce development and training. Those workforce efforts are being led by a new Strategic Initiatives Unit within ODHS, which is building collaborations among ODHS, OHA, and external stakeholders to grow the direct care workforce and enhance its well-being. The largest effort is financial support for the RISE Partnership to expand its apprenticeship training program for certified nursing assistants (CNAs). Support will also be provided for the NurseLearn program to train community health nurses, the Oregon Care Partners training clearinghouse for family caregivers and direct care workers, and other training and well-being programs, such as a Leading Employee Well-being: Promoting Organizational Change in Long Term Care Learning Collaborative and RN Well-being mini grants targeted for long-term care settings.

In September 2022, ODHS's Aging People with Disabilities' Strategic Initiatives Unit contracted with the Institute on Aging at Portland State University for an independent research study on the costs of care and staff wages in Residential Care, Assisted Living, and

[11] SB1549 A Staff Measure Summary. Senate Committee on Labor and Business. Prepared by Cummings, Wenzel. 11, Feb. 2022, available at https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureAnalysisDocument/64137

[12] Stites, S. (2022, February 26). Nurses would get more support under Oregon Legislative Plan, available at https://www.opb.org/article/2022/02/26/oregon-legislature-nurses-shortage-house-bill-4003-license-nursing-students-practice/

Memory Care (AL/RC/MC) facilities in response to the requirements set forth in SB 703. The final report will be available in January 2023, examining:

- The compensation structure (wages and benefits, incentives, other payments) of care workers employed in Oregon AL/RC/MC communities
- The cost of care provided in these settings to ODHS and residents who use private funds to pay for services
- Staffing challenges in AL/RC/MC communities

In the summer of 2022, ODHS contracted with PHI National to conduct a research project to scan policies and programs concerning the direct care workforce in Oregon and to quantify and describe the direct care workforce in Oregon, including demographic characteristics, wage trends and competitiveness, economic stability, and current and projected demand. PHI National delivered a virtual presentation to executive agency staff and community partners on September 30, 2022 during which a synthesis of the findings from their research were shared, which included a list of evidence-informed policy recommendations to strengthen and stabilize the direct care workforce recruitment and retention in Oregon.

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Section 2

Experience of Other States

Two states, Massachusetts and Minnesota, currently have statutes that require setting maximum rates that temporary staffing agencies can charge. Research was conducted on these two states to understand the impacts of such rate setting, and to understand the differences in implementation in the two states.

Massachusetts

State Environment Related to Temporary Nursing Agencies

According to a report provided to the Massachusetts legislature in May 2021, as of 2018, there are roughly 130,000 RN licenses, with 90,000 actively employed RNs working in the Commonwealth.[13] The Massachusetts Health & Hospital Association and Organization of Nurse Leaders in Massachusetts, Rhode Island, New Hampshire, Connecticut, Vermont 2018 Survey of Hospital Nursing Staff Issues in Massachusetts reports the vacancy rate for RN positions in hospitals was 5.9%, with the percentage of unfilled positions varying by specialty and region.[14] Hospitals reported that 91% of open positions took longer than 30 days to fill. In order to fill the vacant RN positions in Massachusetts, hospitals use per diem nurses, staffing pools, and agency/travel nurses. On average, 14.3 full-time positions were filled by temporary workers per hospital.

Regulations pertaining to prices which temporary nursing services may charge date back to 1988 with 114.3 CMR 45.00: Temporary Nursing Services which establishes *a methodology for determination of reasonable rates of payment for services provided by temporary nursing agencies registered with the Department of Public Health*.[15]

114.3 CMR 45.00 was repealed and re-promulgated as 101 CMR 345.00: Temporary Nursing Services effective March 4, 2013.[16] Last amended in January 2022, 101 CMR 345.00 governs the rates paid by health care providers to temporary nursing agencies registered with the Department of Public Health.[17] Multiple amendments were made to 101 CMR 345.00 between 2014 and 2022. Most of the amendments are adjustments to the maximum rates, with few changes made to definitions included in the bill in 2015 and 2018. In May 2020, Executive Office of Health and Human Services (EOHHS) added additional

[13] Commonwealth Of Massachusetts Health Policy Commission. "Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact Report to the Massachusetts Legislature" (2021, May), available at https://archives.lib.state.ma.us/bitstream/handle/2452/844357/on1252307407.pdf

[14] Massachusetts Health & Hospital Association (MHA) & Organization of Nurse Leaders MA, RI, NH, CT, VT (ONL). "Survey of Hospital Nurse Staffing Issues in Massachusetts, 2018 Highlights", available at https://patientcarelink.org/wp-content/uploads/2021/02/2018-MHA-ONL-Nursing-Survey-Highlights-2-11-2021.pdf

[15] 114.3 CMR 45.00 can be found on page 73 of the Massachusetts Register, Issue: 595, Date: November 11, 1988, available at https://archives.lib.state.ma.us/handle/2452/857985

[16] 101 CMR 345.00 can be found on page 201 of The Massachusetts Register, Issue: 1229, Date: March 1, 2013.

[17] Executive Office of Health and Human Services, *101 CMR 345.00: Temporary Nursing Services*, pp. 851–855.

provisions to supplement 101 CMR 345.00 to address the potential for increased costs associated with COVID-19 and the need to provide temporary nursing services in alternate locations. A summary of the changes for each amendment are shown in **Table 1** below.

Table 1 – 101 CMR 345.00 Summary of Amendment Changes

Year of Amendment	Summary of Changes
2014[18]	Amendment to maximum prices in 345.03 Rate Provisions.
2015[19]	Amendment to 345.02: Definitions by adding "Governmental Unit." Amendment to 345.02: Definitions, language change to Temporary Nursing Agency (Agency). Amendment to 345.05: Reporting Requirements sub-section (6) Failure to File Information.
2017[20]	Amendment to maximum prices in 345.03 Rate Provisions. In 345.03(3)(b), in the rate chart for "Weekend 3" / "HSA 4," change the rate from "$101.84" to "$102.84."
2018[21]	Amendment to 345.02: Definitions removing "Center" definition. Amendment to maximum prices in 345.03 Rate Provisions.
2019[22]	Amendment to maximum prices in 345.03 Rate Provisions.
2020[23]	Amendment to file as an emergency. Amendment to 345.03 Rate Provisions, sub-section (4) Rates for Temporary Nursing Services Related to COVID-19.
May 2020[24]	Amendment to maximum prices in 345.03 Rate Provisions to address additional staffing needs due to COVID-19.

[18] 101 CMR 345.00 can be found on page 123 of The Massachusetts Register, Issue 1265, Date: July 18, 2014, available at https://archives.lib.state.ma.us/bitstream/handle/2452/213276/ocm04109606-2014-07-18.pdf?sequence=1&isAllowed=y

[19] 101 CMR 345.00 can be found on page 37 of The Massachusetts Register, Issue 1299, Date: November 9, 2015, available at https://archives.lib.state.ma.us/bitstream/handle/2452/303455/ocm04109606-2015-11-06.pdf?sequence=1&isAllowed=y

[20] 101 CMR 345.00 can be found on page 81 of The Massachusetts Register, Issue: 1340, Date: June 2, 2017, available at https://archives.lib.state.ma.us/handle/2452/724600

[21] 101 CMR 345.00 can be found on page 171 of The Massachusetts Register, Issue: 1361, Date: March 23, 2018, available at https://archives.lib.state.ma.us/bitstream/handle/2452/783531/ocm04109606-2018-03-23.pdf?sequence=1&isAllowed=y

[22] 101 CMR 345.00 can be found on page 83 of The Massachusetts Register, Issue: 1389, Date: April 19, 2019, available at https://archives.lib.state.ma.us/bitstream/handle/2452/801018/ocm04109606-2019-04-19.pdf?sequence=1&isAllowed=y

[23] 101 CMR 345.00 can be found on page 107 of The Massachusetts Register, Issue: 1424, Date: August 21, 2020, available at https://archives.lib.state.ma.us/bitstream/handle/2452/832176/ocm04109606-2020-08-21.pdf?sequence=1&isAllowed=y

[24] Administrative Bulletin 20-39 regarding 101 CMR 345.00 can be found on page 9 of The Massachusetts Register, Issue: 1418, Date: May 29, 2020, available at https://archives.lib.state.ma.us/handle/2452/827541

Year of Amendment	Summary of Changes
2021[25]	Amendment to maximum prices in 345.03 Rate Provisions. EOHHS has determined that immediate adoption of this regulation is necessary to preserve the public health, safety, and general welfare of residents of the Commonwealth, and to ensure continued access to these services.
2022[26]	Amendment to maximum prices in 345.03 Rate Provisions. 101 CMR 345.00 was originally filed as an emergency on 10/7/21, was refiled as an emergency on 12/23/21, and is now being finalized with changes after the public hearing.

Impacts of COVID-19 Pandemic

The COVID-19 public health emergency has made the delivery of critical services by temporary nursing service providers more difficult and costly. As a result, in May 2020, EOHHS enacted new provisions through Order No. 20: *Order Authorizing the Executive Office of Health and Human Services to Adjust Essential Provider Rates During the COVID-19 Public Health Emergency* to supplement the rate regulation for temporary nursing services, allowing for greater flexibility in dealing with the potential for increased costs associated with COVID-19 and the need to provide these critical services in alternate service locations.[17, 27] From May 1, 2020 through June 30, 2020, the EOHHS increased the maximum rates by 35% above the maximum rates set previously for the year, and removed the cap altogether for nurses and CNAs working with COVID-19 patients.

The Commonwealth of Massachusetts' Health Policy Commission (HPC) published a report to the Massachusetts Legislature, required by Chapter 227 of the Acts of 2020 that conducted a number of analyses, including nurse job vacancies in the state. The report to the legislature stated from March 2020 to February 2021 RN job postings in Massachusetts increased by 12%, while neighboring states — New Hampshire, Maryland, and Maine — reported a 9% decrease in RN job postings. Specifically, the demand for critical care, or ICU nurses, increased by 40% over the prior year (2019) compared to an average of 6% in New Hampshire, Maryland, and Maine. Posted compensation offers for ICU RNs in Massachusetts increased by 3.1% in an effort to mitigate critical staffing issues.[13]

During the rise of COVID-19, Massachusetts did not participate in the Nursing Licensure Compact (NLC), which limited the available labor pool, further exacerbating the nursing shortage. The NLC was originally developed in 2000 and is an agreement among states that

[25] 101 CMR 345.00 can be found on page 93 of The Massachusetts Register, Issue 1460, Date: January 7, 2022, available at https://archives.lib.state.ma.us/handle/2452/853819

[26] 101 CMR 345.00 can be found on page 150 of The Massachusetts Register, Issue 1461, Date: January 21, 2022, available at https://archives.lib.state.ma.us/bitstream/handle/2452/854437/ocm04109606-2022-01-21.pdf?sequence=1&isAllowed=y

[27] Executive Office of Health and Human Services. "101 CMR 345.00: Rates for Temporary Nursing Services", available at https://www.mass.gov/doc/101-cmr-345-rates-for-temporary-nursing-services/download

allows nurses to have one compact state nursing license that gives them the ability to practice nursing in other compact states.[28] As of April 2022, 37 states, Guam, and U.S. Virgin Islands are active NLC states. Ohio and Pennsylvania have recently passed legislation to become NLC states, but have not yet enacted it. Alaska, Illinois, Massachusetts, Michigan, Minnesota, New York, Rhode Island, and Washington have pending legislation to join the NLC states. California, Connecticut, the District of Columbia, Hawaii, Nevada, and Oregon do not participate and do not have pending legislation.

Rate Development Process

101 CMR 345.00 governs the rates in Massachusetts paid by health care providers to temporary nursing agencies registered with the Department of Public Health. These rates include a maximum price per hour that can be paid for RNs, licensed practical nurses (LPNs), and CNAs, dependent on health service area (HSA).

There are six HSAs defined in Massachusetts:

1. Western
2. Central
3. Merrimack Valley
4. Greater Boston
5. Southeastern
6. North Shore

Nursing facilities and hospitals, have different rates by HSA and shift time (e.g., weekends or overnight), with additional stipulations for holidays and overtime. Holiday pay is capped at a maximum of 150% of the rates listed in the legislation. Overtime pay can be added for hours worked in excess of 40 hours per week, or eight hours in one day, if agreed to by the temporary nursing agency and the health care facility. Employees who work exclusively for a particular health care facility for a fixed term of at least 90 days are exempt from these rules.

Temporary nursing agencies and facilities may also agree to an hourly rate for 12-hour shifts that do not exceed the weighted average rate of the maximum rates for the applicable shifts as listed in the legislation. To cover housing and any additional costs, including but not limited to meals, rates paid to facilities for nurses who are compelled to move into temporary accommodations may be increased by up to 19.7% of their comparable maximum rate.**Error! Bookmark not defined.**

Rates set for services provided on and after October 1, 2021 are shown in

[28] Kathleen, G. “Compact Nursing States List 2022”, available at https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/

Table **2** and Table 3 below, for nursing facilities and hospitals.

Table 2 – Maximum Prices for Nursing Facility Staff

(2) Maximum Prices, Nursing Facilities.

(a) Registered Nurse (RN) – Nursing Facility.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$71.03	$68.84	$69.49	$71.37	$69.80	$70.51
Weekday 2	$75.29	$73.10	$73.75	$75.63	$74.06	$74.76
Weekday 3	$77.42	$75.22	$75.88	$77.76	$76.18	$76.89
Weekend 1	$76.35	$74.16	$74.81	$76.69	$75.12	$75.83
Weekend 2	$78.48	$76.29	$76.94	$78.82	$77.25	$77.96
Weekend 3	$78.48	$76.29	$76.94	$78.82	$77.25	$77.96

(b) Licensed Practical Nurse (LPN) – Nursing Facility.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$60.06	$58.77	$59.93	$63.24	$61.28	$63.15
Weekday 2	$64.32	$63.03	$64.19	$67.50	$65.54	$67.41
Weekday 3	$66.44	$65.15	$66.32	$69.63	$67.67	$69.54
Weekend 1	$65.38	$64.09	$65.25	$68.57	$66.60	$68.47
Weekend 2	$67.51	$66.22	$67.38	$70.69	$68.73	$70.60
Weekend 3	$67.51	$66.22	$67.38	$70.69	$68.73	$70.60

(c) Certified Nurse Aide (CNA) – Nursing Facility.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$32.43	$32.86	$33.45	$33.33	$32.89	$34.00
Weekday 2	$34.56	$34.99	$35.58	$35.46	$35.02	$36.12
Weekday 3	$35.62	$36.06	$36.64	$36.53	$36.08	$37.19
Weekend 1	$35.62	$36.06	$36.64	$36.53	$36.08	$37.19
Weekend 2	$36.69	$37.12	$37.70	$37.59	$37.14	$38.25
Weekend 3	$37.22	$37.65	$38.24	$38.12	$37.68	$38.78

Table 3 – Maximum Prices for Hospital Staff[Error! Bookmark not defined.]

(3) Maximum Prices, Hospitals.

(a) Registered Nurse (RN) – Hospital.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$96.76	$102.35	$100.28	$105.00	$100.21	$100.08
Weekday 2	$106.81	$112.40	$110.33	$115.05	$110.27	$110.13
Weekday 3	$110.49	$116.08	$114.01	$118.73	$113.94	$113.81
Weekend 1	$107.16	$112.75	$110.68	$115.40	$110.61	$110.48
Weekend 2	$110.99	$116.57	$114.51	$119.23	$114.44	$114.31
Weekend 3	$112.74	$118.32	$116.26	$120.98	$116.19	$116.06

(b) Registered Nurse Specialist (RN-Specialist) – Hospital.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$106.75	$108.12	$111.73	$113.62	$103.50	$109.16
Weekday 2	$131.09	$132.46	$136.07	$137.97	$127.84	$133.51
Weekday 3	$134.60	$135.96	$139.58	$141.47	$131.34	$137.01
Weekend 1	$133.21	$134.58	$138.19	$140.08	$129.96	$135.63
Weekend 2	$134.19	$135.55	$139.16	$141.06	$130.93	$136.60
Weekend 3	$135.87	$137.24	$140.85	$142.74	$132.62	$138.29

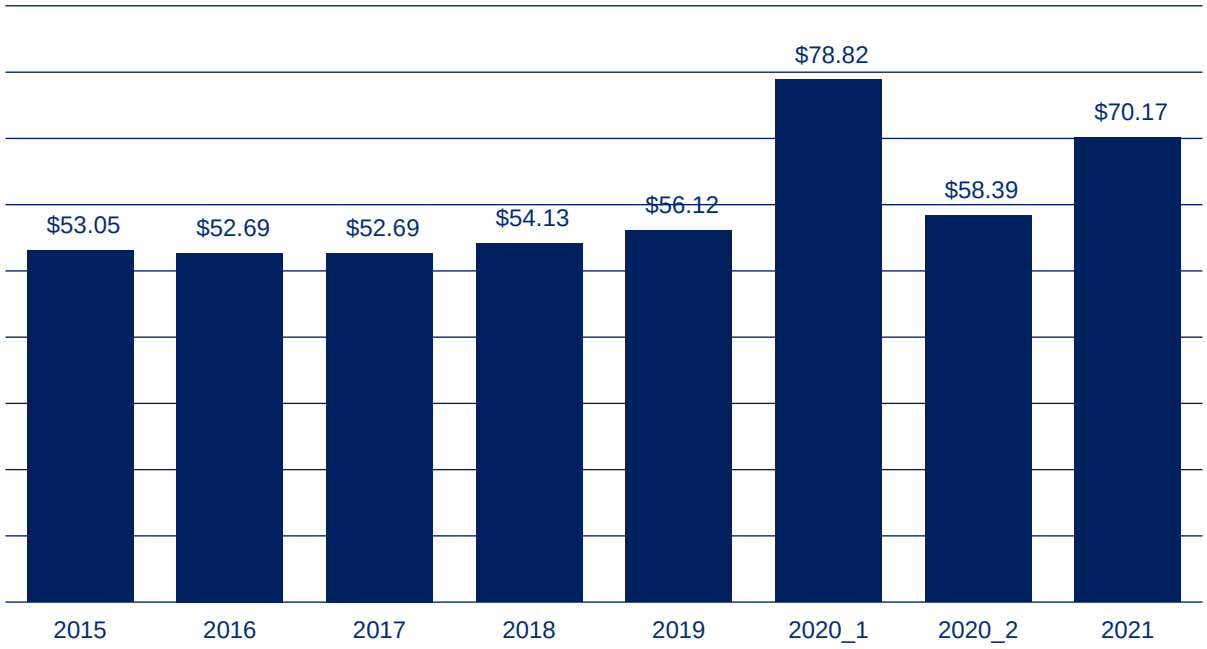
(c) Licensed Practical Nurse (LPN) – Hospital.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$63.35	$61.66	$63.93	$64.24	$65.47	$62.72
Weekday 2	$71.66	$69.96	$72.24	$72.54	$73.77	$71.02
Weekday 3	$73.91	$72.21	$74.48	$74.79	$76.02	$73.27
Weekend 1	$72.37	$70.67	$72.95	$73.25	$74.49	$71.73
Weekend 2	$75.53	$73.83	$76.11	$76.41	$77.65	$74.89
Weekend 3	$76.33	$74.63	$76.91	$77.21	$78.45	$75.69

(d) Certified Nurse Aide (CNA) – Hospital.

Shift	HSA 1 Western	HSA 2 Central	HSA 3 Merrimack Valley	HSA 4 Greater Boston	HSA 5 Southeastern	HSA 6 North Shore
Weekday 1	$35.76	$35.31	$36.03	$36.61	$36.10	$37.26
Weekday 2	$44.32	$43.87	$44.59	$45.17	$44.66	$45.82
Weekday 3	$46.18	$45.73	$46.45	$47.03	$46.52	$47.68
Weekend 1	$45.53	$45.08	$45.81	$46.38	$45.87	$47.03
Weekend 2	$49.58	$49.13	$49.85	$50.42	$49.92	$51.08
Weekend 3	$50.38	$49.93	$50.65	$51.22	$50.72	$51.88

Figure 1 – Historical Maximum Rates for RNs in Nursing Facilities[Error! Bookmark not defined.,29,30,31,32]



2020_1 shows the average rates allowed for services provided May 1, 2020 through June 30, 2020.
2020_2 shows rates for services provided on or after August 1, 2020.

Massachusetts sets maximum rates by both shift and geographical region. Figure 1 above shows the average rate across all regions in the Commonwealth for the RNs working a *Weekday 1* shift.[33] Maximum rates allowed during the COVID-19 pandemic increased roughly 40%, compared to 2.75% and 3.7% from 2017 to 2018 and 2018 to 2019, respectively.

[29] Executive Office of Health and Human Services. "101 CMR 345.00: Temporary Nursing Services", available at https://www.maseniorcare.org/system/files/resources/TNS101-cmr-345-proposed-redlined-2.pdf

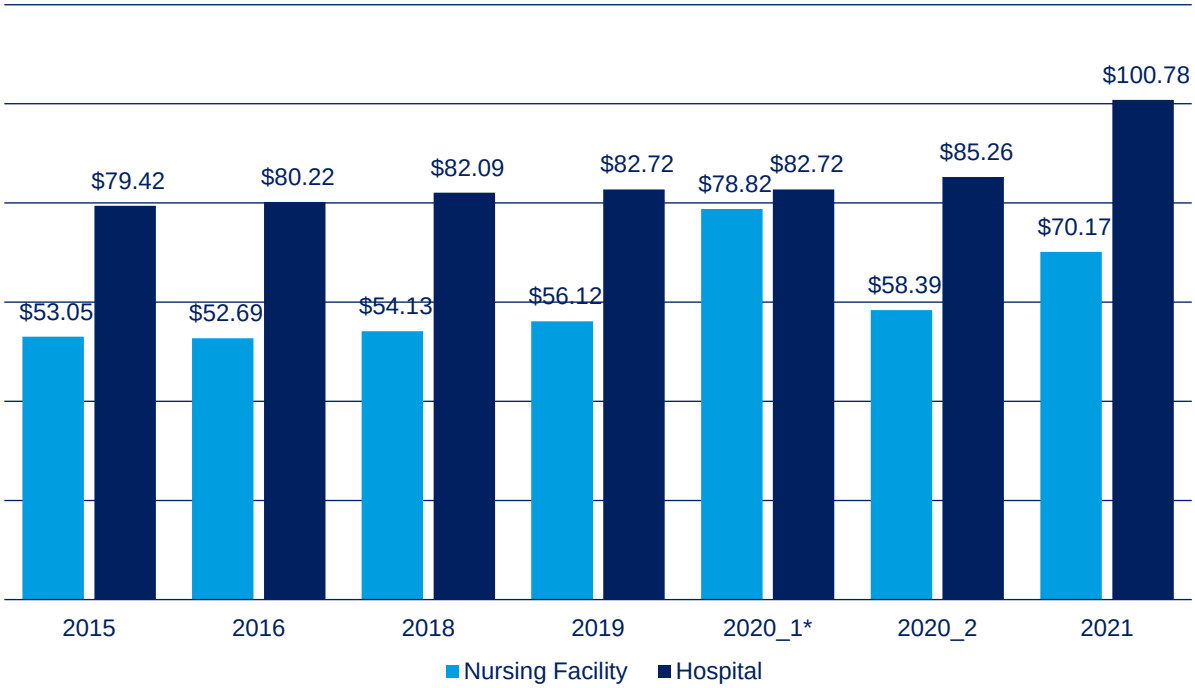
[30] State Library of Massachusetts. "The Massachusetts Register", available at https://archives.lib.state.ma.us/bitstream/handle/2452/801018/ocm04109606-2019-04-19.pdf?sequence=1&isAllowed=y, Pg. 83.

[31] The Commonwealth of Massachusetts Executive Office of Health and Human Services. "Additional Rate Provision Applicable to Temporary Nursing Services Purchased by Governmental Units to Compensate for Costs Associated with Coronavirus Disease 2019 (COVID-19)", available at https://www.mass.gov/doc/ab-20-39-101-cmr-34500-rates-for-temporary-nursing-services-additional-rate-provision/download

[32] State Library of Massachusetts. "The Massachusetts Register", available at https://archives.lib.state.ma.us/bitstream/handle/2452/832176/ocm04109606-2020-08-21.pdf?sequence=1&isAllowed=y, Pg. 107.

[33] Maximum rates in Massachusetts are set by region, position/title, and shift time. There are six different shifts for each position/title in each geographical region. These rates are available at https://casetext.com/regulation/code-of-massachusetts-regulations/department-101-cmr-executive-office-of-health-and-human-services/title-101-cmr-34500-rates-for-temporary-nursing-services/section-34503-rate-provisions

Figure 2 – Nursing Facility vs. Hospital Setting Maximum Rates



2020_1 shows the average rates allowed for services provided May 1, 2020 through June 30, 2020.
2020_2 shows rates for services provided on or after August 1, 2020.
** Rates for RNs in hospitals between May 1, 2020 and June 30, 2020 were not amended.*

Wages shown in

Figure ***2*** show the average wage across all HSAs for *Weekday1* shift for each year. Excluding the maximum wages for RNs during *2020_1*, maximum wages are roughly 50% higher in hospitals compared to nursing facilities.

Wage differentials across HSAs do not vary significantly; the Central region has the lowest wages across the six regions and the Greater Boston region has the highest, however, the rates across HSA vary by 3.7% at the most. By shift, the hourly rates have more variance, with the *Weekend 3* wages approximately 11% higher than the *Weekday 1* wages. Differences in wages by shift are consistent across HSAs.

Maximum Rate Setting Methodology

In establishing rates for nursing agencies under section 72Y of chapter 111, the executive office establishes annually the limit for the rate for service provided by nursing agencies to licensed facilities. The rates include an allowance for wages, payroll taxes and fringe benefits, which shall be based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to permanent medical personnel of the same type at health care facilities in the same geographic region.[34] Rates must also include a "reasonable" administrative expense allowance and a reasonable profit factor, as determined by the executive office.

The executive office established procedures for nursing agencies to submit cost reports, which may be audited, to the office in order to establish rates. Using wage and benefit data from cost reports received from nursing pools and health care facilities, the executive office determines the nursing pool rate.

In accordance with its statutory authority under M.G.L. c. 12C, the Center for Health Information and Analysis (Center or CHIA) collects cost reports to further its mission of monitoring the Massachusetts health care system and providing reliable information and meaningful analysis to those seeking to improve health care quality, affordability, access, and outcomes. The data collected by the Center through the Nursing Services Cost Report (NSR) is used to support the EOHHS' rate-setting obligations, which use the data to establish rates for continuous skilled nursing (CSN) agencies, home health agencies (HHA), and temporary nursing services (TNS) agencies.[35]

Agencies must file a cost report for the fiscal year ending in the year prior to the filing date with the Center on an annual basis. Financial statements and other external documentation that supports that accuracy of the data reported on the cost report must also be submitted. Information required in the cost report includes:

- Agency Information
- Direct Care Staff Expenses

[34] Section 13D. General Law - Part I, Title XVII, Chapter 118E, Section 13D, available at https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118E/Section13D#:~:text=No%20hospital%20shall%20receive%20reimbursement,persuade%20the%20employees%20of%20the

[35] Center for Health Information and Analysis. (2022, April). NURSING SERVICES COST REPORT FOR TEMPORARY NURSING SERVICES (TNS) AGENCIES. COST REPORT INSTRUCTIONS, available at https://www.chiamass.gov/assets/docs/p/nsr-cost-reports/FY2021-Reporting/FY2021-NSR-Cost-Report-Instructions-TNS.pdf

- Administrative Expenses for Non-Direct Care Staff
- Gross Revenue
- Summary of Expenses
- Income Statement and Balance Sheet Data
- Related Party Disclosures
- Statistics
- Other Business Information
- Certification

The Center provides detailed instructions on the information each agency must submit. Once filed with the Center, these reports become public documents and will be provided upon request to any interested party.

Minnesota

State Environment Related to Temporary Nursing Agencies

A publication from Workday Minnesota in 2001 reported the wages paid to temporary nursing employees were two to two and a half times higher than the rates paid to regular, full-time employees.[36] While a portion of these higher rates were received by temporary workers as wages and benefits, the increased rates drained money from nursing homes and caused rate disparities. In an interview with Workday, a union representative stated more than $40 million was flowing out of nursing homes into temporary staffing agencies, creating 'a very direct cause and effect' in limiting the pay raises homes could afford to give staff workers, making it difficult to retain and attract new permanent employees.

In 2001, the Minnesota legislature passed the Supplemental Nursing Services Agency (SNSA) registration law which requires a person, firm, corporation, partnership, or association that provides temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies to register with the Minnesota Department of Health and pay a registration fee.[37,38] Amongst the regulations and requirements within the law, "the SNSA may not receive or charge payments from nursing homes of more than 150% of the average wage for an employee." These average wages are determined by the Commissioner of Human Services, and the maximum allowed rates may not exceed 150% above the

[36] Workday Minnesota. "Judge upholds law placing cap on nursing home fees", available at https://workdayminnesota.org/judge-upholds-law-placing-cap-on-nursing-home-fees/

[37] Minnesota Department of Health. "Supplemental Nursing Services Agency - SNSA Minnesota Statute 2000, Section 144.057; 144a.70 - 144A.74," available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib01_21.html

[38] "Supplemental Nursing Services Agency" means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing service agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

average rate that is determined by the Commissioner of Human Services. Maximum rates for temporary workers are specific to workers in nursing home facilities only and do not apply to temporary workers in hospitals or other health care facilities. At the onset of this program, this maximum charge included all charges, and an SNSA is unable to charge any additional fees. Recently, this has changed to allow the temporary staffing agencies to add on charges to cover travel, lodging, and meals.

The regulation of SNSAs was passed to advance two primary policy objections: (1) to reduce the costs associated with the operation of nursing homes by regulating the amount SNSAs may charge nursing homes for their own operating costs and the wages and benefits of their employees; and (2) to create parity between the wages offered by SNSAs and by nursing homes for permanent nursing staff, allowing the nursing homes to better compete for potential employees and thereby, according to the State, improve the quality of nursing care in nursing homes.

A 2013 study evaluated the geographic and industry mobility of recent RN graduates in Minnesota and found that RNs are in high demand in all regions of the state; though nursing job openings varied depending on the location, size, and type of facility.[39] Facilities in the metropolitan area reported that 22% of their vacancies were challenging to fill compared to 34% for other regions of Minnesota. Hospitals and ambulatory care facilities reported that 37% and 27% had difficulty filling vacancies, respectively, whereas 47% of nursing and residential care facilities reported having difficulties. Supply shortages of nursing staff played a large role in those difficult-to-fill positions, as 82% of employers claimed that lack of available nurses was a factor in their failure to locate personnel.[40] Nursing job mobility trends are impacted by variations in salary and skill levels within the health care industry.

Impacts of COVID-19 Pandemic

In a May 2020 bulletin, the Minnesota Department of Health, Health Regulation Division allowed temporary waivers to the maximum charge amounts for SNSAs when these agencies provide staff to work in Minnesota Medicaid-certified nursing facilities that serve residents with COVID-19.

In Minnesota, Medicaid reimbursement rates for nursing facilities are cost-based, and nursing facilities will not be reimbursed for the cost of temporary staff at a rate higher than the maximum rates. Nursing facilities in Minnesota are allowed to pay SNSAs higher than the maximum rates, though there is no statute or rule that specifically authorizes this. The waiver process allowed a nursing facility to be reimbursed the full costs of using temporary staff, even if the facilitate paid higher than the maximum rate. A request form is required to be completed by the licensed nursing facilities and must be approved prior to contracting with an

[39] Minnesota Department of Employment and Economic Development, Leibert, A. “Geographic and Industry Mobility of New Nursing Grads”, available at https://mn.gov/deed/newscenter/publications/review/january-2014/nursing-grads.jsp

[40] Leibert, A. (2013, March). “Matching Workers with Registered Nurse Openings: Are Skills Scarce?” Trends Magazine - Nursing Skills, available at https://mn.gov/deed/assets/march-2013-nursing-supply-demand_tcm1045-133566.pdf

SNSA for payment that exceeded the maximum rates allowed by law, MS 144A.74. The maximum rates for 2020 are shown in Table 4 below.

Table 4 – SNSA Maximum Charges 2020[41]

Statewide Maximum Allowed Charges Effective January 1, 2020 – December 31, 2020		
Job Position	**Non-Holiday Wages**	**Holiday Wages**
RN	$57.65	$99.15
LPN	$46.01	$80.97
CNA	$29.73	$51.74
TMA*	$32.88	$49.52

*Trained Medication Aide

Reports in Minnesota found that 46% of health facilities experienced nursing shortages and 50% experienced aide shortages during the COVID-19 pandemic.[42] With the additional surge of the omicron COVID-19 variant putting strain on hospitals and staff, the state contracted with a temporary staffing agency from Texas in January 2022 to hire nearly 200 RNs and 20 respiratory therapists to work in hospitals and other medical facilities.[43] These temporary nurses contracted at a rate of $275 per hour with additional amounts up to $375 per day for lodging, food, and other living expenses.

In September 2022, 15,000 members of the Minnesota Nurses Association (MNA) participated in a three-day strike. According to MNA, nurses across 15 hospitals participated in the strike to protest staffing shortages, poor staff retention, and poor patient care, in addition to requesting a seat at the table when staffing decisions are made in order to address under-staffing and to keep more nurses at the bedside.[44] MNA's strike also was intended to put pressure on the state legislature to pass the Keeping Nurses at the Bedside Act (SF 4006).

Hospital representatives responded to MNAs request by voicing the inability to meet the desired wage increase of 31% over three years, stating the *request is not financially viable for community members and health care systems recovering from a pandemic*.[45] Nurses and hospitals have been in negotiations since May 2022, and as of September 2022, the parties

[41] Minnesota Department of Human Services. "SNSA Maximum Charges - December 2020", available at https://mn.gov/dhs/

[42] Van Houtven, C., Miller, K., Gorges, R., Campbell, H., Dawson, W., McHugh, J. Norton, E. C. "State Policy Responses to COVID-19 in Nursing Homes" *Journal of Long-term Care*, (2021), pp 264–282. DOI: http://doi.org/10.31389/jltc.81

[43] Magan, C. "Minnesota to pay $275 per hour, or more, for nurses to battle omicron surge", 2022, available at https://www.twincities.com/2022/01/19/minnesota-to-pay-275-per-hour-or-more-for-nurses-to-battle-omicron-surge/

[44] Minnesota Nurses Association. "15,000 nurses determined to win a fair contract to put patients before profits after historic strike", 2022, available at https://mnnurses.org/15000-nurses-determined-to-win-a-fair-contract-to-put-patients-before-profits-after-historic-strike/

[45] Twin Cities, Magan, C. "Minnesota nurses to strike for three days starting Sept. 12", 2022, available at https://www.twincities.com/2022/09/01/mn-nurses-strike-association-minneapolis-st-paul-duluth/

have reached “tentative agreements” on matters of workplace safety, but ongoing negotiations are planned to continue.[46]

Rate Development Process

Introduced in 2001, Minnesota Statute 2000, section 144.057 states that supplemental nursing may not bill or receive payments from long-term care facilities that exceed 150% of the average wages for permanent staff. Data on wages paid to permanent staff are collected from Medicaid-certified nursing facilities, and the wages for facilities in the metropolitan areas of the state are used to calculate the averages wages. Minnesota originally set maximum rates by geographic region. Later, statutes were amended to have one statewide rate standard for administration simplification (e.g., some providers operate nursing facilities in multiple regions). Statewide maximum allowed rates for holidays differ from maximum rates for non-holidays.

The maximum rates are inclusive of all charges for administrative or contract fees or other special charges in addition to the hourly rates, though recent changes now allow SNSA’s to charge add-ons for travel, lodging, and meals. **Error! Not a valid bookmark self-reference.** below shows the current maximum rates allowed to temporary staff by the SNSA.[47] Full text of the 144A.74 maximum charge provisions for calendar year 2022 is excerpted in Appendix B.

Table 5 – 2022 SNSA Maximum Charges for Licensed Nursing Homes [48]

Statewide Maximum Allowed Charges Effective January 1, 2022 – December 31, 2022		
Job Position	**Non-Holiday Wages**	**Holiday Wages**
RN	$62.36	$107.25
LPN	$50.75	$89.31
CNA	$34.10	$59.33
TMA	$36.57	$66.20

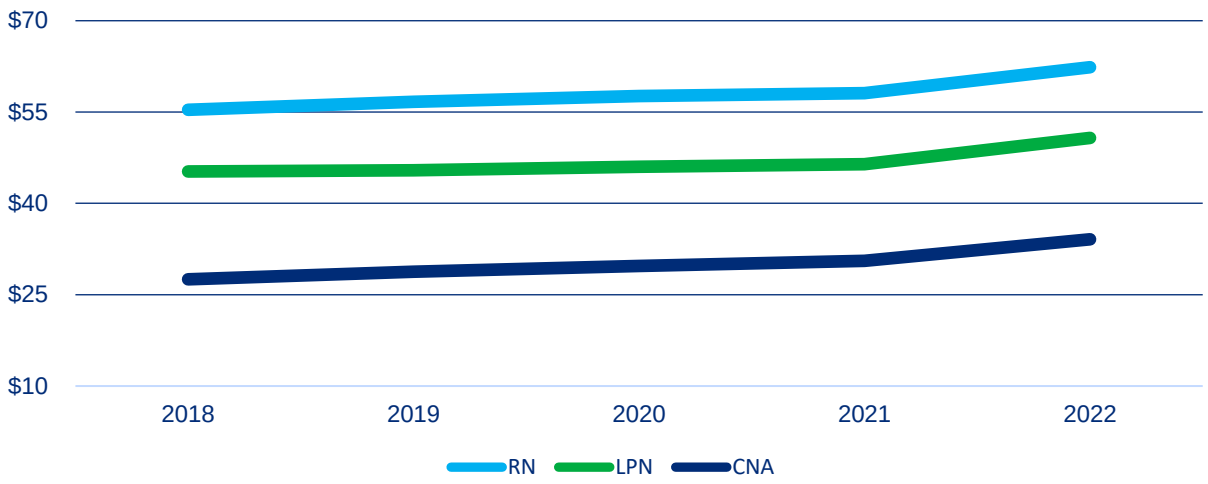
[46] Muoio, D. (2022, September 12). Largest private-sector nurses' strike in U.S. history kicks off across 16 Minnesota hospitals, available at https://www.fiercehealthcare.com/providers/over-15000-minnesota-nurses-across-15-hospitals-sign-labor-strike

[47] Supplemental Nursing Services Agency means a person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental nursing services agency does not include an individual who only engages in providing the individual's services on a temporary basis to health care facilities. Supplemental nursing services agency also does not include any nursing service agency that is limited to providing temporary nursing personnel solely to one or more health care facilities owned or operated by the same person, firm, corporation, or partnership.

[48] Minnesota Department of Health. “SNSA Maximum Charges 2022 for Licensed Nursing Homes in Minnesota” available at https://www.health.state.mn.us/facilities/regulation/snsa/docs/snsa.pdf

Figure ***3*** below shows maximum rates set by the SNSA from 2018 to 2022 for non-holiday rates for RNs, LPNs, and CNAs.

Figure 3 – SNSA Maximum Charges[41,49,50]



While rates have increased steadily from 2018 to 2021, the impact of the wage increases during the COVID-19 pandemic did not significantly impact the base maximum charges until 2022.

Maximum Rate Setting Methodology

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under Chapter 144A Section 74 at a rate higher than 150% of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes for the applicable employee classification for the geographic group. Payroll taxes, as defined in 256R.02, subdivision 37, are defined as the costs for the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Annually, the state calculates the average wages of RNs, LPNs, CNAs, and TMAs in care centers using the data provided from annual cost reports, and then computes the statutory limits on the amount that SNSAs can charge per hour for each type of staff. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home. A nursing home that pays for the actual travel and housing costs for supplemental

[49] Minnesota Department of Human Services. "SNSA Maximum Charges - December 2020", available at https://mn.gov/dhs/

[50] Minnesota Department of Human Services. "2019 SNSA Maximum Charges", available at https://mn.gov/dhs/

nursing services agency staff working at the facility and that pays these costs to the employee, the agency, or another vendor, is not violating the limitation on charges.

However, shortly after the passage of SNSA Minnesota Statute 2000, Section 144.057; 144a.70 - 144a.74, Allied Professionals, Inc. filed a lawsuit against the State of Minnesota, and on August 29, 2001, subsequently won the suit, preventing the State from administrating and enforcing certain sections of 2001 Minnesota Laws, 1st Special Session, Chapter 9, Article 7 ("Regulation of Supplemental Nursing Services Agencies"). Amendments to the statute have been made since, but the information provided by the State which inevitably contributed in the Court's decision proved useful in gaining information in how the average and maximum rates were calculated.

The Court's decision was stated to be solely on the equal protection act claim, however, *the Court is also deeply troubled by the manner in which the Department of Human Services ("DHS") calculated the maximum allowable rates. At present, the Court has only the most vague description of how DHS arrived at the figures which are scheduled to go into effect; the record remains unclear about what, specifically, was averaged and what factor was used in the weighting. But the Court has been provided with an explanation of how DHS incorporated shift differentials into its calculation, and the process appears grievously flawed.*[51]

In response to the request for further methodology explanations, the State described how DHS incorporated shift differentials:

DHS started with the average wage differential for each type of shift (evening, night, or weekend) for each job group (RN, LPN, or CNA) as reported in a survey by the Minnesota Health and Housing Alliance (a trade association). Next, for each combination of shift and job group, DHS multiplied the average shift differential by the percentage of facilities paying any differential, and then multiplied that product by the percentage of all hours which qualify for that shift differential within that job category. The result was then added to the base weighted average wage rates.

The end result is that only between 0.0525% and 0.266% of each average wage differential was added onto the weighted average wage rates.

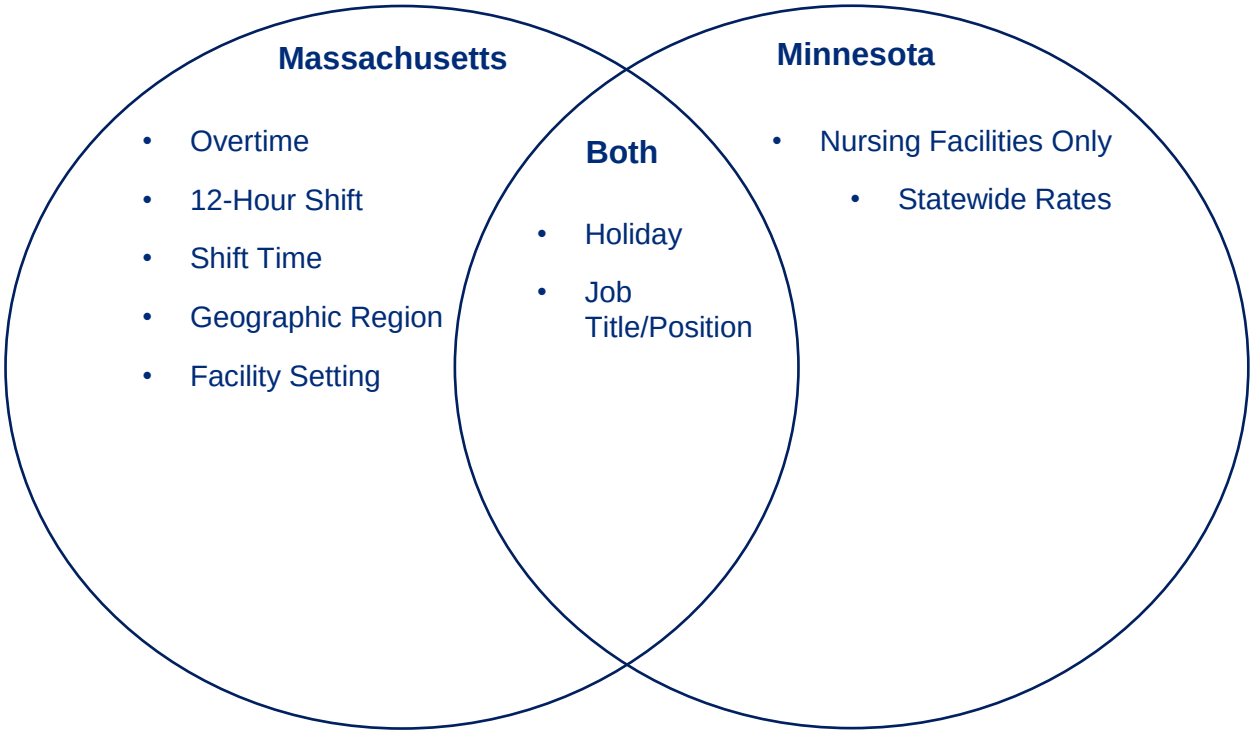
Minnesota DHS does publish an instruction manual for the Annual Statistical and Cost Report of Nursing Facilities intended to assist providers participating in the Minnesota Medical Assistance Program in completing the annual statistical and cost report of nursing facilities. The cost report, supplemental schedules and other data required to be submitted with the cost report provides the cost basis for the determination of rates to be paid to nursing facilities.

[51] Allied Professionals, Inc. v. State of Minnesota, Civil No. 01-1534 (DWF/AJB) (D. Minn. Aug. 30, 2001), available at https://casetext.com/case/allied-professionals-inc-v-state-of-minnesota

Summary

Massachusetts and Minnesota both have legislation for maximum rates within health care facilities, however, the methods/considerations each state incorporated in setting maximum rates differ. Figure 4 below shows the factors considered when setting maximum rates in Massachusetts and Minnesota, showing the similarities and differences.

Figure 4 – Considerations in Maximum Rates



Massachusetts and Minnesota remain the only two states that implement maximum rates that temporary staffing agencies can charge for temporary nursing staff. Pennsylvania recently passed HB 2293 which establishes oversight of temporary health care services agencies through complaint investigations.[52] The information gathered from these other states was used to inform the recommendations within this report.

[52] The General Assembly of Pennsylvania. (2022, June 30). Pennsylvania HB2293: 2021-2022: Regular session, available at https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2021&sessInd=0&billBody=H&billTyp=B&billNbr=2293&pn=3344

Impacts of Setting Maximum Rates

Price Controls

Prices are critical components to any economic system because they convey information to all collaborators about the value of any service and the cost of production. Price caps limit the maximum price providers can charge for a given service or set of services without establishing the exact payment amount, allowing market forces and market-based policies to influence prices below the caps and allowing prices to vary to some extent across providers and health plans.[53]

Since rate caps retain the potential for market forces and market-based policies to influence prices under the cap, they can be less disruptive than setting prices. This is especially true when caps are set to only bind at the highest prices. Some proposals advocate for beginning with generous caps that can then be reduced, recognizing the tradeoff between the efficiency of caps in reducing spending and their potential for unintended consequences for provider financial viability, quality, and access.[54]

Facilitation of meetings with collaborators allowed organizations to express either favorable statements in support of rate caps for temporary staffing or their disapproval of the policy. Representatives from staffing agencies, public research universities, nonprofit long-term care associations, and health care associations participated in multiple meetings and provided additional comments and perspectives.

Perspectives of Collaborators

Note that SB 1549 does not require a recommendation on whether Oregon should set maximum rates that temporary staffing can charge. However, it was important to understand the perspectives of various parties on setting maximum rates, as we developed a recommendation on a *process for setting rates* (see next section).

As mentioned, Mercer and OHA facilitated virtual meetings with collaborators to understand the perspectives of those who would be impacted by setting maximum rates that temporary staffing agencies can charge for health care workers in Oregon. Initially, one meeting was held for those in favor of setting rate caps and one meeting for those opposed to setting rate caps, followed by five meetings with both groups in attendance. Based on these meetings, as

[53] Fuglesten Biniek, J., & Pany, M. (2022, July 21). Price Regulation, global budgets, and spending targets: A road map to reduce health care spending, and improve affordability. Health Costs, available at https://www.kff.org/health-costs/report/price-regulation-global-budgets-and-spending-targets-a-road-map-to-reduce-health-care-spending-and-improve-affordability/

[54] Michael E. Chernew, Leemore S. Dafny, and Maximilian J. Pany, A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market (Washington, DC: The Hamilton Project, March 2020), available at https://www.hamiltonproject.org/papers/a_proposal_to_cap_provider_prices_and_price_growth_in_the_commercial_health_care_market

well as responses from a survey administered by OHA, these viewpoints are summarized below.

In Favor of Setting Maximum Rates

- Current temporary staff rates are high compared to historical standards and are having negative impacts on the financial stability of health care facilities, as reimbursement rates for health care services are not correspondingly increasing.
- Since the pay for temporary staff has drastically increased, facilities are seeing permanent full-time employees quit and work in other facilities as temporary staff in return for higher pay; there are quality of care issues as permanent staff are more familiar with a facility's service users and protocols.
- Current permanent staff are experiencing significant unhappiness due to having to train the temporary staff, who are being paid a much higher wage than the permanent workers.
- Due to the high costs for temporary staffing, some health care facilities are unable to hire enough staff, potentially causing issues with continuity of care and other quality of service issues.
- Not having rate caps on temporary nursing staff has caused bidding wars among health care facilities, as they compete for limited staff resources, and health care facilities stated that they are being required to offer high bonuses in order to get positions filled.
- Rate caps on temporary staffing agencies would provide more consistency when reviewing contracts and pricing details (e.g., wages, bonuses add-ons) as these tend to vary across agencies.
- High costs of temporary staffing for providers with fixed revenues could pull resources away from wages for permanent staff, and setting rates could bring more fiscal stability for providers.

Opposed to Setting Maximum Rates

- Capping rates that temporary agencies can charge would lead to lower wages for temporary staff in Oregon, causing some temporary staff to choose to work in other states, and Oregon facilities would not be able to hire enough temporary staff to fill needs.
- Rate caps on temporary staffing agencies would limit compensation not only for temporary workers, but permanent staff as well, which would drive more workers out of the industry or encourage workers to obtain employment in states without rate caps.
- Rate caps are an artificial constraint on the wages of the temporary workers and the current higher wages are necessary due to national economic conditions.
- Setting rate caps would constrain the ability of temporary staffing agencies to operate effectively and would impact the profitability of those agencies.

Mercer

Section 2

Recommended Process for Setting Maximum Rates

Review of Massachusetts' and Minnesota's rate setting requirements revealed commonalities between the states that should be considered when developing a process for setting maximum rates for temporary nursing staff in Oregon. However, there are also significant differences between how each state has appraoched their maximum rate setting process. In these circumstances, decisions should be informed by collecting data from both temporary staffing agencies and health care facilities. These considerations were presented and discussed with collaborators during multiple meetings and deemed to be of importance for this recommended process. These considerations include:

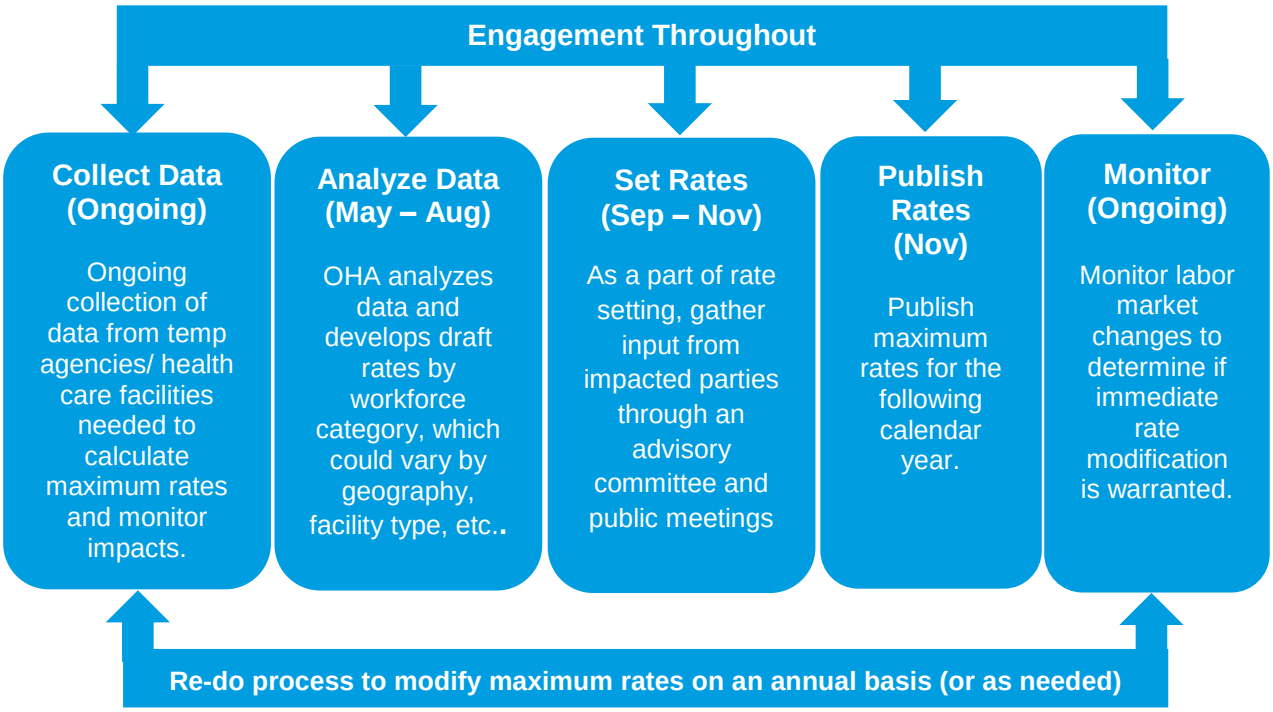
1. Basic Mechanism for Setting Maximum Rates
2. Categories of Temporary Health Care Workers
3. Additional Staff Qualifications that Impact Maximum Rates
4. Workplace Setting
5. Geographic Variation
6. Holiday Rates
7. Shift Differentials
8. Modifying Maximum Rates Outside of the Regular Annual Cycle

The general process for setting maximum rates is described in

Figure **5** below and explains the rate setting process framework for the governing body to follow. Clear and accurate collection of staff wages from temporary staffing agencies and health care facilities, is pertinent to understand the landscape of any wage disparities that may exist between temporary staff and permanent staff. This ongoing collection of data across the state will allow for timely assessment of wage differences. Once the data is collected and then analyzed, draft rates can be developed by OHA. The rates may vary by geographic location or facility type and would depend on where and to what extent any wage disparities exist. After the wages are set, they are then published for the public to see and comment. Finally, continuous monitoring of the wages, data, and community input throughout, will allow for flexible and necessary changes to the rates.

Mercer

Figure 5 – Annual Process Framework



Summary Table of Recommendations

Factor	Recommendation	Explanation
Basic Mechanism for Setting Maximum Rates	Use wages for permanent staff as a baseline for the calculation of maximum rates for temporary staff.	Under the requirements and constraints of the current economic situation, using permanent workers' wages as the baseline for the maximum rate calculation may be the best option. The full report compares the potential impacts of using wages for permanent staff, wages for temporary staff, or both.
Categories of Temporary Health Care Workers	Set maximum rates for a limited number of categories of workers and include the most common temporary staffing categories.	The maximum rates in Massachusetts and Minnesota apply only to the nursing workforce, and Oregon could also include direct care workers and physician categories.
Workplace Setting	Differentiate maximum rates across facility type. More data are needed before determining which facilities	There was near consensus that maximum rates should vary by facility type.

Factor	Recommendation	Explanation
	should be subject to the maximum rates.	
Geographic Variation	Vary rates by geographic regions, making a final determination of regions based on the wage data collected.	Economic conditions vary by geography across the state. There was near consensus that the maximum rates for temporary staff should vary by geography, and a desire was expressed for a small number of regions.
Holiday Rates	Set a 50% higher maximum rate for holidays.	A 50% increase in pay is fairly standard for holidays, and the other two states increase the maximum rates for holidays.
Shift Differentials	Vary maximum rates by work shift, including looking at day-parts and weekends.	There was widespread support for shift differentials; higher rates are needed to fill less desirable shifts. Massachusetts differentiates 3 shifts per day and weekdays versus weekends.
Modifying Maximum Rates Outside of the Regular Annual Cycle	Allow the regulating authority to modify maximum rates when the labor market changes abruptly and consider other policy options for specific circumstances.	Massachusetts and Minnesota modified maximum rates outside of the annual process, during the COVID-19 pandemic. Other policy options include allowing temporary staffing agencies to apply for waivers so facilities can charge more than the maximum rates. Such policy options should be limited to special circumstances (i.e. workforce shortage for a specific profession, or labor market conditions limited to a geographic area)

Basic Mechanism for Setting Maximum Rates

Recommendation

Determine whether the benchmark for the rate setting process is based on permanent staff, temporary staff wages, or a combination of both.

- Using permanent staff wages could reduce the differences between the permanent worker wages and temporary staffer wages that were exacerbated during the COVID-19 pandemic, but placing constraints on the compensation of health care workers could reduce available labor and make positions, permanent and temporary, more difficult to fill.
- Using temporary staff wages, both historical rates and current rates, could provide the state the ability to constrain future growth in staffing costs while minimizing the disruption

the establishment of maximum rates would have on the market, but would not address the current structural challenges for health care staffing that are caused by higher rates for temporary staffing.

- Using a combination of both permanent staff wages and temporary staff wages could reduce the appeal of leaving permanent positions for temporary work that is currently driven by the markedly higher wages paid to temporary staff and allow flexibility for the wages of permanent staff to be increased and to remain below the maximum rate cap. This approach also requires the most effort by far to collect and analyze data needed to establish the blended rate; the administrative cost of this has to be considered

Other States

Massachusetts

Detail on how Massachusetts sets maximum rates for temporary nursing staff is outlined in Section 2. Briefly, the executive office establishes rates on an annual basis based on the following criteria:

- Separate rates for RNs, LPNs, and CNAs
- Geographic region
- Include an allowance for wages, payroll taxes and fringe benefits
  - This rate is based upon median wages, payroll taxes and fringe benefits paid to permanent medical personnel of the same type at health care facilities in the same geographic region
- Include an allowance for administrative expenses and a reasonable profit factor
- An agency may charge a nursing facility or hospital less than the maximum rate for temporary nursing staff
- Each agency must complete and file a TNS Cost Report with EOHHS or its designee each calendar year

Minnesota

Detail on how Minnesota sets maximum rates for temporary nursing staff is outlined in Section 2. Briefly, Minnesota sets rates only for staff working in nursing facilities by position, holiday or non-holiday rates, but not by geographic location. The maximum rates are inclusive of all charges for administrative or contract fees or other special charges in addition to the hourly rates. Supplemental nursing may not bill or receive payments from long-term care facilities that exceed 150% of the maximum allowed rate established by the Commissioner of Human Services.

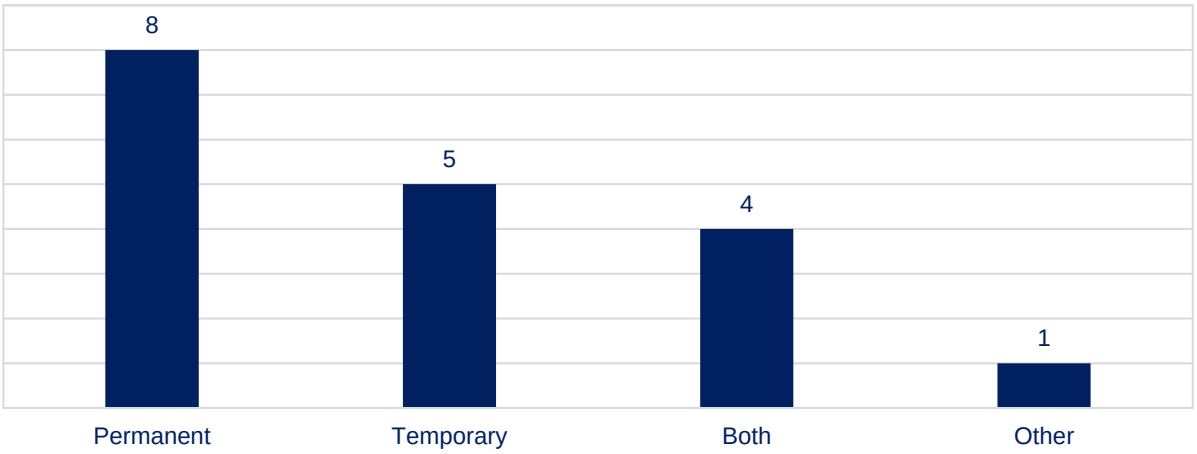
Collaborator Perspectives

Wages to be used when setting initial maximum rates was a heavily discussed topic amongst the collaborator meetings. Participants were also asked what worker wages should be used to set maximum rates in the survey provided to collaborators and resulted in the answers and feedback in Figure 6.

A consensus on what wages should be used when initially setting maximum rates was not reached amongst collaborators, but the majority of opinions side with using permanent staffing wages. However, collecting data on both temporary and permanent wage data could be helpful when informing future decisions regarding maximum rates for temporary nursing staff.

Figure 6 – Maximum Rate Wage Base Data

Should the process for setting maximum rates for temporary staff be based on data for wages currently paid to temporary agency staff or to permanent staff?



Question Response	Corresponding Additional Feedback From Survey
Temporary Staff Wages	"The pay wage differences in Perm staff are significant. We see facilities paying (for example) $15 for a CNA and others $25. Some facilities are doing it right- paying fairly and they are retaining staff while others are paying just minimum wage. Some facilities pay higher in lieu of benefits as well. How do you qualify these variances?"
Permanent Staff Wages	"Using the permanent average wage will ensure that the state is using the right base wage and then would add an appropriate escalator on top of that. We also know that other states that have rate-setting in place or are considering rate setting are using the permanent staff average wage."

Question Response	Corresponding Additional Feedback From Survey
Permanent Staff Wages	“Utilizing the inflated, exorbitant costs temporary staffing agencies are charging long-term care providers as the baseline for any kind of data to be used in determining appropriate caps is not a reasonable solution to this issue. It entirely defeats the purpose of this request. Permanent staffing data must be used.”
Both	“We need a model that creates transparency and flexibility.”
Both	“Would expect to pay agency costs in addition to the wage of permanent staff.”

Discussion

Data Reporting

Developing an understanding of the current rates for temporary staff as well as total compensation and benefit costs of permanent staff would require reporting from facilities and staffing agencies. Data around the wages and costs by the rate consideration categories will be required to inform the rate setting process. The following is a partial list of costs and considerations that should be considered as part of the maximum rates that temporary staffing agencies can charge:

- Direct Wages
- Worker’s Compensation and Disability Costs
- Number of workers or FTEs
- Insurance Costs
- Administrative Costs
- Taxes and Other Fees
- Staffing Agency Profit Margin

Other costs and compensation, for example travel and lodging or health and welfare benefits, may be part of the overall costs for temporary staff. However, the variability and specific situations that might warrant those costs are not consistent and therefore may need to be included as an add-on to the maximum rates.

Frequent refreshing of the actual costs and contracted rates would provide insight as to the current market conditions and can inform if the maximum rates need to change due to economic and other factors. While the legislation requires an annual process to set rates, the potential need to make adjustments to the rates on a more frequent basis should be included in the rate setting process.

Permanent Staff Wages as Base Data

Using permanent staff wages as a benchmark for the maximum rate cap could reduce the differences between the permanent worker wages and temporary staffer wages that were exacerbated during the COVID-19 pandemic. This process would be established by having maximum temporary agency wages correlated to a specified percentile of salaried wages for permanent staff of similar position, facility, and geographic region. For example, Massachusetts uses the median of the permanent worker wages as their benchmark, and the maximum rates are calculated as 150% of this benchmark; if Oregon did so, this would provide significant cost savings to the facilities using temporary staffing services.

Collaborators in favor of this approach argue the importance of using permanent employee salaries as a baseline for maximum rates for temporary staff rates because of the economic rationale with this approach that temporary workers are economic substitutes for salaried works. When dealing with substitutes, the cost of each type of staffer needs to be considered, not just one in isolation because the consumer, a health care facility in this case, will pull from which ever brings the highest value.

With this approach, a process will need to be determined on how best to monetize the benefits that a permanent worker may receive but a temporary worker does not (e.g., paid time off, pension/retirement options, bonuses, richer health benefit, paid licensing/board certification, paid continuing education credits, etc.). It will be necessary to consider the entire benefit package, not just the dollars of the salary, however, aggregating the benefits poses challenges as benefits many vary across facilities. This is hard to do in the aggregate because some facilities may offer very rich benefits, while others less so, and will need to be updated based on market changes.

Additionally, a method by which the mean (or median) salary for a given profession, plus all the monetized fringe benefits, is needed to understand the range or variability of salaries analyze that standard deviation. The maximum rate could then be set in relation to the fully loaded salary/compensation amount (e.g., 125% of the mean, 90th percentile, 200% of the median, etc.).

Benefits

Setting rates so that temporary workers earn a maximum rate that is a set percentage of permanent worker wages would serve as a “leveler” for the compensation of both temporary workers and permanent workers. This would reduce the attractiveness of becoming a temporary worker for permanent workers who see the higher wages paid to temporary workers; this should help to increase the retention of permanent workers. This should also provide for reduced labor costs for providers who have been faced with significant escalation in these costs, particularly during COVID-19.

Constraints

There is evidence that setting costs at this level might not prove a panacea, as history in Minnesota and Massachusetts has shown. The Minnesota study released in 2014 showed that nursing and residential care facilities had the lowest hourly wages, and staffers were more likely to leave those positions within their first 18 months of employment if they

remained in health care. Placing constraints on the compensation of health care workers such as are contemplated here could reduce available labor and make positions, permanent and temporary, more difficult to fill.

In Massachusetts, while the maximum rates help constrain costs, the consequences of those capped salaries resulted in higher open positions in Massachusetts while neighboring states which do not have rate caps saw a decrease in postings. For specialized services, the delta in open positions was more acute as ICU nurse job postings increased by 40% over the prior year (2019) in Massachusetts compared to an average of 6% in New Hampshire, Maryland, and Maine.

Temporary Staff Wages as Base Data

Unlike the use of permanent staff wages as the basis for setting a maximum rate cap, there are no examples where temporary staff wages have been used for this purpose. That makes this inherently more speculative as an option but it is still a viable one. Setting maximum rates for temporary nursing staff based on current and historical temporary staff wages would require reporting from temporary agencies on the average hourly rate charged by facilities, average direct wages paid to temporary workers, and number of workers contracted/placed on an annual basis by the following categories: geographic region, shift type, employee position (education/certifications), and facility type. Once data is collected, percentiles of hourly rates charged would be stratified by each category for the 10th, 25th, 50th, 75th, and 90th percentiles for the percent of rates paid as direct wages.

For example, the first years' rate cap could be based upon the 90th percentile of direct wages based on each category. The 50th percentile of non-direct wage expenses included in the hourly rate charged to facilities would be applied to the 90th percentile of wages to serve as the maximum hourly rate. Temp agencies currently charging above the maximum hourly rate could continue to do so, however, they may not increase the hourly rate until the maximum rate is set at a higher level than their current rate. Agencies would be allowed to decrease their hourly rate below the maximum rate, and subsequently increase to, but not exceeding the maximum hourly rate.

Benefits

Setting maximum rates based upon current and historical rates for temporary staff would recognize the forces of supply and demand at work in the market for labor in health care. The increases in costs for temporary workers have occurred in response to unmet demand, and this trend has accelerated, not declined. Using current and historical rates for temporary staff as the basis for maximum rates would provide the state the ability to constrain future growth in staffing costs while minimizing the disruption the establishment of maximum rates would have on the market. To the extent it constrains temporary wages from continuing the rapid growth seen in recent years, it would put some constraints on the attractiveness of leaving permanent positions for temporary work.

Constraints

Setting maximum rates based upon current and historical rates for temporary staff does not address the current structural challenges for health care staffing that are caused by higher rates for temporary staffing. To the extent higher wages paid for temporary staff are exacerbating the loss of permanent staff and are creating unsustainable cost structures for health care providers, this approach would serve to "lock in" those factors for the foreseeable future, not ameliorate them. This approach does not appear to reflect the policy intent of the legislation.

Without a significantly growing workforce, facilities will continually be looking to hire the same pool of workers, and if the workforce is decreasing due to people leaving the industry, additional pressures would be placed on wages and compensation, as the negotiating power of the staffers increase. Oregon, as stated previously in this report, does not participate in the NLC, which allows for recognition of licenses from other states. Joining the NLC would increase the pool of available workers, and may ease some of the pressures facing the health care industry. However, a position on joining the NLC in this report is not a direct request of the legislation.

Using Both Temporary and Permanent Staff Wages as Base Data

A third option for the state to consider would be to take both permanent staff wages and temporary staff wages into account in establishing a maximum rate cap. As with using just temporary staff wages, there are no examples of this having been used in other states, but there are no inherent barriers that would prohibit doing so.

This approach is conceptually straightforward, using both a calculated maximum rate cap for permanent staff wages and a calculated maximum rate cap for temporary staff wages and then using those two maximum rates to create a blended rate that reflects the mix of permanent and temporary staff. This approach can be very simply illustrated using fictional maximum rates and staff mix: if the maximum rate for permanent staff is established at $50, the maximum rate for temporary staff is $60, and the mix of permanent and temporary staff is 50-50, then the blended maximum rate cap could be $55. Likewise, if the mix of permanent and temporary staff is 75-25, then the blended maximum rate cap could be $52.50.

As with the other base data approaches outlined earlier, this method could be applied to different categories of employees and adjusted as appropriate for such factors as geography, holidays, etc.

The data reporting requirements for this approach would be the most extensive, requiring all or nearly all of the data collection and analysis for both using permanent and temporary wages to establish maximum rate caps. Given this, the benefits of this approach will need to outweigh the increased costs.

This approach introduces an important additional variable, the staffing mix, in establishing the maximum rate cap. To an extent that both permanent and temporary staff rates likely do not, the staffing mix may vary significantly by facility because of a number of factors. This may suggest an approach of calculating a facility-specific maximum rate cap that reflects each facility's staffing mix. However, it is important to note that the data collection and

analysis requirements of this approach – already much more significant than either of the other two methods – would significantly increase if facility-specific blended rates were to be required. This would also introduce new and unpredictable incentives into the market, with providers in close geographic proximity potentially having significantly different maximum rate caps.

Benefits

Taking a blended approach would enable the state to have some of the advantages of both models. While the blended approach would not provide the same full recognition of market forces as using temporary staff wages for base data, it would provide some sensitivity to supply and demand and would have the ability to adjust in response. If the mix of temporary staff increases, for example, that change could be reflected in the calculation of the blended rate. It would put constraints on the attractiveness of leaving permanent positions for temporary work that is currently driven by the markedly higher wages paid to temporary staff. It would also provide room for the wages of permanent staff to be increased and to remain below the maximum rate cap, easing the limiting pressure on wages for permanent staff that would result if permanent staff wages were used as the base data.

Constraints

Using both permanent and temporary wages also carries some of the potential constraints of each of the other frameworks. To the extent provider cost structures are currently unsustainable because of the costs of temporary staff, this approach would not reduce those costs as much as if permanent staff wages were used as the base data. It would institutionalize a wage discrepancy between permanent and temporary staff wages that could continue to provide a rationale for permanent staff to leave and join temporary staffing firms. It would impose a lower cap than if temporary staff wages were used for base data and this could accelerate labor shortages as temporary staff look outside of Oregon for better-paying work. Creating a blended rate takes an overall mix of permanent and temporary staff into account, and to the extent an individual facility has different staff ratios, that rate may pose difficulties for that facility. It also requires the most effort by far to collect and analyze data needed to establish the blended rate; the administrative cost of this has to be considered.

Discussion Conclusion

Under the requirements and constraints of the current economic situation, targeting the permanent workers' wages as the baseline for the rate cap may be the best course of action. Direct and indirect costs of the staffing agencies will need to be added to the wage portion of the cap, and reporting requirements will help inform the loads to cover those costs.

As stated earlier, setting rates where temporary workers earn at most the median amount of permanent workers would serve as an artificial constraint on the compensation of both the temporary workers and permanent workers, however, this could be mitigated by allowing some additional wage payments to staffers who feel their needs may be better met while serving as a temporary worker. Therefore, targeting the 75th percentile of permanent workers' wages as the base may serve as an acceptable benchmark, with the administrative load being determined based on the median costs of the temporary workers. The initial reporting

data may show that the 75th percentile is either too high or too low of a benchmark and the initial rate cap could be set at a different percentile that is deemed appropriate.

Categories of Temporary Health Care Workers

Recommendation

Focus setting rate for on a limited number of categories of workers and include the most common temporary staffing categories. Clarification of which providers are covered under the legislation is needed in order to determine the specific categories of health care workers subject to the maximum rate caps.

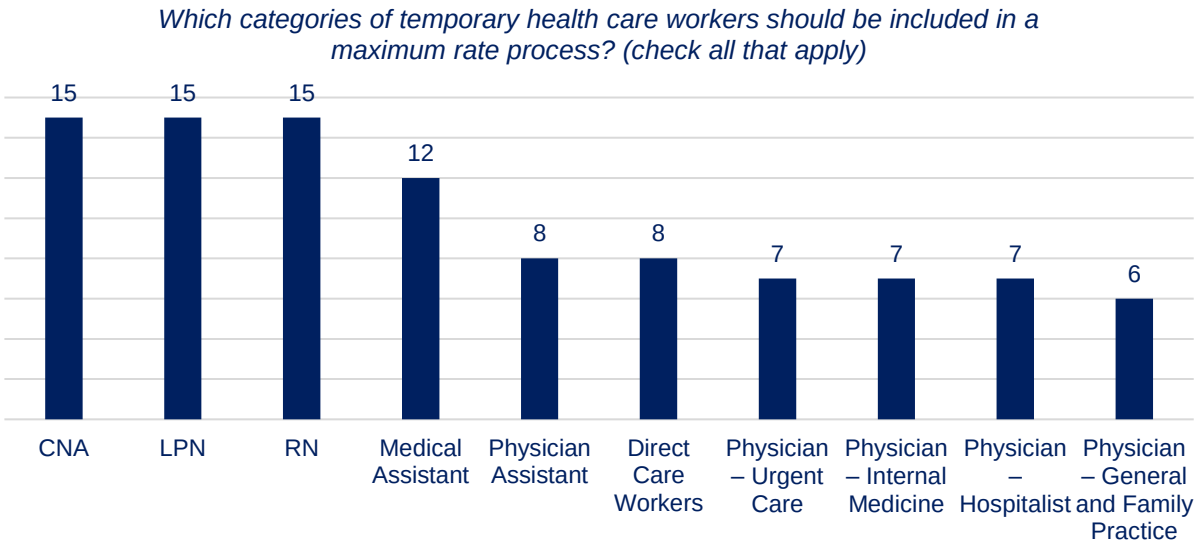
Other States

Massachusetts sets rates for RNs, RN specialists, LPNs, and CNAs, Minnesota sets rates for RNs, LPNs, CNAs, and TMAs.

Collaborator Perspectives

When asked which categories of temporary health care workers should be included in the maximum rate process, collaborators responded with the responses in Figure 7.

Figure 7 – Categories of Health Care Workers



Discussion

Text from SB 1549 states the bill applies to an *individual, regardless of whether the individual is licensed or otherwise authorized by the state to practice a health care occupation or*

profession, who provides health care services or assistance with activities of daily living to clients, patients or residents.

The definition of temporary health care workers in SB 1549 is very broad and as such includes a variety of providers, such as medical assistants, chiropractors, naturopaths, as well as physicians. Discussions among the collaborators were clear that any maximum rate calculation should apply to a limited set of workforce categories.

Additional Staff Qualifications that Impact Maximum Rates

Recommendation

Review data to determine the typical categories of qualifications that impact wages earned.

Other States

Massachusetts distinguishes between RNs and RN specialists. Providers with additional skills and certifications should be compensated for their specialties, however, more clarity is needed on the categories of temporary health care workers before determining the breadth of the certifications that would impact rates.

Discussion

Incorporating additional staff qualifications to maximum rates for healthcare workers would add complexities to the process, but could also add appropriate incentives for workers who have more experience or additional certifications.

Workplace Setting

Recommendation

Maximum rates should be differentiated across facility type, however, more data are needed to inform a recommendation on which facilities should be subject to these regulations.

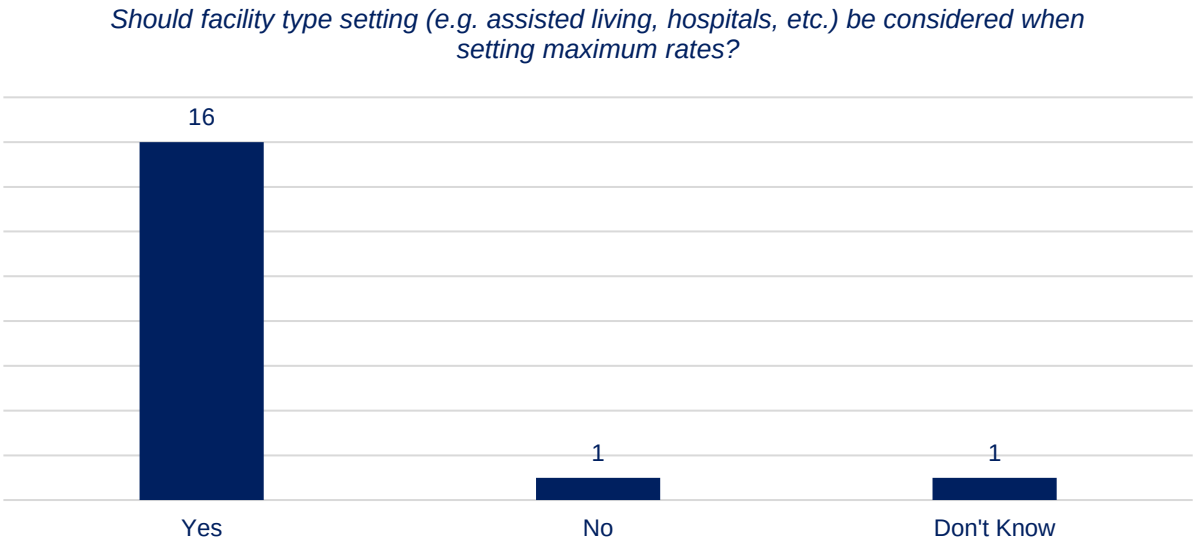
Other States

Massachusetts has different rates for nursing facilities and hospitals while in Minnesota, nursing homes are the only facilities subject to the maximum rate cap.

Collaborator Perspectives

Discussions with collaborators reached a general consensus that rates should be split out by facility type, but more input is needed on additional settings or subcategorization of long-term care facilities. Setting rates by facility type is important to understand the potential impact rates could have to specific health care groups. The process for setting rates could include a period of testing. OAHHS recommends pilot testing set rates through Long Term Care facilities first, and providing evaluation to all interested parties, in order to make any necessary adjustments.

Figure 8 – Facility Setting



Discussion

For Oregon, potential settings include hospitals, ambulatory service centers, nursing facilities, and long-term care or residential care facilities. Behavioral and chemical dependency centers could be considered as facility breakouts and depending on the breadth of providers covered under this bill, primary care clinics and other facilities, for example crisis centers.

When deciding whether to vary maximum rates by facility type in Oregon, evaluating the repercussions of Massachusetts and Minnesota's approach should be heavily weighted. Minnesota's nursing homes reported the largest workforce shortages in the country, according to an analysis of Centers for Medicare & Medicaid Services (CMS) data conducted by Seniorly.[55] Analysis of the CMS data revealed Minnesota was affected the most by staffing shortages (categories included nurses, aides, clinical staff and other staff), with 41.4% of nursing facilitates reporting shortages. This same analysis reported Massachusetts ranking the third, with only 5.8% of nursing facilities reporting staffing shortages.

[55] Rajecki, R. (2022, April 17). Nursing Home workforce shortages hit Minnesota the hardest, California the least. McKnight's Senior Living, available at https://www.mcknightsseniorliving.com/home/news/business-daily-news/nursing-home-workforce-shortages-hit-minnesota-the-hardest-california-the-least/

Geographic Variation

Recommendation

Health care in Oregon is regional with the availability of facilities and services and their associated costs varying significantly. In order to ensure appropriate rates for health care workers, maximum rates for temporary staff differing by geographic region is recommended.

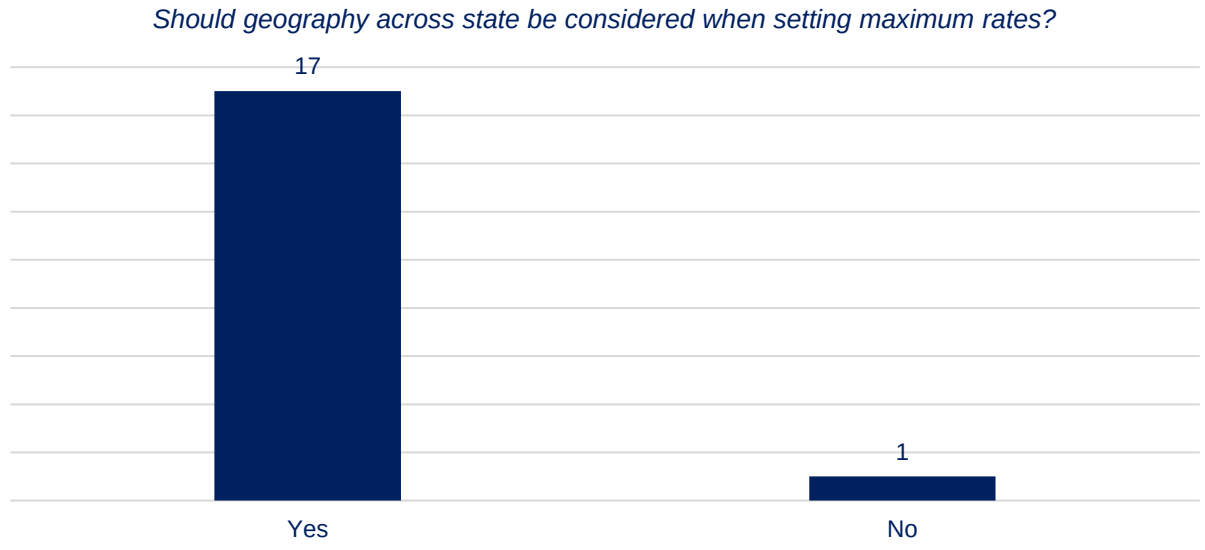
Other States

In Massachusetts, rates vary by their six HSAs and the location of the nursing facility or hospital determines the maximum price that may be charged. Minnesota sets rates on a statewide basis and does not account for geographic location when setting maximum rates.

Collaborator Perspectives

Representatives from temporary staffing agencies and health care facilities have reported that certain geographic regions in Oregon are more difficult to staff than others. In order to provide an incentive for those hard-to-fill regions, maximum rates varying by region was agreed upon by most collaborators.

Figure 9 – Wage Differentials by Geographic Region



Question Response	Corresponding Additional Feedback
Yes	"The state could consider using the minimum wage regions as a starting place for geographic discrepancies in rates. This approach would acknowledge the differences in urban, rural, and frontier counties. However, for ease of

Question Response	Corresponding Additional Feedback
	implementation and simplicity, it may make sense to have as few regions as possible.”
Yes	“It seems logical that there should be an Urban and Rural differentiation, assuming collected data supports this idea as well.”
Yes	“Hard to hire geographical areas may need increased rates for high cost housing or other undesirable conditions.”
Yes	“Any proposed rate percentage caps should consider the geographical region of the Facility. The costs in the Portland metro area are substantially different than those in Eastern rural Oregon. Rate should be different by region but the proposed cap percentage could be the same across the state.”

Discussion

Based on discussions during collaborator meetings and evaluating the methods in Massachusetts and Minnesota, maximum rates should be differentiated across geographic region, however, the number of regions should be determined by data collected from staffing agencies and health care facilities.

Holiday Rates

Recommendation

While Oregon does not have a state law that requires pay to be higher on a holiday versus a non-holiday, a rate increase for work performed on holidays is recommended.

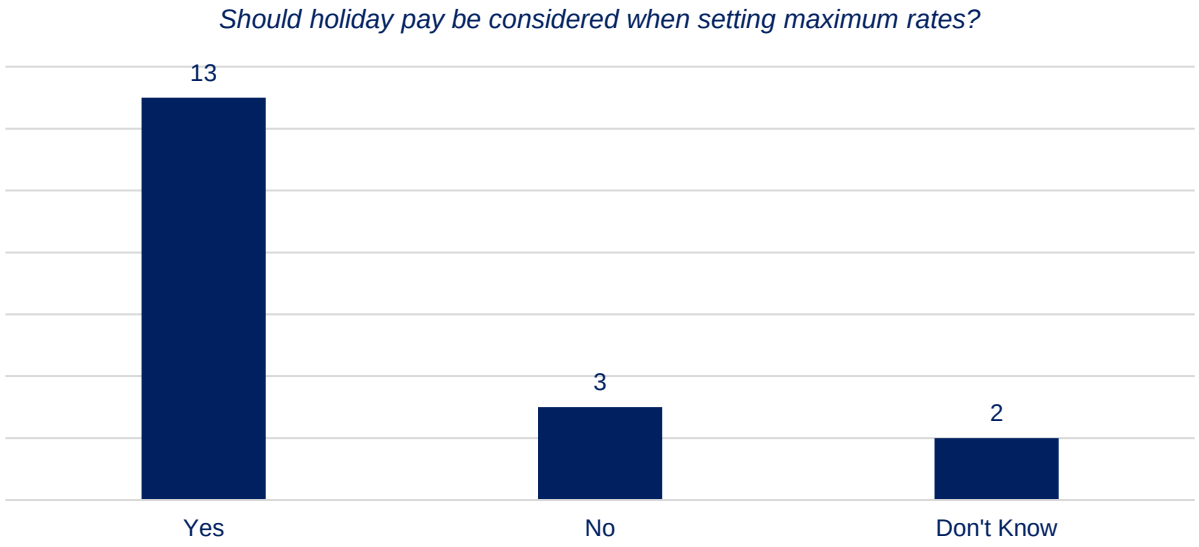
Other States

Both Massachusetts and Minnesota increase the rates during holidays; Massachusetts increases maximum rates by 50%, and Minnesota does not have a distinct percentage increase from non-holiday to holiday pay, but 2022 maximum rates for RNs increase from $62.36 to $107.25, respectively. While Oregon does not have a state law that requires pay to be higher on a holiday versus a non-holiday, a 50% rate increase for work performed on holidays is recommended.

Collaborator Perspectives

Most participants of the virtual collaborator meetings, and those responding to the survey, agreed the maximum rates should have a separate rate for holidays. A 50% increase in maximum rates was determined to be an appropriate percentage increase in rates.

Figure 10 – Wage Differentials for Holidays



Question Response	Corresponding Additional Feedback
Yes	"We are required to pay time and a half for holiday pay. Most providers pay 1.5 times the normal wage for stated holidays."
Yes	"Should be equal to permanent staff holiday pay."
Don't Know	"Holidays should be considered, but I'm not sure there needs to be a separate holiday rate."

Discussion

Health care facilities are not typically able to shut down for holidays, requiring enough staff to keep the facility staffed to meet demands. While the Fair Labor Standards Act (FLSA) does not require a premium pay or financial incentive for employees who work on holidays, similar to shift differentials, facilities typically provide extra payments for working a less desirable shift, such as a holiday.

Shift Differentials

Recommendation

Maximum allowed rates should vary by shift, and an agency and a nursing facility or hospital may agree to an overtime differential to be added to a maximum service price to pay an employee for overtime hours worked.

Other States

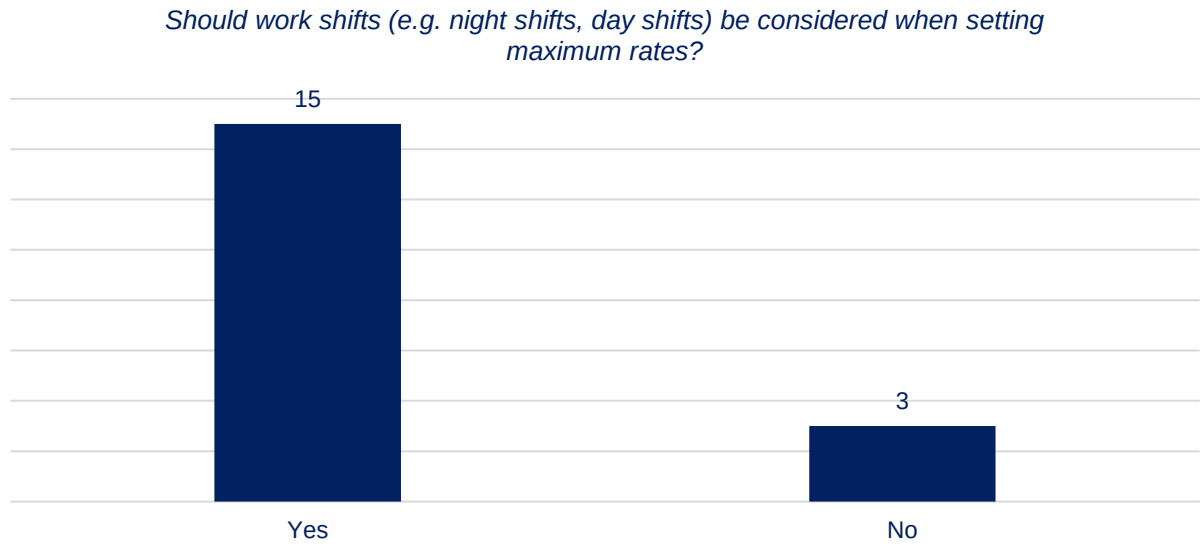
Massachusetts varies rates by shift with three weekday shifts and three weekend shifts, and allows overtime pay for hours worked in excess of 40 hours per week or eight hours in one day. Massachusetts also has additional provisions for travel nurses allowing agencies to charge 19.7% above the maximum rates established in 101 CMR 345.03.

Minnesota Statutes 177.23, subdivision 7, requires that hours worked in excess of 48 in a seven-day period be paid at one-and-a-half of the employee's regular rate of pay.[56] The legislation states that the average wages used to define the maximum charges include hourly rate of pay and shift differential, including weekend shift differential and overtime. While holidays allow for a higher maximum rate, no such consideration is provided for overtime or shift differentials.

Collaborator Perspectives

Shift differentials, in general, were mostly agreed upon, as shown in Figure 11, though the number of shift differentials should be advised by data. Having more shift differentials gives a facility a competitive advantage for attracting workers, could improve moral and reduce turnover, and increase employee productivity. Despite this, concern was raised regarding the reporting requirements and processes for updating rates becoming progressively difficult with the increased number of shift differentials.

Figure 11 – Wage Differentials by Shift



[56] Overtime Laws. Overtime laws | Minnesota Department of Labor and Industry, available at https://www.dli.mn.gov/business/employment-practices/overtime-laws

Question Response	Corresponding Additional Feedback
No	"This is a logistic nightmare. Differentials create another set of pay and bill rates. Would recommend keeping it clean IF a rate cap is required."
Yes	"There are pay differentials for night shifts for permanent staff, so it stands to reason there may be a differential for temp staff as well."
Yes	"Since most long-term care facilities do in fact have wage differentials depending upon the shift, it seems appropriate to include this. That said, the differentials paid currently for permanent staff usually are in the 50 cents to $2 more per hour range depending upon the shift."
Yes	"It is important to have rate differentials for Day, Evening, Night, Weekend Day, Weekend Evening, and Weekend Night shifts to incentivize health care employees to work non-standard hours to support patient care twenty-four hours a day, seven days a week."

Discussion

While the Department of Labor does not require shift differentials, health care facilities typically offer them as a way to fill less desirable shifts, including night shifts, weekends, and holiday shifts. Maximum rates should differ by shift, similar to Massachusetts' approach, explain in Section 2, with different shift times and respective maximum rates.

In Oregon, certain rules regarding overtime apply to nursing staff.[57] These rules declare that a hospital may not require a nursing staff member to work:

- *Beyond the agreed-upon and prearranged shift, regardless of the length of the shift*
- *More than 48 hours in any hospital-defined work week*
- *More than 12 hours in a 24-hour period*
- *During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift; or*
  - *During the 10-hour period immediately following any agreed-upon and prearranged shift in which the nurse worked more than 12 hours in a 24-hour period*
- *Nothing in the rule precludes a nursing staff member from volunteering to work overtime and each hospital must have a policy and procedure in place to ensure that mandatory overtime, when required, is document in writing; and*

[57] Oregon Health Authority, Public Health Division. (2021, June 8). Rule 333-510-0130 Nursing Staff Member Overtime. Rule 333-510-0130 Nursing Staff Member Overtime, available at https://oregon.public.law/rules/oar_333-510-0130

- *Mandatory overtime policies and procedures are clearly written, provided to all new nursing staff and readily available to all nursing staff*

When overtime is required, it is recommended that the maximum rate can be increased by 50%, however, when this exception is used, documentation of the policy and mandatory overtime is required to be provided.

When non-mandatory overtime, e.g., over 40 hours in a work week is performed, the maximum rates will not be increased, however, the temporary health care worker is required to be paid time and a half. A staffing agency and a nursing facility or hospital may agree to an overtime differential to be added to a maximum service price to compensate an employee for overtime hours worked. Inflating the hourly rates paid by the facility beyond the maximum rate for those overtime hours worked would not be permitted and any instances of doing so would be considered a violation of SB 1549.

Modifying Maximum Rates Outside of the Regular Annual Cycle

Discussion

The annual rate setting process is dependent upon receipt of the transparency reporting. Reporting and subsequent would indicate when and how much wages for permanent workers are increasing, and this can help inform the new level that the temporary worker rate cap should be set.

The recommended process is to set the rate cap at the same benchmark as the initial rate cap process, with the selected percentile of wages as the baseline and the median administrative costs as the non-wage load. This would ensure that the cap is tied to market forces and would not create distortions from the initial rate setting process. Additional review of changes in legislation, malpractice insurance, workers' compensation, or other legislative or environmental factors should be considered as part of the annual process.

For an exception process, the more often the reporting is provided, the more flexible this rate resetting process can be. Quarterly or semi-annual reporting could be used to determine if an interim rate increase or decrease is needed. If median permanent workers' wages increase beyond the 75th percentile, or if a certain percentage of temporary workers are placed at the maximum allowable rate, then this would indicate that the rate cap is set too low and needs to be reassessed.

Also, declared states of emergency, pandemics, or other factors such as significantly increased contracted rates between facilities and health plans, including Medicaid or Medicare, could be triggers to institute a rate review. For example, if a facility cancels its current contract with an insurance plan in search of higher negotiated fees, this could trigger a review of the rate caps for an increase commensurate with the renegotiated fees.

Additionally, if permanent worker wages decrease or facilities are subject to payment limits, such as legislative reductions to a percentage of Medicare payment, then the negotiated cap could be reviewed to determine if a decrease is warranted.

Collaborator Perspectives

Additional questions on what additional factors should be considered in the process of setting maximum rates, the ability for temporary staffing agencies to request an except to the wage caps, circumstances in which the rate caps can/should be lifted, and if health care facilities should be able to offer wages above the maximum rate. Responses to these questions are shown in Figure 12 through

Figure **15**.

Figure 12 – Considering Additional Factors

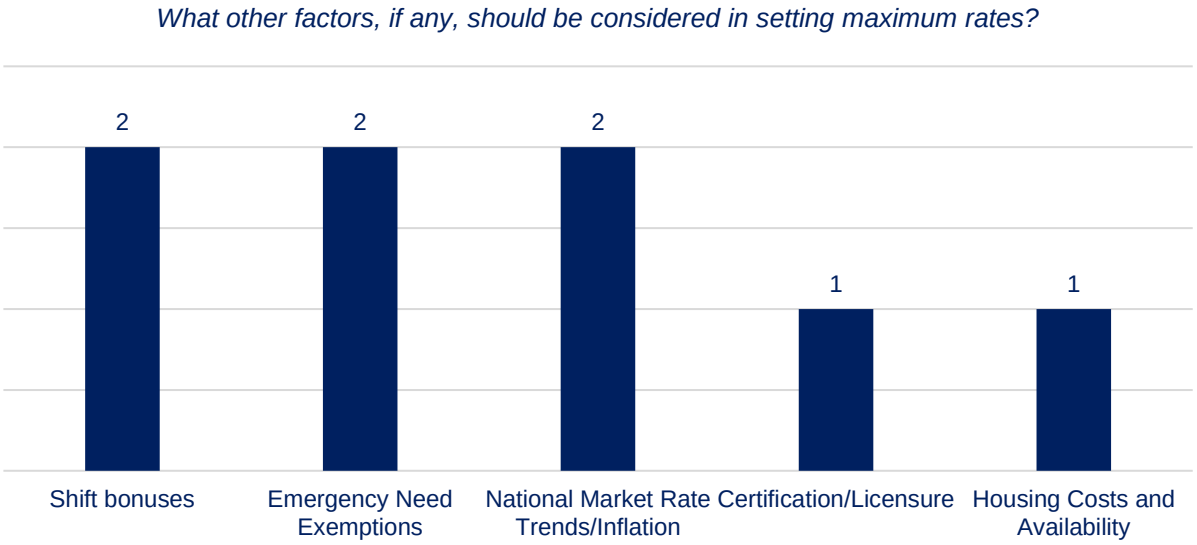
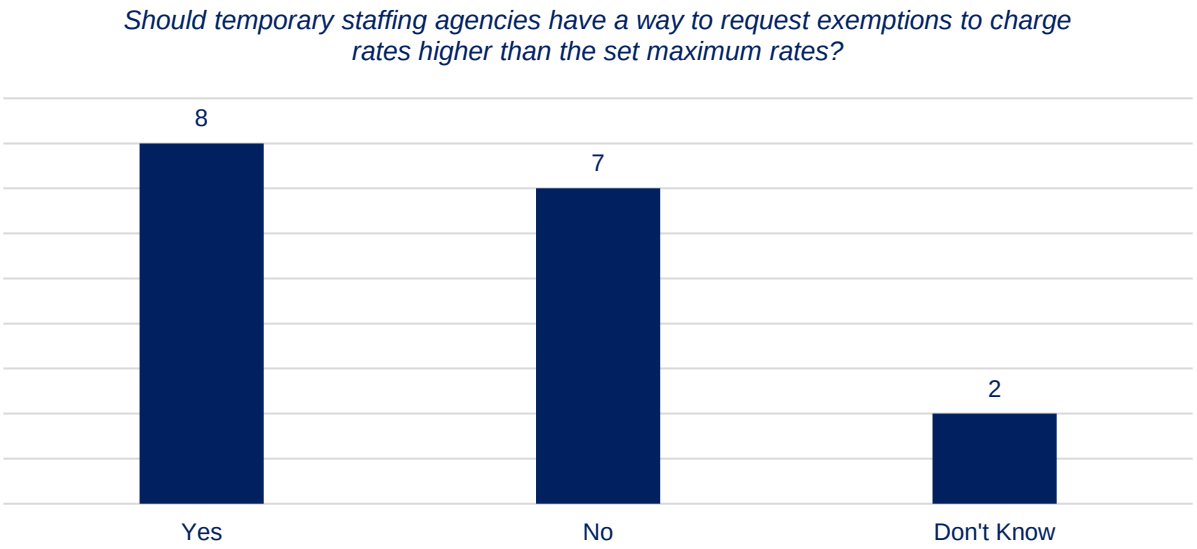


Figure 13 – Request Maximum Rate Changes



Question Response	Corresponding Additional Feedback
Yes	“Currently we [staffing agency] have over 4000 open shifts facilities are requesting staff from us. If rate caps are set, there will be an absolute catastrophe in health care in Oregon. We will need an immediate exemption to eliminate the rate caps.”
Yes	“Housing costs and availability, urgent/expedited need, holiday contracts and possibly experience. Also, if the maximum rate cap hinders the State in acquiring travelers.”
No	“Providers should have the option of requesting to pay higher rates to serve a specific need.”
No	“Health care providers should have a way to request a waiver to go beyond the annual rate if certain circumstances are met that are needed to provide critical care. However, staffing agencies themselves should not be able to request to go beyond the rate or else this avenue could be over-utilized, and the intent of the policy would be undermined.”

Figure 14 – Changes in Maximum Rates Due to Market Changes

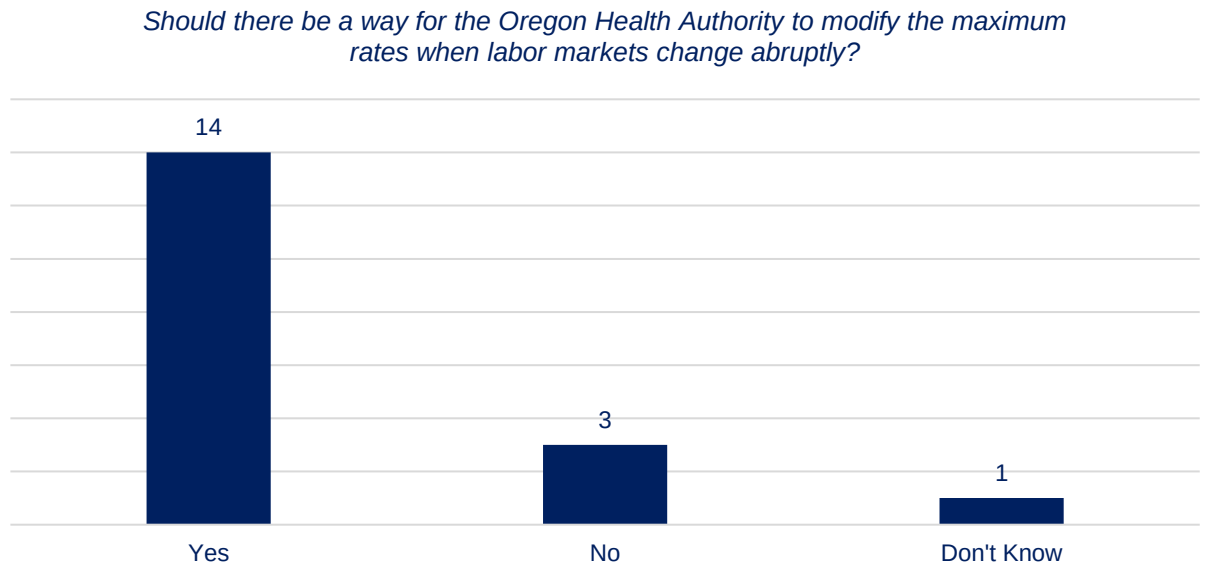
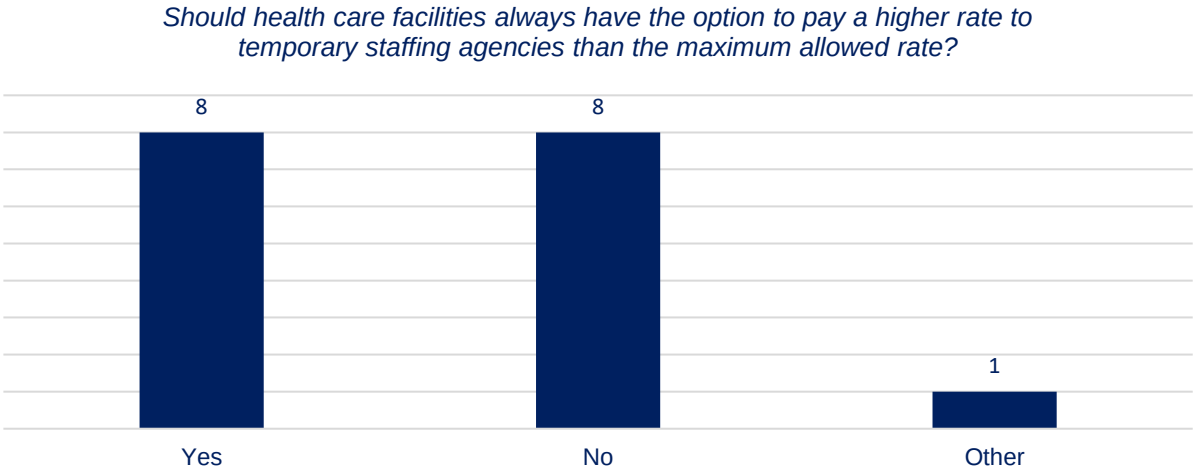


Figure 15 – Allow Higher Pay



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Section 3

Other Policy Options

Price Gouging

Price gouging, defined by the National Conference of State Legislatures, refers to when retailers and others exploit surges in demand by charging exorbitant prices for necessities, often following a natural disaster or other state of emergency. Thirty-seven states, Guam, Puerto Rico, the U.S. Virgin Islands and the District of Columbia have statutes or regulations that define price gouging during a time of disaster or emergency. In most states, price gouging is set as a violation of unfair or deceptive trade practices law. The majority of these laws impose civil penalties, which are enforced by the state attorney general, while some state laws impose criminal penalties for price gouging violations.[58]

Oregon's current price gouging statutes are outlined as ORS 401.965 Abnormal Disruption of Market, and excerpted in Appendix D. Current price gouging statutes in Oregon do not apply to temporary staffing agencies. The law covers merchants (retail businesses) and wholesalers that sell essential consumer goods or services. The law does not cover non-merchants, public bodies or most utilities.[59]

Table 6 below provides an overview of other states that have proposed price gouging regulations related to staffing agencies.

Table 6 – Price Gouging and Other State Efforts

State	Bill	Status	Summary
Idaho[60]	SB1300	Not Passed	Amends existing law to prohibit taking advantage of a disaster or an emergency by charging exorbitant or excessive prices for temporary health care services.
Indiana[61]	HB1332	Not Passed	Consider price gouging to be in excess of three times the fair market value of the health care services by a health care employee or temporary worker and prohibits a staffing agency from implementing fees, charges or commissions more than three times the fair market value.

[58] Morton, H. (2022, March 10). Price Gouging State Statutes. Price gouging state statutes, available at https://www.ncsl.org/research/financial-services-and-commerce/price-gouging-state-statutes.aspx

[59] Oregon Department of Justice. (2022, August 18). Price gouging. Consumer Protection, available at https://www.doj.state.or.us/consumer-protection/sales-scams-fraud/price-gouging/

[60] Legislature of the State of Idaho. Senate Bill No. 1300. Commerce and Human Resources Committee, available at https://legislature.idaho.gov/sessioninfo/billbookmark/?yr=2022&bn=S1300

[61] General Assembly of the State of Indiana. Indiana HB1332: 2020: Regular session, available at https://legiscan.com/IN/text/HB1332/id/2158911

State	Bill	Status	Summary
Kansas[62]	HB2524	Not Passed	Requires the secretary for aging and disability services to regulate supplemental nursing service agencies, or temporary employment agencies for health care facilities.
Kentucky[63]	HB282	Passed	Define and establish registration of health care services agencies; require the Cabinet for Health and Family Services to promulgate administrative regulations for registration; require health care services agencies to retain documentation of direct care staff credentials and establish other requirements; require quarterly reports to the cabinet; add direct care staff services to emergency price gouging limitations.
Maryland[64]	SB565	Not Passed	Prohibits a person from selling an essential good or service during a state of emergency, plus 90 days after the emergency ends, for 10% more of the product or service's price before the emergency, which would apply to health care staffing agencies.
New York[65]	SB4565	Currently in Review	Amends the state's general business law as it relates to price gouging, and further defines "unconscionably excessive price" as "a price that is excessive as compared to the price at which the good or service was sold or offered for sale by the seller in the usual course of business immediately prior to the state of emergency." Price gouging would be prohibited during periods of abnormal disruption of the market, including a local or national emergency.
Pennsylvania[52]	HB2293	Passed	Although this bill does not have price gouging provisions, it does require temporary staffing agencies to register annually with the state and provide a list of each separate location. It also requires agencies to provide health care facilities with documentation that each temporary employee meets licensing or certification, training and continuing education standards for the position, among other oversight rules.

[62] Kansas State Legislature. HB 2524 | Bills and Resolutions | Kansas State Legislature. HB 2524 | Bills and Resolutions |, available at http://www.kslegislature.org/li/b2021_22/measures/hb2524/

[63] General Assembly of the Commonwealth of Kentucky. Kentucky House Bill 282, available at https://legislature.ky.gov/Legislation/Pages/default.aspx

[64] General Assembly of Maryland. Maryland SB565: 2022: Regular session, available at https://legiscan.com/MD/text/SB565/id/2500596

[65] State of New York. Senate Bill 565, available at https://legiscan.com/NY/text/S04565/id/2277203/New_York-2021-S04565-Introduced.html

Summary of perspectives of the interested parties on price gouging

The American Staffing Association (ASA) proposed an idea regarding price gouging. The submission proposes, in lieu of capping agency bill rates, an alternative approach for dealing with alleged excess pricing based on the provisions of existing Oregon unfair trade practices law—which addresses selling essential goods and services at excessive prices during "abnormal disruptions of the market." The provisions are similar to a law in Kentucky that was amended in 2022 to expressly apply to temporary staffing services provided to health care facilities. The ASA proposal would amend the existing Oregon unfair trade practices law to expressly include temporary staffing agencies.

How price gouging could work in Oregon

Price gouging occurs when rates charged are well above the costs of providing those services or goods during times where external forces create a market disruption. During the COVID-19 pandemic, prices increased dramatically for temporary workers. However, it is uncertain if price gouging occurred as the costs of providing those services, i.e., wages and compensation for the temporary workers, increased dramatically.

In order to determine if there is price gouging occurring, information about the underlying costs of those services is needed. Transparency as to those costs are required. In many instances, this evidence is easily obtained via records of prices set before the market disruption or wholesale prices paid by competing retailers. For temporary staffing workers, such information is not as easily obtained, therefore reporting requirements, as detailed in the following section, are needed to help develop rules around price gouging.

Assuming that regulations and reporting on the direct and indirect costs of temporary staff workers and the administrative load required by the agencies is available, a maximum allowable increase on top of the prices before the market disruption could be set as a threshold for determining price gouging. Additional limitations, including requiring that the compensation of the staffing be increased proportionally with the cost increase, as well as maximum allowable increases to the administrative loads.

Price/Cost Transparency

Price transparency requirements have been in place since 2018, having been incorporated into the Consolidated Appropriations Act passed by Congress in 2020 and detailed in subsequent interim final rules. Price transparency in health care aims to identify costs for providers, insurers, and consumers, especially those in need of specific types of health care services. The primary goals of these transparency requirements are to provide more information to consumers, allowing them to make more informed health care decisions, and to promote competition in the health care marketplace, resulting in lower health care costs.

Rules requiring hospitals to publish their charge masters were the first step toward price transparency. In August 2018, CMS issued a final rule requiring hospitals to *establish and make public a list of their standard charges.* On January 1, 2021, the federal Hospital Price Transparency Rule went into effect. The rule requires hospitals to post a machine-readable file containing, charges, discounted cash prices, and payer negotiated rates/prices for all

items and services, as well as a consumer-friendly display of the same information for at least 300 "shoppable" services. As part of this final rule, plans must provide price comparison information for 500 items and services identified by the CMS through an internet-based self-service tool by January 1, 2023, and prescription drug prices must be included by January 1, 2024.

Summary of Kentucky's price/cost transparency provisions

Kentucky amended HB 282, KRS 367.374 in May 2022 to add health care services agency to the previously existing list of covered goods and services subject to penalties for *selling/offering a services that is "grossly in excess of the price" prior to the declaration and unrelated to any increased cost to the seller* when a state of emergency has been declared. **Error! Bookmark not defined.** When a "Condition Red" has been declared by the U.S. Department of Homeland Security under the Homeland Security Advisory System, the Secretary of the Department of Health and Human Services, under Section 319 of the Public Health Service Act, declares a public health emergency, or the Governor has declared a state of emergency, the Governor may implement the following regulations for a period of fifteen (15) days from notification of implementation:

> *No person shall sell, rent, or offer to sell or rent, regardless of whether an actual sale or rental occurs, a good or service listed in this paragraph or any repair or reconstruction service for a price which is grossly in excess of the price prior to the declaration and unrelated to any increased cost to the seller. Goods and services to which this section applies are: […]*
>
> ***10**. Direct care staff services provided by a health care services agency as defined in Section 1 of this Act*[66]

In addition to adding health care service agencies to the list of services subject to price gouging regulations, six new sections related to health care service agencies were promulgated.

Section 1 contains definitions used in Sections 1 to 6 of the Act. "Health care services agency" is defined as *any person, firm, corporation, partnership, or other business entity engaged in the business of referring direct care staff to render temporary direct care services to an assisted living community, a long-term care facility, or a hospital but does not include a health care services agency operated by an assisted-living community, a long-term care facility, a hospital, or any affiliates thereof, solely for the purpose of procuring, furnishing, or referring temporary or permanent direct care staff for employment at that assisted-living community, long-term care facility, hospital, or any affiliates thereof.*

Section 2 details requirements for health care services agencies to register with the Cabinet for Health and Family Services and obtain a registration. Each agency must submit an application to the agency with the following information on an annual basis:

[66] "Direct care service" means a service provided to a resident in an assisted-living community, a resident in a long-term care facility, or a patient in a hospital, by direct care staff. "Direct care staff" means an individual who contracts with or is employed by a health care services agency to provide direct care services to residents in assisted-living communities, residents in long-term care facilities, or patients in hospitals.

- Names and addresses of:
  - (a) A corporation, partnership, or other business entity, or an officer, program administrator or director thereof, whose responsibilities include the direction of the management or policies of a health care services agency; or
  - (b) An individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business entity that is a health care services agency;
- A policy and procedure that describes how the health care services agency's records will be immediately available to the cabinet upon request;
- Any other relevant information that the cabinet determines is necessary to properly evaluate an application for registration; and
- A registration fee in the amount of three thousand dollars ($3,000) per registration.

If an agency fails to provide/comply with the above provisions, the Cabinet has the ability to deny any application for health services agency registration. Section 3 describes additional requirements relating to documentation, liability insurance, and penalties for insubordination of terms.

Staffing agencies cannot restrict employment opportunities for any direct care staff contracted with or employed by the agency in any way, including, but not limited to, contract buy-out provisions or contract non-compete clauses. Agencies are also restricted from requiring any payment of liquidated damages, employment fees, or other compensation by paid by the facility the staff is working at unless specified in the contract terms for the employee by the agency and the facility. Solicitation or recruitment of current staff in an assisted-living community, long-term care facility, or hospital is not permitted by a staffing agency.

How price/cost transparency might work in Oregon

Under Massachusetts regulations, licensed temporary staff agencies and facilities are required to provide reporting regarding payments, costs, and hiring associated with temporary staff workers. Similar regulations in Oregon could be enacted to not only inform the maximum rate setting process, but to also provide transparency to agencies and facilities as to the current costs and variance in those costs of hiring the temporary staff workers.

A potential proposal would be for all licensed agencies to provide regular reporting, whether quarterly, semi-annually, or annually, on the direct wages, ancillary compensation and benefit costs, contracted rates, as well as agency administrative costs and profit. Additionally, the number and type of placed temporary workers would be required. Facilities that hire temporary workers would also be required to provide reporting on the number and cost of those workers which would provide a check on the accuracy of the reporting by the licensed agencies.

The data would be used to not only for reviewing and setting the maximum rate caps, but would also be reported on a collated and blinded basis to the public so that temporary staffing agencies, facilities, and health care workers would be able to see the if their rates and costs are in line with their competitors and provide transparency to all collaborators.

Inequities occur when information is disproportionately held or shared and transparency could eliminate those disparities and lead to a market equilibrium, which could ensure the stability of the agencies, facilities, and health care workers' jobs. Additionally, this could also sharpen the focus on the importance of working conditions for the staffers, and help retain a robust workforce to care for the needs of Oregonians.

Summary of perspectives of the interested parties on price/cost transparency

Under Massachusetts regulations, licensed temporary staff agencies and facilities are required to provide reporting regarding payments, costs, and hiring associated with temporary staff workers. Similar regulations in Oregon could be enacted to not only inform the maximum rate setting process, but to also provide transparency to agencies and facilities as to the current costs and variance in those costs of hiring the temporary staff workers.

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Inequities occur when information is disproportionately held or shared and transparency could eliminate those disparities and lead to a market equilibrium, which could ensure the stability of the agencies, facilities, and health care workers' jobs. Additionally, this could also sharpen the focus on the importance of working conditions for the staffers, and help retain a robust workforce to care for the needs of Oregonians.

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Section 4

Summary

The prospect of a rate cap on temporary staff is a contentious issue, as evidenced by the conversations with interested parties and results of the survey have shown. The legislation requires that a policy proposal and recommendations to establish a process in setting annual rates and prioritization of compensation of personnel, quality care outcomes for clients, patients, and residents of facilities engaged by a temporary staffing agency.

An annual process for setting rates can be developed if data is provided by the staffing agencies and facilities. Once the wage, compensation, and other cost and usage data is obtained, appropriate hourly rates by facility, region, and shifts can be ascertained and developed. While the legislation states that individuals that provide "health care services or assistance with activities of daily living" are covered by the bill, the interested parties generally stated that nurses, certified nursing assistants and direct care workers are those they believe should be covered by the rate cap. Additional clarity is needed in order to better define who is covered by the rate cap.

The legislation requires an annual process, however, interested parties believe a more frequent reassessment is needed. If reporting is provided by the facilities and temporary staff on a semi-annual or quarterly basis, the rate cap process could be structured to more quickly respond to labor changes.

Minnesota and Massachusetts do not allow for exemptions to the rate cap and the final SB 1549 removed potential amendments to allow for exemptions to the rate cap. Therefore, it appears that exemptions to the rate caps are not to be considered in the final process.

Only two states currently have rate caps in place for temporary staffing and while the wages are lower, there are issues arising from the rate caps in those states. In Massachusetts, open nursing positions are more numerous than neighboring states and in Minnesota, rate caps only impact nursing facilities, which has resulted in difficulty in hiring for those nursing homes while hospitals and other facilities, which are not subject to the cap, have fewer difficult to fill positions.

Rate caps can provide cost relief to facilities, however, this does not prioritize compensation of personnel. In addition, staff, when faced with the potential of limited compensation, may leave the industry or move to another state in search of higher wages. Implementing a rate cap in Oregon might result in similar issues to those states' open positions and the additional turnover and staffing shortages would not improve quality care outcomes for the residents of those facilities.

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Section 5

Appendix

Appendix A: SB 1549 Section 15 Excerpt

SECTION 15.

(1) As used in this section:

(a) “Personnel” means an individual, regardless of whether the individual is licensed or otherwise authorized by the state to practice a health care occupation or profession, who provides health care services or assistance with activities of daily living to clients, patients or residents for or on behalf of an entity that engages the temporary staffing agency with which the individual is associated.

(b) “Rate” means the total amount that a temporary staffing agency charges to or receives from an entity that engages the temporary staffing agency to assign personnel to the entity on a temporary basis.

(c)

(A) “Temporary staffing agency” means an entity that operates in this state for the purpose of providing temporary work to personnel providing health care services or assistance with activities of daily living for or on behalf of entities that engage the temporary staffing agency.

(B) “Temporary staffing agency” does not include:

(i) A staff arrangement established by an entity solely for use by the entity, or by any entity associated with the entity, and in which the only costs are salaries paid to individuals who perform work;

(ii) An individual who provides the individual’s services on a temporary basis;

(iii) An employment agency as defined in ORS 658.005;

(iv) Home health agencies licensed under ORS 443.015;

(v) In-home care agencies licensed under ORS 443.315; or

(vi) Home care workers and personal support workers listed on the home care registry as defined in ORS 410.600.

(2) Not later than December 31, 2022, the Oregon Health Authority shall, in collaboration with the stakeholders described in subsection (3) of this section, create and submit a report in the manner provided in ORS 192.245 to an interim committee of the Legislative Assembly related to health care. The report must include:

(a) A policy proposal and recommendations to establish a process to determine annual rates that a temporary staffing agency may charge to or receive from an entity that engages the temporary staffing agency; and

(b) Prioritization of the compensation of personnel, quality care outcomes for clients, patients and residents of an entity that engages a temporary staffing agency and the fiscal viability of care providers based in this state.

(3) The stakeholders must include, but are not limited to:

(a) Providers of long-term care, acute care services and primary care services, or representatives of the providers;

(b) Personnel;

(c) A representative of the Department of Human Services; and

(d) A representative of the Office of the Governor.

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Appendix B: Massachusetts Excerpted Text from the Legislation

Excerpted Text from the Legislation

(1) General. All prices are per hour. An agency's price for a service provided to a nursing facility or hospital may not exceed the maximum price set forth in 101 CMR 345.03(2) or (3). Rates vary by health service area (HSA). The location of the nursing facility or hospital determines the maximum price that may be charged.

(a) Holidays. Rates for holidays may not exceed 150% of the maximum prices set forth in 101 CMR 345.03(2) or (3). An agency and the purchasing nursing facility or hospital may define the specific times for each shift and the days that constitute holidays in the written agreement for services as required by 105 CMR 157.220: Written Agreements.

(b) Overtime. An agency and a nursing facility or hospital may agree to an overtime differential to be added to a maximum service price to compensate an employee for overtime hours worked.

The rates determined in accordance with 101 CMR 345.00 are full compensation for temporary nursing services rendered to a nursing facility or hospital, including any related administrative or supervising duties provided by the agency in connection with patient care.

(c) Exemptions. Fixed-term employees are not subject to the maximum prices set forth in 101 CMR 345.03.

(d) 12-hour Shift. An agency and a nursing facility or hospital may agree to a single price per hour for services provided during a 12-hour shift. The price per hour cannot exceed the weighted average of the combined maximum prices for the applicable shifts as set forth in 101 CMR 345.03(2) or (3). For example, an RN in HSA 1 providing weekday services at a nursing facility from 7:00 A.M. to 7:00 P.M. could be billed at a single rate of $72.45, using eight hours at $71.03 and four hours at $75.29. (Example calculation: 8 x $71.03 + 4 x $75.29 = $869.40. $869.40/12 = $72.45.)

(e) Travel Nurse Factor. For temporary nursing services provided at nursing facilities or hospitals that are performed by travel nurse employees, agencies may charge, and nursing facilities and hospitals may purchase, temporary nursing services performed by such travel nurse employees at a factor of 19.7% above the rate limits established in 101 CMR 345.03.

COVID-19 Rules

(4) Rates for Temporary Nursing Services Related to COVID-19. Temporary nursing services related to COVID-19 may be purchased by governmental units at individually considered rates that exceed the maximum rates established in 101 CMR 345.00, and governmental units may enter into contracts for the provision of these services in alternate service locations other than a hospital or nursing facility. A governmental unit, in its sole discretion, may determine whether a rate above the maximum rates established in 101 CMR 345.00 is

necessary and appropriate, as well as the appropriate rate for services provided in a service location other than a hospital or nursing facility.

Appendix C: Minnesota Excerpted Text from the Legislation

144A.74 MAXIMUM CHARGES[67]

A supplemental nursing services agency must not bill or receive payments from a nursing home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted average wage rate, plus a factor determined by the commissioner to incorporate payroll taxes as defined in section 256R.02, subdivision 37, for the applicable employee classification for the geographic group specified in section 256R.23, subdivision 4. The weighted average wage rates must be determined by the commissioner of human services and reported to the commissioner of health on an annual basis. Wages are defined as hourly rate of pay and shift differential, including weekend shift differential and overtime. Facilities shall provide information necessary to determine weighted average wage rates to the commissioner of human services in a format requested by the commissioner. The maximum rate must include all charges for administrative fees, contract fees, or other special charges in addition to the hourly rates for the temporary nursing pool personnel supplied to a nursing home. A nursing home that pays for the actual travel and housing costs for supplemental nursing services agency staff working at the facility and that pays these costs to the employee, the agency, or another vendor, is not violating the limitation on charges described in this section.[68]

[67] Minnesota Legislature. "2021 Minnesota Statutes", *Office of the Revisor of Statutes*, Sec. 144A.74, available at https://www.revisor.mn.gov/statutes/cite/144A.74

[68] Minnesota Legislature. "2021 Minnesota Statutes", *Office of the Revisor of Statutes*, Sec. 144A.74, available at https://www.revisor.mn.gov/statutes/cite/144A.74

Appendix D: ORS 401.965 Abnormal Disruption of Market Excerpt

401.965 Abnormal disruption of market. (1) As used in subsections (1) to (4) of this section, the terms “merchant” and “wholesaler” do not include a public body as that term is defined in ORS 174.109, a public utility as defined in ORS 757.005 (1)(a)(A) or an electric utility as defined in ORS 757.600.

(2) A merchant or wholesaler may not sell or offer to sell essential consumer goods or services for an amount that represents an unconscionably excessive price during a declaration of an abnormal disruption of the market under subsections (5) to (7) of this section.

(3) It is a question of law whether a price is unconscionably excessive. Proof that a price is unconscionably excessive may be shown by evidence that:

(a) The amount charged for essential consumer goods or services exceeds by 15 percent or more the price at which the goods or services were sold or offered for sale by the merchant or wholesaler in the usual course of business immediately prior to or during a declaration of an abnormal disruption of the market; or

(b) The amount charged for the essential consumer goods or services exceeds by 15 percent or more the price at which the same or similar consumer goods or services were readily obtainable by other consumers in or near the geographical area covered by the declaration of an abnormal disruption of the market.

(4) Evidence described in subsection (3) of this section constitutes prima facie proof of a violation of subsections (1) to (4) of this section. Evidence described in subsection (3) of this section is not prima facie evidence of a violation of subsections (1) to (4) of this section if the amount charged by the merchant or wholesaler is:

(a) Attributable to additional costs imposed by the merchant’s or wholesaler’s suppliers or necessarily incurred in procuring the essential consumer goods or services immediately prior to or during the declaration of an abnormal disruption of the market; or

(b) The result of increased internal costs or expenses related to the declaration of an abnormal disruption of the market or the result of increased costs unrelated to the declaration of an abnormal disruption of the market.

(5) If the Governor determines that an abnormal disruption of the market has occurred, the Governor may declare an abnormal disruption of the market by a proclamation, as part of a state of emergency declared under ORS 401.165, or both.

(6) The Governor’s declaration of an abnormal disruption of the market under subsection (5) of this section shall specify:

(a) The geographical area covered by the declaration. The area may be no larger than necessary to effectively respond to the abnormal disruption of the market.

(b) The date and time at which the abnormal disruption of the market commenced. The date of commencement of the abnormal disruption of the market may precede the date on which the declaration is made.

(c) That the declaration will terminate automatically 30 days after the date on which the Governor makes the declaration unless the Governor extends the declaration in accordance with paragraph (d) of this subsection or unless the Governor or the Legislative Assembly terminates the declaration sooner.

(d) That the Governor may extend the declaration for additional 30-day periods by subsequent declarations that the abnormal disruption of the market continues to exist.

(7) The Governor's declaration of an abnormal disruption of the market is subject to termination:

(a) By the Governor when the Governor determines that an abnormal disruption of the market no longer exists.

(b) At any time by joint resolution of the Legislative Assembly.

(c) Automatically 30 days after the date on which the Governor makes the declaration unless the Governor or the Legislative Assembly terminates the declaration sooner. The Governor may extend the declaration for subsequent 30-day periods by declaring for each such extension that the abnormal disruption of the market continues to exist. An extension the Governor declares in accordance with this paragraph also terminates 30 days after the date on which the Governor declared the extension unless the Governor declares another extension or unless the Governor or the Legislative Assembly terminates the extension sooner. [Formerly 401.107]

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Appendix E: Survey Administered to Collaborators

Questions	Response Options
Which of the following do you represent:	O Hospital O Long Term Care O Temporary Staffing Agency O Workforce/Union O Other – _____
Should the process for setting maximum rates for temporary staff be based on data for wages currently paid to temporary agency staff or to permanent staff?	O Temporary Staff O Permanent Staff O Both O Other – _____
Should geography across state be considered when setting maximum rates?	O Yes O No O Don't Know
Should holiday pay be considered when setting maximum rates?	O Yes O No O Don't Know
Should work shifts (e.g., night shifts, day shifts) be considered when setting maximum rates?	O Yes O No O Don't Know
Should facility type setting (e.g., assisted living, hospitals, etc.) be considered when setting maximum rates?	O Yes O No O Don't Know
What other factors, if any, should be considered in setting maximum rates?	Open-end

What factors, if any, should NOT be considered when setting maximum rates?	Open-end
Which categories of temporary health care workers should be included in a maximum rate process? (check all that apply)	O Physician - Urgent Care O Physician - General and Family Practice O Physician - Internal Medicine O Physician - Hospitalist O Registered Nurse O Certified Nurse Assistant (CNA) O Licensed Practical Nurse (LPN) O Physician Assistant O Medical Assistant O Direct Care Workers (e.g., in long term care facilities
What other categories of health care workers should be included when setting maximum rates for temporary staff?	Open-end
What categories, if any, of health care workers should NOT be included when setting maximum rates for temporary staff? Why?	Open-end

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