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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

Testimony of the Maine Hospital Association

Neither For Nor Against

LD 2271 - *An Act to Implement the Recommendations of the Task Force to Evaluate the Impact of Facility Fees on Patients to Improve Facility Fee Transparency and Notification and to Prohibit Facility Fees for Certain Services*

March 19, 2024

Senator Bailey, Representative Perry and members of the Health Care, Insurance and Financial Services Committee, my name is Jeff Austin and I am presenting testimony neither for nor against LD 2271 on behalf of the Maine Hospital Association. The Maine Hospital Association (MHA) represents all 36 community-governed hospitals including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital.

Opening Statement.

We believe the issue of facility fees has been both misrepresented and misunderstood in Maine. Suffice it to say, facility fees are a method of receiving reimbursement for costs other than the professional fee. It generally includes overhead costs – like the building and administration; but it also can include direct clinical costs like nursing or pharmaceuticals.

Facility fees are neither 'good' nor 'bad'; they are simply a method of billing. In fact, it's the method of billing that hospitals are obligated to follow in Medicare and Medicaid for many services.

Task Force.

I was a member of the Task Force and appreciate that the presentations we received from most Maine entities correctly explained that facility fees are NOT charged for office visits in the Maine commercial market. Statements or implications to the contrary are simply false.

Legislation.

We are fine with most of the bill but we would like to delete two sections.

1. **Section 4 / Proposed subsection (E)(2): Lines 22-24.**

Section 4 requires hospitals to post notices. To the extent that the requirements are reasonable, we have no objection. However, proposed subsection (E)(2) is unreasonable.

It essentially requires hospitals to post a notice that their patients should go elsewhere for service.

Furthermore, in many instances, the statement is simply false. Here are four examples of how the statement is false:

1. When the cost of the procedure will max out the patient's deductible regardless of where it is performed;
2. Many non-hospital, outpatient surgical centers also charge facility fees;
3. Most of the services for which a facility fee is charged by hospitals are simply not available elsewhere; there is no non-hospital facility at which the patient can get the service.
4. All Medicaid patients – facility fees are charged but the patient is not financially liable for any of them.

In this section, the government is compelling speech. This has First Amendment implications. Obligating providers to post accurate notices about facts are probably defensible; value-laden statements, particularly ones that are not true, like the statement in (E)(2) are not defensible.

Please delete (E)(2) from the bill.

2. Section 5 / Proposed section 1718(I): Top of page 2.

This section, and Section 7 seek to prohibit providers from collecting a facility fee when the patient is receiving telehealth services while at home. The gut reaction that a facility fee shouldn't be charged when the patient is at home is understandable.

Please remember, the professional has overhead costs even when the patient is at home. All administrative costs are still borne by the provider (billing & collections; regulatory compliance; legal etc.) even when the patient is at home.

Nevertheless, if you proceed with a ban on facility fees, we feel quite strongly that you should only do so for the Title 24 commercial insurance products that you regulate (Section 7).

Section 5 amends Title 22, and it you enact a prohibition in Title 22 it will impact Medicare and Medicaid. This is simply a line you should not cross, no matter how strongly you feel about the policy.

Medicare is not your program and you should not put regulatory conditions (or prohibitions) on Medicare reimbursement.

While Medicaid is a program the state regulates, this is not the Committee that regulates Medicaid reimbursements. The HHS Committee governs provider reimbursement, there is a new state law that governs changes to provider reimbursement and this reimbursement change has not gone through that process. Furthermore, DHHS could institute such a ban at any time should it choose to do so.

Please do not enact any prohibitions in Title 22; if you choose to do a prohibition, please restrict its reach to the commercial plans you regulate in Title 24.