Office of Affordable Health Care

Advisory Council Meeting, January 7th, 2026

Agenda

- Welcoming New Council Members
- Analytics Updates
  - Data Refresh – Hospital Payments and Utilization
  - Professional Services Dashboards
- Rural Health Transformation Program
- Legislation Development

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 Payment and Utilization Dashboards

Overview: Working with MHDO, we created aggregate and 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 -

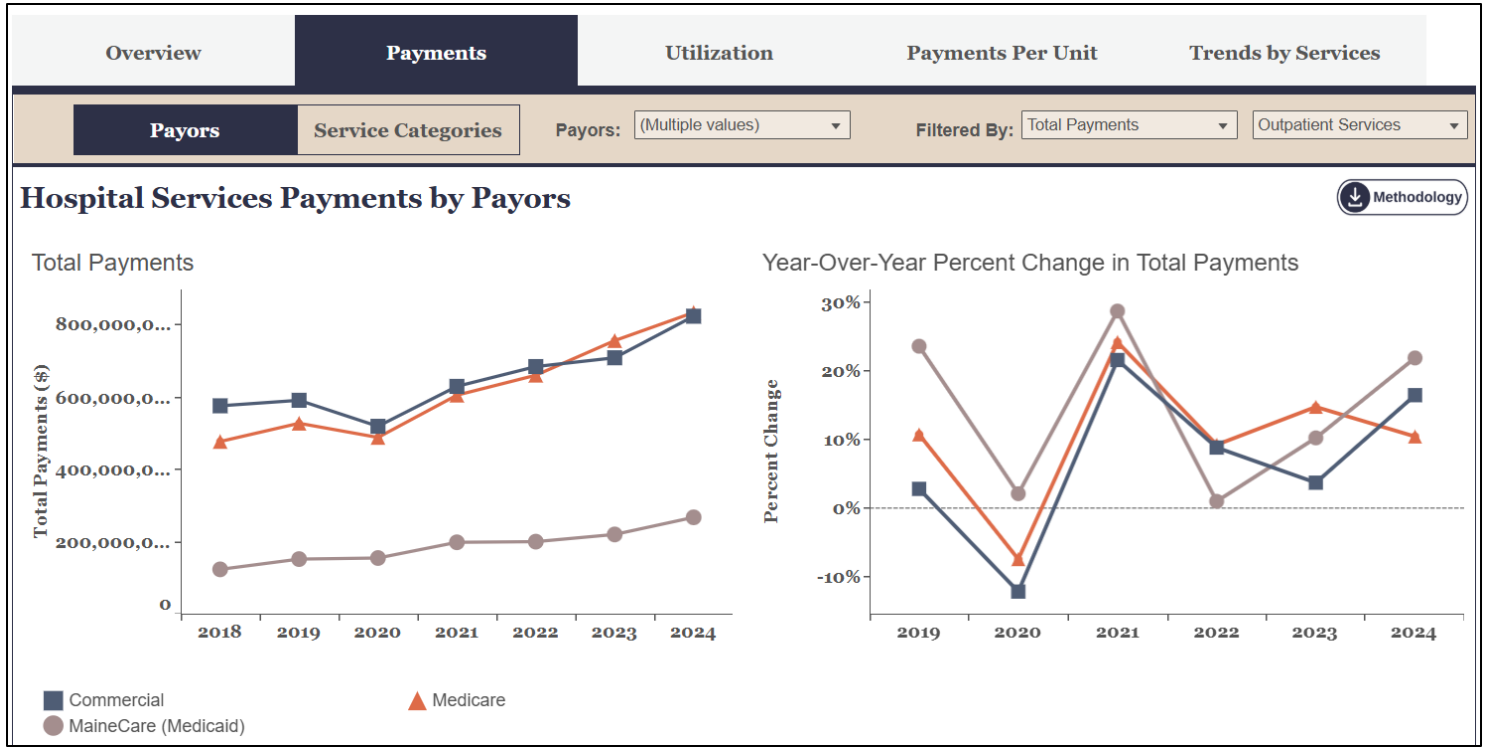
- Total payments and payments per unit by hospital inpatient, outpatient, and professional services
- Total utilization by hospital inpatient, outpatient, and professional services
- Select service level total payments and payments per unit
- Select service level total utilization

Data Source: MHDO All Payor-Claims Database, January 2018 - December 2024

Aggregate Hospital Payments and Utilization Dashboards Refresh - 2023 and 2024 data

- STATUS – Dashboards refreshed 2018-2024 data.
- TODAY – Overview of Aggregate Hospital Payments and Utilization Dashboards

Hospital Services Payments and Utilization (2025 Nov DRAFT) | Tableau Public



Review of Non-Hospital Payment and Utilization Dashboards

Overview: Working with MHDO, we created dashboards to measure payments and utilization across non-hospital settings in Maine.

Purpose: To identify and describe variation in payments and utilization across non-hospital settings in Maine.

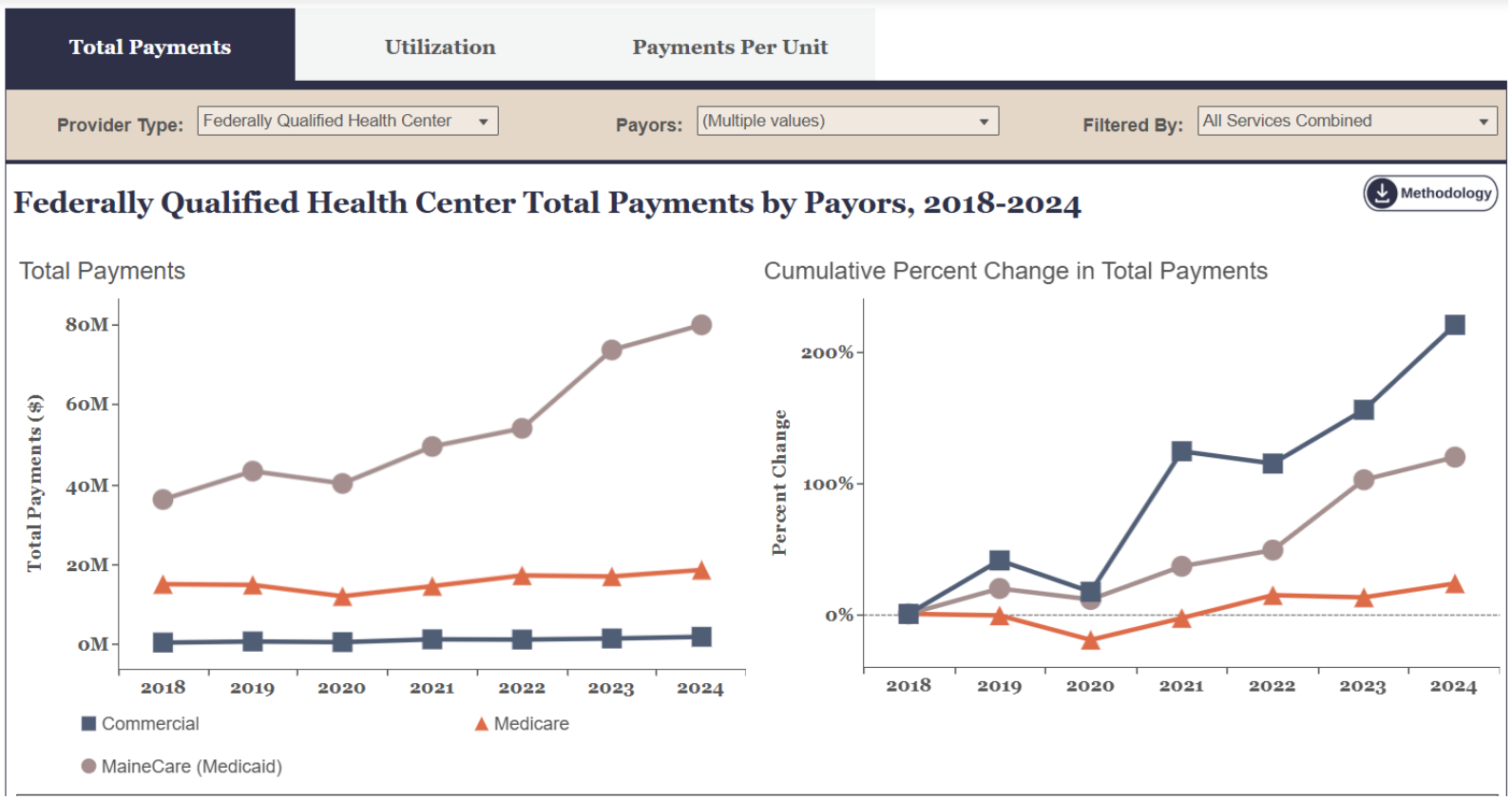
Metrics: For each non-hospital setting type we will report -

- Total payments by payor and bill type (institutional and professional)
- Payments per unit by payor and bill type (institutional and professional)
- Total utilization by payor and bill type (institutional and professional)

Data Source: MHDO All Payor-Claims Database, January 2018 - December 2024

Non-Hospital Payments and Utilization Dashboards

- STATUS – **In development**
- TODAY – Overview of non-hospital setting type classification



Non-Hospital Setting Type Classification

- Non-hospital setting services are identified by the *Type of Bill* code and or the *Place of Service* code on the submitted claims.
- The blue highlighted categories are not mutually exclusive. These setting types are created through the combination of data across multiple setting types.
- Long Term Care has been excluded from this stage of analysis. Given the coverage differences amongst the payors and the resulting data availability for long term care claims, we made the decision not to include those services in this initial analysis.
- Currently working with MHDO to finalize methodology and dashboard displays.

Non-hospital Setting Type
• Ambulatory Surgery Center
• Community Mental Health Center
• Federally Qualified Health Center
• Physician and provider groups operating in hospitals
• Off campus hospital services
• Independent Laboratory
• Office: Primary Care
• Office: Other
• Renal Dialysis Center/Treatment Facility
• Rural Health Clinic
• Urgent Care Facility

Non-Hospital Setting Type Classification

Setting Type	Service Category	
	Institutional	Professional
Ambulatory Surgery Center	TOB 83	POS 24
Community Mental Health Center	TOB 76	POS 53
Federally Qualified Health Center	TOB 77	POS 50
Physician and provider groups operating in hospitals	TOB 11, 12, 13, 14, 18	POS 21, 22, 23 POS 19 without Maine Hospital NPI
Off campus hospital services	n/a	POS 19 with Maine Hospital NPI
Independent Laboratory	n/a	POS 81
Office: Primary Care	n/a	POS 2, 10, 11; with primary care service match
Office: Other	n/a	POS 2, 10, 11; without primary care service match
Renal Dialysis Center/Treatment Facility	TOB 72	POS 65
Rural Health Clinic	TOB 71	POS 72
Urgent Care Facility	n/a	POS 20

Rural Health Transformation Program

Rural Health Transformation Program (RHTP)

Creation

- H.R. 1 enacted in July 2025; will cause Maine to lose ~$5B in federal health funding over 10 yrs; projected impacts:
  - Rural health providers at risk
  - Higher costs for consumers
  - Increased number of uninsured individuals
- RHTP included in HR1 as federal initiative to bolster rural health

RHTP Funding

- $50B over 5 years (2026-2030)
- Distributed by US Centers for Medicare & Medicaid Services (CMS) to states with approved applications
- Two-Part Funding Allocation
  - Part 1: $25B allocated evenly across all states ($100M min per state each year)
  - Part 2: $25B allocated to subset of states (at least 14) at CMS' discretion
  - All funds must be used quickly, with demonstrated results
  - States must use funds by end of 2nd fiscal year after funds distributed
  - Unused funds within stated time limits will be redistributed to other states

Maine's Year 1 Award: $190,008,051

Federal RHTP Goals

- Make Rural America Healthy Again
- Sustainable Access
- Workforce Development
- Innovative Care
- Technology Innovation

Federally-Defined Funding Scope

Use funding to pay for…	Do not use funding to pay for…
✓ Transformation of care delivery	× New construction
✓ Improved access to, quality of, and cost of healthcare in rural America	× Clinical services that duplicate billable services and/or attempt to change payment amounts of existing fee schedules
✓ Expanded or enhanced services but not duplicate programs	× Other specified limitations outlined in the NOFO
✓ Technological & infrastructure investments and startup costs that will have sustainable impact beyond the end of the program	

Maine's Proposal Components

We Envision a Future Rural Health System that...

- ✓ **Bridges the Rural Divide:**
  - Where one lives no longer dictates health outcomes or access to care
  - All Mainers have tools to make healthy choices and live healthier lives, and rural communities have information, choices, and flexibility to create their own local, data-driven solutions

- ✓ **Provides Seamless Delivery:**
  - A stronger rural healthcare workforce, innovations, and technologies ensure convenient, accessible and effective care
  - Care is available to rural Mainers when they need it, where they need it

- ✓ **Offers Efficient, Incentive-Aligned Systems:**
  - Communities come together to reduce fragmented service delivery
  - Value-based payments move us beyond fee-for-service, ensuring dollars go further
  - Rural health systems are strong and sustainable for future generations of Mainers

5 Initiatives, Each Comprised of Multiple Proposed Activities

Initiative 1	**Population Health:** Promoting timely access to high-quality care
Initiative 2	**Workforce:** Strengthening Maine's rural health workforce
Initiative 3	**Technology Innovation:** Modernizing rural care delivery with digital health technology
Initiative 4	**Access:** Bridging the health care affordability gap for rural Mainers
Initiative 5	**Sustainable rural health ecosystems:** Addressing financial instability of rural providers

Initiative 5: Sustainable Rural Health Ecosystem

Ensure care will be available & affordable: Ensure a sustainable rural health care ecosystem by addressing persistent financial instability facing rural healthcare systems

Proposed Activities
• Improve hospital financial stability through tailored hospital financial management, planning and targeted investment
• Conduct rural regional health ecosystems planning and implementation
• Develop multi-payer alternative payment models
• Strengthen Maine's interfacility non-emergency transport system
• Expand access to high-acuity, non-inpatient hospital care for children with complex behavioral health needs

Legislation Development

OAHC Areas of Policy Focus

Provider Market Oversight and Competition: Private equity (PE) investment in health care has grown dramatically in the U.S. over the last 10 years, and early evidence suggests that PE ownership of health care providers can lead to higher prices, staff reductions, and in some cases lower quality of care. While Maine has seen less PE activity in the health care sector than other parts of the country, protective action could be warranted given the significant impacts to access and quality experienced in other states.

Regulating Commercial Prices for Health Services: Increasing commercial prices for health care services are a driver of higher insurance premiums and out-of-pocket costs, which are widely cited by consumers as a barrier to accessing care and a growing financial burden on households and employers. Meanwhile, providers cite difficulty in financing key services, particularly primary care and behavioral health care, and recruiting and retaining physicians, nurses, and other staff.

Aligning Incentives to Promote Efficiency and Quality: There is general agreement that paying for health care on a traditional fee-for-service basis is not the best model to support efficient, high-quality, and patient-centered care. Payers and providers in Maine have made progress in introducing new models for payment and delivery of care, but fragmentation of the payer landscape and other operational challenges are a barrier to more significant transformation.

Recommended Policy Framework

Set Reasonable Limits on Commercial Hospital Facility Prices

- Cap outlier high prices for hospital services
- Establish a cap on the growth of hospital prices

Use Savings To:

Reduce health care costs for families and businesses

Invest in higher payments for primary and behavioral health care

Reform prior authorization to lessen admin burden on providers

Policy Development Updates

- **Benchmark:** Medicare prices to be used as the benchmark for both price caps and price floors - rates are developed through a rigorous and transparent process, and made available through public data files.
- **Growth Cap:** the cap on growth in hospital prices will be benchmarked to the Market Basket used for annual Medicare IPPS/OPPS payment adjustments.
- **Scope of service level price cap, and exemptions:**
  - Exclusion of Critical Access Hospitals from service level price caps – majority of Maine's small and rural hospitals.
  - Temporary exemption for poor financial performance.
- **Primary Care and Behavioral Health Investment:** a core set of evaluation and management, preventative services, and counseling service will benefit from a minimum floor on commercial prices, benchmarked to Medicare. This floor will apply to all providers, not just those affiliated with a hospital. Self-insured plan sponsors will only benefit from price caps if they also comply with floors.

Policy Components →	Caps on how much hospitals can charge for services	Caps on how much hospital prices can grow annually	Increased reimbursement for primary care and behavioral health	Prior authorization reform
Hospitals				
Non-CAH, financially stable	X	X	X	X
CAH or financially vulnerable		X	X	X
Commercial Insurance Plans				
Fully insured	X	X	X	X
Self-insured opt in	X	X	X	X
Self-insured opt out		X		

GOALS →

- Reduce the cost and growth of health insurance premiums
- Support critical services
- Reduce admin burden

Establishing the Level of Caps and Floors

Repricing Commercial Claims to Medicare FFS

Working with Wakely/HMA to reprice one year of commercial claims in the MHDO APCD data (commercial claims only) to the amount traditional Medicare would have paid. The aims of this analysis are to:

1. Estimate the Medicare relative rate of commercial claims at the claim level for each Maine hospital.
2. Estimate the amount of avoided spending/savings that would occur under different service level price caps at each Maine hospital.
3. Estimate the amount of additional spending that would occur under different service level price floors.

Estimating Policy Impact

Working with the Urban Institute using their Health Insurance Policy Simulation Model to estimate the impact of the policy. This analysis will:

1. Quantify overall changes in spending resulting from the policy over time and under different cap and floor scenarios
2. Estimate the impact of the policy on individuals and employers

Incorporating Changes to Prior Authorization – Request for Feedback

- Proposed starting point would be to require self-insured plans to comply with the limitations on prior authorization which currently apply to the fully-insured market, as a condition of benefitting from price caps. These current limitations include:
  - A request by a provider for PA must be answered by a carrier within 72 hours or 2 business days, whichever is less
  - Prohibition on retrospective denials coverage or payment for the originally approved service (with exception for fraud or materially incorrect information)
  - Requirement that appeals be reviewed by a clinical peer who was not involved in the initial decision

- Also soliciting input from Advisory Council members and others about changes that could reduce the use of prior authorization in the case of services that are generally approved, or other opportunities to reduce inefficient PA processes.