HOUSE . . . . . No. 4113

The Commonwealth of Massachusetts

INITIATIVE PETITION OF DONNA KELLY-WILLIAMS AND OTHERS.

OFFICE OF THE SECRETARY.

BOSTON, JANUARY 3, 2018.

Steven T. James
Clerk of the House of Representatives
State House
Boston, Massachusetts 02133

Sir: - I herewith transmit to you, in accordance with the requirements of Article XLVIII of the Amendments to the Constitution and as ordered by the Supreme Judicial Court for Suffolk County,[i] an Initiative Petition for a Law Relative to Patient Safety and Hospital Transparency (Version B), signed by ten qualified voters and filed with this department on or before December 6, 2017, together with additional signatures of qualified voters in the number of 86,440, being a sufficient number to comply with the Provisions of said Article.

Sincerely,

WILLIAM FRANCIS GALVIN,
Secretary of the Commonwealth.

[i] See Amended Order, attached, Williams, et al. v. Attorney General and Secretary of the Commonwealth, No. SJ-2017-0339, December 13, 2017.

AN INITIATIVE PETITION.

Pursuant to Article XLVIII of the Amendments to the Constitution of the Commonwealth, as amended, the undersigned qualified voters of the Commonwealth, ten in number at least, hereby petition for the enactment into law of the following measure:

The Commonwealth of Massachusetts
SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY
JOHN ADAMS COURTHOUSE
ONE PEMBERTON SQUARE, SUITE 1300
BOSTON, MASSACHUSETTS 02108-1707
WWW.SJCCOUNTYCLERK.COM

MAURA S. DOYLE
CLERK

CASE INFORMATION (617) 557-1100
FACSIMILE (617) 557-1117
ATTORNEY SERVICES (617) 557-1050
FACSIMILE (617) 557-1055

December 13, 2017

Juliana deHaan Rice, Assistant Attorney General
Office of the Attorney General
One Ashburton Place
Boston, MA 02108-1698

RE: No. SJ-2017-0339

DONNA KELLY WILLIAMS, KAREN A. COUGHLIN, SUSAN WRIGHT THOMAS, MARY ELIZABETH AMSLER, DANIEL R. REC, NORA A. WATTS, LINDA BARTON, ELLEN SMITH, PAULA RYAN, HARLEY W. KEISCH
v.
ATTORNEY GENERAL and SECRETARY OF THE COMMONWEALTH

NOTICE OF DOCKET ENTRY

You are hereby notified that on December 13, 2017, the following was entered on the docket of the above referenced case:

AMENDED ORDER: as on file. (Lowy, J.)

Maura S. Doyle, Clerk

To: Juliana deHaan Rice, Assistant Attorney General
Edward V. Colbert, III, Esquire
David Koha, Esquire
Carmen Francis Francella III, Esquire

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPREME JUDICIAL COURT
FOR SUFFOLK COUNTY
DOCKET NO. SJ-2017-339

PATRICIA K. DUFFY, MARY H. CROTTY, MARY S. HOWLETT, LYNNE P. STARBARD, ABIGAIL P. HOWLETT, ELIZABETH J. SPARKS, ANN MCDONAGH, KAREN ANN HIGGINS, CHARLENE RICHARDSON, LISA M. FIELD

VS.

ATTORNEY GENERAL AND SECRETARY OF THE COMMONWEALTH

ORDER

This matter came before the Court, Lowy, J., on a complaint in the nature of mandamus and request for a preliminary injunction. With the agreement of all parties and without making any determination as to whether the plaintiffs are likely to succeed on the merits of their claim, it is ORDERED, pending a final decision in this case, that: (a) the Attorney General release a summary of Initiative Petition No. 17-08 to the Secretary; and (b) the Secretary, subject to the filing of all required materials with him, prepare and release to the plaintiffs blank petition forms for the gathering of signatures.

Local election officials will not be obligated or requested to certify signatures on this petition unless the following steps first occur:

(1) On or before November 24, 2017, one or more of the plaintiffs or their legal counsel file an affidavit with the Secretary, stating a reasonable belief that at least 64,750 signatures have been collected on this petition and submitted to local election officials.

(2) Upon receipt of this affidavit, the Secretary shall request local election officials to certify the names on the petitions as they would ordinarily do in accordance with G.L. c. 53, § 7. Absent this request, local election officials will not be obligated to certify any signatures on this petition, notwithstanding G.L. c. 53, § 7, or any other law or regulation to the contrary.

(3) Only if at least 64,750 certified signatures appear in statewide Voter Registration Information System (VRIS) as of December 6, 2017 (the deadline set by article 48, Init., pt. 2, § 3, for filing additional signed petitions with the Secretary) will the Secretary accept the plaintiffs' petitions for filing and process and count the certified signatures in accordance with G.L. c. 53, § 22A. Absent the appearance of at least 64,750 signatures in VRIS as of December 6, 2017, the Secretary will not be obligated to accept the petitions for filing or to process and count any signatures thereon, notwithstanding G.L. c. 53, § 22A, or any other law or regulation to the contrary.

(4) Because the Secretary will not be tracking the number of signatures collected and submitted to local election officials unless and until those signatures are certified in accordance with this order, the plaintiffs acknowledge that the Secretary will not be responsible for providing that information to them until November 24, 2017, or such date as the certified signatures appear in VRIS, whichever is later.

If the Secretary does not receive the affidavit described above in Paragraph 1 on or before November 24, 2017, the defendants shall so notify this court promptly. Unless plaintiffs file with this court an affidavit asserting that they have gathered at least 64,750 signatures within ten (10) days thereafter, this action shall be dismissed as moot with prejudice.

By the Court (Lowy, J.),

Assistant Clerk

Entered: September 8, 2017

FILED ON: 1/10/2018

HOUSE . . . . . No. 4113

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act relative to patient safety and hospital transparency.

Be it enacted by the People, and by their authority, as follows:

SECTION 1. SECTIONS 2 through 4 below, along with section 231 of Chapter 111 of the General Laws, shall hereby be known as "The Patient Safety and Hospital Transparency Act."

SECTION 2. Chapter 111 of the General Laws is hereby amended by adding the following sections after section 231:

Section 231A. Definitions.

As used in sections 231 through 231K the following words shall have the following meanings: "Patient assignment", a person admitted to a facility where a registered nurse accepts responsibility for the patient's direct nursing care. A patient must be assigned to a registered nurse at all times.

"Complaint", any oral or written communication by a patient, medical professional, facility or any of its employees that a facility has violated any term or condition of this act.

"Facility", a hospital licensed under section 51 of this chapter, the teaching hospital of the University of Massachusetts medical school, any licensed private or state-owned and state-operated general acute care hospital, an acute psychiatric hospital, an acute care specialty hospital, or any acute care unit within a state operated healthcare facility. This definition shall not include rehabilitation facilities or long-term care facilities.

"Health Care Workforce", personnel employed by or contracted to work at a facility that have an effect upon the delivery of quality care to patients, including but not limited to registered nurses, licensed practical nurses, unlicensed assistive personnel, service, maintenance, clerical, professional and technical workers, and all other health care workers.

"Nursing care", care which falls within the scope of practice as defined in Section 80B of Chapter

112 of the General Laws or is otherwise encompassed within recognized standards of nursing practice, including assessment, nursing diagnosis, planning, intervention, evaluation and patient advocacy.

"Violation", any failure by a facility to abide by a term or condition of this act.

"Written Implementation Plan", a written plan detailing both the maximum number of patients to be assigned at all times to a registered nurse in each of the units enumerated in section 231C as well as concurrently detailing the facility's plans to ensure that it will implement such limits without diminishing the staffing levels of its health care workforce.

Section 231B: Concurrently with establishing and enforcing the maximum patient assignment limits enumerated in Section 231C below, each facility shall submit a written implementation plan to the Massachusetts Health Policy Commission certifying that it will implement the patient assignment limits without diminishing the staffing levels of its health care workforce.

Section 231C: It is the right of every patient in a facility to nursing care deemed safe by the registered nurse who has accepted responsibility for his or her care. It is the responsibility of each facility to provide the resources necessary to support the safe patient limits enumerated in this section. The maximum number of patients assigned at all times to a registered nurse in a facility shall not exceed the limits enumerated in this section.

Nothing shall preclude a facility from assigning fewer patients to a registered nurse than the limits enumerated in this section; provided, however, that no such assignment shall result in a reduction in the staffing level of the health care workforce assigned to the facility's patients.

The patient assignment limits shall be as follows:

a. In all units with step-down/intermediate care patients, the maximum patient assignment of step-down/intermediate patients is three (3). Step-down/intermediate care patients are those patients that require an intermediate level of care between the intensive care unit and general medical surgical unit.

b. In all units with post anesthesia care (PACU) patients, the maximum patient assignment of PACU patients under anesthesia is one (1). The maximum patient assignment of PACU patients post anesthesia is two (2).

c. In all units with operating room (OR) patients, the maximum patient assignment of OR patients under anesthesia is one (1). The maximum patient assignment of OR patients post anesthesia is two (2).

d. In the Emergency Services Department:

(1) The maximum patient assignment of critical care or intensive care patients is one (1). A registered nurse may accept a second critical care or intensive care patient if that nurse assesses that each patient's condition is stable.

(2) The maximum patient assignment of urgent non-stable patients is two (2). A patient is in an urgent non-stable condition when prompt care of the patient is necessary within fifteen to sixty minutes.

(3) The maximum patient assignment of urgent stable patients is three (3). A patient is in an urgent stable condition when prompt care of the patient is necessary but can wait up to three hours if necessary.

(4) The maximum patient assignment of non-urgent stable patients is five (5). A patient is in a non-urgent stable condition when the patient has a condition or conditions that need attention, but time is not a critical factor.

e. In all units with maternal child care patients:

(1) The maximum patient assignment of active labor patients, patients with intermittent auscultation for fetal assessment, and patients with medical or obstetrical complications is one (1) patient.

(2) The maximum patient assignment during birth and for up to two (2) hours immediately postpartum is one (1) nurse responsible for the mother and, for each baby, one (1) nurse whose sole responsibility is the baby. When the condition of the mother and baby are determined to be stable and the critical elements are met, one (1) nurse may care for both the mother and the baby(ies).

(3) The maximum patient assignment during the postpartum period for uncomplicated mothers or babies is six (6), which shall be comprised of either six (6) mothers or babies, three (3) couplets of mothers and babies, or, in the case of multiple babies, not more than a total of six (6) patients. As used in this subsection, couplet shall mean one (1) mother and one (1) baby.

(4) The maximum patient assignment of intermediate care or continuing care babies is two (2) babies.

(5) The maximum patient assignment of well-baby patients is six (6) babies.

f. In all units with pediatric patients, the maximum patient assignment of pediatric patients is four (4).

g. In all units with psychiatric patients, the maximum patient assignment of psychiatric patients is five (5).

h. In all units with medical, surgical and telemetry patients, the maximum patient assignment of medical, surgical and telemetry patients is four (4).

1. In all units with observational/outpatient treatment patients, the maximum patient assignment of observational/outpatient treatment patients is four (4).

J. In all units with rehabilitation patients, the maximum patient assignment of rehabilitation patients is five (5).

k. In any unit not otherwise listed, the maximum patient assignment is four (4).

Section 231D: Each facility shall implement the patient assignment limits established by Section 231C. However, implementation of these limits shall not result in a reduction in the staffing levels of the health care workforce.

Section 231E: The Massachusetts Health Policy Commission shall promulgate regulations governing and ensuring the implementation and operation of this act, including but not limited to regulations setting forth the contents and implementation of: (a) certification plans each facility must prepare for implementing the patient assignment limits enumerated in Section 231C, including the facility obligation that implementation of limits shall not result in a reduction in the staffing level of the health care workforce assigned to such patients; and (b) written compliance plans that shall be required for each facility out of compliance with the patient assignment limits. Notwithstanding the terms of this or any other section of this act, the Massachusetts Health Policy Commission shall not promulgate any regulation that directly or indirectly permits any delay, temporary or permanent waiver, or modification of the requirements set forth in sections 231C and 231D above.

Section 231F: Patient Acuity Tool. The patient acuity tool shall serve as an adjunct to the assessment of the registered nurse and shall be designed to promote and support the provision of safe nursing care for the patient(s); however, such tools are not to be utilized as a substitute for the assessment and clinical judgment of the registered nurse assigned to the patients. Each facility shall develop a patient acuity tool for each unit designated in Section 231C. The patient

assessment and use of the patient acuity tool shall be performed by the nurse who has accepted the assignment for that patient(s). The patient acuity tool for each unit in a facility shall be developed by a committee, the majority of which is comprised of staff nurses assigned to the particular unit. The patient acuity tool shall be developed to determine if the maximum number of patients that may be assigned to a registered nurse(s) should be lower than the patient assignment limits specified in Section 231C, in which case that lower number will govern for those patients. The patient acuity tool shall be written so as to be readily used and understood by registered nurses, shall measure the acuity of patients not less frequently than each shift, upon admission of a patient, and upon significant change(s) in a patient's condition and shall consider criteria including but not limited to: (1) the need for specialized equipment and technology; (2) the intensity of nursing interventions required and the complexity of clinical nursing judgment needed to design, implement and evaluate each patient's nursing care plans consistent with professional standards of care; (3) the skill mix of members of the health care workforce necessary for the delivery of quality care for each patient; and (4) the proximity of patients to one another who are assigned to the same nurse, the proximity and availability of other healthcare resources, and facility design. A facility's patient acuity tool shall, prior to implementation, be certified by the Massachusetts Health Policy Commission as meeting the above criteria, and the Commission may issue regulations governing such tools, including their content and implementation.

Such patient acuity tool and information contained and documented therein shall be part of the patient medical record.

Section 231G: This act shall not be construed to impair any collective bargaining agreement or any other contract in effect as of the effective date of this act, but shall have full

force and effect upon the earliest expiration date of any such collective bargaining agreement or other contract. Nothing in this act shall prevent the validity or enforcement of terms in a collective bargaining agreement or other contract that provides for a lower number of patients assigned to a nurse than the number mandated by the patient assignment limits set forth in this act.

Section 231H: Enforcement. The Massachusetts Health Policy Commission may conduct inspections of facilities to ensure compliance with the terms of this act. A facility's failure to adhere to the patient assignment limits set forth in Section 231C, as adjusted per the requirements set forth in Sections 231D and 231F, shall be reported by the Massachusetts Health Policy Commission to the Attorney General for enforcement. The Attorney General may bring a Superior Court action seeking injunctive relief and civil penalties in the amount of up to twenty-five thousand dollars per violation. A separate and distinct violation, for which the facility shall be subject to a civil penalty of up to twenty five thousand dollars, shall be deemed to have been committed on each day during which a violation continues following notice to the facility. Upon written notice by the Health Policy Commission that a complaint has been made or a violation has occurred, a facility receiving such notice shall submit a written compliance plan to the Commission that demonstrates the manner in which the facility will ensure future compliance with all of the provisions of this act within the time frame required by the Commission. No employee shall be disciplined or retaliated against in any manner for complying with the patient limits set forth in section 231C above, and any such employee so disciplined or retaliated against shall be entitled to the remedies provided in section 185(d) of chapter 149 regardless of whether the employee satisfies any other terms or conditions set forth in section 185 of chapter 149. The

requirements of this act, and its enforcement, shall be suspended during a state or nationally declared public health emergency.

Section 231I: Every facility shall post in a conspicuous place or places on its premises, including within each unit, patient room, and waiting areas, a notice to be prepared or approved by the Massachusetts Health Policy Commission that is easily readable in lay terms in English and in other languages determined by the commission setting forth excerpts of this act, including all of the patient assignment limits set forth in Section 231C, along with the manner in which to report violations and such other relevant information which the commission deems necessary to explain the requirements of this act. Any facility subject to this act which refuses to comply with the provisions of this section shall be punished by a civil penalty of not less than two hundred and fifty dollars and not more than two thousand five hundred dollars for each day the facility is not in compliance. The provisions of this section shall be enforced by the Attorney General.

Section 231J: The Massachusetts Health Policy Commission shall establish a toll-free telephone number where complaints against facilities can be reported, and a public website where complaints, certification and compliance plans, and violations shall appear and be updated at least quarterly for each facility. The toll-free telephone number and website location shall be included in all notices prepared and posted pursuant to Section 231I above.

Section 231K. It is in the public interest to have access to a transparent, detailed, and comprehensive record of the financial health of each facility that accepts funds from the Commonwealth to provide healthcare to its residents. Each facility that accepts funds from the Commonwealth shall report annually to the Massachusetts Health Policy Commission all financial assets owned by the facility, along with the assets of any holding company and any and

all parent, subsidiary, or affiliated companies, including those held in financial institutions outside the United States or invested outside the United States. Unless prohibited by other law, the Massachusetts Health Policy Commission shall make this information public within seven calendar days of receipt.

SECTION 2: Severability. The provisions of this act are severable, such that, if any clause, sentence, paragraph or section, or an application thereof, shall be adjudged by any court of competent jurisdiction to be invalid, such adjudication shall not affect, impair, or invalidate the remainder of any clause, sentence, paragraph or section thereof and shall be confined in its operation to such clause, sentence, paragraph, section or application adjudged invalid; provided further, that any such clause, sentence, paragraph, section or application deemed invalid shall be reformed and construed such that it would be valid to the maximum extent permitted.

SECTION 3: This act shall take effect on January 1, 2019.

FIRST TEN SIGNERS

NAME	RESIDENCE	CITY OR TOWN
Donna Kelly-Williams	110 Mary Street	Arlington
Karen A. Coughlin	30 Smith Road	Mansfield
Susan J. Wright Thomas	2 Christine Road	Hull
Mary Elizabeth Amsler	53 Meeting House Path	Ashland
Daniel R. Rec	14 Staci Drive	Bridgewater
Nora A. Watts	62 Warren Street	Westborough
Linda C. Barton	166 Powell Street	Stoughton
Ellen Smith	31 Chestnut Street, Unit #1	Worcester
Paula Ryan	5 Mariners Drive	Marshfield
Harley W. Keisch	197 View Drive	Richmond

THE COMMONWEALTH OF MASSACHUSETTS
OFFICE OF THE ATTORNEY GENERAL
ONE ASHBURTON PLACE
BOSTON, MASSACHUSETTS 02108

MAURA HEALEY
ATTORNEY GENERAL

(617) 727-2200
www.mass.gov/ago

September 6, 2017

Edward V. Colbert III, Esq.
Casner & Edwards, LLP
303 Congress Street
Boston, Massachusetts 02210

Re: Initiative Petition No. 17-08, A Law Relative to Patient Safety and Hospital Transparency

Dear Mr. Colbert:

In accordance with the provisions of Article 48 of the Amendments to the Massachusetts Constitution, we have reviewed the above-referenced initiative petition, which was submitted to the Attorney General on or before the first Wednesday of August of this year. I regret that we are unable to certify that the proposed law complies with Article 48's requirement that it "contain[] only subjects . . . which are related or which are mutually dependent." Our decision, as with all decisions on certification of initiative petitions, is based solely on Article 48's legal standards; it does not reflect any policy views the Attorney General may have on the merits of the proposed law.

The proposed measure would establish a maximum number of patients that could be assigned to registered nurses in Massachusetts hospitals and other specified health care facilities. The proposed measure contains various provisions concerning how covered facilities should implement the patient assignment limits and directs the state Health Policy Commission ("HPC") to develop regulations concerning the measure's enactment. The proposed measure would also require each covered facility that accepts funds from the state to annually report to the HPC all financial assets owned by the facility, along with the assets of any holding company and any and all parent, subsidiary, or affiliated companies.

Because the proposed measure contains both patient assignment limits and financial disclosure requirements, we cannot certify that it contains "only subjects . . . which are related or which are mutually dependent[.]" Art. 48, Init., pt. 2, § 3. For a petition to meet this relatedness requirement, voters must be able to "identify a common purpose to which each subject . . . can reasonably be said to be germane." Massachusetts Teachers Association v. Secretary of the Commonwealth, 384 Mass. 209, 219 (1981). In addition, the provisions of the proposed law

must bear a "meaningful operational relationship" to one another, so as to "permit a reasonable voter to affirm or reject the entire petition as a unified statement of public policy." Carney v. Attorney General, 447 Mass. 218, 220, 231 (2006). "It is not enough that the provisions in an initiative petition all 'relate' to some same broad topic at some conceivable level of abstraction[;] [t]o clear the relatedness hurdle, the initiative petition must express an operational relatedness among its substantive parts." Id. at 230-31. See also Abdow v. Attorney General, 468 Mass. 478, 499-504 (2014) (petition need not be limited to a single subject but may not meet relatedness requirement if it includes subjects with only a marginal relationship to one another such that voters may be confused or placed in the untenable position of having to cast a single vote on dissimilar subjects).

Under the SJC's recent holding in Gray v. Attorney General, 474 Mass. 638 (2016), Petition 17-08 fails to meet Article 48's relatedness requirement. In Gray, the Court considered a petition that would have (1) rescinded a vote to adopt the "common core" curriculum in schools, reinstated the previous curriculum frameworks, and changed the process for altering the curriculum in the future; and (2) required the annual release of the test items used to perform a "diagnostic assessment" of students in the previous year. 474 Mass. at 641-43. The Court held that these two subjects were not "related or mutually dependent" because "whether the diagnostic assessment tests are based on the common core standards or some previous set of academic standards ... will not affect in any way the commissioner's obligation ... to release before the start of every school year all the previous year's test items ...; the commissioner's obligation will exist independently of the specific curriculum content on which the tests are based." Id. at 648.

Similarly, here, mutual dependence does not link the staffing requirements with the financial disclosure requirement: the financial status of a covered facility bears no relationship to that facility's obligation to adhere to the required patient assignment limits. The proposed measure does not excuse non-compliance with the patient assignment limits if a facility lacks the financial ability to comply,[1] nor is the financial reporting obligation triggered by a facility's failure to comply with the assignment limits. Rather, the two obligations would operate wholly independently from one another.[2]

Moreover, the two goals of Petition 17-08 are not sufficiently related to "permit a reasonable voter to affirm or reject the entire petition as a unified statement of public policy." Carney, 447 Mass. at 231. A voter might believe that financial disclosure of assets by hospitals is appropriate without believing that nurse staffing levels should be mandated, or vice-versa. This disparity arises because the two requirements do not work together toward a single goal.

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[1] There are no exceptions to compliance in the proposed measure, and the law would explicitly bar HPC from creating any regulations that would "permit any delay, temporary or permanent waiver, or modification" of the staffing requirements. (Petition 17-08, proposed M.G.L. c. 111 § 231E.)

[2] Their independence is accentuated by the fact that the reporting requirement is limited to facilities that "accept funds from the Commonwealth," whereas the patient assignment provisions do not contain such a limitation. Thus, it would be possible that some facilities required to obey the patient assignment maximums would not be required to make the financial disclosures. This possibility demonstrates the lack of mutual dependence between them.

Unlike other reporting obligations contained in the proposed measure, which would demonstrate a covered facility's implementation and performance under the law's new staffing requirements, the financial reporting obligation is unconnected with those requirements. "The combination of these two issues in one initiative petition does not offer the voters a 'unified statement of public policy.'" Gray, 474 Mass. at 649 (citing Carney, 447 Mass. at 231). Put another way, the petition's similarities fail to dominate what each provision provides separately such that "the petition, considered as a whole, 'is sufficiently coherent to be voted on 'yes' or 'no' by the voters." Id. (citing Carney, 447 Mass. at 226).

For the foregoing reasons, we are unable to certify Petition 17-08 as meeting the requirements of Article 48.

Very truly yours,

Juliana deHaan Rice
Deputy Chief, Government Bureau
617-963-2583

cc: William Francis Galvin, Secretary of the Commonwealth

Summary of 17-08.

This proposed law would limit how many patients could be assigned to each registered nurse in Massachusetts hospitals and certain other health care facilities. The maximum number of patients per registered nurse would vary by type of unit and level of care, as follows:

- In units with step-down/intermediate care patients: 3 patients per nurse;

- In units with post-anesthesia care or operating room patients: 1 patient under anesthesia per nurse; 2 patients post-anesthesia per nurse;

- In the emergency services department: 1 critical or intensive care patient per nurse (or 2 if the nurse has assessed each patient's condition as stable); 2 urgent non-stable patients per nurse; 3 urgent stable patients per nurse; or 5 non-urgent stable patients per nurse;

- In units with maternity patients: (a) active labor patients: 1 patient per nurse; (b) during birth and for up to two hours immediately postpartum: 1 mother per nurse and 1 baby per nurse; (c) when the condition of the mother and baby are determined to be stable: 1 mother and her baby or babies per nurse; (d) postpartum: 6 patients per nurse; (e) intermediate care or continuing care babies: 2 babies per nurse; (f) well-babies: 6 babies per nurse;

- In units with pediatric, medical, surgical, telemetry, or observational/outpatient treatment patients, or any other unit: 4 patients per nurse; and

- In units with psychiatric or rehabilitation patients: 5 patients per nurse.

The proposed law would require a covered facility to comply with the patient assignment limits without reducing its level of nursing, service, maintenance, clerical, professional, and other staff.

The proposed law would also require every covered facility to develop a written patient acuity tool for each unit to evaluate the condition of each patient. This tool would be used by nurses in deciding whether patient limits should be lower than the limits of the proposed law at any given time.

The proposed law would not override any contract in effect on January 1, 2019 that set higher patient limits. The proposed law's limits would take effect after any such contract expired.

The state Health Policy Commission would be required to promulgate regulations to implement the proposed law. The Commission could conduct inspections to ensure compliance with the law. Any facility receiving written notice from the Commission of a complaint or a violation would be required to submit a written compliance plan to the Commission. The Commission could report violations to the state Attorney General, who could file suit to obtain a civil penalty of up to $25,000 per violation as well as up to $25,000 for each day a violation continued after the Commission notified the covered facility of the violation. The Health Policy

Commission would be required to establish a toll-free telephone number for complaints and a website where complaints, compliance plans, and violations would appear.

The proposed law would prohibit discipline or retaliation against any employee for complying with the patient assignment limits of the law. The proposed law would require every covered facility to post within each unit, patient room, and waiting area a notice explaining the patient limits and how to report violations. Each day of a facility's non-compliance with the posting requirement would be punishable by a civil penalty between $250 and $2,500.

The proposed law's requirements would be suspended during a state or nationally declared public health emergency.

The proposed law would require each hospital and health care facility that accepts funds from the state to disclose annually to the Health Policy Commission all financial assets owned or invested by the facility or by any affiliated, subsidiary, or parent companies. Unless otherwise prohibited by law, the Commission would make this information publicly available within seven days.

The proposed law states that, if any of its parts were declared invalid, the other parts would stay in effect. The proposed law would take effect on January 1, 2019. The proposed law states that, if any of its parts were declared invalid, the other parts would stay in effect.