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PCHC
Penobscot Community Health Care

State of Maine | 132nd Legislature
Joint Standing Committee on Health Coverage, Insurance, and Financial Services
Testimony of Lori Dwyer on behalf of Penobscot Community Health Care

February 18, 2026

In opposition to:
LD 2199, An Act to Prohibit Interference with the Professional Judgment and Clinical Decisions of Licensed Health Care Professionals as Recommended by the Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Senator Bailey, Representative Mathieson, and members of the Committee, I am Lori Dwyer, President & CEO of Penobscot Community Health Care (PCHC). Thank you for the opportunity to testify in opposition to LD 2199.

PCHC is the largest of Maine's 20 federally qualified health centers (FQHC), serving approximately 55,000 patients with locations in Penobscot, Waldo, and Somerset Counties. We provide high quality integrated primary care – including mental health services, pediatrics, care management, pharmacy, dental care, audiology and speech services, and treatment for substance use disorder—at 22 clinical service sites, regardless of a patient's ability to pay. That mission depends on both protecting the independent clinical judgment of our providers and maintaining responsible operational standards that allow us to serve our communities efficiently, safely, and in compliance with the law.

We employ approximately 715 mission-driven staff, including more than 200 clinicians. Community health centers are the largest independent primary care network in Maine.

We appreciate and share the intent behind LD 2199 — ensuring that licensed health care professionals can exercise independent clinical judgment free from inappropriate interference. However, as drafted, this bill is overly broad, ambiguous, and could unintentionally undermine the ability of health care organizations like PCHC to operate safely, efficiently, and in compliance with state and federal requirements.

First, the bill's use of the term "person" is extraordinarily broad and unworkable.
Subsection 2 prohibits any "person" from directly or indirectly interfering with, controlling, or otherwise directing the professional judgment or clinical decision of a licensed health care professional. As written, a "person" could include a licensing board, an accrediting body, an educational institution or residency program, an employer, an experienced colleague, a patient, a family member, a regulator, or a member of law enforcement. Without clarification, this sweeping prohibition creates legal uncertainty and could chill routine, appropriate interactions and required oversight that are necessary in a team-based care environment.

Second, the bill does not account for situations where clinical decisions fail to meet standards of care, ethical or legal requirements, or evidence-based practice.
Health care organizations have a legal and ethical obligation to ensure that care delivered under their auspices meets professional standards and complies with applicable laws and regulations, including meeting applicable standards of care. LD 2199 contains no clear exception allowing organizations to intervene when a provider's decisions fall outside accepted standards of care, , violates rules implemented by federal or commercial payers, or otherwise jeopardize patient safety.

Third, the bill could be interpreted to prohibit standard employment expectations that are essential to patient access.
PCHC, like many health systems, establishes reasonable productivity expectations — for example, an average number of patients seen per hour — in order to ensure timely access to care for our patients. When a provider consistently cannot meet those expectations, we work collaboratively to identify barriers and improve efficiency, assuring that patients can access care when care is required, necessary, and/or acutely recommended. In rare cases, performance management may be necessary. The language in LD 2199 restricting an employer's ability to influence "the number of patients seen in a given time period" could be interpreted to prohibit these standard and appropriate practices, potentially reducing patient access and destabilizing care delivery.

Similarly, health care organizations must establish scheduling frameworks — such as 15-minute or 30-minute appointment types — to ensure that patients receive timely care tied to the patient's unique medical circumstances. Allowing individual providers to override these operational frameworks solely by asserting a difference in professional judgment could create significant disruption and inequity in patient access.

Fourth, the bill could interfere with legal and regulatory compliance and anti-fraud, waste, and abuse obligations.
Routine auditing of diagnosis, billing, and other codes is a routine and necessary safeguard to ensure compliance with payer contracts, federal payer programs, and federal and state regulations. When clinical documentation does not support a particular billing code, organizations must correct the coding before submitting claims. This is not interference with clinical judgment; it is a legal requirement designed to prevent fraud, waste and abuse and protect public resources. LD 2199 could hinder these important compliance processes.

Fifth, the bill relies on undefined and subjective terms such as "excessive pressure."
Without clear definitions, these terms invite inconsistent interpretation, increased litigation risk, and operational uncertainty for providers and health care organizations alike.

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In short, LD 2199 attempts to address a legitimate concern but does so in a way that could produce unintended and harmful consequences for patient access, organizational accountability and financial sustainability, and legal compliance — particularly for community-based providers serving vulnerable populations.

PCHC respectfully urges the Committee to vote Ought Not to Pass on LD 2199. At a minimum, substantial amendments would be necessary to clarify definitions, preserve the ability of health care organizations to set reasonable operational standards, ensure compliance with law, licensing and ethical requirement, and payer requirements, and explicitly allow intervention when patient safety or standards of care are at risk.

We would welcome the opportunity to work with the Committee to develop a more balanced approach that protects both clinical independence and the operational structures required to deliver care safely and effectively to Maine people.

Thank you very much for your time and the work you do for the State. Please reach out to me if you have any questions. I am happy to answer any additional questions you may have.

Sincerely,

Lori Dwyer, Esq.
President and CEO
Penobscot Community Health Care