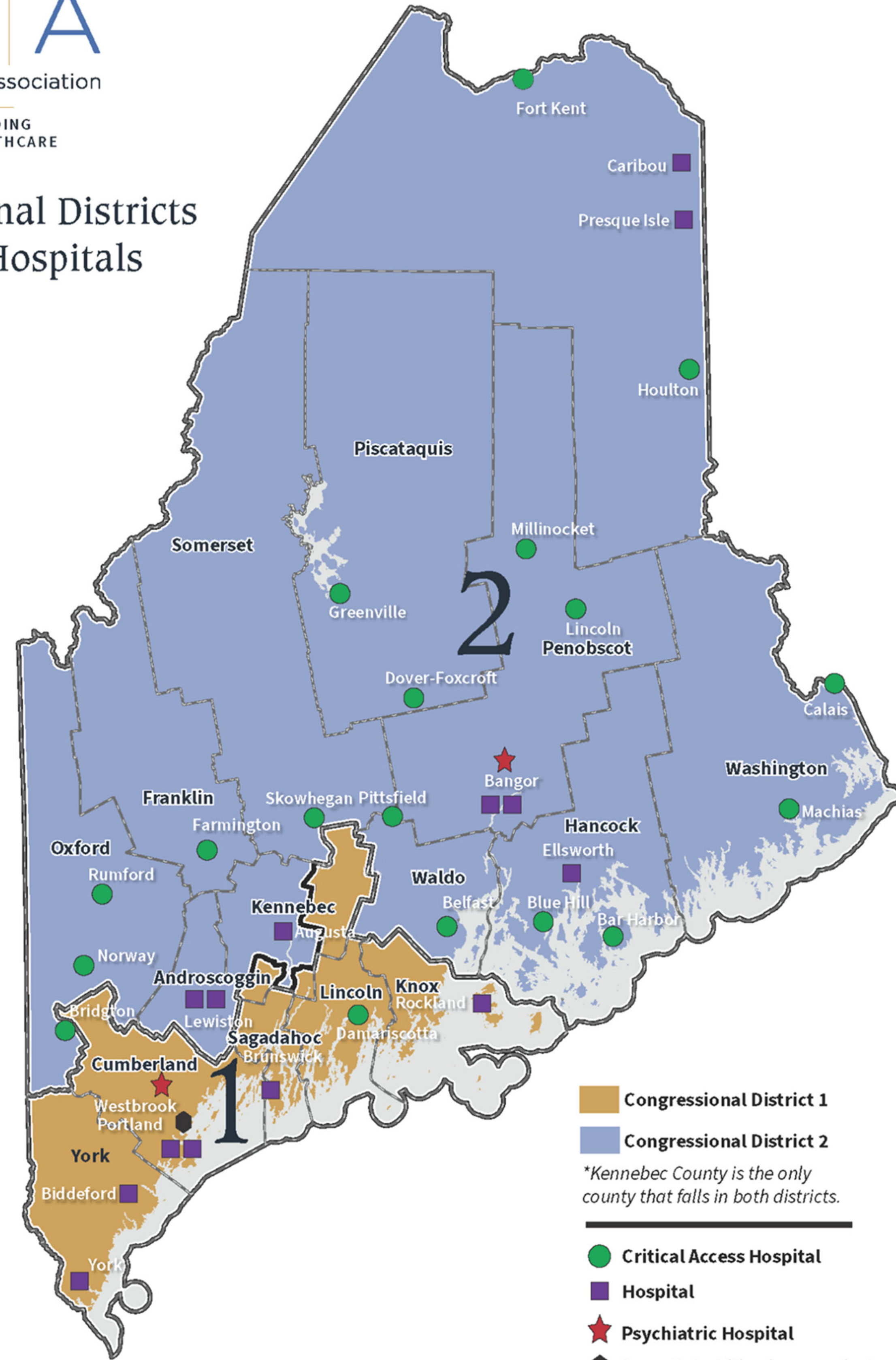
Maine Hospital Association

Federal Issues

2026

Congressional Districts for Maine Hospitals



Caring for Our Communities

Chasing Affordability

The “Internet of Things” was the phrase developed a few years ago to describe how our appliances, cars, and even the lights in our homes—everything—would be connected to the internet. And now, for better or worse, they are.

It feels as if the “affordability of things” is the phrase for 2026. Life just feels unaffordable—all of it. Housing is expensive, food is expensive, cars are expensive, and if you can afford a car, the gas, taxes, and insurance are expensive too.

And, of course, healthcare is expensive.

There is no shortage of statistics and headlines about the rising cost of healthcare. The public sees the price tag—whether it’s an insurance premium or an emergency room bill—and winces.

For hospitals, however, the price of healthcare simply reflects the sum of the input costs required to provide it. Those input costs—salaries, overhead, utilities, regulations, pharmaceuticals, and more—are also becoming increasingly unaffordable.

The challenge lies in how we describe those input costs. Is their unaffordability a “problem” to be solved?

A higher salary doesn’t feel like a problem to a nurse. Higher utility costs that support renewable energy aren’t a problem to those concerned about the environment. Additional administrative requirements aren’t a problem to the government agencies that seek more—whether in price transparency, cybersecurity preparedness, or quality data.

So if, in some sense, we value these inputs but don’t like the prices they produce, what’s to be done?

It can feel as though government has two choices: subsidize prices or cap them through regulation. Neither approach is appealing to everyone.

The federal government has pulled back somewhat on subsidies, while the state government is poised to adopt new caps on certain hospital prices. Something will have to give.

Affordability won’t mean much if the hospital doors close for good. We need better solutions.

Thank you for the work you do and the efforts you make on our behalf. We look forward to seeing you at the American Hospital Association Annual Meeting.

About MHA

The Maine Hospital Association (MHA) represents 32 community-governed hospitals in Maine. Formed in 1937, the Augusta-based nonprofit Association is the primary advocate for hospitals in the Maine State Legislature, the U.S. Congress and state and federal regulatory agencies. It also provides educational services and serves as a clearinghouse for comprehensive information for its hospital members, lawmakers and the public. MHA is a leader in developing healthcare policy and works to stimulate public debate on important healthcare issues that affect all Maine citizens.

Rural Health Transformation Fund—Maine Update

Here are some of the rural statistics that Maine included in its Rural Fund application:

- 51% of Maine residents live in rural areas;
- Median age in rural Maine is over 50 (compared to 45 statewide);
- Median income is 13% below the national average;
- One-third of rural residents are on Medicare (vs. one-fourth in non-rural areas);
- Rural residents nationally have higher rates of:
  - Heart disease and diabetes;
  - Depression and suicide;
  - Suicide and drug-related deaths
- Age adjusted mortality is 14% in rural America.
- Hospital Statistics in Rural Maine vs. S&P standards:
  - 83% are below the S&P threshold for adequate cash reserves;
  - 43% have vulnerable operating margins; 57% for total margins;
  - 74% fall below the threshold for age of plant;
  - One-fourth of rural Maine hospitals failed all four of these S&P financial benchmarks.

Maine hospitals are committed to leveraging the Rural Health Transformation Program (RHTP) to strengthen rural access, stabilize providers, and invest in workforce, technology, and population health. However, tight timelines, evolving federal requirements, and post-award policy changes are constraining the program's impact.

Maine was awarded $190 million in Year 1 funding under RHTP, with funds required to be obligated by September 30, 2026, and expended by September 30, 2027. The state's proposal is organized around five core initiatives, which are population health, workforce, technology, access, and system sustainability. Hospitals are actively identifying "shovel-ready" projects aligned with these priorities.

Maine's budget was not approved by Centers for Medicare & Medicaid Services (CMS) until February 27, 2026, delaying implementation. Since then, Maine Department of Health and Human Services (DHHS) has begun stakeholder engagement, initiated hiring, and is preparing RFPs to support program rollout. However, key program details, including project criteria and scoring, have not yet been released, limiting providers' ability to prepare.

At the federal level, CMS requirements are adding further complexity and delay. CMS has stated to ME DHHS that they require pre-approval of all contracts and consultants, creating additional administrative steps that compress an already tight timeline. More concerning, CMS made a post-award change prohibiting direct payments to providers for uncompensated care, a core component included in Maine's original proposal and critical to addressing the financial instability of rural hospitals (see next page).

These combined factors raise serious concerns about the state's ability to fully deploy funds within the required timeframe. Providers must submit proposals, undergo review, and execute agreements with the state by September 30, 2026, leaving a narrow window given current delays and federal approval requirements.

Maine hospitals remain ready to act and are developing projects focused on workforce, digital infrastructure, care transformation, and population health. However, without greater flexibility and timely guidance, there is a real risk that those hospitals that most need these funds will struggle to secure them in year 1.

The implementation window is shrinking rapidly. Additional federal flexibility, particularly around allowable uses of funds and contract approval processes, will be critical to ensuring Maine can fully utilize RHTP funding to stabilize and strengthen rural healthcare.

Direct Payments to Providers for Uncompensated Care Should be Allowed.

The original Notice of Funding Opportunity (NOFO) for the Rural Health Transformation Program explicitly allowed direct payments to providers as long as insurance was not otherwise available.

Program requirements and expectations

Use of funds

You may use funds awarded under this opportunity only for the permissible uses specified in the statute and described here. As a condition of approval, your application must reflect that you will use awarded funds to invest in at least three of these permissible uses that are described in Section 71401 of Public Law 119-21:

A. **Prevention and chronic disease:** Promoting evidence-based, measurable interventions to improve prevention and chronic disease management.

B. **Provider payments:** Providing payments to health care providers for the provision of health care items or services, subject to restrictions described in the funding policies and limitations.

The limitations were not material and readily satisfied. The primary limitation was insurability:

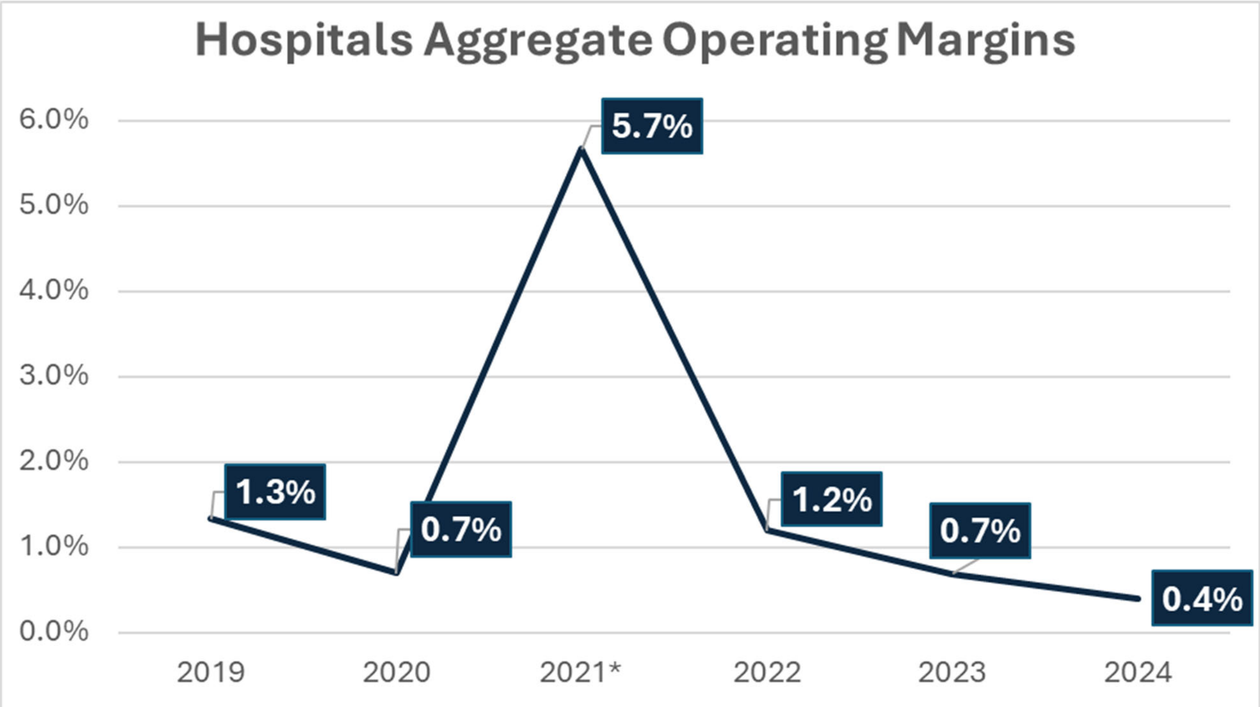
> If you plan to fund direct health care services, you must justify why they are not already reimbursable, how the payment will fill a gap in care coverage (such as uncompensated care or services not covered by insurance), and/or how they transform the current care delivery model.

Maine's initial application included funding for Direct Payments to hospitals for uncompensated care. The subsequent disallowance both surprised and greatly disappointed us. One of the original justifications for the entire fund was as an offset to some of the potential increases in uncompensated care costs at hospitals from the loss of coverage H.R. 1 might cause. **The permissibility of these payments must be restored.**

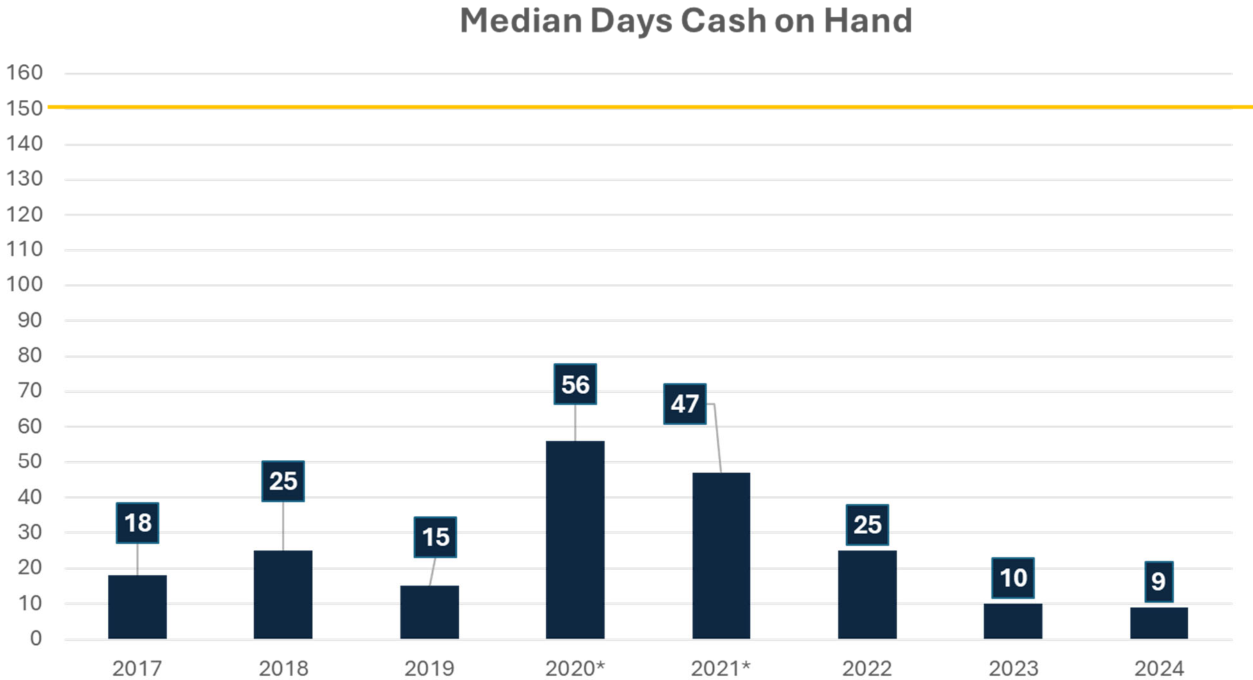
Hospital Financial Condition—Maine Update

Operating margins in Maine hospitals remain thin.

The median margin in 2024 was 0.4%. Other than the pandemic year of 2021, hospital margins continue to indicate significant financial stress.

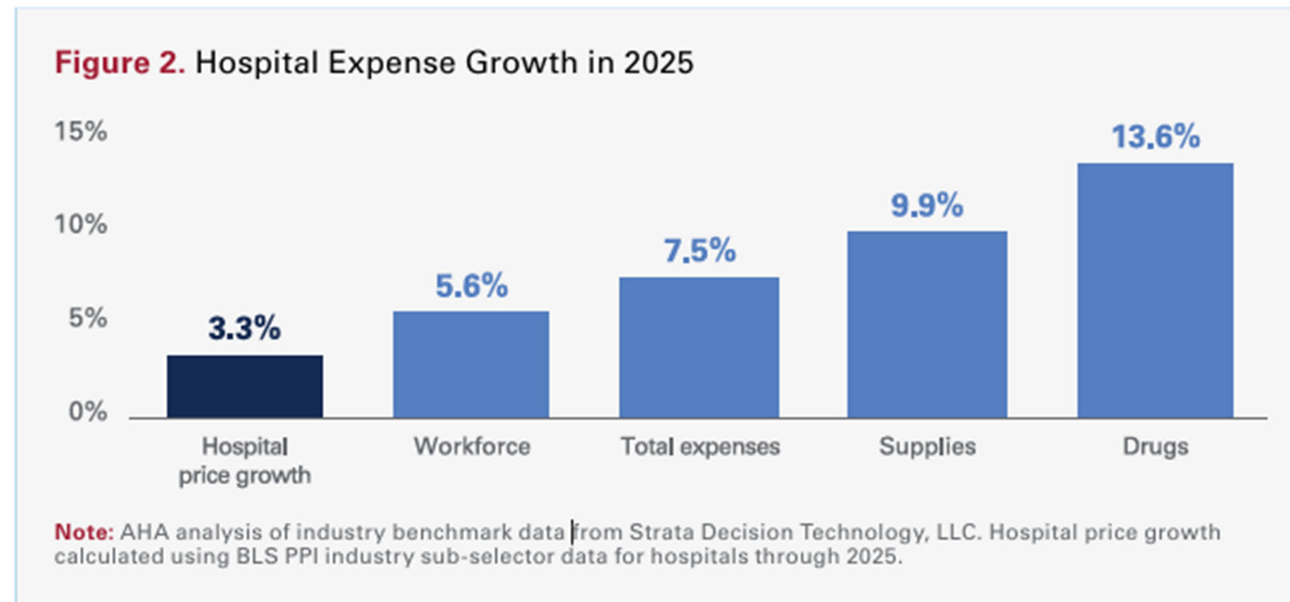


Even more troubling, the amount of cash hospitals have on hand is dwindling.

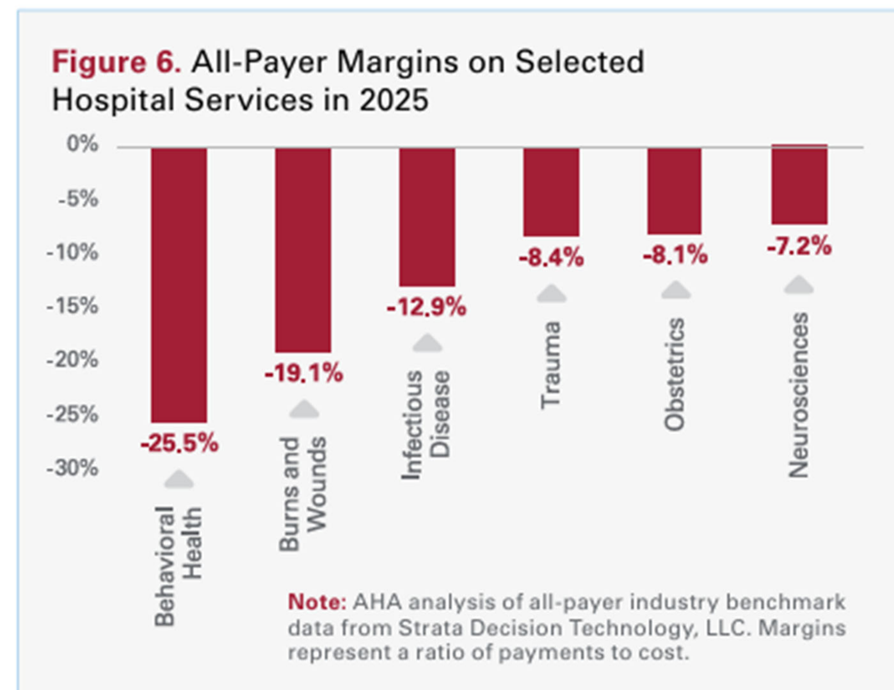


There are a few primary reasons for this continued financial difficulty. Chief among them is the fact that expenses remain high.

The American Hospital Association "Cost of Caring" report illustrates how costs are outpacing price increases.



Furthermore, there are just some services that are structurally underwater across the industry.



These are not relatively small service lines either. As AHA noted in its report, over half of hospital costs are incurred providing service lines that lose money.

Hospitals need to get both the cost structure for these services right as well as reimbursements, particularly from public payers.

The financial picture for hospitals in Maine is not going to get better anytime soon and the very hospital system itself is going to be in trouble if unnecessary losses are piled on top due to policy change.

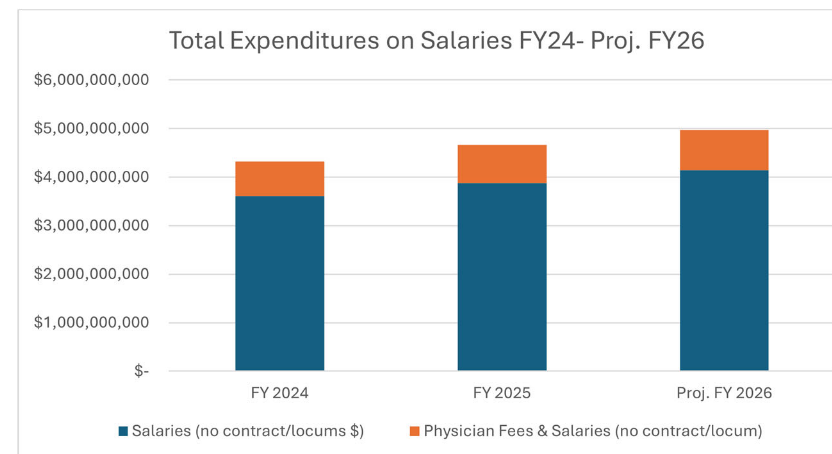
Maine's Hospital Workforce

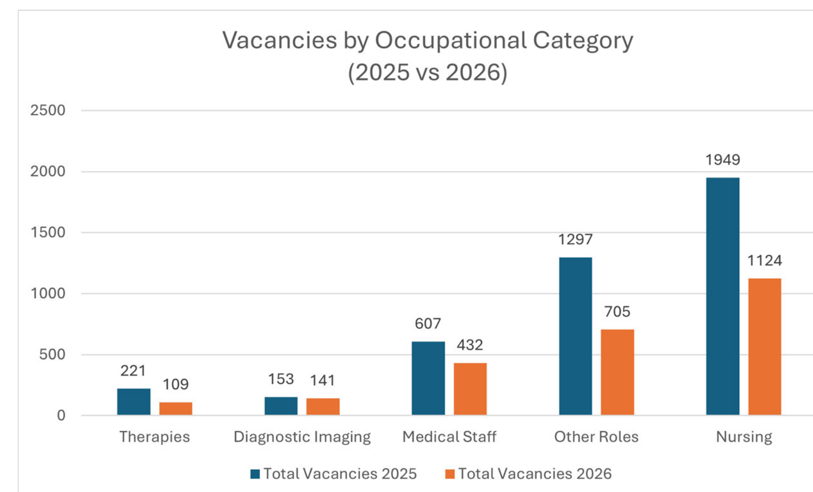
Key Takeaways

- Reported vacancies declined significantly, from 4,227 in 2025 to 2,512 in 2026 (↓40%).
- Reliance on contract/traveler staff dropped by 48%, improving workforce stability and reducing costs.
- Hospitals increased wages by ~7%, reflecting continued competition for workers.
- The statewide vacancy rate remains elevated at 14.9%, indicating ongoing workforce strain.
- Workforce aging is accelerating, with 6,322 hospital employees age 55+ (↑13% year-over-year).
- Hospitals invested nearly $13 million in workforce development in FY2025, yet demand continues to exceed supply.

Maine hospitals have made progress stabilizing the healthcare workforce following the COVID-19 pandemic. However, structural workforce shortages, an aging workforce, and constrained training pipelines continue to pose significant risks to healthcare access, particularly in rural communities.

Importantly, hospitals report that the decline in vacancies reflects both real improvements in workforce stability and changes in hiring and budgeting practices. Many organizations have implemented more rigorous internal review processes before posting positions, reduced duplicate job postings, and, in some cases, delayed or eliminated roles due to financial pressures.

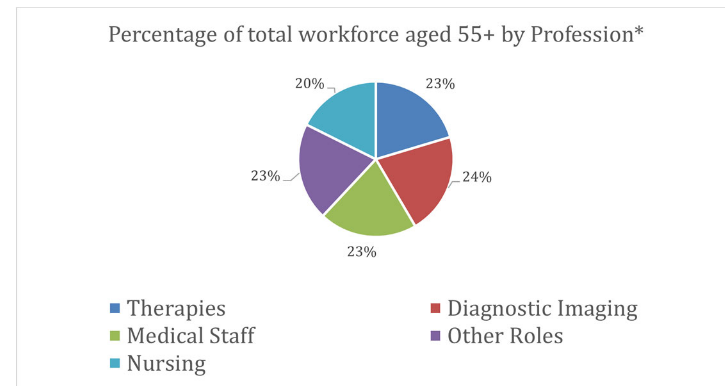


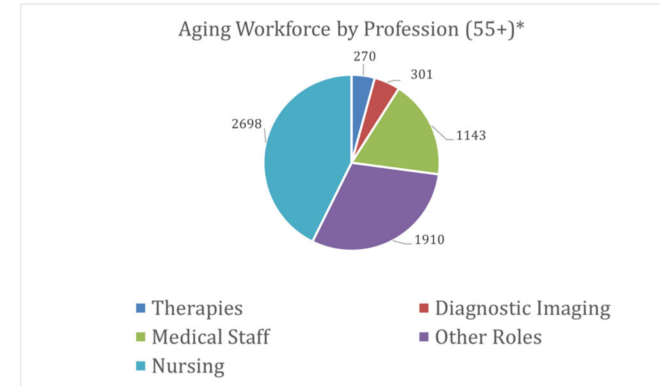


Ongoing Workforce Challenges:

Aging workforce threatens future access. Maine has one of the oldest populations in the nation—and its healthcare workforce reflects that reality.

- Over 20% of the workforce in most professions is age 55+
- More than 1,100 physicians and advanced practice providers are nearing retirement

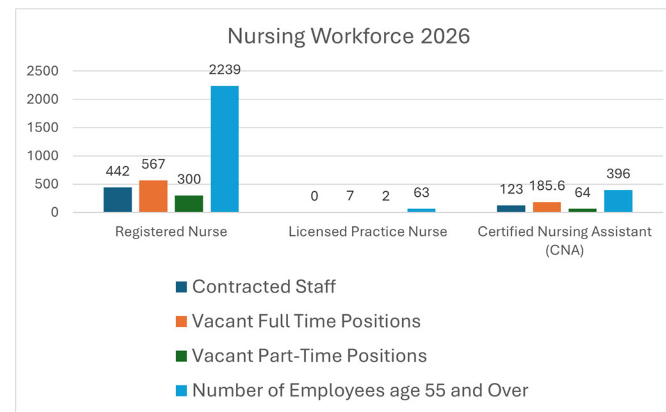


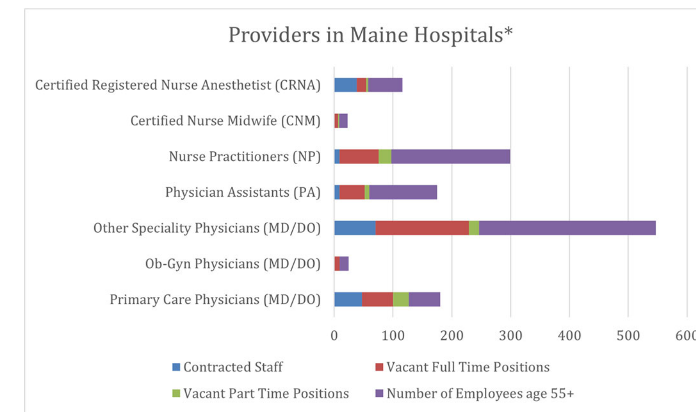


Persistent shortages in critical services.

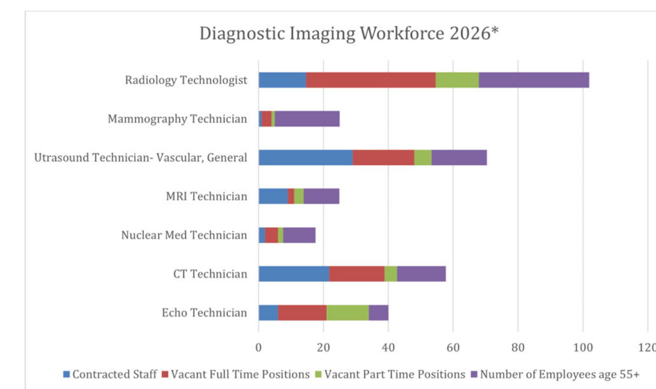
Nursing: Registered nurse vacancies declined 35%, but still represent the largest shortage category.

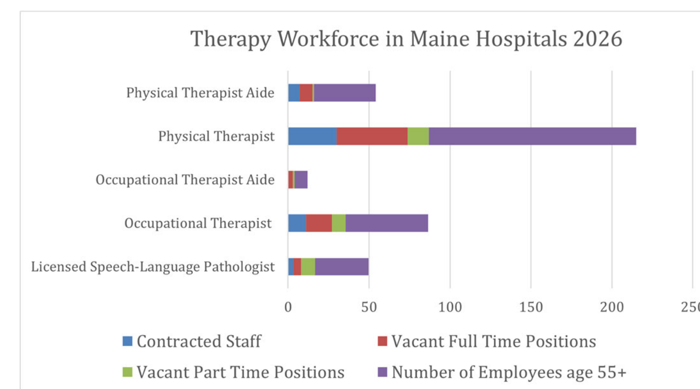
Physicians and Providers: 432 provider vacancies statewide, with persistent shortages in rural and specialty care.





Diagnostic Imaging (Emerging Risk Area): Vacancy rates as high as 38.7% (echo technicians).





Therapy Workforce: Vacancy rates remain elevated (≈9–20%) despite improvements.

Conclusion: Persistent shortages, combined with a rapidly aging workforce, pose significant long-term risks to healthcare access and system sustainability. Sustained investment in workforce development, education, and rural healthcare infrastructure will be essential to ensuring Maine's healthcare system can meet the needs of its residents in the years ahead.

Our Asks

1. No More Cuts

The first request we have is simple: please no more major cuts this year. The changes from H.R. 1 have not all been implemented yet. Some of them, like the work requirements, begin later this year.

There is discussion about another reconciliation package, particularly in light of the war in Iran. We would implore you not to let the healthcare system get used as the 'pay for' this year.

2. Protect 340B

The majority of Maine hospitals qualify for participation in the 340B drug discount program. It is a vital financial pillar keeping hospitals aloft.

The pharmaceutical industry is relentless in their attacks on the system. For example, when Maine enacted its state-level protections for hospital relationships with partner pharmacies, no less than 4 federal lawsuits were filed to stop the law (all have failed, so far).

Nevertheless, the attacks at the federal level continue, including with a proposed "rebate model" from CMS/HRSA. We would ask you to continue to protect this vital program for our members.

3. Continue to Police Medicare Advantage

Congress has begun monitoring Medicare Advantage more aggressively in recent years and we appreciate it.

We would urge you to support Medicare Advantage Prompt Pay Act (H.R.5454/S.2879) that would require clean claims to be paid in a timely fashion and require interest payments when they are not.

4. Restore Direct Payment Under the Rural Health Transformation Program

As outlined earlier in this document, direct payments to hospitals must be permitted.

5. Workforce

Maine's workforce data highlight several clear opportunities for federal action:

- Expand loan repayment and scholarship programs (NHSC, Public Service Loan Forgiveness enhancements) and modify the pace at which graduate student loans are restructured for professional degrees as implemented in H.R.1.
- Support ongoing funding for Title VIII Nursing Workforce Development Programs (HRSA)
- Develop targeted shortage designations for allied health (not just physicians)
- Increase funding for Graduate Medical Education (GME), especially rural and specialty slots
- Medicare reimbursement flexibility to support team-based care and non-traditional staffing models
- Age-friendly workforce initiatives (potential demonstration projects through CMS or HRSA)
- Expansion of Teaching Health Center GME and Rural Residency programs to pair experienced clinicians with trainees
- Waive the $100,000 fee for H1B visas for health care positions.

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2026

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Bridgton Hospital, Bridgton
Cary Medical Center, Caribou
Central Maine Medical Center, Lewiston
Houlton Regional Hospital, Houlton
MaineGeneral Medical Center, Augusta & Waterville
MaineHealth Behavioral Health, Westbrook
MaineHealth Franklin Hospital, Farmington
MaineHealth Lincoln Hospital, Damariscotta & Boothbay Harbor
MaineHealth Maine Medical Center, Portland & Biddeford
MaineHealth Mid Coast Hospital, Brunswick
MaineHealth Pen Bay Hospital, Rockport
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MaineHealth Waldo Hospital, Belfast
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Northern Light Blue Hill Hospital, Blue Hill
Northern Light C.A. Dean Hospital, Greenville
Northern Light Eastern Maine Medical Center, Bangor
Northern Light Maine Coast Hospital, Ellsworth
Northern Light Mayo Hospital, Dover-Foxcroft
Northern Light Mercy Hospital, Portland
Northern Light Sebasticook Valley Hospital, Pittsfield
Northern Maine Medical Center, Fort Kent
Penobscot Valley Hospital, Lincoln
Redington-Fairview General Hospital, Skowhegan
Rumford Hospital, Rumford
St. Joseph Hospital, Bangor
St. Mary's Regional Medical Center, Lewiston
York Hospital, York

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