Office of Affordable Health Care

Advisory Council Meeting, September 3rd, 2025

Agenda

- Annual Public Hearing – Monday, September 29th at 1:00
  - Sign-up to testify (virtually or in-person) or submit comments at: https://www.maine.gov/oahc/annual-public-hearing
  - Written comments will be due Friday, October 10th
- Behavioral Health Access Research from Summer Fellow Rudy Rudinski
- Review and Discussion of Payment and Utilization Dashboards
- Policy Deep-Dive: Regulating Commercial Provider Prices

Assessing Options to Improve Behavioral Health Care Access

Rudy Rudinski
Muskie School of Public Health, USM
OAHC 2025 Summer Fellow

Behavioral Health Needs in Maine

2025 Community Health Needs Assessment

- Mental health is the **#1 social concern** impacting Maine residents
- **73%** of respondents reported negative impact of behavioral health (BH) needs on themselves or a community member
- **39%** reported lack of access to BH treatment services

Health Professional Shortage Areas

- **15 of the 16 counties** in Maine are classified by HRSA as BH professional shortage areas

Efforts in Other States to Reduce Barriers to Access

Initiative	Description
BH Spending Benchmark	Several states including RI, OR, and CT created benchmarks for primary care spending as a total of all health care expenditures. CA is the first state to propose a similar methodology for BH care.
Reference-Based Price Floors	In 2025 WA state passed a law for reference-based pricing used to create a price floor for BH and primary care prices at least 150% of Medicare rates. This law only applies to the WA Public Employee Benefit Board (PEBB) and School Employees Benefit Board (SEBB) health plans.
Addressing Gaps in BH Coverage	In 2023 OR passed a law stating that fully insured group health insurance policies and individual health benefit plans must cover coordinated care and case management as a part of BH treatment.
Workforce Improvements	Between 2021 and 2023 OR provided $2 million to provide sign-on bonuses, retention bonuses, and housing stipends to BH care providers. A maximum of $120,000 awarded to any one qualified BH care organization over the course of 2 years.

Existing Maine Initiatives

Initiative	Description
BH Care Spending Reporting	MHDO's Annual Behavioral Health Spending Report tracks how much Maine spends on BH as a total of health care expenditures. In 2023, 8.3% of commercial payments were for BH care (increase from 7.3% in 2021).
Addressing Gaps in BH Coverage	Certified Community Behavioral Health Clinics combine case management, behavioral health, and primary care within one practice. The Office of MaineCare Services has been collaborating with state partners to refine the design of a payment model to support CCBHCs and expand implementation in Maine.
Workforce Improvements	Maine DHHS utilized federal CDC funds to help launch the Building-ME Network, a statewide system to streamline clinical placements for trainees and preceptors in rural communities.
Workforce Improvements	The Student Loan Repayment Tax Credit provides $2,500 annually, and up to $25,000 lifetime, per taxpayer to Maine residents with an associate's, bachelor's, or graduate degree.

Facility Level Payment and Utilization Dashboards

Analysis Planning

Complete

In Progress

Not Yet Started

OAHC Claims Dashboards

Health Expenditures Dashboards

Hospital Payment and Utilization Dashboards

Professional Services Payment and Utilization

Facility Level Payment and Utilization

Cost Driver Deep-Dives

MHDO and MQF Reporting

Drug Spending Dashboards

Primary Care Spending Report

Behavioral Health Care Spending Report

Hospital Quality Data

Hospital Financial Data

Health Care Payments in Maine V 2.0

CompareMaine: Payment and Quality Data

OAHC Non-claims Analyses

Household Spending on Health Care

Access and Equity Dashboards

Clinical Quality Metric Dashboards

Provider Cost Analysis

Review of Hospital Level Payment and Utilization Dashboards

Overview: Working with MHDO, we created hospital level dashboards to measure payments and utilization across hospitals in Maine.

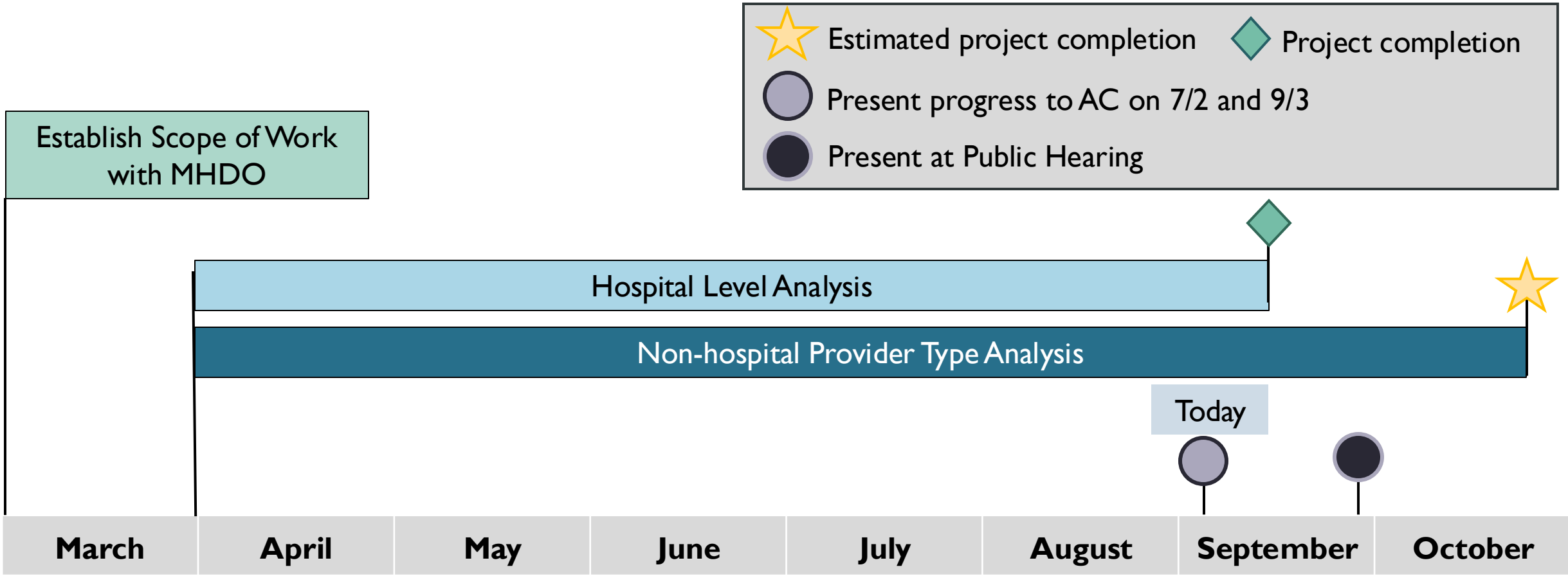
Purpose: To identify and describe variation in payments and utilization across Maine hospitals and for select services.

Metrics: For each hospital we will report -

- Total payments and payments per unit by hospital inpatient, outpatient, and professional services
- Total utilization by hospital inpatient, outpatient, and professional services
- Select service level total payments and payments per unit
- Select service level total utilization

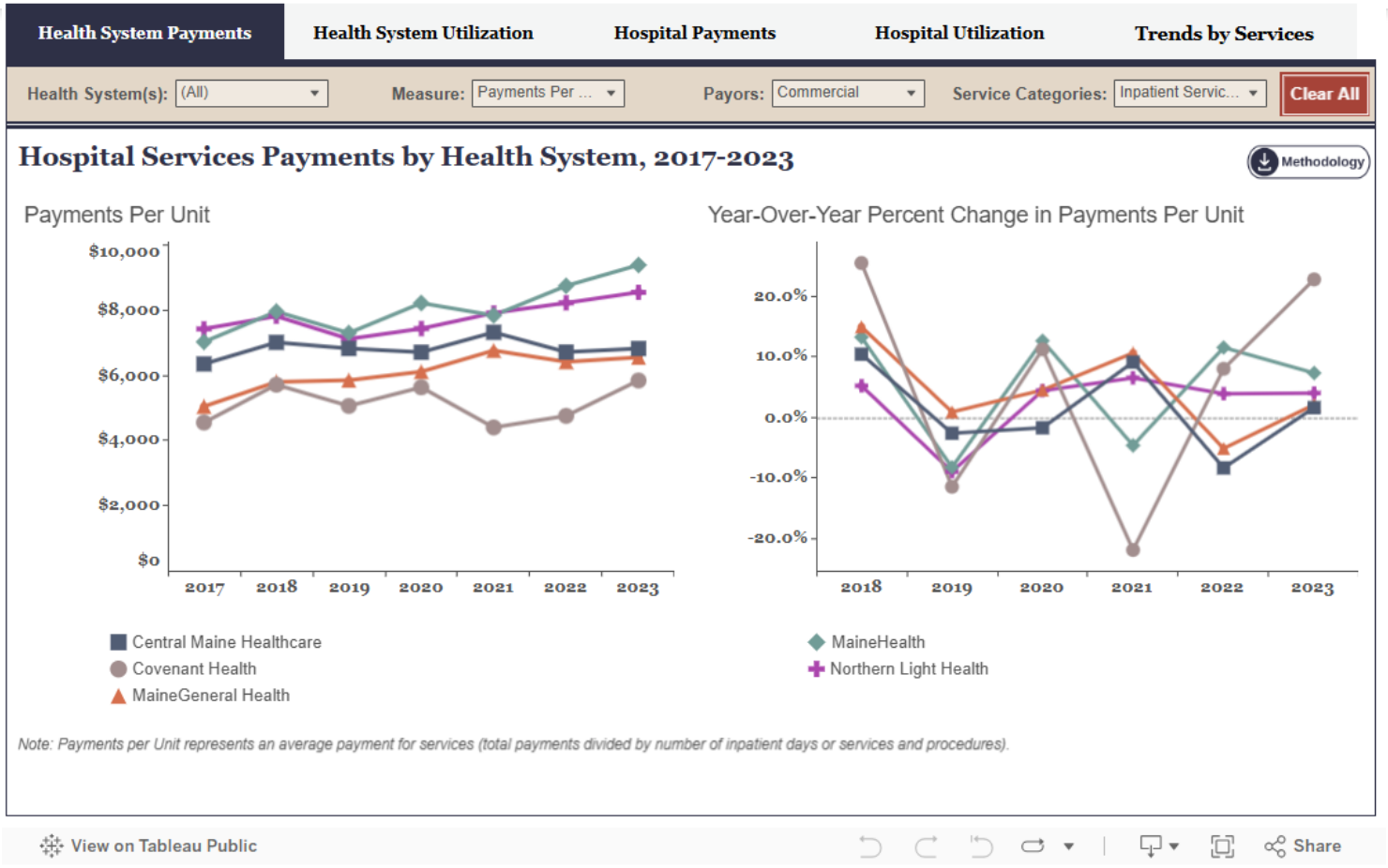
Data Source: MHDO All Payor-Claims Database, January 2017-December 2023

Hospital Level and Non-hospital Provider Payment and Utilization Dashboards – Tentative Timeline



Hospital Level Payment and Utilization Dashboards

- STATUS – Final draft complete, soliciting AC review and thoughts.
- TODAY – Overview of Hospital Level Dashboard Tool and Demonstration of Functionality



Hospital Level and Non-hospital Provider Payment and Utilization Dashboards – Demonstration

Demonstration will highlight trends and variation in Maine's medium sized acute care hospitals (Maine Peer Group B).

Maine Peer Group B Hospital	Location (city, county)	Bed Size (2024)
MaineHealth Mid Coast Hospital	Brunswick, Sagadahoc	102
MaineHealth Pen Bay Medical Center	Rockport, Knox	99
MaineHealth Maine Medical Center Biddeford*	Biddeford, York	229
Northern Light Health A.R. Gould Hospital	Presque Isle, Aroostook	89
Northern Light Health Mercy Hospital	Portland, Cumberland	200
St. Mary's Regional Medical Center	Lewiston, Androscoggin	220
St. Joseph Hospital	Bangor, Penobscot	112
York Hospital	York, York	79

Deep Dive: State Actions Addressing Commercial Health Care Prices

2026 Rate Increases Requested by Maine's Largest Individual and Small Group Carriers

Individual Market

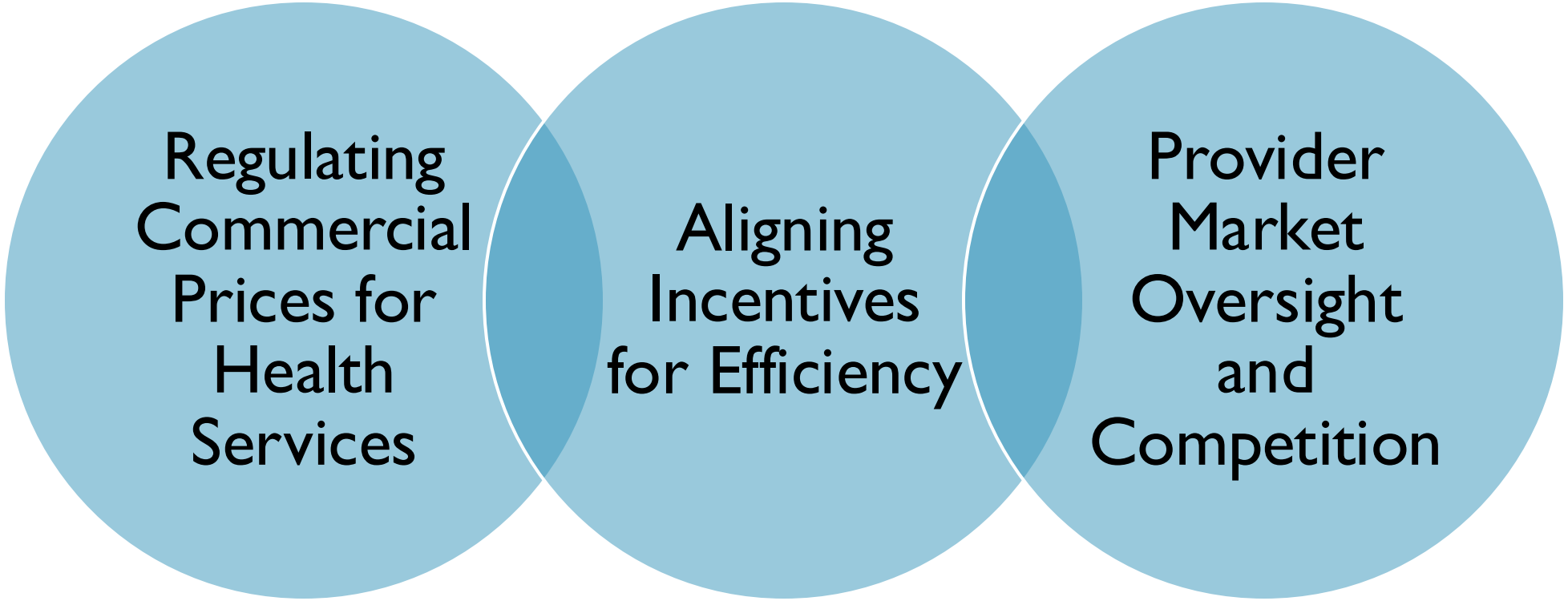
Carrier	Initial Filing	Revised Filing	Covered Lives
Anthem	19%	23.1%	33,118
Harvard Pilgrim	20%	21.3%	13,718
Community Health Options	34.4%	30.1%	22,845

Small Group Market

Carrier	Initial Filing	Revised Filing	Covered Lives
Anthem	16.4%	15.7%	25,784
Harvard Pilgrim	19.4%	20.4%	9,346
Community Health Options	29.9%	25.1%	6,341

Priority Policy Domains

Identified in fall 2024 meetings

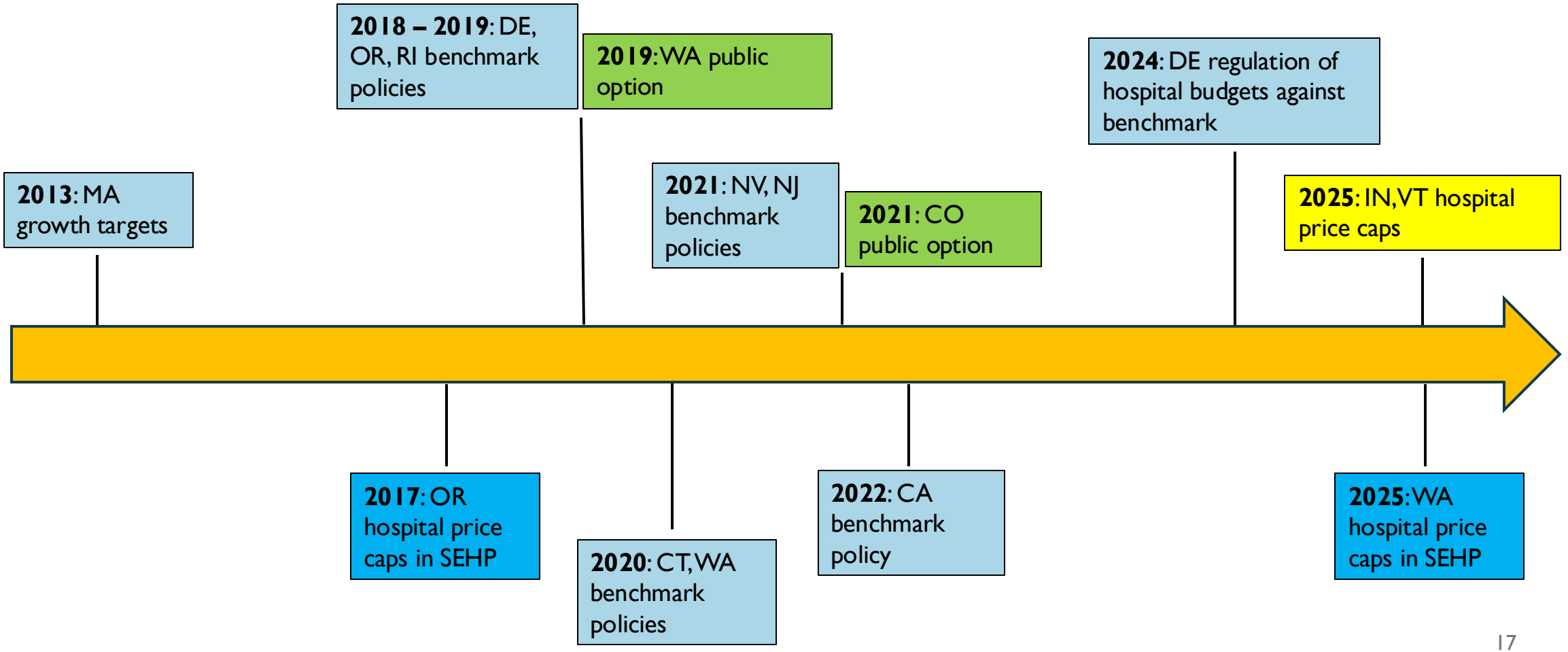


Cost Containment Policies Across States

Recognizing the role that prices paid for health care services contribute to both household health spending and system-wide spending, states are increasingly beginning to consider programs to monitor and exert direct or indirect downward pressure on provider prices, such as:

- Cost growth target programs
- Reference-based pricing in state employee health programs
- Reference-based pricing used to reduce consumer costs in public option plans

A growing wave of state activity



Growth Caps and Benchmarking

Summary: A cost-growth benchmark program or growth cap is a cost-containment strategy that limits how much a state's health care spending can grow each year. While approaches and enforcement vary, policies typically seek to measure performance against other health care entities and economic trends, improve efficiency, and control costs.

State	Growth Cap/Benchmarking Policy	Enforcement
Massachusetts (2013)	Program includes a statewide cost growth target and establishes accountability for meeting that target across broad sectors (hospitals, carriers, etc)	Health Policy Commission – can impose PIPs & non-compliance fines
Delaware (2018)	Sets annual healthcare cost growth targets. Newly established Review Board is designed to support state in achieving the goals of its health care cost growth benchmark	Diamond State Hospital Cost Review Board – can implement PIPs and require hospitals to submit subsequent fiscal year budget for review/approval or modification if PIP is not acceptable
Rhode Island (2019)	Limits the average annual price increase rates for both inpatient and outpatient hospital services within each insurer-provider contract	Office of the Health Insurance Commissioner – enforced through rate review process
Oregon (2019)	Sets a growth target that applies to insurance companies, hospitals and health care providers	Sustainable Health Care Cost Growth Target Implementation Committee – can implement PIP for those exceeding benchmark and impose additional fines if entities continue to exceed target over time

Growth Caps and Benchmarking (cont.)

State	Growth Cap/Benchmarking Policy	Enforcement
Connecticut (2020)	Sets annual healthcare cost growth targets. Also monitors primary care spending as a proportion of total health care spending, with the goal of increasing it to 10% of total spending by 2025	The Office of Health Strategy – holds public hearings and may require participation from health entity
Washington (2020)	Set an annual statewide health care cost growth benchmark. Target for 2025 is 3% and 2.8% in 2026.	Health Care Cost Transparency Board – public hearing with required testimony for those exceeding benchmark
Nevada (2021)	Sets a growth cap for total health care spending for carriers, large provider entities, and the state	Patient Protection Commission - Enforcement not discussed
New Jersey (2021)	Spending targets are set through 2027 and encompass all areas of health care costs including insurance, hospital and provider, and pharmaceutical spending	Department of Banking and Insurance - Enforcement not discussed
California (2022)	Approved a statewide health care spending target of 3% (will be phased in over time, initially starting at 3.5% for 2025 and 2026, 3.2% for 2027 and 2028, before reaching 3% for 2029 and beyond). Applies to health care entities, including health plans, provider organizations and hospitals	Office of Health Care Affordability – can impose PIPs, TA, & financial penalties, for example

Reference-based Pricing in Public Employee Health Plans

Summary

Under reference-based pricing strategies, hospital payments are capped at a certain level, typically at a percentage of Medicare rates, for both inpatient and outpatient services. To date, this approach has been implemented in Montana, Oregon, and most recently Washington. An additional seven states reported on a recent survey conducted by Georgetown CHIR that they also use some form of reference-based pricing in public employee plans.

State Examples

- Oregon's SEHP is prohibited from paying more than 200% of Medicare prices for in-network hospital services, and 185% of Medicare prices for out-of-network services
  - Research estimated $107.5 million (or 4 percent of total plan spending) in savings to the SEHP during the first two years of the program's implementation, no evidence of reductions in network access or cost-shifting to other payers
- Washington's recently passed legislation limiting how much Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) plans pay for hospital inpatient and outpatient services to no more than 200% of the Medicare rate. The law also sets minimum payment levels for primary care and behavioral health services to at least 150% of Medicare

Reference-based Pricing in Public Option Plans

Summary

State based public option plans are a strategy that states are increasingly turning towards to contain health care costs – particularly by putting downward pressure on health care prices and carriers' administrative costs. The two operational public option plans in the country also include some form of price caps to contain costs for members.

State Examples

- Washington and Colorado both offer public option plans through their state-based marketplaces. Their models provide an option for consumers to enroll in public option plans administered through private insurers.
  - Washington's program includes a provider reimbursement cap of 160% of Medicare, a primary care rate floor at 135% of Medicare, and 101% of Medicare rate floor for rural CAHs and sole community hospitals
  - Carriers offering a public option plan in Colorado must meet premium rate reduction targets statewide. If they fail to do so, the Department of Insurance is authorized to set hospital and provider rates at no less than 165% and 135% of Medicare rates, respectively
- Nevada will begin offering public option plans on the individual market beginning in January 2026. Minnesota, pending state legislation and federal approval, may see a public option available as soon as 2027.

Recent Legislation in IN, VT, & DE

State	Legislative Action
Indiana	HB 1004 (2025): Mandates that Indiana nonprofit hospital systems' aggregate average inpatient and outpatient hospital prices must be at or below the statewide average by June 2029, or risk forfeiting their nonprofit status
Delaware	HB 350 (2024): Established the Diamond State Hospital Cost Review Board, tasked with overseeing hospital compliance with a spending growth benchmark the state established in 2019. When hospitals fail to meet the state's benchmark the law requires that they engage with the Board to establish a Performance Improvement Plan, and if the Board and the hospital cannot agree on a PIP or where the hospital fails to successfully implement required changes, the Board may require the hospital to have its future budget approved.
Vermont	S0126 (2025): Charges the Green Mountain Care Board with setting Medicare-based price caps for hospitals by 2027 and establishing global hospital budgets by 2030. The legislation also allows them to implement reference-based pricing for services delivered outside a hospital (such as primary care)

Considering How Policies Directly Regulating Provider Price Would Impact Maine

- Reach of policy – which market or markets could be impacted?
- Affordability – how would varying structures impact household and/or employer health care costs?
  - How could savings be assured for consumers?
- Provider impact – how would rate caps or floors change reimbursement and margins for health care providers?