

Non-Hospital Provider Payments and Utilization by Setting Type in Maine: Methodology Notes

The State of Maine’s Office of Affordable Health Care (OAHC) *Non-Hospital Provider Payments and Utilization by Setting Type in Maine* report builds off the *Health Care Payments in Maine*¹ report, which the Maine Health Data Organization (MHDO) produced in January 2023, and presents aggregated information on payments and utilization for selected setting types in the state of Maine.

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¹ Current version of the report is available on MHDO’s website, here: <https://mhdo.maine.gov/tableau/healthCarePayments.cshtml>

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Data Source

The data source used for this analysis is the MHDO's All-Payer Claims Data (APCD) medical claims and medical eligibility records for the period January 1, 2018 – December 31, 2024. MHDO has been collecting APCD data for over two decades. This data is the most comprehensive statewide, multi-payor claims data available and has been used to understand health care costs, utilization, and outcomes.

MaineCare (the State's Medicaid/ CHILDREN'S Health Program [CHIP]) and commercial payors submit their claims data (referred to as raw data) to the MHDO as prescribed in 90-590 [Chapter 243, Uniform Reporting System for Health Care Claims Data Sets](#). The data submitted by payors align closely with the information that is populated in the standardized claims forms (UB-04 and the CMS-1500) used by hospitals and other health care providers.

Chapter 243 provides the provisions for the filing of standardized health care claims data sets, including the identification of the organizations required to report; establishment of requirements for the content, format, method, and time frame for filing health care claims data; and the establishment of standards for the data reported.

The claims reported to the MHDO include all MaineCare and Medicare (both Original Medicare and Medicare Advantage) members, approximately 84% of the fully insured individual and employer-sponsored plans and approximately 26% of the self-funded employer-sponsored plans (referred to as Commercial). A portion of the self-funded employer-sponsored plans are Employee Retirement Income Security Act of 1974 (ERISA) plans are exempt from submitting data to state APCDs due to a United States Supreme Court decision released in March 2016 in *Gobeille v. Liberty Mutual Insurance Company*. However, some of the largest self-funded ERISA plans submit data to MHDO on a voluntary basis. Health plans with less than \$2,000,000 in annual premiums are exempt from submitting data to MHDO. MHDO's claims data does not include data for the uninsured.

Non-claims-based payments are not included in this analysis as payors were not required to submit these types of payments to MHDO until 2022, for CY 2021 data. Non-claims-based payments include, but are not limited to: Capitation Payments, Care Management/ Care Coordination/ Population Health Payments, COVID-19-Related Supplemental Payments, Electronic Health Records/Health Information Technology Infrastructure/Other Data Analytics Payments, Global Budget Payments, Patient-Centered Medical Home Payments, Pay-for-Performance Payments, Pay-for-reporting Payments, Primary Care and Behavioral Health Integration Payments, Prospective Case Rate Payments, Prospective Episode-Based Payments, Provider Salary Payments, Retrospective/Prospective Incentive Payments, Risk-Based Payments, Shared-Risk Recoupments, and Shared-Savings Distributions.

For the reporting period of this report, payors have redacted substance use disorder claims from their submissions to MHDO based on their interpretation of the Department of Health and Human Services, Federal Rule 42 CFR Part 2.

Reporting Period

The analysis uses MHDO's APCD medical claims and medical eligibility records for the period January 1, 2018 – December 31, 2024, based on the following criteria:

- a) **Medical eligibility records** for 2018 through 2024 are selected based on the *insurance-month* records (i.e. records that provide information on the insurance coverage for a specific payor and plan at the month level) available in the APCD.
- b) **Medical claims** for 2018 through 2024 are selected based on the *service start date* on the institutional and non-institutional medical claim lines available in the APCD.

Data Scrubbing and Preparing Data Structures for Analyses

The claims data that is submitted to MHDO undergoes data scrubbing which is the process of fixing errors in a database by identifying and removing fully reversed claims, incomplete, incorrect, or duplicate data. It also involves standardizing formats, updating outdated information, and creating a de-identified person ID that consolidates data across payors for distinct individuals. This process is designed to improve the accuracy and reliability of the data. The impact of the data scrubbing and application of methodologies of the submitted data is summarized in [Appendix A](#).

[Appendix B](#) is the list of the medical claims and eligibility data elements that were used in this analysis.

Provider Selection

This analysis is limited to MHDO APCD claims billed for Maine providers other than hospital entities. We excluded claims attributed to one of the 36 Maine hospitals which were included in the hospital-based reports released by OAHC^{2,3} and claims attributed to state psychiatric hospitals (which had not been included in the aforementioned reports). Additionally, claims billed as long-term care, hospice and home health settings were excluded.

The selection of Maine providers involved determining the out-of-state provider status at the National Provider Identifier (NPI) level using their primary and secondary locations of service as documented in the November 2025 version of the publicly available National Plan and Provider Enumeration System (NPPES) data. Claims without any (primary or secondary) Maine locations of service for billing, servicing, or service facility NPIs were excluded from the analysis. (10.5 million claims, or 6.4% of the initial set of claims).

² *Hospital Services Payment and Utilization Dashboards*, available at <https://www.maine.gov/oaahc/hospital-payments-utilization-dashboards>

³ *Facility Level Payment and Utilization Dashboards*, available at <https://www.maine.gov/oaahc/node/135>

Service Category Assignment

The service categorization used in this analysis is primarily dependent on whether the claim uses an institutional billing standard (UB-04 form) or non-institutional billing standard (CMS-1500 form).

The medical billing process is an intricate and complex system. Although there are national standards and guidelines from the Centers for Medicare and Medicaid Services (CMS), there are differences in how these standards and guidelines are applied in the private sector (commercial insurance companies) primarily based on differences in commercial payor policies.

The UB-04 standardized claim form is used by institutional providers for the billing of claims generated for work performed in hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services, including physicians' fees, the use of equipment and supplies, laboratory services, radiology services, and other charges. (Note: This is the claim form CMS requires for the submission of charges under Medicare Part A, often referred to as hospital insurance.) This report refers to claims billed using UB-04 as “institutional claims.”

The CMS-1500 standardized claim form is used by non-institutional providers for the billing of claims generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services. (Note: This is the claim form CMS requires for the submission of charges under Medicare Part B, often referred to as medical insurance.) A CMS-1500 may also include a technical component, indicated as a specific Procedure Modifier, to account for the cost of equipment, supplies, and/or technical personnel associated with a service. This report refers to claims billed using CMS-1500 as “non-institutional claims.”

MHDO claims data for setting types selected for this analysis are classified into one of the following broad categories of services:

- **Institutional** – Institutional claims originating from a UB-04 claim form, with one of the following Type of Bill codes:
 - 13 – Hospital Outpatient
 - 71 – Clinic - Rural Health
 - 72 – Clinic - Hospital Based or Independent Renal Dialysis Center
 - 76 – Clinic – Community Mental Health Center
 - 77 – Clinic - Federally Qualified Health Center (FQHC)
 - 83 – Ambulatory Surgery Center (ASC)
 - 85 – Critical Access Hospital (CAH)

- **Non-Institutional Services** – Non-institutional claims originating from a CMS-1500 claim form related to professional services by clinicians with one of the following Place of Service codes:
 - 02 – Telehealth Provided Other than in Patient’s Home
 - 10 – Telehealth Provided in Patient’s Home
 - 11 – Office
 - 19 – Off Campus-Outpatient Hospital
 - 20 – Urgent Care Facility

- 21 – Inpatient Hospital
- 22 – On Campus, Outpatient Hospital
- 23 – Hospital Emergency Room
- 24 – Ambulatory Surgical Center
- 50 – Federally Qualified Health Center
- 53 – Community Mental Health Center
- 65 – End-Stage Renal Disease Treatment Facility
- 72 – Rural Health Clinic
- 81 – Independent Laboratory

Payments aggregated in the Institutional category could include professional fees billed on institutional claims (revenue codes 0960 through 0989), and payments aggregated in the Non-Institutional category could include technical components, such as when procedure codes are associated with the ‘TC’ or technical component modifier. The extent to which these situations are present in these service categories depends on the setting type, billing practices and other factors. Fluctuations across time may reflect changes in provider billing practices.

The report includes an ‘All Service Categories’ option which represents a *combination* of the listed categories.

Setting Type

This analysis focuses on particular setting types which were selected because they represent most of the non-hospital claims in the MHDO APCD, after excluding long-term care, hospice and home health settings.

The setting types included in the report, listed in [Table 1](#), were assigned based on Place of Service (POS) or Type of Bill (TOB) information on the claim. Additional information beyond POS and TOB was used for primary care vs other office claims designation, and for the classification into the Hospital Outpatient related setting types.

After applying the POS and TOB selection, the 2018-2024 claims included in the analysis may have either an individual or an organization billing provider. [Appendix C](#) presents a count of distinct NPIs, by NPI type, that bill under each setting type as defined in [Table 1](#). Note that some NPIs, such as offices that provide both primary and non-primary care, bill under multiple setting types. Also, a small share of payments on these claims were billed by NPIs which were active at the time of service but were deactivated, or were billed on claims that had missing (blank) or invalid billing NPIs.

Table 1 – Setting Type Assignment Criteria

Setting Type	Service Category	
	Institutional Claims	Non-Institutional Claims
Ambulatory Surgery Center	TOB 83	POS 24
Community Mental Health Center	TOB 76	POS 53
Federally Qualified Health Center	TOB 77	POS 50
Physician Practices and Groups Providing Services in Hospitals	TOB 13, 85	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 02, 10, 11; with primary care service match
Office: Other	n/a	POS 02, 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

Ambulatory Surgery Center (ASC)

ASCs are, according to the CMS definition, facilities that provide surgical services to patients who do not require hospitalization and whose expected duration of services does not exceed 24 hours. This selection includes claims with TOB 83 or POS 24.

Examples of providers for ASC services included in the report are: Eyecare Medical Group, Maine Eye Center, Portland Endoscopy Center, Acadia Medical Arts Ambulatory Surgical Suite, Spectrum Ambulatory Surgery Center, Plastic & Hand Surgical Associates, Portland Gastroenterology Associates, Maine Eye Care Associates, Coastal Eye Surgery Center (CESC), LLC.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Community Mental Health Center

A Community Mental Health Center is, based on CMS’ definition, a facility that provides a range of services, including screening, emergency services, and a specific level of non-inpatient and non-residential treatment. It must offer screening, outpatient therapy, day treatment/partial hospitalization, 24-hour emergency services, and psychosocial rehabilitation services. This selection includes claims with TOB 76 and POS 53.

Examples of such providers included in the report are: Kennebec Valley Mental Health Center, Sweetser, Counseling and Trauma Therapy Associates, Aroostook Mental Health Services, Inc., Tri-

County Mental Health Services, HealthReach Network of Maine General Community Care, Anglez Behavioral Health Services.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Federally Qualified Health Center (FQHC)

A FQHC is a community-based health center that provides primary and preventive care to underserved populations. Using CMS' definition, FQHCs are organizations that must serve a high-need community, offer a sliding fee scale based on ability to pay, provide a comprehensive range of services, and have a patient-majority governing board. This includes claims with TOB 77 or POS 50.

Examples of such providers with top total payments included in the report are: Katahdin Valley Health Center, Penobscot Community Health Center, Fish River Rural Health, Community Clinical Services, Inc., Bucksport Regional Health Center, York County Community Health Care, DFD Russell Medical Center Inc., Health Access Network Inc.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Independent Laboratory

Using CMS' definition, an independent laboratory is a facility that is independent of both hospital and an attending or consulting physician's office. These are free-standing laboratories that are not owned or operated by a hospital and are approved for specific services under Medicare and other government programs. This includes claims with POS 81.

This setting type is limited to laboratory-only claims, excluding claim lines for laboratory services in a long-term care or other setting where the claim encompasses multiple setting types. Examples of such providers included in the report are: NorDx, Affiliated Laboratory, Inc., Quest Diagnostics LLC, Exact Sciences Laboratories, LLC, Laboratory Corporation of America Holdings, Aegis Sciences Corporation, Genomic Health, Inc., Dominion Diagnostics, LLC.

This setting type is assigned to the non-institutional claim type only ([Table 1](#)).

Off Campus Hospital Services

As defined by CMS, "Outpatient Hospital-Off campus" is used to report services provided in a hospital's off-campus, provider-based department, meaning in locations physically separated from the hospital's main campus. This code is for diagnostic, therapeutic, and rehabilitation services for patients who do not require hospitalization. This setting type is displayed separately from the "Physician Practices and Groups Providing Services in Hospitals" type above in order to separate direct hospital billing from contracted vendors in hospital-affiliated settings, because the off campus hospital services are services billed with NPIs attributed to Maine hospitals (refer to [Appendix D](#) for a complete list of hospital billing NPIs). This category of services was intentionally excluded from prior OAH's hospital reports, which targeted hospital "on campus" services.

This setting type includes claims with POS 19 and NPIs associated with one of the 36 Maine hospitals and is assigned to the non-institutional claim type only ([Table 1](#)).

Office: Primary Care

This setting type represents primary care services from individual and organization providers, including those affiliated with Maine hospitals.

First, claims were selected based on one of the POS codes for Office settings, POS 02, 10, or 11. Then services that matched the primary care designation as specified in the methodology used for the *Maine Primary Care Spending, 2021-2023* report⁴, developed by the Maine Quality Forum (MQF), were included in this setting type.

While there may be overlap between some data points displayed in the *Maine Primary Care Spending, 2021-2023* report and the current analysis, the differences in methodologies otherwise do not allow for a direct comparison of statistics presented in these reports. In the current report, the primary care assignment methodology is used solely to classify Office claims, defined above, into primary care versus the rest of services. Services in the FQHC and Rural Health Clinic (RHC) setting types, presented as standalone setting types in this analysis, are not duplicated in the 'Office: Primary Care' type, though they include primary care services.

Note that some services counted as primary care in this setting type fall into the definition of behavioral health care services, as primary care practitioners may deliver behavioral health services and the primary care methodology used in this analysis is inclusive of some behavioral health services.

Examples of providers for primary care office services included in the report are: Intermed, Martin's Point Health Care, MaineGeneral Medical Center, Eastern Maine Medical Center, Central Maine Medical Center, Penobscot Community Health Center, MaineHealth SMHC Physician Services, Pediatric Associates of Lewiston.

This setting type is assigned to the non-institutional claim type only ([Table 1](#)).

Office: Other

This setting type represents all services provided in an office setting that do not fall into one of the other provider categories. That is, it covers office services except for primary care that do not occur at Community Mental Health Center, FQHC, RHC, or other setting type categorized by this report.

First, claims were selected based on one of the POS codes for Office settings, POS 02, 10, or 11. Then, all services that did not match the primary care designation as described above were included in this 'Office: Other' setting type.

Examples of such providers included in the report are: Maine Center for Cancer Medicine and Blood Disorders, Intermed, Eyecare Medical Group, Health Affiliates Maine, LLC, Maine Eye Center, Dermatology Associates, LLC, Spurwink Services Incorporated, Rheumatology Associates,

⁴ Retrieved from https://mhdo.maine.gov/_mqfdocs/MQF%20Annual%20PC%20Spending%20Report_250127.pdf on October 1, 2025.

Maine Eye Care Associates, Vision Care of Maine LLA, Eastern Maine Medical Center, Portland Gastroenterology Associates.

This setting type is assigned to the non-institutional claim type only ([Table 1](#)).

Physician Practices and Groups Providing Services in Hospitals

This selection includes claims with (a) TOBs 13 or 85, or (b) POS 21, 22, 23, or (c) those with POS 19 that *did not have* an NPI associated with one of the 36 Maine hospitals (refer to [Appendix D](#) for a complete list of hospital billing NPIs).

This setting type covers clinician staffing groups and other vendors contracted by hospitals for work with one or more of Maine's hospitals billed under separate NPIs. Examples of such providers for this service type included in the report are: Spectrum Healthcare Partners, SMHC Physician Services, MaineHealth Mid Coast Medical Group, MaineHealth Medical Group – Specialty Care, MaineHealth Pen Bay Hospital, Maine Medical Partners MaineHealth Cardiology, Maine Medical Partners Neurosurgery & Spine, Maine Medical Partners Orthopedics (Div of Joint Replacements), Spectrum Pathology.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Renal Dialysis Center/Treatment Facility

This setting type combines Renal Dialysis Centers and Renal Treatment Facilities. The CMS-defined Renal Dialysis Center is a hospital-based unit approved to provide the full range of diagnostic, therapeutic, and rehabilitative services for end-stage renal disease (ESRD) patients, including both inpatient and outpatient dialysis. Renal Dialysis Centers are a type of ESRD facility that is distinct from independent Renal Dialysis Facilities or Self-Dialysis Unit. Renal Treatment Facilities are more commonly referred to in the CMS documentation as an ESRD facility or dialysis facility, and they are entities that provide outpatient maintenance dialysis services, home dialysis training and support services, or both. This selection includes claims with TOB 72 or POS 65.

Examples of such providers included in the report are: Total Renal Care Inc (with multiple locations such as Boyd Dialysis, Eastern Maine Dialysis, Brewer Dialysis), Bio-Medical Applications of Maine, Inc. (with multiple locations such as Androscoggin Kidney Center, Fresenius Medical Care Portland, Coastal Dialysis Center, Kennebeck Kidney Center), Dialysis Clinic Inc., Northern Light Dialysis at the Aroostook Medical Center.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Rural Health Clinic (RHC)

The RHC is a primary care facility certified by CMS to provide services in federally designated shortage areas, ensuring access to health care in rural communities. To be able to operate as an RHC, CMS requires the facility to be located in a non-urbanized area that is a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), employing a nurse practitioner, physician assistant, or certified nurse-midwife who is available at least 50% of the time the clinic is open, and offering primary care and routine diagnostic services. This selection includes claims with TOB 71 or POS 72.

Examples of such providers included in the report are: MaineHealth Primary Care and Internal Medicine, MaineHealth Franklin Health Center, Sigrid E Tompkins Health Center, MaineHealth Herbert and Roberta Watson Health Center, Acadia Family Health Center, Swift River Family Medicine, Calais Community Provider Practices, MaineHealth John F Andrews Health Center.

This setting type is assigned to both institutional and non-institutional claim types ([Table 1](#)).

Urgent Care Facility

An urgent care facility is, as defined by CMS, a location distinct from a hospital emergency room or physician's office, that provides immediate medical attention for unscheduled, ambulatory patients with illnesses or injuries that need to be treated within 12 to 24 hours to avoid the likely onset of an emergency. These conditions would not be life-threatening if not treated immediately but could cause harm or disability if delayed. This selection includes claims with POS 20.

Examples of such providers included in the report are: ConvenientMD LLC, York Hospital (urgent care billing), MaineHealth Maine Medical Center (urgent care billing), ClearChoiceMD, LLC, St. Mary's Urgent Care, American Family Care, Mercy Hospital (urgent care billing), Maine Urgent Care, LLC.

This setting type is assigned to the non-institutional claim type only ([Table 1](#)).

Other Setting Types - Excluded

Claims that could not be grouped into one of the above setting types were excluded from this report ([Table 3](#)). That exclusion applies primarily to claims with setting types that were not selected for reporting, or it may be due to missing type of bill and place of service information on the claim. Setting types were selected to represent most of the non-hospital, non-residential claims in the MHDO APCD, excluding long-term care, hospice and home health settings as well as settings with relatively low utilization and payments such as mass immunization centers, ambulances, or religious nonmedical care centers.

Payor Type Development and Assignment

The payor type used in this analysis represents mutually exclusive categories, so that in any given month, an individual and the claims for services during that month are assigned to a single payor type. The payor types are based on the payor code and medical plan information in the MHDO APCD eligibility files for individuals with **medical insurance**, whether the payor represents the primary, secondary or tertiary payor for medical services. The payor types are assigned to member months based on all available MHDO APCD medical plan information across payors within a given month of the reporting period. Member-months for individuals with medical insurance from more than one type of payor (for example, having both MaineCare (Medicaid) and Medicare insurance) during the respective month are therefore classified in a payor type indicative of the multiple payors (i.e., dual eligible Medicare-MaineCare). APCD records for vision and dental payors are excluded from the analysis.

As a second step, the eligibility-based payor types are then assigned to claims, which initially have their own claim-based payor type (assigned based on the payor code and medical plan information

on the claim). The goal is for the dashboard to display a payor type developed based on the integration of the eligibility-developed payor type with the payor types observed on claims for the respective service start dates. If the eligibility and claim-based payor types match, the analytic payor type on the claim becomes the eligibility-developed payor type. For example, if services occurred during months with Medicare-MaineCare coverage, claims paid by MaineCare (Medicaid) and claims paid by Medicare will both have the ‘Dual Eligible (Medicare-MaineCare)’ analytic payor type. A small share of claims with claim-level payor type diverging from the expected payor type based on eligibility records are classified as ‘Unassigned’ in the analytic payor type and excluded from analyses (0.3% of the initial set of claims; refer to the [Analytic Selection Criteria and Limitations](#) section and [Table 3](#) for further details about exclusion criteria for claims).

The payor types developed for this analysis are as follows:

1. **Commercial** – individuals with only commercial insurance during the month
2. **MaineCare (Medicaid)** – individuals with only MaineCare (Medicaid) insurance during the month; exclusive of Dual Eligible (Medicare-MaineCare) member-months
3. **Medicare** – combines Original Medicare and Medicare Advantage, defined as follows:
 - 3a. **Original Medicare** – individuals with only Original Medicare insurance during the month; exclusive of Dual Eligible (Medicare-MaineCare); exclusive of commercial-Medicare coverage
 - 3b. **Medicare Advantage** – individuals with only Medicare Advantage insurance during the month; exclusive of Dual Eligible (Medicare-MaineCare) (Medicaid); exclusive of commercial-Medicare coverage
4. **Dual Eligible (Medicare-MaineCare)** – individuals with insurance for medical services from both Medicare *and* MaineCare (Medicaid) during the month
5. **Commercial and Medicare** – individuals with commercial insurance *and* with either Original Medicare or Medicare Advantage during the month

The member-months **not** allocated to one of the payor types listed above (the “Other – Not Included” rows in [Table 2](#) below) primarily represent individuals with Commercial and MaineCare (Medicaid) coverage, or another combination of Commercial, MaineCare (Medicaid) and Medicare coverage. For the purposes of this analysis, their eligibility records and associated claims were excluded.

Table 2. Member Months by Payor Type

Payor Type	Member Months	Percent of Member Months
Commercial	29,044,407	35.0%
MaineCare (Medicaid)	21,885,554	26.4%
Medicare	20,063,994	24.2%
Original Medicare	9,199,092	11.1%
Medicare Advantage	10,864,902	13.1%
Dual Eligible (Medicare-MaineCare)	6,611,741	8.0%
Commercial and Medicare	2,964,347	3.6%
Other - Not Included	2,343,369	2.8%

Payor Type	Member Months	Percent of Member Months
Commercial and MaineCare (Medicaid), under 65	2,204,246	2.7%
Medicare, MaineCare (Medicaid), Commercial	129,995	0.2%
Remainder of other	9,128	0.0%
Total	82,913,412	100.0%

Charts 1 and 2 below show the number of unique insured individuals that were allocated to each payor type, by eligibility year and separately by detailed age. The number of insured individuals is calculated as the number of distinct MHDO deidentified Person IDs which allow for the consolidation of data across submitters for a single individual. Age represents the age of the member as of December 2024, displayed only for members with eligibility information during that month.

Chart 1. Insured Individuals by Payor Type and Eligibility Year

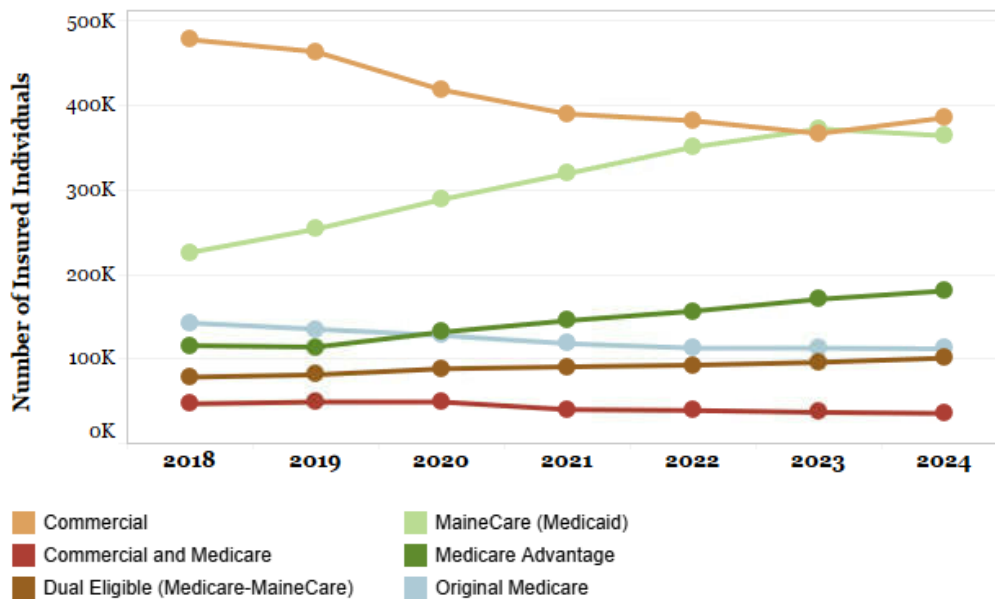
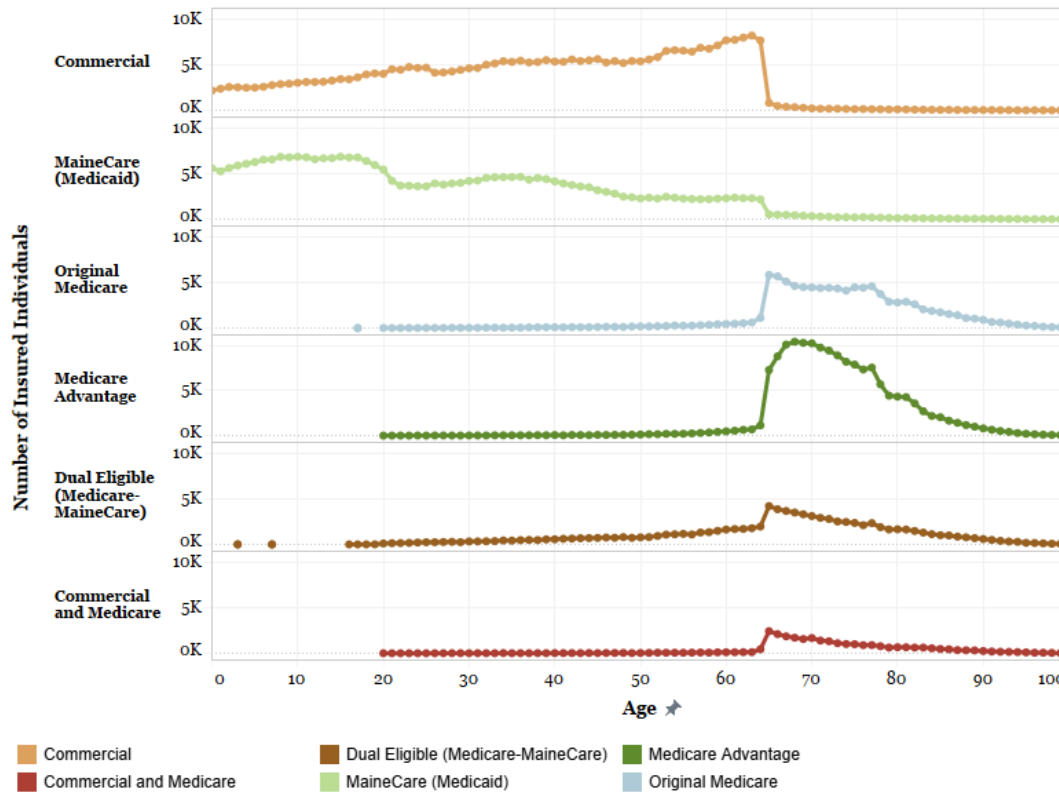


Chart 2 allows for a comparison of age groups covered by the payor types used in this report. For example, it is evident that there are individuals under 65 with Medicare coverage. Most individuals with MaineCare (Medicaid) coverage are under age 40, and there are few that are ages 65 or older.

Chart 2. Insured Individuals by Payor Type and Age as of December 2024



Analytic Selection Criteria and Limitations

This analysis is based on MHDO APCD medical claims data only. Vision, dental, and retail pharmacy claims and eligibility records were excluded from this analysis.

For the first four years of this analysis’s time frame (2018 – 2021), payment information submitted to MHDO by the payors does not include a data element that identifies the payment arrangement type (examples include: Capitation, DRG, Fee-For-Service (FFS), Global Payments etc.) on medical claims. The MHDO’s APCD data collection rule, 90-590 [Chapter 243, Uniform Reporting System for Health Care Claims Data Sets](#), was amended in 2021 to include a payment arrangement type indicator beginning with 2022 claims data submissions. There are, however, two distinct scenarios present among the 2018 – 2024 medical claim records that provide an indication of a payment arrangement other than FFS. These scenarios are described below.

Scenario 1: Approximately 3 million claims in the reporting period have zero dollars reported in the standard payment fields on the claim (payor and member liability); the payments and utilization from these claims are *excluded* from the analysis. See [Table 3](#). Approximately 62% of these claims are MaineCare (Medicaid) claims (representing approximately 7% of total MaineCare claims), as prospective interim payments paid to Critical Access Hospitals (CAH) on behalf of MaineCare members (where MaineCare is the primary payor) are not included in the MHDO APCD. This matters primarily for the Off Campus Hospital Services setting type, for which the selection criteria in this analysis is based on the hospital-attributed NPIs ([Appendix D](#)). Note that, during this

reporting period, in addition to the 17 CAH hospitals in the state, MaineCare reimbursed Cary Medical Center and York Hospital in the same manner as CAHs. Beginning with the fourth quarter of 2022 MaineCare began to submit estimated payments to MHDO for CAHs; since these estimated payments are not available for the entire reporting period, they have not been included in the analysis. For the other all-zero payment claims, 32% are Medicare (Original or Advantage), and the remaining 7% are commercial (representing approximately 1-5% of claims).

Scenario 2: Additionally, approximately 8% of the medical claims selected for the analysis present a pattern where one service (revenue code or procedure code) on the claim appears to be populated with the overall amount paid for all services reported on the claim, and the rest of the services have zero payments. The claims where we see this pattern are primarily MaineCare (Medicaid) and Medicare hospital outpatient claims. This pattern is likely indicative of a “bundled payment” arrangement. The Scenario 2 set of claims is *included* in the analysis.

[Table 3](#) shows the most important analytic selections applied to claims, referenced above and in previous report sections. The final set of claims used in the analysis represents 47% of the initial set of medical claims (excluding vision, denied claims or claims not tied to eligibility records) with 2018 – 2024 service dates.

Table 3. Analytic Selection Criteria Applied to Medical Claims

MHDO APCD		
Data Submitted to MHDO under Chapter 243, Uniform Reporting System for Health Care Claims Data Sets	Includes medical, vision, dental, retail pharmacy claims and member eligibility data from Medicare (CMS), MaineCare (Medicaid), and approximately 84% of the fully insured individual and employer-sponsored plans and approximately 26% of the self-funded employer-sponsored plans (referred to as Commercial). Pharmacy claims and dental claims were excluded from this analysis.	
MHDO data scrubbing and validations applied to submitted claims	This process involves several steps, detailed in Appendix A, such as the claim consolidation (removal of fully reversed claims) and the assignment of a deidentified person ID that consolidates data across submitters for distinct individuals.	
DATA USED IN THIS ANALYSIS		
Releasable MHDO APCD medical claims (excludes vision, denied claims or claims not tied to eligibility records), with 2018-2024 service dates	165,422,541	100.0%
EXCLUSIONS APPLIED		
Claims with unassigned or conflicting claim type	-774,114	0.5%
Inpatient or outpatient hospital claims attributed to one of 36 Maine hospitals (i.e., included in hospital-based OAHG analyses). Off campus hospital claims (POS 19) are included in the analysis.	-41,641,702	25.2%
Claims attributed to state psychiatric hospitals in Maine	-11,812	< 0.1%
Medical claims for non-hospital setting types	= 122,994,913	74.4%

Claims referencing only out-of-state NPIs	-10,521,986	6.4%
Medical claims for non-hospital setting types in Maine	= 112,472,927	68.0%
Claims for non-hospital setting types that are outside of the scope of the current analysis (long term care settings, home health settings, etc.)	-28,928,108	17.5%
Medical claims for non-hospital setting types selected for reporting	= 83,544,819	50.5%
All-zero payment claims	-2,950,840	1.8%
Medical claims with non-zero payments on at least one claim line	= 80,593,979	48.7%
Claims with Payor Type = “Other” or “Unassigned”	-2,796,142	1.7%
Medical claims having one of the payor types selected for reporting	= 77,797,837	47.0%
Claims with no HCPCS/CPT code populated	-172,274	0.1%
Final set of medical claims selected for reporting	= 77,625,563	46.9%
TOTAL NUMBER OF CLAIMS USED IN THIS ANALYSIS BY SERVICE CATEGORY		
Institutional claims included	7,651,578	4.6%
Non-Institutional claims included	69,973,985	42.3%

Report Measures

This section displays the list of measures created for this report. All measures are created *without* adjustments for inflation or the changing demographics and comorbidities of the patient population.

Total Payments

Total payments are calculated as the sum of payor payments and member liability payments (i.e., the out-of-pocket amount to be paid by the insured member to the service provider; inclusive of copay, coinsurance, and deductible amounts) for medical services and procedures.

The member liability payments are submitted in MHDO’s claims data and have not been adjusted to account for instances when the service provider cannot obtain reimbursement from the individual for care provided.

In response to the COVID-19 public health emergency, declared in March 2020 and ending in May 2023, temporary changes were made to MaineCare (Medicaid) eligibility and member liability requirements⁵. As a result, MaineCare enrollees were able to maintain benefits under the

⁵ Maine Department of Health and Human Services, MaineCare Services (May 28, 2024). *MaineCare Member Copayments*. Retrieved from <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/May%202024%20Member%20Copayments.pdf> on September 16, 2024.

continuous coverage requirement, and copayments were waived for several services, including but not limited to: Clinical Visits (includes hospital inpatient, outpatient and physician services), Medical Imaging Services, Laboratory Services, Behavioral Health Services, Medical Supplies and Durable Medical Equipment, and COVID-19 specific treatments and/or vaccines.

Among the other claim details used for this analysis, the claim status (codes indicating how the claim was processed, for example processed as primary, processed as secondary, denied, reversal of previous payment, etc.) on the claim plays an important role in the calculation of member liability payments. The submitted claim status is used to categorize claims as follows:

- a) Claims paid as a primary payor – referred to as the “primary claims”;
- b) Claims paid as a secondary or tertiary payor – referred to as the “secondary/tertiary claims”;
- c) Reversals – claims which reverse prior payments; these claims were attributed to either the primary or secondary/tertiary payors through matching to the forward claim using payor codes, individual and service characteristics on the claim line; after this attribution step, the claim records with the reversal status are included in calculations as either “primary claims” or “secondary/tertiary claims”, respectively

Most payment situations have a single payor, in which case the member liability amount is simply the amount to be paid by the *member* on the claims incurred for the respective services, as a sum of the copay, coinsurance, and deductible amounts. If there is a secondary payor, or a secondary and a tertiary payor, the member liability amount is calculated as the amount to be paid by the *member* on primary claims (sum of the copay, coinsurance, and deductible amounts), subtracting the amount paid by the *payor* on secondary/tertiary claims.

Units and Utilization Count

The utilization units are defined, for both Institutional and Non-Institutional services, as distinct combinations of HCPCS/CPT codes, date of service and MHDO de-identified Person ID, across multiple claim lines or even multiple claims. Quantity information or number of units of service recorded on the claim are not considered. The utilization count represents the total count of services.

Payments Per Unit

The payments per unit measure represent an average payment for services and is calculated as the total payments (combining payor payments and member liability amounts to be paid, as described above) divided by the number of services (i.e. total utilization) during the specified reporting year.

Cumulative Percent Change

The cumulative percent change represents the relative difference in values between 2018 and another reporting year, for example, 2020, calculated as the 2020 value minus the 2018 value, divided by the 2018 value, then multiplying the result by 100. A *negative* percent change indicates that the 2020 value has *decreased* compared to 2018. A *positive* percent change indicates that the 2020 value has *increased* compared to 2018. If the value was *the same* in both 2018 and 2020, the

cumulative percent change is *zero*. If the value in 2018 is zero, the cumulative percent change is not calculated.

Data Suppression

Values are suppressed if either the number of unique de-identified person IDs or the number of claims used to calculate the respective value is below 11. As a result of suppression or no data reported for particular selection combinations, the report may have absent years on a trend line, or entire trend lines that are absent.

Appendices

Appendix A: MHDO Data Intake and Processing

The MHDO All-Payer-Claims Data is submitted to MHDO per the requirements in 90-590 [Chapter 243, Uniform Reporting System for Health Care Claims Data Sets](#). The claims data that is submitted to MHDO undergoes data scrubbing which is the process of fixing errors in a database by identifying and removing incomplete, incorrect, or duplicate data. It also involves standardizing formats and updating outdated information. This process is designed to improve the accuracy and reliability of the data.

After passing the data intake validations, data are ingested in the MHDO Data Warehouse, processed and enhanced with value-add fields and then undergo another set of internal quality checks. The table below outlines the steps in this process.

Table A.1. MHDO APCD Data Processing Steps in the Data Warehouse

Step	Task	Description
1	Receive Raw Data Files	Once the raw data are received from the source, the data are loaded into the MHDO Data Warehouse.
2	Enhance Data	Process the data files by running queries and batch jobs to load the data into the appropriate file formats and bring the files into output tables. Specifications for enhancements are documented in the Business Rules.
3	Conduct Internal Quality Control (QC)	Execute QC based on data set. This may include: Running variable checks to ensure key variables are used in analysis; checking output tables to ensure the correct relationships are established and information is appearing correctly; comparing current estimates to previous estimates; performing outlier analysis; reviewing data for new procedure or methodological changes; reviewing any open issues identified in past processing iterations. Document progress and results as needed.
4	Investigate and Resolve Issues	Investigate and resolve critical issues identified during the internal QC process.
5	Rerun Data (if necessary)	If data issues are identified, rerun the data and conduct internal QC.
7	Investigate and Resolve Issues	Investigate and resolve critical issues identified during the external QC process, as discussed with the MHDO Compliance Officer and Executive Director.
8	Accept or Reject Data	MHDO accepts or rejects the data deliverable based on the testing results. When accepted, the data is released.
9	Metadata and Release Documentation	Metadata and associated release documentation is updated with changes or data quality concerns and released with data.

Appendix B: MHDO APCD Data Elements Used in the Analysis

This appendix includes two lists of MHDO APCD data elements used for this analysis, one for medical eligibility (Table B.1) and the second for medical claims (Table B.2).

Table B.1. MHDO APCD Medical Eligibility

Data Element	Data Element Name	Transformation Type
ME001_SUBMITTER	MHDO Submitter ID	As Submitted
ME002_PAYER	MHDO Payer ID	As Submitted
ME004_YEAR	Year	As Submitted
ME005_MONTH	Month	As Submitted
ME014_DOB	Member Date of Birth	Derived
ME018_MEDICAL	Medical Coverage	As Submitted
ME028_PRIMARY	Primary Insurance Indicator	As Submitted
ME912_MHDO_PRODUCT	Standardized Insurance Type/Product Code	Derived
ME976_Person_ID	Deidentified MHDO-assigned replacement Person ID	Derived

Table B.2. MHDO APCD Medical Claims

Data Element	Data Element Name	Transformation Type
MC001_SUBMITTER	MHDO Submitter ID	As Submitted
MC002_PAYER	MHDO Payer ID	As Submitted
MC036_BILLTYPE	Type of Bill - Institutional	As Submitted
MC037_FACTYPE	Place of Service - Professional	As Submitted
MC038_STATUS	Claim Status	As Submitted
MC059_FDATE	Date of Service From	As Submitted
MC060_LDATE	Date of Service through	As Submitted
MC063_TPAY	Paid Amount	As Submitted
MC065_COPAY	Copay Amount	As Submitted
MC066_COINS	Coinsurance Amount	As Submitted
MC067_DED	Deductible Amount	As Submitted
MC077_NPI	National Provider ID - Billing Provider	As Submitted
MC902_IDN	Record ID#	Derived
MC907_MHDO_CLAIM	MHDO assigned replacement for payor's claim ID	Derived
MC913_MHDO_PRODUCT	Standardized Insurance Type/Product Code	Derived
MC950_SERVICING_NPI	National Provider Identifier	Derived
MC968_ServiceFacility_NPI	National Service Facility ID	Derived
MC976_Person_ID	Deidentified MHDO-assigned replacement Person ID	Derived

Appendix C: Billing NPI Summary for NPIs Included in the Analysis, by Setting Type

Setting Type	NPI Type	Number of NPIs	Percentage of Total Payments for the Selected Setting Type
Ambulatory Surgery Center	(1) Individual	1,352	3.9%
	(2) Organization	2,108	91.7%
	NPI details not available	n/a	4.5%
Community Mental Health Center	(1) Individual	636	1.3%
	(2) Organization	83	98.7%
	NPI details not available	n/a	Less than 0.1%
Federally Qualified Health Center	(1) Individual	377	0.3%
	(2) Organization	1,060	99.4%
	NPI details not available	n/a	0.3%
Independent Laboratory	(1) Individual	4,056	3.0%
	(2) Organization	1,466	93.7%
	NPI details not available	n/a	3.3%
Off Campus Hospital Services	(1) Individual	239	Less than 0.1%
	(2) Organization	65	99.9%
	NPI details not available	n/a	Less than 0.1%
Office: Other	(1) Individual	26,460	14.6%
	(2) Organization	19,407	84.1%
	NPI details not available	n/a	1.3%
Office: Primary Care	(1) Individual	11,578	11.0%
	(2) Organization	7,231	88.7%
	NPI details not available	n/a	0.2%
Physician Practices and Groups Providing Services in Hospitals	(1) Individual	35,437	11.6%
	(2) Organization	9,648	85.0%
	NPI details not available	n/a	3.5%
Renal Dialysis Center/Treatment Facility	(1) Individual	88	0.4%
	(2) Organization	602	99.4%
	NPI details not available	n/a	0.1%
Rural Health Clinic	(1) Individual	128	0.2%
	(2) Organization	749	99.7%
	NPI details not available	n/a	0.1%
Urgent Care Facility	(1) Individual	2,256	4.3%
	(2) Organization	2,170	95.3%
	NPI details not available	n/a	0.4%

Appendix D: Billing National Provider Identifiers (NPIs) for Maine Hospitals

Hospital Name	Total NPIs Per Hospital	Billing NPI
Bridgton Hospital	2	1154370153
		1477691467
Calais Community Hospital	2	1376546143
		1922001049
Cary Medical Center	1	1780615492
Central Maine Medical Center	2	1073651576
		1689653487
Down East Community Hospital	3	1336587542
		1528087004
		1689670242
Houlton Regional Hospital	5	1013355254
		1386601524
		1386804268
		1508823741
		1639147101
MaineGeneral Medical Center	5	1083949184
		1285672436
		1447289996
		1548204480
		1669423380
MaineHealth Behavioral Health	1	1598798787
MaineHealth Franklin Hospital	2	1558305847
		1861184509
MaineHealth Lincoln Hospital	3	1316035116
		1548355654
		1912094806
MaineHealth Maine Medical Center Biddeford	1	1659392819
MaineHealth Maine Medical Center Portland	1	1760436216
MaineHealth Mid Coast Hospital	1	1932164795
MaineHealth Pen Bay Hospital	1	1982645305
MaineHealth Stephens Hospital	1	1346299815
MaineHealth Waldo Hospital	1	1841397932
		1265443196
Millinocket Regional Hospital	3	1275646150
		1578677456
Mount Desert Island Hospital	2	1518064047
		1790764512
New England Rehabilitation Hospital	1	1194799023
		1255791026
		1265551212
Northern Light A.R. Gould Hospital	5	1396858999
		1396864336
		1982723037

Hospital Name	Total NPIs Per Hospital	Billing NPI
Northern Light Acadia Hospital	2	1215940523
		1568477297
Northern Light Blue Hill Hospital	2	1023057809
		1023272853
		1104834977
Northern Light Charles A. Dean Hospital	5	1134354228
		1265441323
		1659388213
		1861401820
		1134492846
Northern Light Eastern Maine Medical Center	7	1487781548
		1588654479
		1598755399
		1780674580
		1780674689
Northern Light Inland Hospital	1	1790789147
		1376579557
Northern Light Maine Coast Hospital	3	1053731026
		1447204763
Northern Light Mayo Hospital	2	1740249739
		1548463623
Northern Light Mercy Hospital	1	1558319103
		1629078712
Northern Light Sebecook Valley Hospital	2	1013176544
		1457461477
		1568465144
Northern Maine Medical Center	4	1790830503
		1801872759
		1891184172
Penobscot Valley Hospital	2	1093716086
		1700805868
Redington-Fairview General Hospital	2	1174549133
		1982029468
Rumford Hospital	2	1205991122
		1982742482
St. Joseph Hospital	2	1154321545
		1881092765
		1245292788
St. Mary's Regional Medical Center	4	1407242522
		1447226584
		1952306524
York Hospital	2	1376528398
		1538144662