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ResearchReport

Facility Fee Limits

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Issue

Summarize limits on health care facility fees under Connecticut law. This report has been updated by OLR Report 2022-R-0181.

Summary

Under Connecticut law, a "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee (CGS § 19a-508c(a)(3)).

In certain circumstances Connecticut limits the facility fees that hospitals, health systems, and hospital-based facilities may charge for outpatient services provided off-site from a hospital campus. State law generally prohibits them from collecting a facility fee:

1. for outpatient services that use a current procedural terminology evaluation and management (CPT E/M) code or
2. from uninsured patients for outpatient services that exceeds the Medicare facility fee rate (CGS § 19a-508c(*l*)).

These limits do not apply to (1) freestanding emergency departments or (2) Medicare and Medicaid patients or those receiving services under a workers' compensation plan. A facility that violates this fee prohibition has committed an unfair trade practice (CGS § 19a-508c(g) & (*l*)).

In addition to the above limits, Connecticut law also:

1. prohibits telehealth providers from charging facility fees for telehealth services (CGS § 19a-906(h) and PA 20-2, July Special Session, § 1(h)) and

2. prohibits hospitals, health systems, or hospital-based facilities that purchase physician group practices from charging facility fees at the purchased facility until a specified period after notifying the practice's patients (CGS § 19a-508c(k)(1) & (k)(4)).

JO:kc