Maine Quality Forum

MEASURING TO IMPROVE

Public Law, Chapter 244

Annual Report:

Maine Primary Care Spending, 2021-2023

November 20, 2025

(Revised from January 27, 2025)

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Overview

Public Law 2019, Chapter 244, *An Act to Establish Transparency in Primary Care Health Care Spending*, requires the Maine Quality Forum (MQF) to submit an annual report on primary care spending in Maine as a percentage of total medical spending using data from the Maine Health Data Organization (MHDO), to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services.[1] (*Attachment B*)

The Maine Quality Forum (MQF) contracts with the University of Southern Maine, Muskie School of Public Service with consultation from Judy Loren and McGuire Consulting Services, for technical support in the preparation of this report.

Primary Care Spending estimates for CY 2023 reported in MQF's sixth annual report rely on analyses of both claims payment data and non-claims-based payments submitted by payors to the MHDO as defined in 90-590 Chapter 243*, Uniform Reporting System for Health Care Claims Data Sets*, and 90-590 Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*.[2,3] Throughout this report, the terms "payment" and "spending" are equivalent.

As required by the statute, MQF annually conducts an environmental scan of other state and national reports to align Maine's definition of primary care with current best practice. Based on our updated review, there continues to be no consistent definition across states. Therefore, MQF's definition of primary care in this report remains the same as prior reports. See *Attachment C* for a more detailed summary of primary care reporting in other states and nationally.

As in previous reports, this report provides a comprehensive estimate of primary care payments by payors as reported in claims, non-claims, and supplemental-reported payments (Part I). For the claims analyses of primary care spending estimates, this represents the payors' paid amount and does not include consumer payments (e.g., copayments, coinsurance). As in prior reports, we also include *claims-only* estimates of insured members' primary care utilization by payor (Part II), an analyses of primary care spending for telehealth services based on payor paid amounts and an analysis of commercially insured consumers' cost share as a portion of total allowed amounts (payor paid amounts plus consumer cost share amounts) (Part III).

For details on the methodology used to estimate primary care spending and member use see *Attachments D and E*.

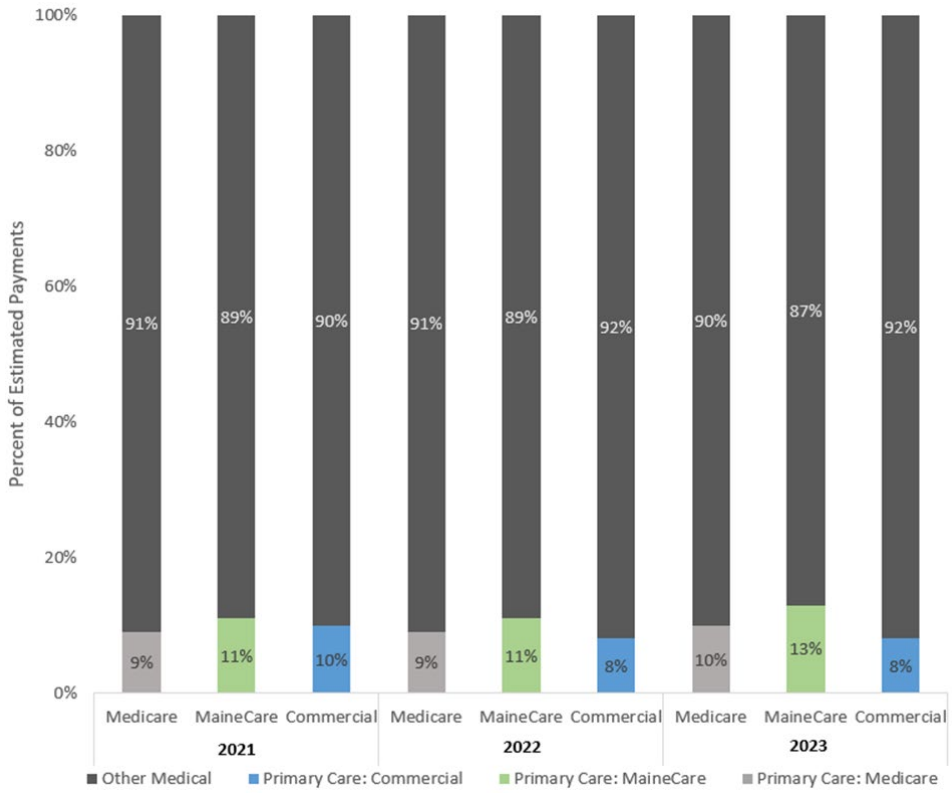
Note: The MQF primary care spending report is separate from the report on Behavioral Health Spending in Maine required under Public Law 2021, Ch 603. However, there is some overlap in the estimates as primary care practitioners may deliver behavioral health services, which are counted in both primary care and behavioral health spending (the overlap is between 4-5% of commercial and Medicare and 16% for MaineCare in 2023).

Key Findings

2023 Primary Care Spending Estimates

- In 2023, primary care spending as a percent of total payments was highest for MaineCare (11.6-12.7%), followed by Medicare (9.6%) and commercial payors (7.6%). (Figure 1, Table 1)
- Compared to 2022, MaineCare and Medicare's percentage of primary care spending increased in 2023, while commercial payors percent primary care spending declined slightly.
- On average, across the three-year period CY 2021 to CY 2023, primary care spending as a percent of total medical spending by all payors combined has remained relatively constant at between 9-10%.

Figure 1. Primary Care Payments as a Percentage of Total Reported Medical Payments by Payor*, 2021-2023



* MaineCare's primary care spending shown in this Figure represents the high end of the range of estimated primary care spending.
Data Source: MHDO 2021-2023 APCD claims data, and non-claims-based payments and supplemental data.

Enhancements to This Year's MQF Primary Care Spending Report

In this report, several new analyses have been added to provide additional context about primary care spending and use in Maine based on claims data.

New analyses this year include:

- **Primary care spending by age group, health insurance rating areas and county** (Figure 3 and *Attachment A* – Table 4, Table 5, and Figure 7)
- **Primary care use as measured by the percent of insured people with at least one primary care claim by county, insurance rating area, and age group by payor*** (Table 3 and *Attachment A* – Table 6 and Figures 8-10).
- **Primary care telehealth spending by payor, county and health insurance rating area** (*Attachment A* – Table 7 and Figures 11-13)

* For this report Insured members whose primary payor changed during the year were counted only once in the primary payor in which they were enrolled in the latest month in the year. Given this change in methods, results will differ from prior report.

Part I: Primary Care Spending Estimates by Payor, Geography and Age

The Primary Care Spending estimates for calendar years 2021-2023 shown in Table 1 and Figure 1 of this report reflect the percent of payors total medical payments[†] reported to MHDO including claims, non-claims, and supplemental data per the requirements in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*, and non-claims-based payments and supplemental data as defined in Chapter 247, *Uniform Reporting System for Non-Claims Based Payments, and Other Supplemental Health Care Data Sets.* "Non-claims-based" means payments that are for something other than a fee-for-service claim. Some examples include Capitation Payments, Care Management/Care Coordination/Population Health Payments, and Pay-for-Performance Payments. Additional examples of non-claims payments can be found in Attachment D.

The spending estimates are based on MQF's definition of Primary Care, which includes all services except inpatient hospital services and services provided in an emergency department by providers with one of the following primary taxonomy specialty codes. (See *Attachment E for the complete list*)

- Family Medicine (including subspecialties of Geriatric, Adult and Adolescent medicine)
- Internal Medicine
- General Medicine
- Pediatrics (including adolescent medicine)
- Geriatric medicine
- Naturopathic/homeopathic medicine
- Physician assistants[‡]
- Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, and gerontology)
- Federally Qualified Health Centers (FQHCs) or Rural health centers (RHCs)
- Preventive medicine

For obstetrics and gynecology providers (including Nurse Practitioners) and attending providers in a hospital setting with any of the above primary care specialties, only a specific list of services are included as primary care services. (See *Attachment E* for the list of services included in these circumstances.)

In reviewing data in this report and estimates in Figure 1 and Table 1, note the following caveats:

- Estimates are based on claims and non-claims data reported to MHDO, which include all of MaineCare and Medicare (includes both Medicare Advantage and Original Medicare) members and approximately 73% of commercially insured members.
- Commercial/SEHC/MEABT Substance use disorder (SUD) data reported by commercial payors per the requirements in 90-590 Chapter 247 do not differentiate the portion paid to primary care and non-primary care. We estimated the portion of SUD paid to primary care based on a limited claims sample.[§]
- MaineCare Non-claims and SUD data reported by MaineCare per the requirements in 90-590 Chapter 247 include payments for long term services and supports (LTSS). To have estimates comparable to other payors, LTSS was excluded from MaineCare's reported non-claims data. For SUD data by

[†] Claims analyses are based on medical claims only and exclude pharmacy and dental claims.

[‡] Some physician assistants and nurse practitioners with a primary care taxonomy but working with specialists may be included in the primary care estimate because they could not be separately identified in claims.

[§] Maine Education Association Benefits Trust (MEABT) is a benefit plan that provides health insurance to Maine public school employees and their families. State Employees Health Commission (SEHC) is a health insurance plan that provides health insurance for employees of Maine State Government. The legislation requires that spending for these two plans be reported.

MaineCare, we estimated the portion of SUD paid to primary care, including removal of LTSS, based on limited MaineCare claims sample and show as a range. For a listing of what services are LTSS see *Attachment D,* Table 9.

- Medicare estimates include both Original Medicare and Medicare Advantage payments. Original Medicare is not subject to 90-590 Chapter 243 and 247 requirements. Reported non-claims and SUD payments for Medicare only reflect those reported by Medicare Advantage plans.
- Absolute $s All payments shown in Table 1 are presented in millions (M) and billions (B). For example, $500,000,000 equals $500 (M) million dollars; $2,500,000,000 equals $2.5 (B) billion dollars.

Table 1 shows the total medical and primary care payments by payor and the percentage of primary care spending in total and for claims, non-claims and SUD supplemental payments.

- Total non-claims-based payments reported to MHDO for all payor categories in CY 2023 were $750M ($689M for MaineCare, $30M for Medicare Advantage, and $30M for commercial payors). Of these 2023 total non-claims-based payments, primary care-related payments represented $13M or 42.2% of total non-claims payments for commercial payors (down from 49.7% in 2022) and $63M or 9.2% of MaineCare's total non-claims (up from 6.1%-7.0% in 2022).
- The total non-claims aggregate payments for substance use disorder (SUD) reported to MHDO for CY 2023 was $77M by commercial payors (up from $76M in 2022), $25M for Medicare Advantage (up from $24M in 2022) and $222M-$250M by MaineCare (up from $189M-$213M in 2022). The estimated portion of SUD payments that were for primary care remained the same for commercial payors ($4M in 2023 and $4M in 2022) and Medicare Advantage ($1M in 2023 and 2022) and increased for MaineCare ($20M-$44M in 2023 up from $19M-$33M in 2022).

Table 1. Medical and Primary Care Payments and Percent Primary Care Spending (Claims, Non-Claims, SUD payments), CY 2021-2023

Payor Category	2021			2022			2023		
	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care
Commercial									
Claims	$1.98B	$182M	9.2%	$2.02B	$149M	7.4%	$2.04B	$147M	7.2%
Non-claims	$40M	$22M	55.0%	$34M	$17M	49.7%	$30M	$13M	42.2%
SUD	$64M	$3*M	5.0%*	$76M	$4*M	5.0%*	$77M	$4M	5.0%
Total	$2.09B	$207M	9.9%	$2.13B	$170M	7.9%	$2.15B	$164M	7.6%
MaineCare									
Claims	$1.30B	$153M	11.8%	$1.33B	$165M	12.4%	$1.51B	$201M	13.3%
Non-claims	$573 - $649^M	$48M	7.4% - 8.4%^	$640-$726^M	$45M	6.1%-7.0%	$689M	$63M	9.2%
SUD	$165 - $186^M	$17 - $29*M	8.9% - 17.5%^*	$189-$213^M	$19-$33*M	8.9%-17.5%^*	$222-$250^M	$20-$44M	8.9%-17.5%^
Total	$2.03 - $2.13B	$218 - $231M	10.2% - 11.3%	$2.16-$2.26B	$228-$242M	10.1%-11.2%	$2.42-$2.45B	$284-$308M	11.6%-12.7%
Medicare (Original and Medicare Advantage)**									
Claims	$3.15B	$278M	8.8%	$3.24B	$296M	9.2%	$3.46B	$324M	9.4%
Non-claims ***	$1M	$1M	100.00%	$24M	$7M	29.7%	$30M	$11M	36.0%
SUD^^	$19M	$0.94M	5.0%	$24M	$1M	5.0%	$25M	$1M	5.0%
Total	$3.17B	$281M	8.9%	$3.29B	$305M	9.3%	$3.52M	$336M	9.6%
SEHC									
Claims	$162M	$15M	9.4%	$155M	$11M	7.1%	$171M	$12M	7.3%
Non-claims	$1M	$1M	98.5%	$2M	$2M	98.0%	$1M	$1M	97.2%
SUD	$5M	$0.24*M	5.0%*	$6M	$0.29*M	5.0%*	$7M	$0.3M	5.0%
Total	$168M	$17M	10.0%	$162M	$13M	7.9%	$179M	$14M	7.9%

Payor Category	2021			2022			2023		
	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care	Total Dollars (M millions B billions)	Primary Care (M millions)	% Primary Care
MEABT									
Claims	$320M	$34M	10.5%	$323M	$25M	7.6%	$352M	$26M	7.5%
Non-claims	$3M	$3M	98.5%	$3M	$2M	65.2%	$3M	$3M	96.9%
SUD	$9M	$0.44*M	5.0%*	$11M	$0.54*M	5.0%*	$11M	$0.6M	5.0%
Total	$332M	$38M	11.3%	$337M	$27M	8.1%	$366M	$30M	8.2%
Total (Commercial, MaineCare, Medicare) §									
Claims	$6.43B	$613M	9.5%	$6.59B	$610M	9.3%	$7.01B	$672M	9.6%
Non-claims	$614-$690M	$71M	10.3%-11.6%	$698-$784M	$69M	8.7%-9.8%	$750M	$87M	11.6%
SUD	$248-$269M	$21-$33M	7.7%-13.3%	$289-$313M	$24-$38M	7.6%-13.2%	$324M-$352M	$25M-$49M	7.1%-15.1%
Total	$7.29-$7.39B	$706-$718M	9.6%-9.9%	$7.58-$7.69B	$703-$717M	9.1%-9.5%	$8.09B-$8.12B	$784M-$808M	9.7%-10.0%

Data Source: MHDO 2021-2023 APCD claims data, and non-claims-based payments and supplemental data.

*Aggregated total SUD data reported by commercial payors and MaineCare per current Chapter 247 requirements did not separate the portions paid to primary care and non-primary care. The estimated portion of SUD paid to primary care was derived based on a limited claims sample.

^ The total non-claims and aggregate SUD data reported by MaineCare per current Chapter 247 requirements include payments for long term services and supports (LTSS). To have estimates comparable to other payors, we removed an estimated portion of MaineCare total non-claims and SUD reported payments that may have been for LTSS. Both were estimated as a range.

**Medicare includes both original and Medicare Advantage claims payments. Original Medicare is not subject to requirements in Chapter 247, thus MHDO does not have non-claims-based payments for original Medicare, only for Medicare Advantage plans.

***Medicare non-claims estimated ranges are based on Medicare Advantage Plan data reported to MHDO.

^^SUD redacted claims shown are for Medicare Advantage Plans that reported to MHDO.

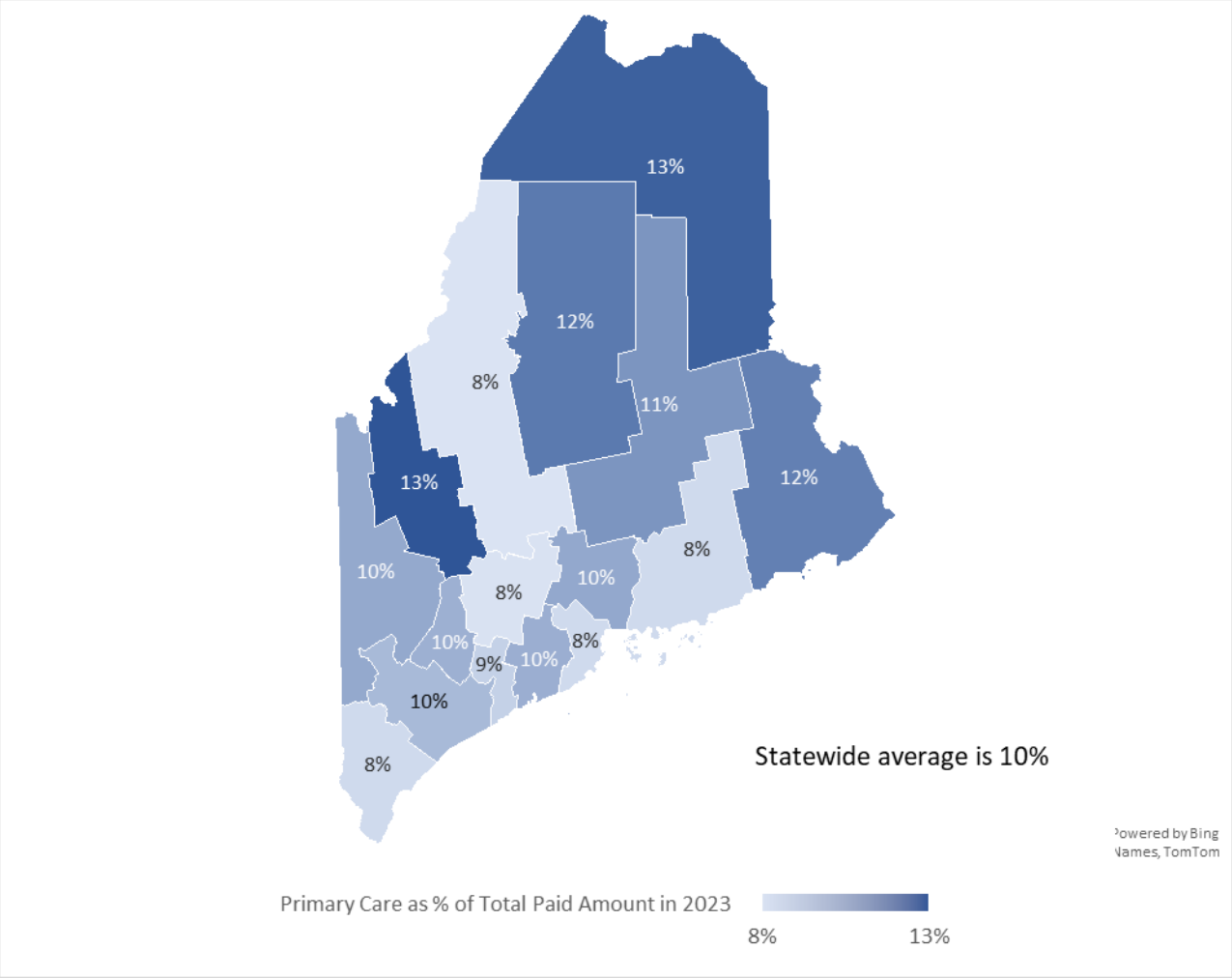
§ Totals reflect the sum of the payors reporting data to MHDO, which includes all public payors and the majority of commercial payors, but do not reflect total primary care and healthcare spending in the state.

Geographic Variation in Primary Care Spending (Revised)

In 2023, the estimated percent of primary care claims spending varied by members' county of residence ranging from a low of 8% in Kennebec, Somerset, Hancock, York, and Knox County to 13% in Franklin and Aroostook County compared to the statewide average of 10% (Figure 2).

Many rural counties (e.g., Aroostook, Franklin, Washington) had higher rates of primary care spending as a percent of total medical spending compared to other more populated counties. This may be due to differences in county demographics (e.g., age, gender, health status) and/or less access to non-primary care providers in rural areas. See *Attachment A* Table 4 and Figure 7 for the percent of primary care spending by member residence by county and health insurance rating area.

Figure 2. Percent Primary Care Payments of Total Medical Paid Amount by County of Member Residence, 2023



Data Source: MHDO 2023 APCD claims data

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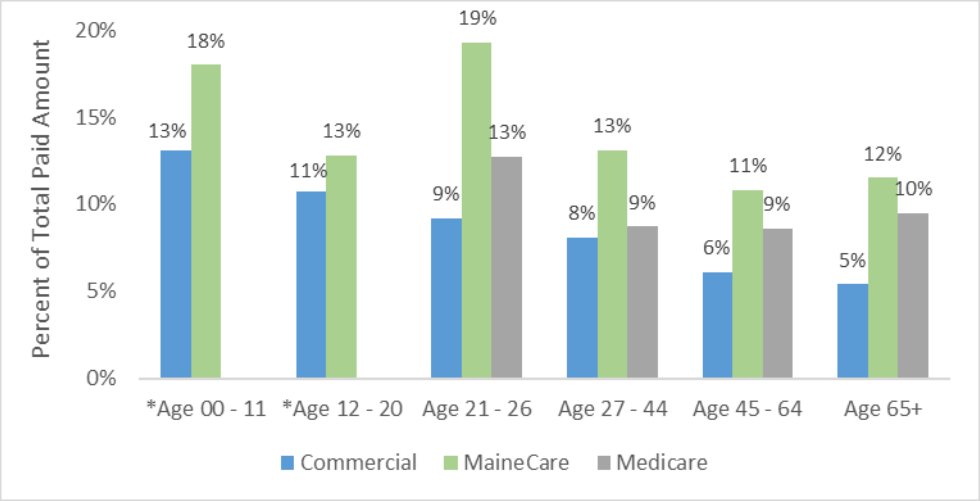
Percent Primary Care Spending by Age and Payor

As a new analysis in this year's report, we examined the percent of primary care of total medical claims spending reported by age group – defined in six age categories (0-11, 12-20, 21-26, 27-44, 45-64, and 65+). For this analysis, for each of these age groups we measured their primary care spending (numerator) as a percentage of overall medical spending (denominator).

As shown in Figure 3 below, primary care spending tends to represent a larger share of overall medical spending for younger people, who are less likely to require specialty and inpatient care than older persons, with the exception of Medicare, whose under 65 population includes disabled adults.

By payor, MaineCare had the highest percentage of primary care spending in every age group with the highest primary care spending for young adults ages 21-26 (19%) and young children ages 0-11 (18%). Both commercial payors' and Medicare primary care spending rates generally decreased for older age groups (e.g. commercial from 13% for children age 0-11 to 5% for persons age 65+, Medicare 13% for young adults age 21-26 to 10% for persons 65+). Note that Medicare coverage was not reported for age groups 0-11 and 12-20 due to insufficient sample size. A table with this data can be found in *Attachment A – Table 5*.

Figure 3. Percent Primary Care Payments of Total Medical Paid Amount, by Age and Payor, 2023



*Medicare size for ages 0-11 and 12-20 too small to report.
Data Source: MHDO 2023 APCD claims data

Part II: Utilization of Primary Care Services

Percent of Insured Members with Primary Care Claims by Payor (Revised)

Various factors contribute to variations in primary care spending rates by payor including changes in the insured members enrolled and their use of primary care and other medical services.

Several studies have identified access to and continuity of primary care as a high-value opportunity to improve health outcomes while reducing total health care expenditures. Many public and private payors have pursued value-based insurance designs that promote greater use of primary care to improve early detection, disease prevention, and chronic disease management to reduce unnecessary specialist care, hospitalizations, and emergency department visits.[4,5] However, despite efforts to promote greater use of primary care, national data suggests a decline in primary care visits among insured persons.[6]

To understand changes in primary care utilization, we examined the proportion of insured members who accessed primary care (defined as having at least one claim with a service date in 2021, 2022 or 2023 to a primary care provider, as identified by our list of taxonomy codes).

Table 2 shows the total insured members by payor and the percentage that had at least one primary care claim in 2021, 2022 and 2023.[**] Across this period, total insured members decreased for commercial payors and increased for MaineCare and Medicare, consistent with regional trends that may contribute to declines in total and primary care commercial payments.

Between 2021 and 2023, all payors saw a decline in the percent of insured members that had at least one primary care claim. Nearly three quarters of people enrolled in commercial insurance (76%) and MaineCare (76%) used primary care in 2021 which declined to 71% (commercial) and 70% (MaineCare) in 2023. Medicare members had a slightly higher percentage of people using primary care, with 83% using primary care in 2021, which declined to 79% in 2023.

[**] For this report Insured members whose primary payor changed during the year were counted only once in the primary payor in which they were enrolled in the latest month in the year. Given this change in methods, results will differ from the prior report.

Table 2. Percent of Insured Members* with at least one Primary Care Claim by Payor, 2021-2023

	2021			2022			2023		
Payor	Members with a Primary Care Claim	Insured Members	% Members Utilizing Primary Care	Members with a Primary Care Claim	Insured Members	% Members Utilizing Primary Care	Members with a Primary Care Claim	Insured Members	% Members Utilizing Primary Care
Commercial	310,798	407,092	76%	290,029	401,762	72%	263,653	369,283	71%
MaineCare	187,663	248,512	76%	190,793	265,010	72%	194,473	276,656	70%
Medicare	326,723	393,024	83%	321,178	402,885	80%	328,996	414,443	79%

Data Source: MHDO 2021-2023 APCD claims data

* Insured members are only counted once in the primary payor category in which they were enrolled in the latest month of the year.

Primary care utilization varied across counties: Table 3 shows insured members who had one or more primary care claims by county and health insurance rating area in 2023. While some counties, such as Knox and Cumberland, had higher primary care use across payors, others, like Oxford, had lower utilization of primary care. Medicare beneficiaries tended to have higher rates of primary care utilization compared to Commercial and MaineCare beneficiaries across most counties. Figures 8, 9, and 10, which show members who had one or more primary care claims by county in 2023, can be found in *Attachment A*.

Table 3. Percent of Insured Members with at least one Primary Care Claim by Member County of Residence and Health Insurance Rating Area by Payor, 2023

Health Insurance Rating Area	County Name	Commercial	MaineCare	Medicare
Rating Area 1	Cumberland	72%	68%	80%
	Sagadahoc	73%	75%	80%
	York	69%	72%	78%
Rating Area 1 Total		**71%**	**70%**	**79%**
Rating Area 2	Kennebec	71%	73%	79%
	Knox	72%	68%	77%
	Lincoln	74%	70%	77%
	Oxford	66%	69%	78%
Rating Area 2 Total		**71%**	**71%**	**78%**
Rating Area 3	Androscoggin	69%	71%	81%
	Franklin	71%	71%	80%
	Waldo	73%	72%	76%
Rating Area 3 Total		**72%**	**73%**	**81%**
Rating Area 4	Penobscot	75%	74%	82%
	Piscataquis	73%	72%	79%
	Somerset	70%	70%	74%
Rating Area 4 Total		**72%**	**71%**	**76%**
Rating Area 5	Aroostook	74%	73%	83%
	Hancock	70%	73%	81%
	Washington	73%	72%	79%
Rating Area 5 Total		**72%**	**73%**	**82%**

Data Source: MHDO 2023 APCD claims data

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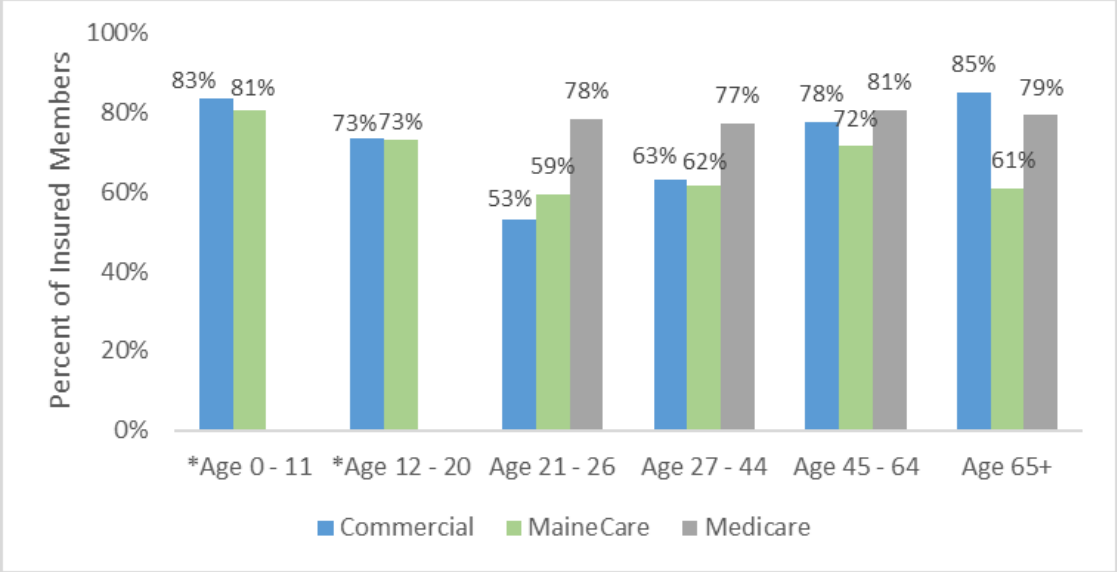
Figure 4 shows the percentage of insured members with at least one primary care claim by age group and by payor. Rates of primary care use vary by age across payers. For MaineCare children 0-11 had the highest percentage of primary care use as measured by having at least one primary care claim at approximately 80% and approximately 70% for ages 12-20. For commercial payors, persons age 65+ had the highest primary care utilization (85.1 %) followed by young children 0-11 (83.4 %). Medicare had comparable rates of primary care usage across age groups of approximately 78%. For all payers, Commercial, MaineCare, and Medicare the young adult age group (ages 21-26) had the lowest percentage of members with at least one primary care claim. For more information, see *Attachment A – Table 6.*

Figure 4. Percent of Insured Members with at least one Primary Care Claim by Payor and Age Group, 2023



*Medicare size for ages 0-11 and 12-20 too small to report.
Data Source: MHDO 2023 APCD claims data

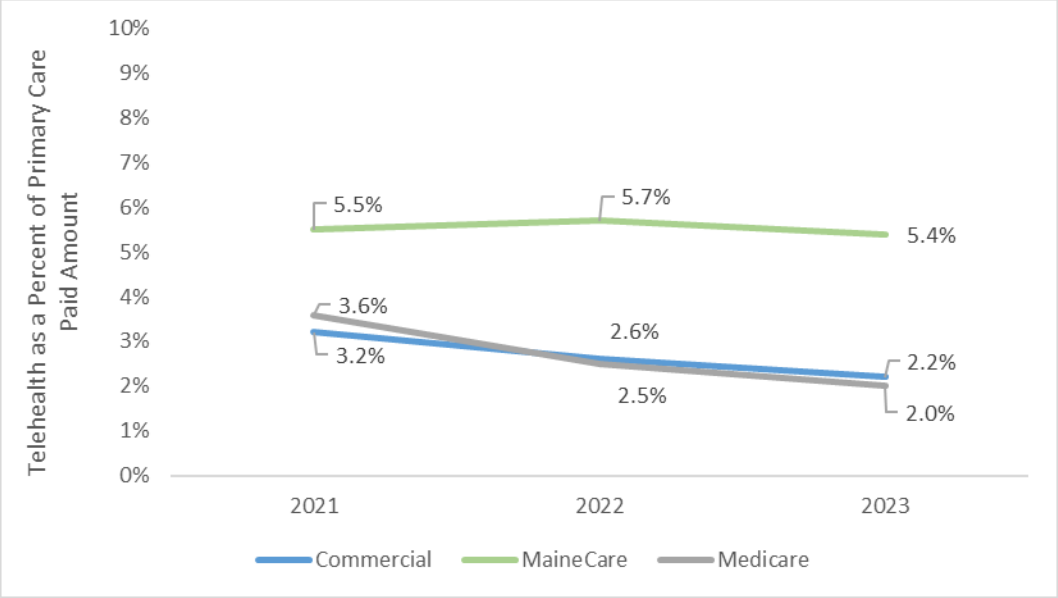
Part III: Telehealth and Consumer Cost Share Claims Analysis

Telehealth Claims Analysis

For the purposes of this report, we have defined telehealth broadly to encompass telecommunication technologies used to provide health services from a distance. Thus, we considered video/audio conferencing from a patient's home or medical office/facility, remote patient monitoring, and provider communications/E-consults. See *Attachment E* for the full list of telehealth procedure codes included. For this report, we analyzed primary care spending based on the broad definition of primary care (all services provided by providers with a primary care provider taxonomy), that were delivered via telehealth. This is a modified method from prior reports, so results will differ from telehealth estimates previously reported.

Since 2021, the percent of spending on primary care services delivered via telehealth is highest for MaineCare, which has remained relatively constant at approximately 5.5% of all primary care spending. In contrast, the percentage of primary care spending delivered via telehealth for commercial payors and Medicare is much lower and has continued to decline since the end of the COVID-19 emergency and telehealth leniencies were lifted.

Figure 5. Telehealth as a Percent of Primary Care Paid Amount, 2021-2023



Data Source: MHDO 2021-2023 APCD claims data

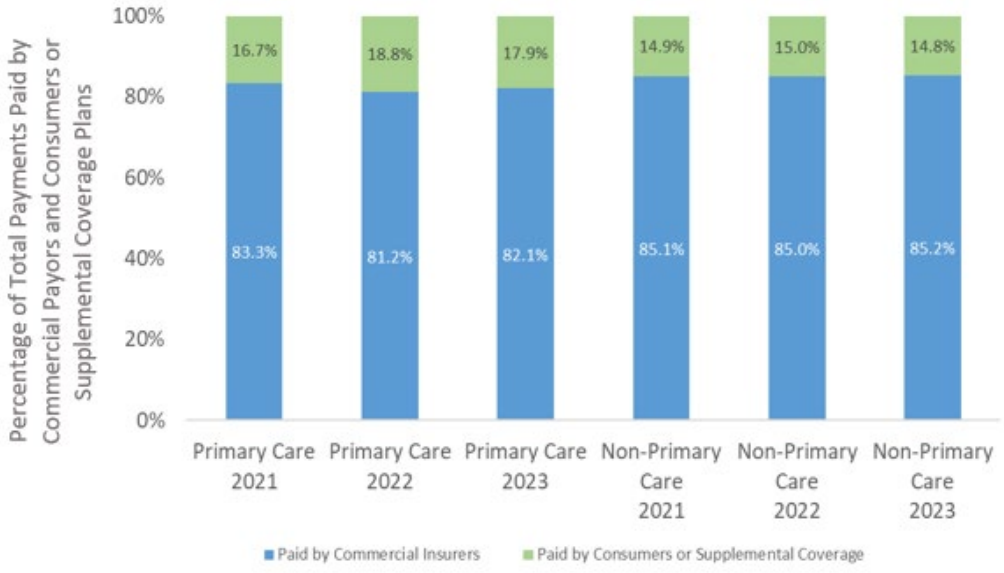
The maps showing the percentage of primary care payments spent on telehealth by the member's county of residence in Maine for 2023 can be found in *Attachment A – Figures 11, 12, 13*. Similar to statewide, MaineCare had a higher percentage of primary care delivered via telehealth in most counties compared to Commercial and Medicare beneficiaries. However, there is considerable variation in primary care telehealth spending rates across payors by county. For commercial payors, the percentage of primary care spending on telehealth was highest in Washington and York counties (3%), while primary care telehealth spending for MaineCare was highest in Penobscot and Waldo counties (10%) and for Medicare was highest in Androscoggin (4%). A table showing this information by health insurance rating areas is included in *Attachment A – Table 7*.

Commercial Payors' Share and Consumer Payments for Primary Care and All Other Medical Expenditure

As in prior reports, we analyzed the share of total primary care and total medical claims payments paid by commercial plans and by the consumer (including consumer's supplemental coverage). This analysis is based on commercially insured consumer's cost share as a portion of total allowed amounts (payor paid amounts plus consumer cost share amounts).

In 2022, commercial insurance paid approximately 81% of the primary care claims payments, while approximately 19% was paid out-of-pocket by consumers (or their supplemental coverage), which was higher than the consumers' cost share for non-primary care payments (15%). This trend continued in 2023, with commercial insurance paid approximately 82% of the primary care claims payments while approximately 18% was paid out-of-pocket by consumers (or their supplemental coverage).

Figure 6. Percentage of Total Medical Payments Paid by Commercial Payors and Consumers or Supplemental Coverage Plans for Primary Care and Non-Primary Care Expenditures, 2021-2023



Data Source: MHDO 2021-2023 APCD claims data

Conclusion and Future Considerations

This sixth annual report on primary care spending adds an additional year of data (CY 2023) and reveals that on average, for the three categories of payors combined (Commercial, MaineCare and Medicare), primary care spending as a percent of total spending has remained relatively constant at just under 10%. MaineCare and Medicare's percentage of primary care spending increased in 2023, while commercial payors percentage declined slightly.

As noted in prior MQF annual reports, understanding why primary care spending varies between payors and/or by county and payor changes in primary care spending as a percent of total spending are strongly affected by changes in both primary care and non-primary care utilization and spending. A variety of factors can contribute to changes in primary and non-primary care spending rates including but not limited to improvements in the data allowing greater precision in identifying primary care and non-primary care providers and services, changes in provider reimbursement or billing practices, service price and intensity, or changes in enrollment, service use, demographics (i.e., age, gender, rural/urban residence), and disease prevalence among insured members.

In consultation with the MQF Primary Care Spending Advisory Committee, several new analyses have been added to this report, including the percent of primary care spending overall and for telehealth and utilization of primary care by age and geography (county and rating area). These more detailed analyses reveal that primary care spending rates vary by county and within county by payor and that primary care spending also varies by age group, with youngest children and adults over 65 having the highest percent spending on primary care.

While three-quarters of insured persons in MHDO's data had at least one primary care visit within the year, use rates also vary considerably by age and county of residence, suggesting that demographic differences or differences in the primary care and/or other medical care available (i.e. telehealth adoption) may also be affecting variations in primary care spending and access across the state.

While this report provides some new insights into how member enrollment, primary care utilization, and county vary by age and county of residence, more research and analyses are needed to determine how these factors might contribute to shifts in primary care spending or total medical spending.

We welcome the opportunity to discuss shifting the direction of our annual primary care spending reports to better support policy discussions specific to the sustainability of primary care in the state of Maine.

Attachments: Supporting Documentation

A. Additional Tables and Figures

B. Public Law Chapter 244

C. Overview of Primary Care Measurement in Other States and Nationally

D. Methodology for Estimating Primary Care Spending

E. Primary Care Provider Taxonomy Codes, Procedure Codes for OB/GYN and Attending Providers, and Telehealth Codes in Primary Care Spending Analyses

F. Endnotes

Attachment A (Revised) - Additional Tables and Figures

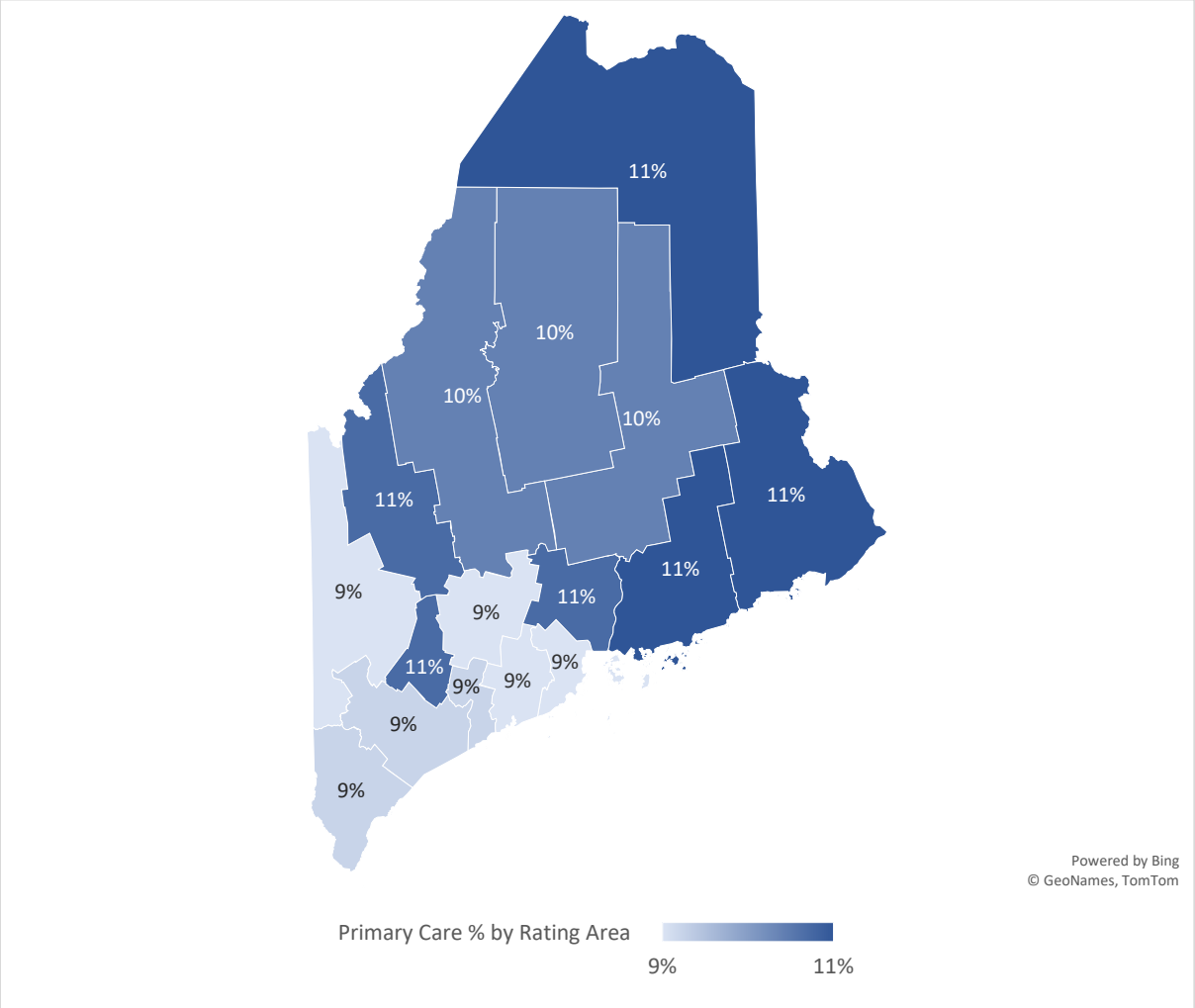
Table 4. Percent Primary Care Payments of Total Medical Paid Amount by County and Health Insurance Rating Area, 2023

Health Insurance Rating Area	**County** Name	Primary Care % Total
Rating Area 1	Cumberland	9.5%
	Sagadahoc	8.7%
	York	8.4%
Rating Area 1 Total		**9.0%**
Rating Area 2	Kennebec	8.1%
	Knox	8.4%
	Lincoln	9.9%
	Oxford	10.1%
Rating Area 2 Total		**8.8%**
Rating Area 3	Androscoggin	10.0%
	Franklin	13.0%
	Waldo	10.1%
Rating Area 3 Total		**10.5%**
Rating Area 4	Penobscot	10.8%
	Piscataquis	11.7%
	Somerset	8.1%
Rating Area 4 Total		**10.2%**
Rating Area 5	Aroostook	12.6%
	Hancock	8.4%
	Washington	11.5%
Rating Area 5 Total		**10.8%**
Grand Total Maine Counties		**9.6%**

Data Source: MHDO 2023 APCD claims data

Revised November 2025

Figure 7. Percent Primary Care Payments of Total Medical Paid Amount by Health Insurance Rating Area, 2023



Data Source: MHDO 2023 APCD claims data

Revised November 2025

Table 5. Percent Primary Care Payments of Total Medical Paid Amount, by Age and Payor, 2023

Age Group	Commercial	MaineCare	Medicare
Age 0 - 11	13.1%	18.0%	0.0%
Age 12 - 20	10.7%	12.8%	0.0%
Age 21 - 26	9.2%	19.3%	12.7%
Age 27 - 44	8.1%	13.1%	8.7%
Age 45 - 64	6.1%	10.8%	8.6%
Age 65+	5.4%	11.5%	9.5%

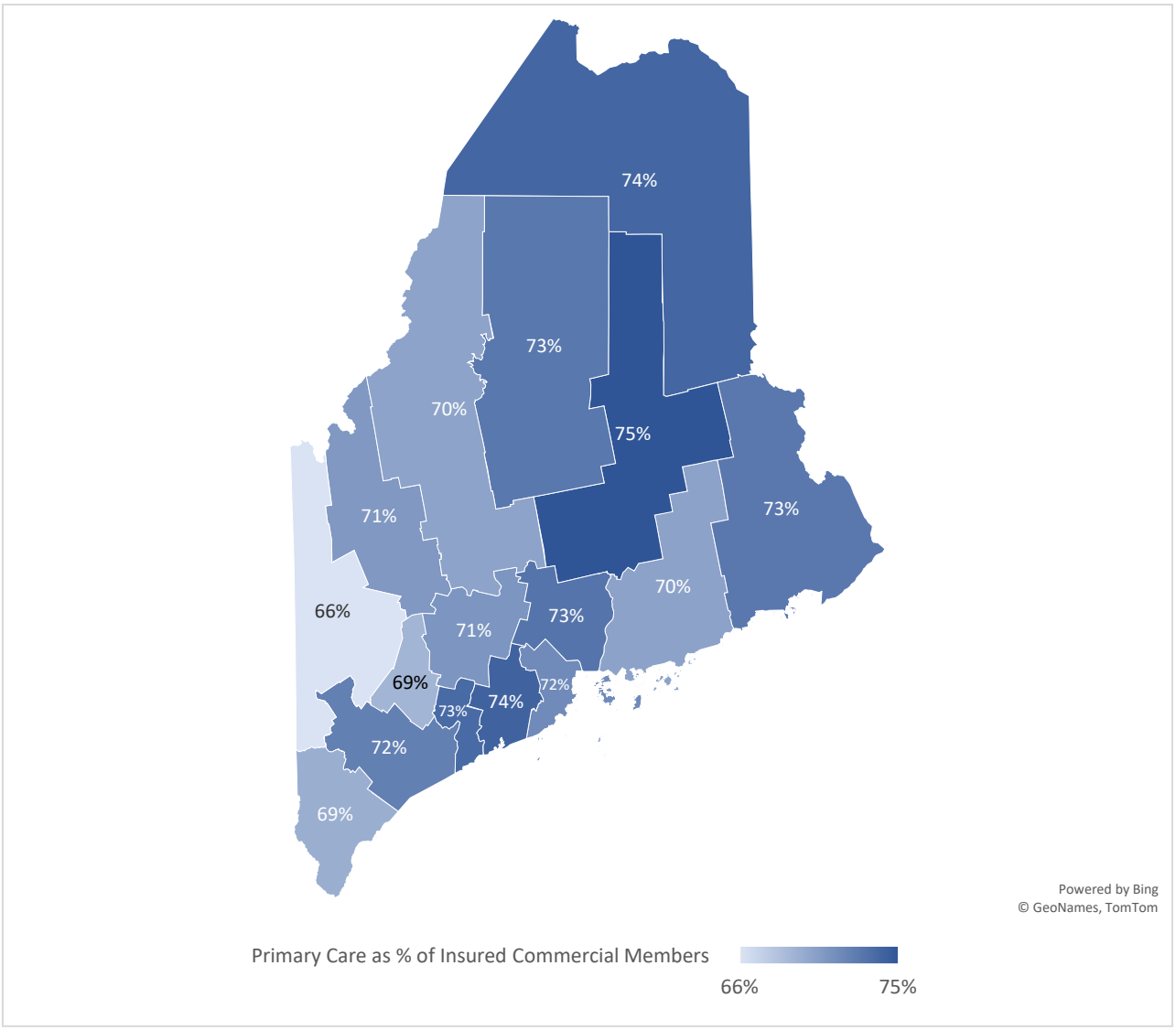
Data Source: MHDO 2023 APCD claims data

Table 6. Percent of Insured Members with at least one Primary Care Claim by Payor and Age Group, 2023

Age Group	Commercial	MaineCare	Medicare
Age 0 - 11	83.4%	80.6%	0.0%
Age 12 - 20	73.4%	73.0%	0.0%
Age 21 - 26	52.9%	59.4%	78.3%
Age 27 - 44	62.9%	61.5%	77.3%
Age 45 - 64	77.5%	71.5%	80.7%
Age 65+	85.1%	61.0%	79.3%

Data Source: MHDO 2023 APCD claims data

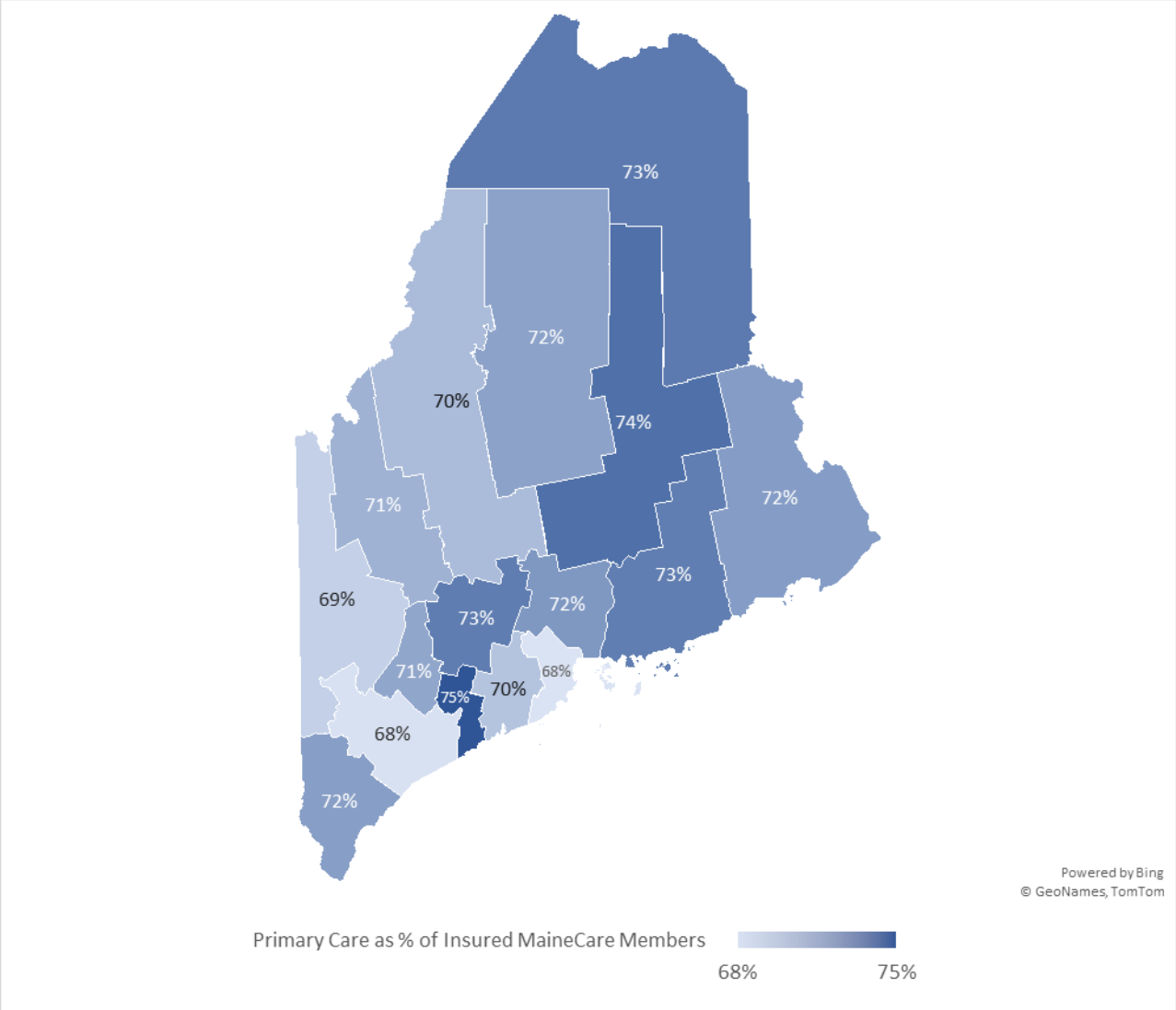
Figure 8. Commercial: Percent of Insured Members with at least one Primary Care Claim by Member County of Residence, 2023



Data Source: MHDO 2023 APCD claims data

Revised November 2025

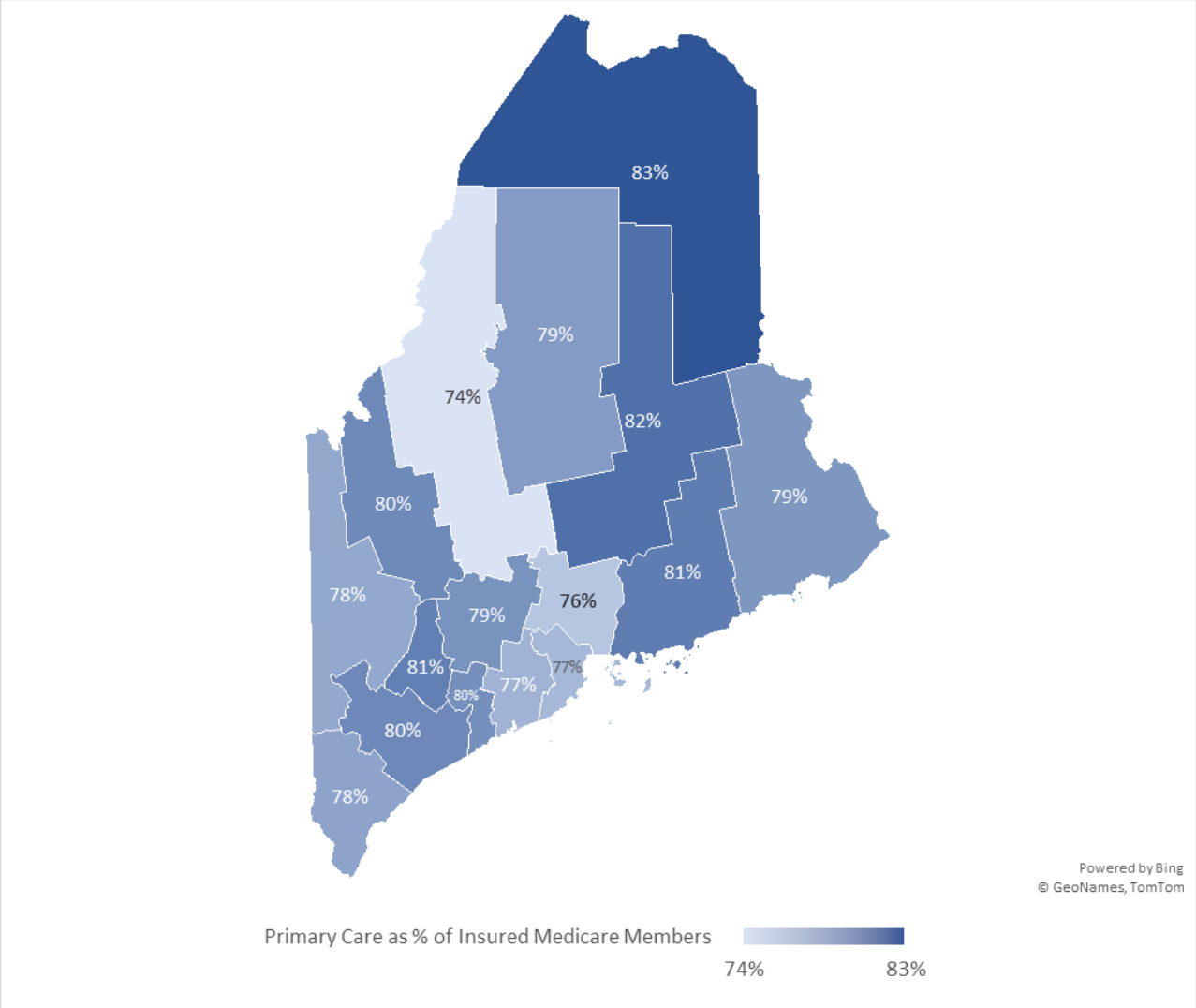
Figure 9. MaineCare: Percent of Insured Members with at least one Primary Care Claim by Member County of Residence, 2023



Data Source: MHDO 2023 APCD claims data

Revised November 2025

Figure 10. Medicare: Percent of Insured Members with at least one Primary Care Claim by Member County of Residence, 2023



Data Source: MHDO 2023 APCD claims data

Revised November 2025

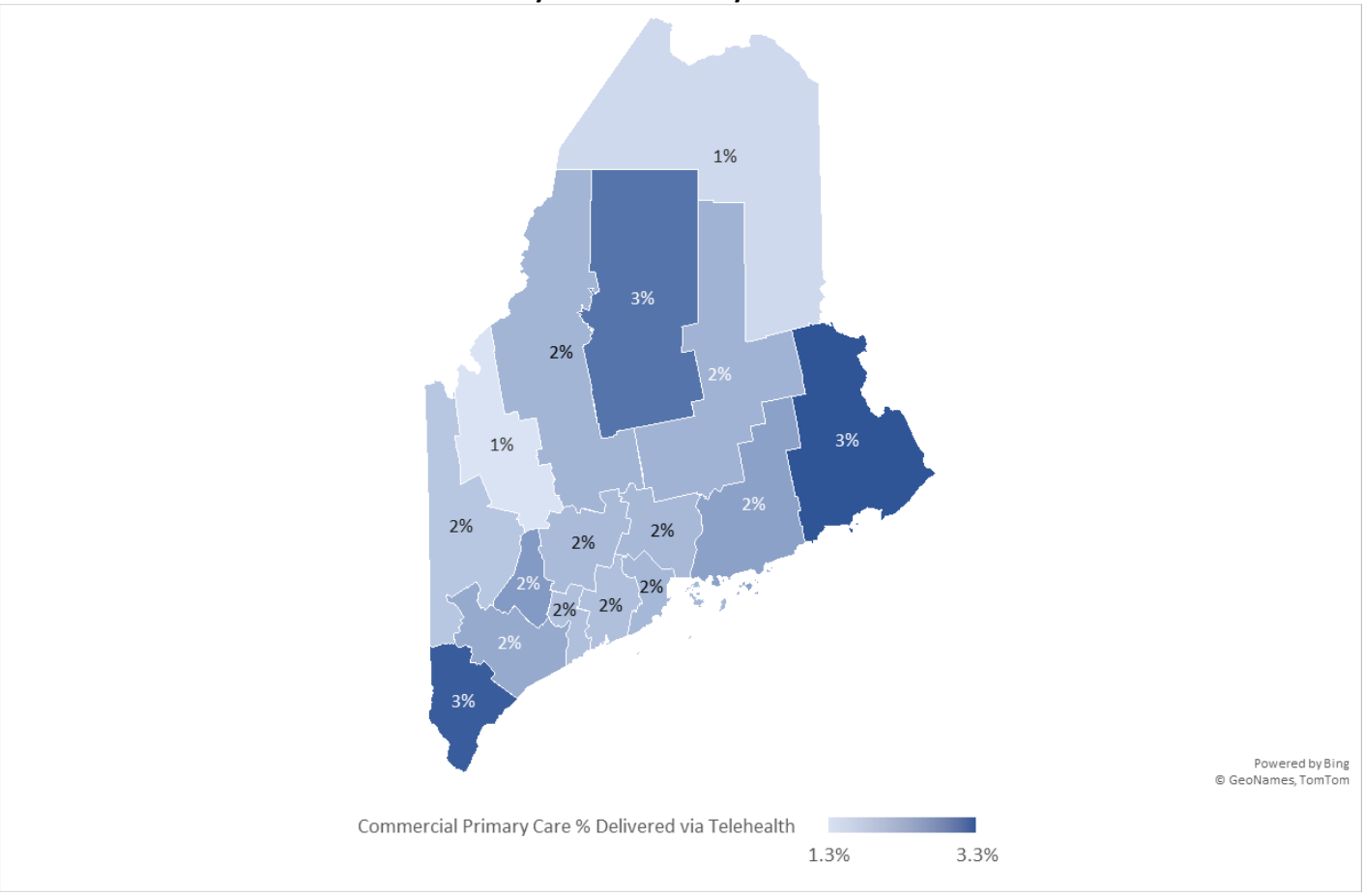
Table 7. Percent of Primary Care Paid Amount Delivered via Telehealth, 2023

Health Insurance Rating Area and County		Commercial	MaineCare	Medicare
Rating Area 1	Cumberland	2.1%	2.4%	1.7%
	Sagadahoc	1.8%	3.9%	1.4%
	York	3.2%	3.0%	2.1%
Rating Area 1 Total		**2.4%**	**2.7%**	**1.8%**
Rating Area 2	Kennebec	1.8%	3.4%	1.7%
	Knox	1.9%	3.4%	1.8%
	Lincoln	1.8%	3.7%	1.6%
	Oxford	1.7%	3.7%	2.2%
Rating Area 2 Total		**1.8%**	**3.5%**	**1.8%**
Rating Area 3	Androscoggin	2.3%	8.4%	3.6%
	Franklin	1.3%	2.1%	1.3%
	Waldo	1.9%	9.8%	2.0%
Rating Area 3 Total		**2.1%**	**7.6%**	**2.7%**
Rating Area 4	Penobscot	2.0%	10.1%	2.7%
	Piscataquis	2.8%	8.2%	2.5%
	Somerset	1.9%	3.6%	1.5%
Rating Area 4 Total		**2.0%**	**9.0%**	**2.4%**
Rating Area 5	Aroostook	1.4%	3.4%	1.5%
	Hancock	2.2%	6.7%	1.4%
	Washington	3.3%	2.9%	2.2%
Rating Area 5 Total		**2.0%**	**3.8%**	**1.6%**
Grand Total Maine Counties		**2.2%**	**5.3%**	**2.0%**

Data Source: MHDO 2023 APCD claims data

Revised November 2025

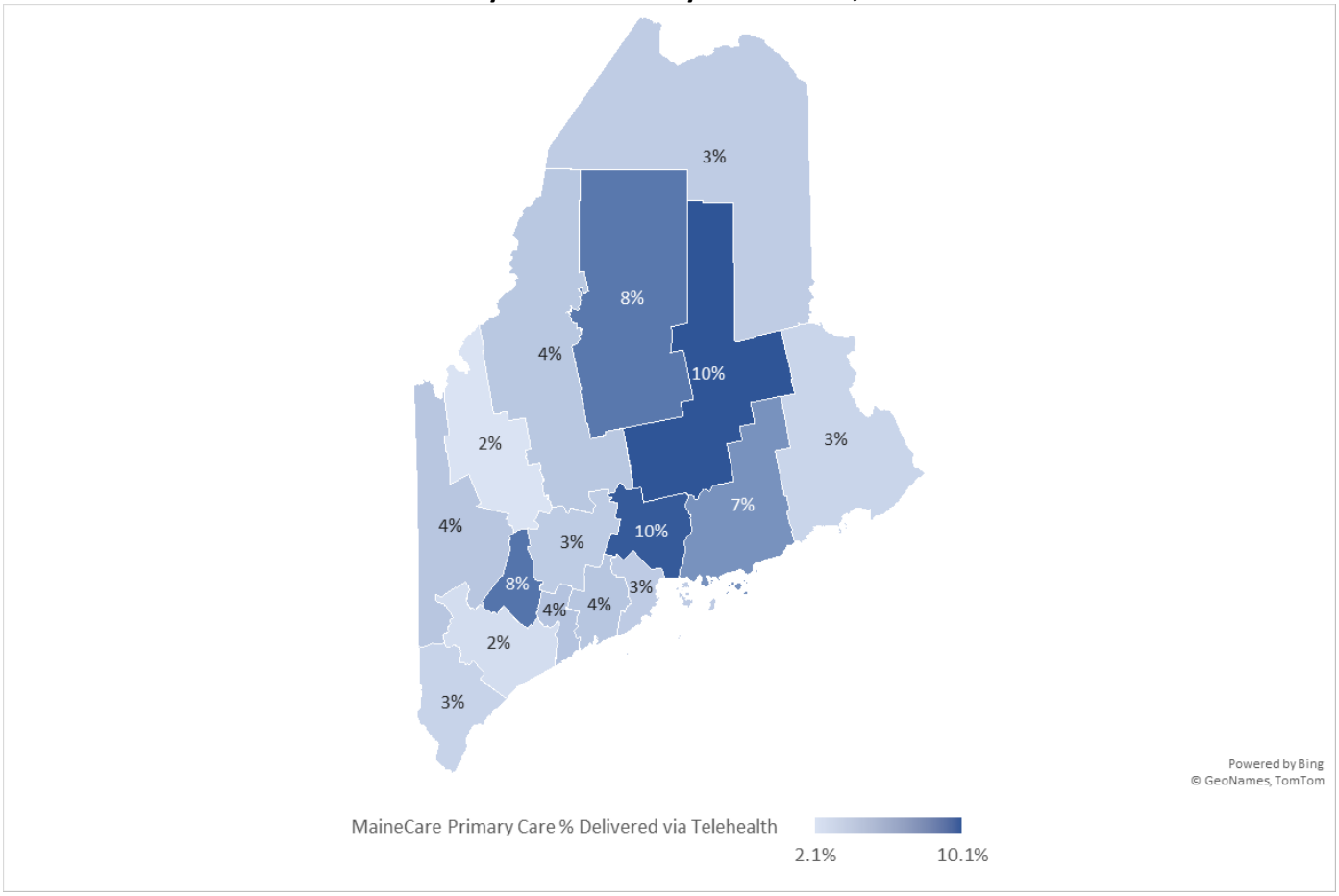
Figure 11. Commercial: Percent of Primary Care Paid Amount Delivered via Telehealth, 2023 by Member County of Residence



Data Source: 2023 MHDO APCD claims data

Revised November 2025

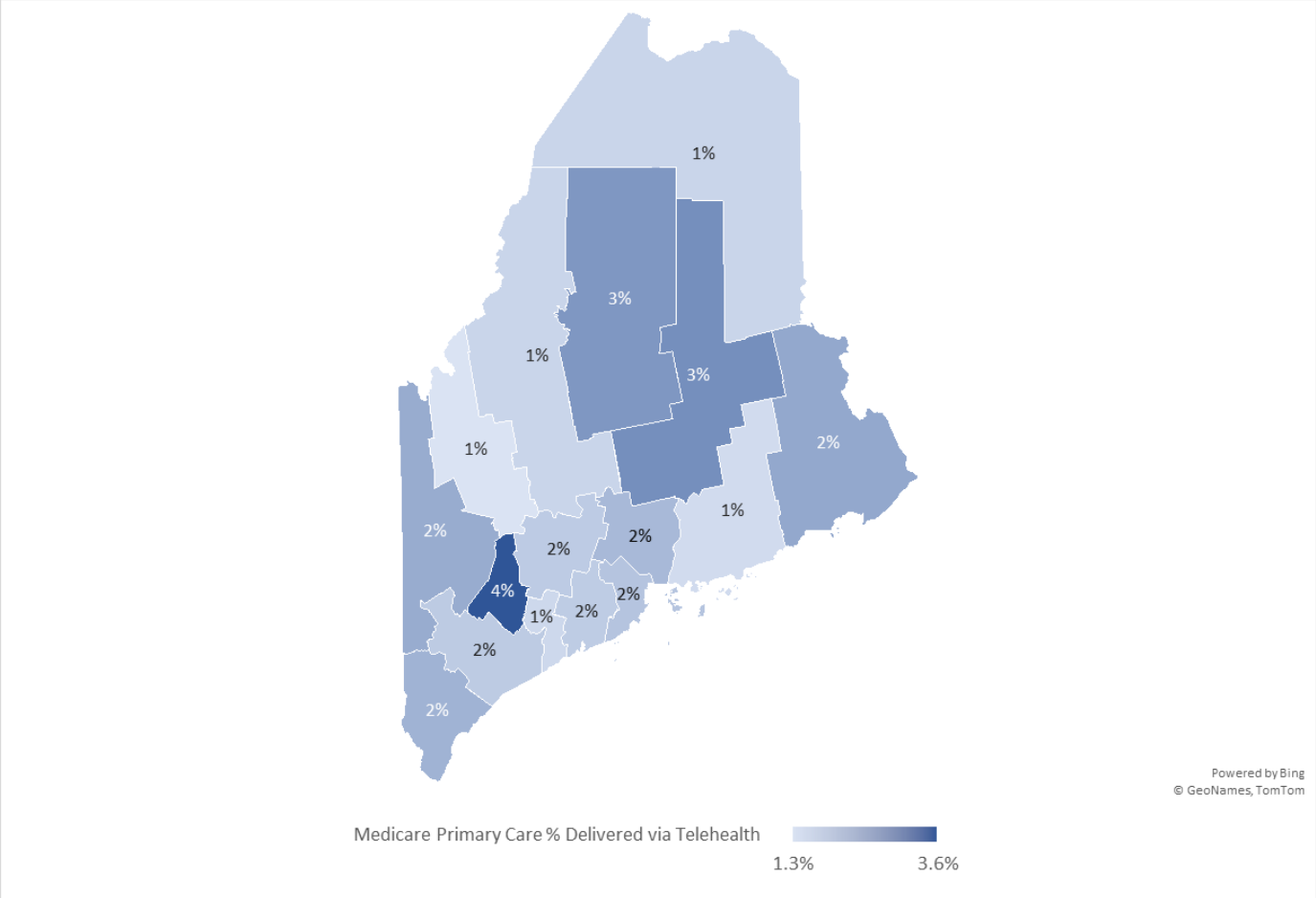
Figure 12. MaineCare: Percent of Primary Care Paid Amount Delivered via Telehealth by Member County of Residence, 2023



Data Source: 2023 MHDO APCD claims data

Revised November 2025

Figure 13. Medicare: Percent of Primary Care Paid Amount Delivered via Telehealth by Member County of Residence, 2023



Data Source: 2023 MHDO APCD claims data

Revised November 2025

Attachment B – Public Law Chapter 244

APPROVED	CHAPTER
JUNE 7, 2019	244
BY GOVERNOR	PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND NINETEEN

S.P. 421 - L.D. 1353

An Act To Establish Transparency in Primary Health Care Spending

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §6903, sub-§13-B is enacted to read:

13-B. Primary care. "Primary care" means regular check-ups, wellness and general health care provided by a provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Sec. 2. 24-A MRSA §6951, sub-§12 is enacted to read:

12. Primary care reporting. Beginning January 15, 2020 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on primary care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse primary care providers requested annually from payors, as defined in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for primary care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for primary care across all payors; and

B. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for primary care.

Sec. 3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on primary care services by insurers. For

purposes of this section, "primary care" means regular check-ups, wellness and general health care provided by a health care provider with whom a patient has initial contact for a health issue, not including an urgent care or emergency health issue, and by whom the patient may be referred to a specialist.

Attachment C – Overview of Primary Care Measurement in Other States and Nationally

Primary Care Spending Definitions

Annually, the Maine Quality Forum is required to complete a report on primary care spending in the state of Maine. As required by the statute, we evaluate state and national reports to identify possible ways to improve our definition of primary care, allowing Maine to align with current best practices of measuring primary care spending. Based on our updated review, there continues to be no consistent definition of primary care spending across states.

This was confirmed in a recent technical brief released by the Agency for Healthcare Research and Quality (AHRQ).[7] The brief analyzed the definitions, data sources, and methodologies used in 67 different primary care spending reports from across the country to identify similarities and differences. Most of the reports were produced by state governments, using narrow and broad definitions of primary care spending, ranging from 3.1 to 10.3 percent of total health care dollars. Each report's methodology varies based on providers, procedures, care settings, types of payments, payers/insurers, and patients that are included. To facilitate future comparisons across states, the authors recommended efforts by State and Federal policymakers to create the following:

- A primary care clinician database to allow for improved identification of clinics and clinicians.
- A data template to improve transparency in reporting methodologies.
- A primary care collaborative charged with developing a consensus definition for estimating primary care spending.
- Advancement of State All-Payer Claims Databases, with expansion to include non-claims payments.

Measures Beyond Spending

In addition to tracking state and national efforts to measure primary care spending, our environmental scan identified numerous states that are reporting other primary care metrics. Several states have produced reports or dashboards on workforce capacity, access to care, and utilization to gain a more comprehensive understanding of their primary care systems using claims and other data collected at the state level. Examples include:

- **Workforce:** Massachusetts and Virginia are two of the states measuring the primary care workforce. Massachusetts reported on the percentage of physicians practicing in primary care, graduate students intending to enter primary care, the percent of primary care physicians leaving the field, and the number of primary care NPs and PAs per 100,000 residents.[8] Virginia's primary care scorecard measures clinician retention, burnout rates, county-level data on the number of primary care providers, and the ratio of primary care NPs and PAs to Virginia residents.[9]
- **Utilization and Access:** California reported on the relationship between primary care (PC) spending and acute hospital emergency department (ED) utilization among the commercially insured. The study found a relationship between higher PC utilization and fewer acute hospital stays or ED visits.[10] Massachusetts examined residents who reported having a PC provider, a usual source of care, and experiences of PC access for adults and children across providers (commercial and MassHealth) based on a statewide survey.[8] New York also reported numerous access measures based on survey data, including the number of Hispanic/Latino residents who reported avoiding care due to cost, the number of residents who reported not having a usual source of care, and potentially preventable hospital rates based on claims among Black residents and children.[11]

Data Dashboards

Interactive data dashboards have been created in several states, allowing users to visualize key metrics and trends. For example:

- Oregon has developed multiple dashboards for indicators of primary care spending using all-payer claims data and non-claims-based payments data. These include PC spending by percentage of total expenditures and per member per month by payer and plan.[12]
- Massachusetts' dashboard can be used to examine the performance of the primary care system across four domains – Finance (spending for PC services), Capacity (PC workforce and pipeline measures), Performance (access and care measures), and Equity (assessing inequities in the PC system such as preventative care visits by age).[8]
- At a national level, Milbank Memorial Fund's Primary Care Scorecard tracks U.S. primary care performance across four key indicators: finance, access, training, and research. The Scorecard uses multiple national data sources, including the Medical Expenditure Panel Survey, American Community Survey, and National Plan and Provider Enumeration System.[13] Where data is available and can support state-level estimates, they also report state-level data.

State Primary Care Collaboratives

Several states have established stakeholder collaboratives focused on strengthening primary care. Often created through formal legislation or executive action, the stakeholder groups are charged with identifying policy changes to address specific concerns facing the primary care system. States that have primary care collaboratives include Colorado, Delaware, New Mexico, Oregon, and Virginia. Lessons learned from these efforts and recommendations for strengthening primary care in Maine can be found in a report by Blythe Thompson (available upon request).[14]

Attachment D – Methodology for Estimating Primary Care Spending and Use by Enrolled Members

To determine the percentage of total medical payor payments that are for primary care in Maine, we used the Maine Health Data Organization's (MHDO) all-payer claims data (APCD) for claims-based payments, and Chapter 247 information collected from payors about payments made outside of claims (non-claims-based payments), as well as information about claims that were redacted before submission to the MHDO due to their inclusion of SUD-related codes (SUD redacted). The following describes the methods used to estimate primary care spending for these data sources.

Primary Care Definition: claims, non-claims and supplemental data

As in prior MQF reports, primary care definitions are based on:

- Language in P.L. Chapter 244, Sec. 2. 24-A MRSA §6903, sub-§13-B,
- Methods and definitions used in the prior annual reports and recommendations for future reporting,
- Consultation with the MQF Primary Care Spending Advisory Committee on proposed changes to Maine's definitions.

For the first annual report, MQF sent a questionnaire to Maine's six largest payors asking how they define primary care, whether they offer non-claims payments or incentives for primary care and whether they track these payments to inform potential future non-claims reporting to the state. We vetted other national and state definitions and those reported by Maine payors with the MQF Primary Care Spending Advisory Committee.

Given the lack of a standard primary care definition, MQF previously reported a range of primary care spending estimates using narrow and broad definitions, using taxonomy codes for primary care providers and specific procedure codes for primary care services identified from the environmental scan and/or where at least one payor identified them in its definition on the Maine payor survey. With the inclusion of non-claims data that lacked the specificity of claims for the narrow definition, MQF's 4th annual report only reported based on the broad definition, which included all services delivered by provider specialties in *Attachment E* (excluding services delivered by these specialties in an inpatient or emergency department setting, as required by Chapter 244) and a specific set of primary care services provided by OB/GYN specialties.

As we had done for the 5th annual report, we continued to use the same definitions including specific primary care services delivered by attending providers with a primary care taxonomy/specialty, similar to the method used for OB/GYN providers. As specialty information on claims is evolving and improving over time there is a degree of uncertainty in all estimates and reported figures should be viewed as estimates rather than pinpoint calculations.

Table 8. Primary Care Providers

Family medicine (including subspecialties of Geriatric, Adult, and Adolescent)	Physician assistants[††]
Internal medicine	Nurse practitioners (family, pediatrics, primary care, general medicine, adult health, gerontology)
General medicine	Federally Qualified Health Centers (FQHCs)[‡‡]
Pediatrics (including adolescent medicine)	Rural health centers
Geriatric medicine	Preventive medicine
Naturopathic/homeopathic medicine	Obstetrics and gynecology (includes NP) – **only for selected primary care services**

The list of procedure codes included in the definition of primary care when delivered by an OB/GYN specialty and by primary care specialties acting as attending providers on facility claims is the same as prior years and can be found in *Attachment E*. Generally, they include:

- Office visits (includes Medicare/Medicaid clinic visits)
- Home visits
- Preventive Visits
- Immunizations and injections
- Transitional Care Management
- Chronic Care Management
- Telehealth Services

For claims analyses, as in previous reports, we also separately analyzed primary care services delivered via telehealth, the percentage of consumer or supplemental payor cost share and payor paid amount relative to total primary care and medical care claim payments. Specific codes used to identify services delivered via telehealth are included in *Attachment E*. This year's report changes the focus of the Telehealth analysis from just the primary care services associated with the narrow definition of primary care delivered via telehealth as previously reported to all services included in the broad definition (all services provided by Primary Care specialties outside of Inpatient or Emergency contexts, plus a specific set of services delivered by OB/GYN specialties and Attending providers with primary care taxonomy codes).

Understanding consumer cost-sharing is relevant in reporting total payments for primary care services. The challenge in measuring consumer cost sharing in all-payer claims data is that the amount that the primary claims processor assigns to the consumer may be paid by additional benefits the consumer has, such as a supplemental plan or membership in two primary plans. This kind of overlap is likely to be particularly large for the population covered by both Medicare and MaineCare, also known as the dually eligible, where MaineCare covers most or all of the members' Medicare out of pocket expenses. As entered in the APCD, the primary claim shows any

[††] Some physician assistants working with specialists may be included in the primary care estimate because they could not be separately identified in claims.

[‡‡] While other states have included behavioral health and psychiatry within their list of primary care providers, based on the guidance of the MQF Advisory Committee, behavioral health providers are not included in MQF's definition of primary care providers for the purposes of estimating primary care spending. However, due to the lack of rendering or servicing provider identification on FQHCs' claims, FQHC estimates may also include behavioral health providers integrated in the FQHC primary care practice model. Given differences in FQHC billing for MaineCare and commercial payors, we were unable to consistently separate/exclude FQHC behavioral health services from primary care services in claims.

amount owed to the provider that the plan does not cover as a consumer expense. Secondary processing may show those same amounts paid by another plan on a separate claim making it difficult to isolate which payments come out of patients' pockets. Since Medicare and MaineCare eligible beneficiaries are more likely to have supplemental policies, we focused our consumer cost-sharing analysis on commercial claims only.

After the third annual primary care spending report was submitted, legislation was passed requiring a similar report on Behavioral Health Spending in Maine (Public Law 2021, Ch 603).[15] The primary care spending and the behavioral health care spending reports will be separate reports. Note that some services provided by a primary care provider as defined by our list of taxonomy codes and/or service codes also have a primary diagnosis of Behavioral Health and therefore will be part of both calculations. In 2023, between four and five percent of commercial and Medicare primary care payments had a behavioral health primary diagnosis. The overlap between primary care and behavioral health is higher for MaineCare where 16% of MaineCare primary care payments were for a behavioral health primary diagnosis.

Claims Data Source and Method

Information for calendar years 2021-2023 from Maine's APCD maintained by the MHDO was used to calculate the claims-based portion of overall Primary Care spending and for telehealth and consumer cost-share analyses.

The Maine APCD contains claims and enrollment information for commercial insurance carriers, third-party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare, and Medicare.[§§] Only medical claims (not dental or pharmacy) were included in the total for this study.

The submission of claims data to the MHDO is governed under the terms and conditions defined in 90-590 CMR Chapter 243, Uniform Reporting System for Health Care Claims Data Sets.

As defined in 90-590 CMR Chapter 243, MHDO's APCD does not include claims information from:

- Claims processors with less than $2 million per calendar year of Maine adjusted premiums or claims processed[***];
- Claims for health care policies issued for specific diseases, accident, injury, hospital indemnity, disability, long-term care, vision [†††], coverage of durable medical equipment;
- Claims related to Medicare supplemental [‡‡‡], and Tricare supplemental; and
- Claims for workplace injuries covered by worker's compensation insurance.

The self-funded ERISA plans in Maine are exempt from the state mandate to submit information to the MHDO due to a Supreme Court ruling[§§§], but many of the largest self-funded ERISA plans in the State voluntarily submit claims data to the MHDO.

[§§] Medicare Advantage plans and regular fee-for-service Medicare are included.

[***] With the exception of self-funded ERISA plans which are not required to report but may voluntarily submit their data. *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

[†††] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.

[‡‡‡] Quality review of the data has identified the submission of some of these types of plans. We have deleted these from this analysis.

[§§§] *Gobeille v. Liberty Mutual Insurance Company*, US Supreme Court Decision that Employee Retirement Income Security Act (ERISA) standards preempt state reporting requirements.

Additionally, the APCD does not include information about Mainers who are uninsured or any health care that is not covered by insurance.

Maine's APCD is a large representative sample of data as it includes claims data for approximately 90% of Maine's insured population including 100% of Medicare and MaineCare claims for Maine members and approximately 70% of the commercially insured population in Maine.

This study used medical claims (CY 2021-2023), excluding dental and pharmacy claims. Additionally, for MaineCare total payments, long-term services and support (LTSS) are excluded based on an estimate of the percentage of total costs these services represent in each year. The MaineCare LTSS estimate used for this report aligns with the Office of MaineCare Services (OMS) definition of long-term services and supports used in their alternative payment methodology (APM). LTSS estimates were based on payments associated with the policy sections from the MaineCare Benefits Manual (MBM) noted in Table 9.[16]

Table 9. MaineCare LTSS Policy Sections

Section	Title
2	Adult Family Care Services
12	Consumer Directed Attendant Services
18	Home and Community-Based Services (HCBS) for Adults with Brain Injury
19	Home and Community Benefits (HCBS) for the Elderly and Adults with Disabilities
20	Home and Community Based Services (HCBS) for Adults with Other Related Conditions
21	Home and Community Benefits (HCBS) for Members with Intellectual Disabilities or Autism Spectrum Disorder
26	Day Health Services
29	Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
40	Home Health Services
50	ICF-MR Services
67	Nursing Facility Services
96	Private Duty Nursing and Personal Care Services
97	Private Non-Medical Institution Services (PNMI) Appendix C and F
102	Rehabilitative Services

The MHDO's APCD contains information about the payor for the health care service. This information was used to categorize claims paid for the following types of payors: commercial (excluding Medicare Advantage), MaineCare, and Medicare (including both Medicare Advantage and Fee-for-service plans). Additionally, as required by the legislation, claims for two plan sponsors were tabulated: the Maine Education Association Benefit Trust (MEABT) and the State Employee Health Commission (SEHC).

Primary Provider Identification on Claims

Medical claims contain identifiers (National Provider Identifiers (NPI)) for multiple levels of providers. To determine whether the main provider of a claim met the definition of a Primary Care Provider, the billing, servicing, rendering and operating provider NPIs s were examined to find an Individual provider and their primary taxonomy code. If all of those providers were organizations, the servicing provider was used as the main provider. The Attending provider was used separately.

For both the main provider and the attending provider, the taxonomy code (medical specialty of the provider) was determined using the primary taxonomy as identified for that NPI in a copy of CMS's National Plan and Provider Enumeration System (NPPES) database maintained in the MHDO Enclave data management system (updated 9/2024). NPPES is a free national directory of providers populated by specialty as indicated by the providers at the time of NPI registration, which providers can update at any time.[17] While the best source of specialty information available, NPPES primary taxonomy information may not be regularly updated or reflect the current primary specialty of the practicing provider, so primary care taxonomy assignments and estimates must be viewed as having a margin of error.

Primary Care identification starts with associating a claim with a taxonomy code from the provider taxonomy list in *Attachment E*. In the claims submitted to the APCD, hospital affiliated providers and FQHC/RHCs that bill on a facility claim type (UB-04) sometimes do not provide an individual rendering/servicing provider and bill for services with only the NPI of the hospital or FQHC/RHC. While we decided to include all claims (except dental) billed by an FQHC/RHC[****], we were not able to establish a reliable mechanism for identification of primary care services for claims that specified only a hospital as the main provider and did not specify an attending provider. Thus hospital-based primary care providers who bill under the hospital NPI with no individual rendering/servicing/attending information provided are not included in our primary care estimates. As a result, primary care spending estimates may be understated.

Identification of Primary Care Services by OB/GYN and Attending providers on Facility Claims

If the main provider on a claim had an OB/GYN taxonomy, or the main provider was an organization and the attending provider had a primary care taxonomy code, a set of procedure codes was used to determine whether the claim was included as Primary Care.[††††] The lists of primary care taxonomy and procedure codes were identified from other state, regional and national studies, as well as the results from the state payor questionnaires collected in prior years by MQF.

Primary care services provided in hospice, nursing and custodial care facilities were also included based on the guidance of the Advisory Committee.

Health care services provided in hospital inpatient situations, emergency departments and urgent care facilities were excluded from Primary Care as mandated by the legislation.

Identification of Telehealth Delivered Services

Claim lines associated with delivery of services via telehealth were identified using specific procedure code modifiers, place of service (POS) codes or procedure codes (HCPCS) and are shown in *Attachment E*. The costs on these claim lines were attributed to telehealth delivery. In this year's report, we analyzed telehealth services for all primary care services included in the broad definition of primary care (i.e. all services provided by Primary Care specialties outside of Inpatient or Emergency contexts, plus a specific set of services delivered by OB/GYN specialties and Attending providers with primary care taxonomy codes). This is a modified method from prior reports that included only specific primary care services (narrow definition), so results will differ from telehealth estimates previously reported.

[****] All medical care provided by FQHCs, excluding dental services, was included as primary care. Therefore, Behavioral Health (BH) services provided by FQHCs are included in primary care. While we can identify the BH services from the MaineCare claims, we could not reliably identify them in the commercial claims. For consistency, all FQHC care is included in the definition of primary care.

[††††] Inclusion of facility claims allowed for the identification of facility fees associated with primary care including hospital associated providers, who use both professional and facility claims, as well as federally qualified (FQHC) and rural (RHC) health care facilities, who use only facility claims.

Identification of Costs

As mandated by the legislation, medical and primary care costs identified in this study include payments by payors for claims incurred during the measurement year that meet the inclusion criteria identified above. For the payors that provided the information, non-claims-based payments were added to their estimates.[‡‡‡‡] The denominator, or base for the calculation of Primary Care percentage, was the sum of plan paid amounts for all medical (not pharmacy or dental) claims used in this study (see *Data Source*, above) plus non-claims based and SUD redacted amounts.

The Primary Care amount (the numerator of the percentage calculation) is the sum of the plan paid amounts on claim lines that met the definition criteria for primary care plus the portion of non-claims expenditures that went to primary care and an estimated portion of SUD redacted claims that would fall into the definition of Primary Care.

We included payor payments made for services that occurred at any time during the calendar year and paid up to at least six months after the service was provided. There is no minimum length of health insurance coverage for a member during the measurement year.

Percent of Members with Primary Care

This report updates the table showing the proportion of insured members who accessed primary care each of the last 3 years (had at least one claim with a service date in that year to a primary care provider that was not in the Inpatient or Emergency Room setting, or for one of the services performed by an OB/GYN provider or attending provider that was counted as primary care). This calculation relied on the Person ID in the MHDO APCD, which uses identification information available only to the MHDO and not made public, to assign a unique anonymous identifier to the same person across changes in coverage. The number of enrolled members by payor is the number of distinct Person IDs that had full medical insurance coverage from that payor for any month in the year, regardless of the number of months of eligibility. Maine residents may be covered by more than one insurance plan. For example, a large portion of those with Medicare also have MaineCare benefits (i.e. the dually-eligible) or commercial Medicare Supplement plans. In prior reports, insured members were counted in more than one payor category if they had primary coverage from more than one payor. For this report, assigned insured members to be only counted once per year under the primary insurer [distinct from secondary or supplemental insurance coverage] in which they were enrolled in the latest month in the year. Given this change in methods, results will differ from the prior report.

Primary Care by County and Health Insurance Rating Area

Another set of analyses breaks down primary care to the Maine county level and by health insurance rating area. As in last year's report, the overall percentage of claims-based payments going to primary care is mapped at the county level. Both the total medical amount paid by payors through claims and the amount paid to primary care providers on those claims were assigned to the county of the member's residence. This same approach was used for health insurance rating area. This report also shows how Telehealth varies by county and health insurance rating area. Both calculations exclude payments associated with members whose residence is unknown or out of state (a tiny portion of the total APCD). Neither factor in any non-claims-based payments.

Primary Care by Age

[‡‡‡‡] MaineCare non-claims-based payments included Prospective Interim and Supplemental Payments to critical access and select general acute care hospitals. These facilities are paid on a cost settlement basis and are not reflected in the APCD claims data.

New this year are two analyses of primary care by age group: primary care as a percent of total medical claims payments, and percent of members who had any primary care. Members were categorized according to their age at the end of the year. Only a tiny number of members did not have age-related information available in the APCD. The following age groups were used: 0-11, 12-20, 21-26, 27-44, 45-64, 65+.

Primary Care by Type of Provider

In an effort to understand how primary care spending is distributed across different types of primary care providers delivering primary care services, this year's report includes an analysis of primary care spending by payor by four provider groups: Physicians (MD/DO); Advanced Practice Providers (Nurse Practitioners (NP)/ Physician Assistants (PA)); Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC); Obstetrician Gynecologists (OBGYN); and Others. The type of provider was determined by the taxonomy code of the provider on the claim (see above).

Non-Claims Data Source and Method

As required by Chapter 247, *Uniform Reporting System for Non-Claims Based Payments and Other Supplemental Health Care Data Sets*, commercial and MaineCare payors are to report annually to MHDO the amounts paid to healthcare providers that are not included in claims submissions to the MHDO. "Non-claims-based" means payments that are for something other than a fee-for-service claim. These payments include but are not limited to Capitation Payments, Care Management/Care Coordination/Population Health 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, Shared-savings Distributions. Non-claims payment information, as submitted, shows the total amount as well as the amount paid for primary care and the amount paid for behavioral health care. CMS, the payor for Medicare FFS, does not submit information about payments made outside of claims.

The majority of payors (those that account for 95% of the claims-reported dollars) submit non-claims information. The primary care spending estimates include both claims and non-claims data.

Estimating primary care percent in SUD: Chapter 247 does not require payors to identify the portion of aggregated SUD redacted payments that went to Primary Care providers. To include these in the calculation, we estimated the percentage of SUD redacted claims that would also qualify as primary care, based on observation of non-redacted SUD claims submitted to MHDO by commercial payors, at 5%. MaineCare primary care percent of SUD was based on analyses of estimates observed in a limited non-redacted claims sample.

MaineCare LTSS exclusion method: MaineCare covers a broader range of services than either commercial or Medicare plans. The additional services are often referred to as LTSS (long-term services and supports). To make the MaineCare numbers more comparable to other payor types, we estimated and removed the amount of LTSS in the medical claims and in the non-claims (prior to 2023, when MaineCare submitted only non-LTSS amounts) and SUD payment aggregates. The estimates are based on analysis of other data sources and were developed with the assistance of the Office of MaineCare Services. These estimates resulted in some uncertainty in the calculation of primary care as a percent of total medical costs for MaineCare and thus are shown as a range.

Medicare estimates: Original Medicare is not subject to Chapter 247 requirements. Reported non-claims and SUD payments for the Medicare payor type reflect those reported by Medicare Advantage plans, which are operated by commercial payors. Original Medicare does not redact SUD payments; these are included in claims.

Attachment E – Primary Care Provider Taxonomy Codes, Procedure Codes for OB/GYN and Attending Providers, and Telehealth Codes in Primary Care Spending Analyses

Primary Care Provider Type Taxonomy Codes and Description

Primary Care	
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary Care Clinic
261QR1300X	Rural Health Clinic
261Q00000X	Clinic/Center when POS or bill type of FQHC
207Q00000X	Physician, Family Medicine
207R00000X	Physician, General Internal Medicine
175F00000X	Naturopathic Medicine
208000000X	Physician, Pediatrics
208D00000X	Physician, General Practice
363L00000X	Nurse Practitioner
363LA2200X	Nurse Practitioner, Adult Health
363LF0000X	Nurse Practitioner, Family
363LG0600X	Nurse Practitioner, Gerontology
363LP0200X	Nurse Practitioner, Pediatrics
363LP2300X	Nurse Practitioner, Primary Care
363A00000X	Physician Assistants
363AM0700X	Physician Assistants, Medical
207RG0300X	Physician, Geriatric Medicine
207QG0300X	Family Practice Geriatrics
207QA0505X	Family Practice Adult
207QA0000X	Family Practice Adolescent
175L00000X	Homeopathic Medicine
2083P0500X	Physician, Preventive Medicine
364S00000X	Certified Clinical Nurse Specialist
163W00000X	Registered Nurse, Non-Practitioner
163WG0000X	General Practice Registered Nurse
OB/GYN Codes[§§§§]	
207V00000X	Physician, Obstetrics and Gynecology
207VG0400X	Physician, Gynecology
363LW0102X	Nurse Practitioner, Women's Health
363LX0001X	Nurse Practitioner, Obstetrics and Gynecology

[§§§§] For OB/GYN providers only a specific set of services provided by these provider specialties are included.

Procedure (HCPCS) Codes Used for OB/GYN and Attending Providers

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
Immunizations and Injections	
90281	Immune Globulin
90287	Botulinum antitoxin, equine, any route
90288	Botulism immune globulin, human, for intravenous use
90291	Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use
90296	Diphtheria antitoxin, equine, any route
90371	Hepatitis B immune globulin
90375 - 90376	Rabies immune globulin
90384 - 90386	Rho(D) immune globulin
90389	Tetanus immune globulin
90393	Vaccinia immune globulin
90396	Varicella-zoster immune globulin
90399	Unlisted immune globulin
90460 - 90461	Immunization through age 18, including provider consult
90465 - 90466	Immunization administration younger than 8 years of age
90467 - 90468	Immunization administration younger than age 8 years
90471 - 90472	Immunization by injection/oral/intranasal route
90473 - 90474	Immunization administration by intranasal or oral route
90476 - 90477	Adenovirus vaccine
90581	Anthrax vaccine
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer,
90587	Dengue vaccine
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine
90621	Meningococcal recombinant lipoprotein vaccine
90625	Cholera vaccine
90630	Influenza virus vaccine
90632 - 90633	Hepatitis A vaccine, pediatric/adolescent dosage-2
90634	Hepatitis A vaccine, pediatric/adolescent dosage
90636	Hepatitis A and hepatitis B vaccine
90644	Meningococcal conjugate vaccine
90645 - 90648	Hemophilus influenza b vaccine
90649 - 90650	Human Papilloma virus (HPV) vaccine
90651	Human Papilloma virus vaccine
90653 - 90661	Influenza virus vaccine
90662	Flu
90663 - 90664	Influenza virus vaccine
90665	Lyme disease vaccine

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
90666 - 90668	Influenza virus vaccine
90669 - 90670	Pneumococcal conjugate vaccine
90672 - 90674	Influenza virus vaccine
90675 - 90676	Rabies vaccine
90680 - 90681	Rotavirus vaccine
90682	Influenza virus vaccine
90685 - 90689	Influenza virus vaccine
90691	Typhoid vaccine
90696	DtaP-IPV
90697	DTaP-IPV-Hib-HepB
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine,
90700	DTaP
90701	DTP
90702	Diphtheria and tetanus toxoids (DT)
90703	Tetanus toxoid adsorbed
90704	Mumps virus vaccine
90705	Measles virus vaccine
90706	Rubella virus vaccine
90707	Measles, mumps and rubella virus vaccine (MMR)
90708	Measles and rubella virus vaccine
90710	Measles, mumps, rubella, and varicella vaccine (MMRV)
90712 - 90713	Poliovirus vaccine
90714 - 90715	Tetanus, diphtheria toxoids adsorbed
90716	Varicella virus vaccine
90717	Yellow fever vaccine
90718	Tetanus and diphtheria toxoids (Td) adsorbed
90719	Diphtheria toxoid,
90720	Diphtheria, tetanus toxoids
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90725	Cholera vaccine
90727	Plague vaccine,
90732	Pneumococcal polysaccharide vaccine
90733	Meningococcal polysaccharide vaccine
90734	Meningococcal conjugate vaccine
90735	Japanese encephalitis virus vaccine
90736	Zoster (shingles) vaccine

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
90738	Japanese encephalitis virus vaccine,
90739 - 90740	Hepatitis B vaccine (HepB)
90743 - 90744	Hepatitis B vaccine
90746 - 90747	Hepatitis B vaccine
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib)
90749	Unlisted vaccine/toxoid
90750	Zoster (shingles) vaccine
90756	Influenza virus vaccine
90785	add-on code specific for psychiatric service
91300 - 91316	COVID immunization
0001A – 0004A	COVID immunization
0011A – 0013A	COVID immunization
0021A – 0022A	COVID immunization
0031A	COVID immunization
0034A	COVID immunization
0041A - 0042A	COVID immunization
0044A	COVID immunization
0051A – 0054A	COVID immunization
0064A	COVID immunization
0071A – 0074A	COVID immunization
0081A – 0083A	COVID immunization
0091A – 0094A	COVID immunization
0104A	COVID immunization
0111A – 0113A	COVID immunization
0124A	COVID immunization
0134A	COVID immunization
0144A	COVID immunization
0154A	COVID immunization
0164A	COVID immunization
Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes chemotherapy and other highly complex drug or highly complex biologic agent administration)	
96160 - 96161	Administration of health risk assessment (replaces 99420 as of 1/1/2017)
96372 - 96374	Therapeutic, prophylactic, or diagnostic injection
Non-face-to-Face Non-Physician Services	
98966 - 98968	Non-physician telephone services
98969	Online assessment, mgmt. services by non-physician
Evaluation and Management Services	
Office Visits	
99201 - 99205	Office or outpatient visit for a new patient
99211 - 99215	Office or outpatient visit for an established patient

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
99241 - 99245	Office or other outpatient consultations
Home/NH Visits	
99304 - 99310	Nursing Facility Care
99315 - 99316	Nursing Facility Care
99318	Nursing Facility Care
99324 - 99328	Domiciliary or rest home Custodial Care
99334 - 99337	Domiciliary or rest home Custodial Care
99339 - 99340	Domiciliary or rest home multidisciplinary care planning
99341 - 99346	Home visit for a new patient
99347 - 99350	Home visit for an established patient
99354 - 99359	Prolonged Service Office Visit
99360	Standby service
99367	Medical team conference
G0181 – G0182	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
S9110	Telemonitoring of patient in their home, including all necessary equipment, patient education and support
Preventive Visits	
96110	Developmental screen
99381 - 99385	Preventive medicine initial evaluation
99386 - 99387	Initial preventive medicine evaluation
99391 - 99397	Preventive medicine periodic reevaluation
99401 - 99404	Preventive medicine counseling and/or risk reduction intervention
99406 - 99409	Smoking and tobacco use cessation counseling visit (Alcohol/Substance Abuse Screening)
99411 - 99412	Group preventive medicine counseling and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
99441 - 99443	Telephone calls for patient mgmt.
99444	Non-face-to-face on-line Medical Evaluation
99446 - 99452	Interpersonal telephone/internet/EHR consultation
99487	Chronic Care Management
99490 - 99491	Chronic Care Management
99495 - 99496	Transitional care management service
99497 - 99498	Advance Care Planning
G0102	Prostate cancer screening; digital rectal examination
G0108 – G0109	Diabetes outpatient self-management training services
G2025	Payment for telehealth distant site service at RHC or FQHC only
G0406	Follow up inpatient consultation, 15 minutes with patient via telehealth

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
G0407	Follow up inpatient consultation, 25 minutes with patient via telehealth
G0408	Follow up inpatient consultation, 35 minutes with patient via telehealth
G0472	Hepatitis C antibody screening
G0475	HIV antigen/antibody, combination assay, screening
G0476	Pap test add-on
G8420	BMI is documented within normal parameters
G8427	Med review
G8482	Influenza immunization administered or previously received
G8709	Patient prescribed antibiotic
G8711	Patient prescribed antibiotic for documented medical reason
G8730 – G8731	Pain assessment documented
G8950	BP reading documented
G9903	Patient screened for tobacco use and identified as a non-user
G9964	Patient received at least one well-child visit with a pcp during the performance period
G9965	Patient did not receive at least one well-child visit with a pcp during the performance period
G9966	Children who were screened for risk of developmental, behavioral and social delays
G9967	Children who were NOT screened for risk of developmental, behavioral and social delays
Q3014	Telehealth originating site facility fee
S0610	Annual gynecological exam, established patient
S0612	Annual gynecological exam, new patient
S0613	Annual gynecological exam; clinical breast exam without pelvic
T1014	Telehealth transmission per minute, professional services billed separately
Other Primary Care HCPCS Codes (Medicare/Medicaid)	
G0008	Administration of influenza virus vaccine
G0009	Administration of influenza virus vaccine
G0103	PSA screening
G0101	CA screen;pelvic/breast exam
G0123	Screen cerv/vag thin layer
G0145	Scr c/v cyto,thinlayer,rescr
G0151	Hhcp-serv of pt,ea 15 min
G0166	Extrnl counterpulse, per tx
G0202	Screening mammography digital
G0249	Provide inr test mater/equip
G0279	Tomosynthesis, mammo
G0283	Elec stim other than wound
G0299	Hhs/hospice of rn ea 15 min
G0399	Home sleep test/type 3 porta
G0402	Welcome to Medicare visit
G0438	Annual wellness visit

Procedure Codes for OB/GYN and Attending Providers	
Procedure Codes	**Description**
G0439	Annual wellness visit
G0424	Pulmonary rehab w exer
G0442	Annual alcohol screening
G0443	Brief alcohol misuse counsel
G0444	Annual depression screening
G0447	Face to face Behavioral Counseling for Obesity
G0454	Md document visit by npp
G0463	Hospital Outpatient Clinic Visit (Medicare)
G0466	FQHC Visit, new patient
G0467	FQHC Visit, established patient
G0468	FQHC Preventive visit
G0480	Drug test def 1-7 classes
G0481	Drug test def 8-14 classes
G0483	Drug test def 22+ classes
G0498	Chemo extend iv infus w/pump
G0500	Mod sedat endo service >5yrs
G8400	Pt w/dxa no results doc
G8978	Mobility current status
G8979	Mobility goal status
G9162	Lang express current status
G9163	Lang express goal status
G9197	Order for ceph
G9551	Abd imag no les,kid/livr/adr
G9557	Ct/cta/mri/a no thyr <1.0cm
G9655	Toc tool incl key elem
G9656	Pt trans from anest to pacu
G9771	Anes end, 1 temp >35.5(95.9)
G9775	Recd 2 anti-emet pre/intraop
G9968	Pt refrd 2 pvdr/spclst in pp
G9969	Pvdr rfrd pt rprt rcvd
G9970	Pvdr rfrd pt no rprt rcvd
T1015	Clinic visit, all-inclusive(FQHC)

Telehealth Codes Included in Telehealth Analysis

Procedure Codes*	Description
2 (Place of Service)	Health services are received through Telecommunications technology
10 (Place of Service)	Telehealth Place of Service Code
FR (Modifier)	Procedure modifier
FQ (Modifier)	Procedure modifier
GT (Modifier)	Via interactive audio and video telecommunication systems
G0 (Modifier)	Procedure modifier
GQ (Modifier)	Procedure modifier
93 (Modifier)	Procedure modifier
95 (Modifier)	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
98966-98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment
99421-99423	Online Digital Evaluation and Management Services
98970 - 98972	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days
98980	Remote monitoring PLUS interacting with patient
98981	Addl time
99441-99444	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
99446-99449	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99451-99452	Interprofessional Telephone/Internet/Electronic Health Record Consultations
99457	QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan
99458	Add-on code; full additional 20 minutes for services described in 99457
0188T-0189T	Remote Real-Time Interactive Video-conferenced Critical Care Services
G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including

Procedure Codes*	Description
	telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0406-G0408	Follow-up inpatient consultation, limited, physicians typically spend [15, 25, 35] minutes communicating with the patient via telehealth
G0425-G0427	Telehealth consultation, emergency department or initial inpatient, typically [30, 50, 70] minutes communicating with the patient via telehealth
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
G0508-G0509	Telehealth consultation, critical care
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report e/m services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
G2025	Payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only
G2061-G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; [5-10, 11-20, 21+] minutes
G2252	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11–20 minutes of medical discussion
Q3014	Telehealth originating site facility fee
S9110	Telemonitoring of patient in their home, including all necessary equipment; computer system, connections, and software; maintenance; patient education and support; per month
T1014	Telehealth transmission, per minute, professional services bill separately
G0320-G0321	HH services using synchronous telehealth
G0322	Collection of physiologic data the patient digitally stores or transmits

Attachment F – Endnotes

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