Senate Bill 411 – Hospitals– Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026)

POSITION: Oppose
February 17, 2026
Senate Finance Committee

The University of Maryland Medical System (UMMS) respectfully submits this letter of opposition to Senate Bill 411 – Hospitals – Clinical Staffing Committees and Plans – Establishment (Safe Staffing Act of 2026) on behalf of the following member hospitals and health systems: University of Maryland Medical Center, UM Capital Region Health, UM Charles Regional Medical Center, UM Shore Regional Health, UM Upper Chesapeake Health, UM Baltimore Washington Medical Center, UM St. Joseph's Medical Center, UM Rehabilitation and Orthopaedic Institute, and Mt. Washington Pediatric Hospital[1].

UMMS provides primary, urgent, emergency and specialty care at 11 hospitals and more than 150 medical facilities across the state. The UMMS network includes academic, community and specialty hospitals that together provide 25% of all hospital-based care in Maryland. Our acute care and specialty hospitals are located in 13 counties and Baltimore City, and serve urban, suburban and rural communities.

[1] Mt. Washington Pediatric Hospital is co-owned by UMMS and Johns Hopkins Medicine.

Senate Bill 411 ("SB 411") would require a hospital to establish a clinical staffing committee – consisting of equal membership from management and employees – to develop and implement mandated clinical staffing plans, by unit, for all staff. The clinical staffing committee responsible for making clinical staffing plans must include a broad range of clinical and *non-clinical* staff, including certified nursing assistants, dietary aides, environmental service workers, and technicians. The clinical staffing plans must be reviewed and amended on at least an annual basis, and the adopted plan must be posted in a conspicuous area in each patient unit of the hospital. If the plan is amended at any time, the amended plan must likewise be posted in a conspicuous area in each patient unit in a timely manner.

Ensuring safe and effective staffing is critical in healthcare settings. While we understand that the intent of this bill is to support hospital staff, it introduces significant challenges that ultimately do not serve the best interest of patients, hospitals or healthcare professionals, establishes mandates that are duplicative of federal law and accreditation standards, and places significant additional administrative burdens on hospitals without improving employee safety or patient care.

In particular, UMMS and its member hospitals share the following foundational concerns with the legislation:

1. **Clinical Staffing is Extensively Regulated under Federal Law and Accreditation Standards**

Maryland hospitals already operate under clinical staffing requirements established by the federal government and national accreditation organizations. The Centers for Medicare & Medicaid Services (CMS) Conditions for Participation require hospitals to provide 24-hour nursing services and maintain adequate numbers of licensed registered nurses and other personnel to meet patient needs (42 CFR §482.23). CMS enforces these staffing regulations through regular surveys and audits, and may levy penalties that include the loss of Medicare and Medicaid reimbursement.

The Joint Commission (TJC) – an accrediting body for hospitals nationwide – recently established clinical staffing as a National Performance Goal, beginning January 1, 2026. TJC standards align with and supplement the CMS Conditions for Participation for staffing and require hospitals to be adequately staffed to meet patient needs. Specifically, the nursing executive is responsible for the operation of nursing services, which includes determining nursing policies and procedures, and the types and numbers of nursing and other staff necessary to provide nursing care for all units of the hospital, as well as monitor compliance data and address any instances where care failed to meet the expected standards. TJC conducts regular, unannounced inspections to ensure compliance with its standards. Failing a TJC inspection can lead to severe consequences, including loss of accreditation and loss of federal reimbursement (e.g., Medicare and Medicaid reimbursement).

Importantly, CMS regulations and TJC national performance goals each require a nursing executive to direct staffing and prepare staffing plans, including the "types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital." As introduced, SB 411 places this authority in a committee consisting of equal membership from management and employees that includes several non-clinical staff. This requirement is inconsistent with federal law and national accreditation standards, thereby creating two different standards – one federal, one state – for hospital staffing.

2. **Hospitals Engage Frontline Staff Directly and Practice Robust Shared Governance**

Bill proponents argue that hospitals do not meaningfully engage frontline clinical staff in staffing decisions. This is not accurate. Pursuant to CMS requirements and national accreditation standards related to clinical staffing, UMMS has implemented much of what the bill seeks to mandate, including collaboration between nurse leaders and nurse team members to ensure adequate and safe staffing. For instance, at the University of Maryland Baltimore Washington Medical Center (UM BWMC) direct care staff are empowered to present evidence-based recommendations through:

- Daily organizational and unit-based safety huddles
- Leader town halls
- Multidisciplinary rounds
- Staff and committee meetings
- Shared Leadership Councils
- Unit Practice Councils (UPCs)

Daily Safety Huddles bring together patient flow coordinators, senior leaders, managers, supervisors, charge nurses, physicians, care managers, and other service line representatives. Participants openly discuss safety concerns, staffing challenges, risks, and operational needs. When team members identify opportunities for improvement in staffing, safety, or workflow, they discuss potential solutions and may form multidisciplinary taskforces or committees to implement change. Representatives include a wide range of clinical staff to ensure comprehensive and inclusive decision-making. These mechanisms also allow real-time input and flexible solutions, and are far more responsive than a rigid statutory staffing committee structure.

Finally, at several of our member hospitals, employee categories covered by the bill already have collectively bargained rights governing workplace conditions and staffing. The potential impact of the legislation on this class of employees is not clear.

3. **Hospitals are Facing Increased Operational and Financial Challenges Due to Changes in Federal Law and Funding Cuts**

SB 411 introduces new regulatory requirements that will divert resources away from direct patient care and place unnecessary strains on hospital operations. Rather than improving patient safety, these additional regulatory requirements could reduce operational efficiency and limit hospitals' ability to ability to respond flexibly to patient needs. For example, Section 19-396 of the bill would require a hospital clinical staffing committee to post a clinical staffing plan on or before January 1 of each year and require the plan to be amended and re-posted each time there is a change to it. Hospital staffing plans are based on the number of patients, types of medical conditions, number of beds, and innumerable other factors that change on a daily or even hourly basis. Given the wide range of factors that must be considered in a clinical staffing plan, and how frequently those factors change, hospitals must adopt and amend staffing plans 4-6 times per day. In addition, staffing plans necessarily look different for each unit and category of staff. Requiring a pre-determined standing committee of staff to be responsible for developing and posting a staffing plan each time there is any change is not feasible given the real-time changes and demands of clinical settings.

Moreover, SB 411 proposes to introduce new compliance burdens at precisely the wrong time. Maryland hospitals are preparing for the transition to the AHEAD Model Agreement, and the subsequent loss of hundreds of millions of dollars in federal Medicare and Medicaid funding under the agreement. Federal cuts to Medicaid under the One Big Beautiful Bill Act (H.R.1) and expiration of federal Affordable Care Act premium subsidies will further reduce federal healthcare spending in Maryland and exacerbate financial challenges for hospitals. This is particularly true for safety net hospitals in the State that disproportionately serve patients enrolled in Medicaid and Medicare. Despite these known and significant challenges, SB 411 would require hospitals to implement clinical staffing plans on the exact day, January 1, 2028, that the federal Medicare reimbursement is reduced under the AHEAD Model.

4. **SB 411 Creates an Inequitable System between State and Private, Nonprofit Hospitals**

As introduced, SB 411 proposes to exempt State hospitals from the requirements to establish clinical staffing committees and plans. Last session, in the House hearing, alternative explanations were provided for the decision to exempt State hospitals: (i) extending the mandate to State hospitals would create a large fiscal note, and (ii) State hospitals are subject to clinical staffing requirements set by CMS. In addition, in a 2024 letter of support with amendments to the bill, the Maryland Department of Health (MDH) indicated that State hospitals are "bound to the Joint Commission and the Centers for Medicare and Medicaid Services (CMS) regulations. CMS does not allow external stakeholders to participate in staffing determinations. Determination of hospital policy by external stakeholders would violate CMS regulations, and could jeopardize federal funding." (*see* House Bill 1194 – Hospitals - Clinical Staffing Committees and Plans - Establishment (Safe Staffing Act of 2024) – Letter of Support with Amendments, Maryland Department of Health, March 13, 2024). However, each hospital in the state is subject to identical CMS Conditions of Participation, meaning the same federal staffing standards apply.

All patients deserve the same standard of care, regardless of where they receive treatment. This exemption undermines the bill's intent and creates an unfair burden on non-state hospitals, which must comply with additional regulations.

5. **Hospital Staffing Committees Will Not Address the Nationwide Healthcare Workplace Shortage**

Many proponents of the bill have identified mandated clinical staffing committees and clinical staffing plans as a mechanism to address workforce shortages. As the committee is aware, the healthcare workforce shortage is a serious and growing issue, with an estimated 1 in 4 nursing positions in the state currently vacant. More healthcare professionals, including nurses, are desperately needed, but this is a national issue and clinical staffing committees, or clinical staffing plans will not help with employee recruitment or retention. The shortage of healthcare professionals is most directly connected with an aging workforce and an inability of nursing, medical, and other professional schools to graduate enough healthcare professionals to meet current workforce demands. Moreover, states that have adopted mandated clinical staffing committees and clinical staffing plans continue to face the same workforce shortages.

UMMS is taking significant steps to address the workforce shortage and ensure adequate staffing. Across the health system, we have created several innovative programs that support training, recruitment, and retention of nurses and other healthcare professionals in Maryland. For example,

the UMMS Academy of Clinical Essentials (ACE) initiative and Community College Tuition Reimbursement Program combined have resulted in the training and recruitment of more than 1,000 new nurses over the past three years. Requiring hospitals to adhere to inflexible staffing plans will not assist our expanding efforts to recruit and retain nurses and other healthcare professionals.

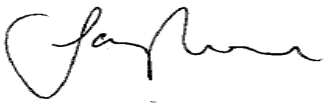
While the goal of ensuring appropriate staffing levels is laudable, SB 411 fails to address this issue in a fair, effective, and evidence-based manner. SB 411 disrupts this well-functioning system without clear evidence that it would lead to better outcomes. This approach does not reflect the complexities of hospital operations or patient care. The exclusion of state hospitals creates inequities, the bill imposes unnecessary administrative burdens, and hospitals are already following federal law and nationally recognized standards to ensure proper staffing.

For these reasons, the University of Maryland Medical System opposes SB 411, and respectfully requests an ***unfavorable*** report on the bill.

For more information, please contact:
Will Tilburg, VP, Government and Regulatory Affairs
University of Maryland Medical System
William.tilburg@umm.edu

VP of Nursing Services & CNO
UM Charles Regional Medical Center

SVP & CNO
UM Baltimore Washington Medical Center

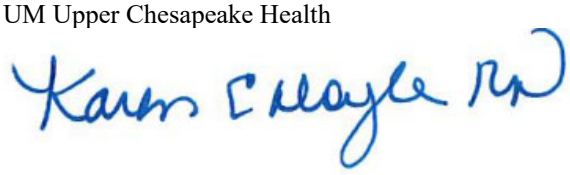


SVP of Patient Care Services & CNO
UM St. Joseph's Medical Center

SVP & CNO
UM Capital Region Health

SVP of Patient Care Services & CNO
UM Upper Chesapeake Health

Director of Nursing Services
UM Rehabilitation and Orthopaedic Institute



SVP of Patient Care Services & CNO
University of Maryland Medical Center

VP of Patient Care Services & CNO
Mt. Washington Pediatric Hospital

SVP, System Chief Nurse Executive
University of Maryland Medical System

SVP & CNO
UM Shore Regional Health