Washington State Health Care Authority

Universal Health Care Commission

August 16, 2022

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

August 16, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Washington State Health Care Authority

Agenda

Tab 1

Washington State Health Care Authority

Universal Health Care Commission

August 16, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

AGENDA

Commission Members:					
☐	Vicki Lowe, Chair	☐	Estell Williams	☐	Kristin Peterson
☐	Senator Ann Rivers	☐	Jane Beyer	☐	Representative Marcus Riccelli
☐	Bidisha Mandal	☐	Joan Altman	☐	Mohamed Shidane
☐	Dave Iseminger	☐	Representative Joe Schmick	☐	Nicole Gomez
☐	Senator Emily Randall	☐	Karen Johnson	☐	Stella Vasquez

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome and call to order	1	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:05-2:15 (10 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:15-2:20 (5 min)	Approval of Meeting Summary from 7/13/2022	2	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:20-2:35 (15 min)	Public comment	3	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State
2:35-4:00 (85 min)	Report to the Legislature draft sections 5 and 7 (including FTAC materials) with Commission member feedback and discussion • For reference, section 5 can be found under Tab 5 • For reference, section 7 can be found under Tab 6 • For reference, updated FTAC materials can be found under Tab 7	4-7	Liz Arjun, Senior Consultant, Gary Cohen, Principal, and Jon Kromm, Principal Health Management Associates
4:00	Adjournment • For reference, updated section 4 can be found under Tab 8 • For reference, updated section 6 can be found under Tab 9	8-9	Vicki Lowe, Chair, Executive Director American Indian Health Commission for Washington State

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Commission has agreed this meeting will be held via Zoom without a physical location.

Washington State Health Care Authority

Meeting summary

Tab 2

Universal Health Care Commission Meeting Summary

July 13, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
3:00 p.m. – 5:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Representative Joe Schmick
Karen Johnson
Kristin Peterson
Representative Marcus Riccelli
Mohamed Shindane
Nicole Gomez

Members absent

Senator Ann Rivers
Estell Williams
Jane Beyer
Joan Altman
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 3:04 p.m.

Agenda items

Welcoming remarks

Vicki Lowe began with a land acknowledgement and welcomed members of the Commission to the sixth meeting. Vicki Lowe provided an overview of the agenda and shared the goals of the meeting.

Meeting Summary review from the previous meeting

The Commission Members present voted by consensus to adopt the Meeting Summary from the Commission's June 2022 meeting.

Public comment

Chair Vicki Lowe called for verbal comments from the public.

Cris Currie, retired Registered Nurse, suggested that fee-for-service is not the problem, and value-based payments and Accountable Care Organizations are not the solution. Cris Currie also remarked that complete patient clinical data must be accessible to clinicians and qualified researchers and shared Talking About Single Payer, p. 87-105 for more detail.

Kelly Powers, a Cascade Care enrollee, asked to clarify which federal Medicaid state plan is being referred to on pg. 43 of today's meeting materials and how it differs from the current state plan. Kelly Powers also encouraged the Commission to explore the Veterans Affairs and Indian Health Services single-payer systems.

David Loud, Co-chair of the steering committee of Health Care as a Human Right Coalition, stressed the importance of understanding the following: how cost savings proposals affect everyone's costs, including Medicare beneficiaries; how those proposals do or do not serve the goals of improving quality and reducing inequities; how state policy may affect federal programs; and that people must be consulted before changes to benefits are made.

Maureen Brinck-Lund, Health Care as a Human Right, suggested that a date certain be set for creating the finance technical advisory committee. Maureen Brinck-Lund also suggested engaging community members and advocates who will be end users of the system to provide their insights in the creation of a finance committee.

Marcia Stedman, volunteer and board member, Health Care for All Washington, shared that equity and efficiency are directly related. A more efficient system will help remove existing barriers and improve access. In a democracy, decisions about health care must be made by people. Public input on system design is crucial to building a system in which people can trust, and governance should include a mechanism for public feedback.

Debby Jackson asked about the implications of the Whole Washington initiative passing, and how the Commission and Whole Washington would interact. Mandy Weeks-Green, Coverage and Market Strategies Manager, HCA, coordinated with Debby Jackson to provide more information on this topic.

Pamela Dalan, Registered Nurse, expressed opposition against value-based payments, suggesting that value-based payments financially penalize physicians and hospitals who deliver evidence-based care.

Presentation:

Liz Arjun, Gary Cohen, and Jon Kromm, Health Management and Associates, shared section 2 and section 6 of the draft report. Section 2 covered proposed strategies for developing implementable changes to Washington's health care financing and delivery system. Section 6 covered transitional solutions to help move Washington to a universal health care system, including the establishment of a finance technical advisory committee.

HMA shared actions the Commission could take in the short-term, mid-term, and long-term in transitioning to a model for implementation. In the near term, the Commission could focus on establishing a financing technical advisory committee (FTAC) to carry out the initial exploration and details of models. HMA shared considerations for the creation of FTAC.

As directed by the Commission, FTAC would provide guidance to inform Commission decision-making and recommendations. FTAC roles and meetings were also outlined. Meetings would meet between Commission meetings for 2 hours on a bi-monthly basis over 2 years.

The opportunity to apply for FTAC membership would be shared through a GovDelievery announcement and posted to the Commission's webpage for 60 days. The Commission would appoint 7 members, including 1 consumer representative, and if possible, 1 member from the Office of Financial Management and 1 member from the Department of Revenue. FTAC applicants should hold subject matter expertise in health care financing and/or revenue.

Commission Member Discussion

Rep. Joe Schmick asked whether FTAC members from the Office of Financial Management and the Dept. of Revenue were already chosen. It was clarified that these members have not yet been chosen and that backgrounds in these areas, rather than specific individuals, are the focus of the recommendation.

Kristin Peterson asked for clarification on the duration of each phase (short-term, mid-term, and long-term) in the proposed strategy timeline. It was clarified that the timeline and duration of each phase is fluid and that there may be some overlap.

Bidisha Mandal asked whether FTAC will be established in time for the Commission's report to the Legislature. It was clarified that FTAC will likely not be fully formed in time for full consideration of the first report due in November. Bidisha Mandal also suggested that cost containment should be included in foundational decisions.

Dave Iseminger added that cost containment permeates foundational decisions as well as secondary and tertiary decisions.

Kristin Peterson suggested that discussions around coverage should also include workforce and that the Commission should consider developing a means of monitoring progress on meeting milestones.

Karen Johnson suggested that FTAC receive an overview of the urgency of this work as well as the current state and build in time for discussion on how to frame the foundational, secondary, and tertiary design elements.

Representative Joe Schmick asked for clarification of how FTAC would arrive at recommendations regarding the foundational decisions. HMA clarified that FTAC would provide the Commission a range of different options for the foundational decisions, likely with pros and cons for each.

Nicole Gomez asked about the feasibility of breaking FTAC into subcommittees based on subject matter expertise as opposed to having one large group. This more granular approach was successful in Oregon.

Chair Vicki Lowe suggested that copays should not be a cost containment strategy or a part of the universal financing system.

Karen Johnson suggested embedding quality and accountability into the foundational design elements.

Rep. Marcus Riccelli added that the discussion around cost containment is a political one, so cost feasibility should also be added to the foundational decisions.

There was a consensus that cost containment should be a foundational decision rather than a secondary decision. Additionally, for a simpler way to understand the relationship between the Commission and FTAC, the Commission will develop the "what," and, as directed by the Commission, FTAC will develop the "how."

HMA presented transitional solutions (section 6) to help improve affordability, access, and quality as Washington transitions to a universal health care system. The Commission has previously discussed measures that may expand coverage for currently uninsured individuals. The Commission has also discussed potential strategies to improve affordability including further aligning existing public coverage programs, establishing a broader set of health care cost targets, and implementing the Integrated Eligibility and Enrollment Modernization Roadmap.

HMA asked the Commission to consider additional opportunities to improve affordability, expand coverage, and quality of coverage through current state programs and markets.

Commission Member Discussion

Rep. Joe Schmick noted that there may be opposition by Washingtonians to paying for some of the current measures to expand coverage.

Rep. Marcus Riccelli noted that individuals without coverage or who are underinsured have to resort to using the emergency room as their source of health care, which is costly. Rep. Marcus Riccelli mentioned the value of reexamining the uninsured population in Washington and getting a better understanding of the costs to the health care system of underinsurance/uninsurance.

Dave Iseminger expressed interest in exploring further consolidating participation within the large commercial government-run pooled purchasing programs (PEBB and SEBB) by other parts of government who are not currently participating in the pool as a transitional path toward universal coverage.

Rep. Marcus Riccelli also expressed interest in leveraging the PEBB and SEBB programs a short-term step to reducing costs and expanding coverage. As much as possible, we should also align current state programs to make transitions between coverage sources integrated and consumer friendly.

Nicole Gomez added that leveraging PEBB and SEBB would also immediately increase the risk pool and reduce costs for public employees. Nicole Gomez added that efforts to streamline current state programs aligns with the Commission's authorizing legislation.

Karen Johnson posed ideas for how to incentivize individual healthy behaviors in order to reduce costs.

Bidisha Mandal posed exploring ways to improve Medicaid reimbursement rates to better serve individuals who are insured but experience barriers in access to care due to low provider participation in Medicaid. Per legislation, the Commission must explore pathways to increase Medicaid provider reimbursement. The Commission will receive a presentation on this topic at their next meeting.

Commission members were asked to consider IT and data infrastructure necessary to perform reimbursement under the universal system as well as to unify administrative processes.

Commission Member Discussion

Currently, the state does not have universal interoperability for all health records. Karen Johnson stressed the importance of developing data and IT infrastructure to support a universal electronic medical record system in order to support the goals of the Triple Aim (improving care quality, improving population health, and reducing per capita costs of care).

Mohamed Shidane emphasized the importance of keeping the patient at the center of developing data and IT infrastructure, as well as for integrating current state programs and sources of coverage as the state transitions to a universal system.

Chair Vicki Lowe noted that the current system is built around payments and as we move toward a more patient-centered system, perhaps the system's various EHR systems and IT infrastructures will follow.

HMA will take the Commission's comments and ideas and incorporate them into the report drafts. HMA will then poll Commission members at the August meeting for concrete recommendations for the report to be finalized in October.

Adjournment

Meeting adjourned at 5:00 p.m.

Next meeting

August 16, 2022
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

Public comment

Tab 3

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received From June 30th

Written Comments Submitted by Email

Additional Comments Received at the July 13th Commission Meeting

- The Zoom video recording is available for viewing here: https://www.youtube.com/watch?v=zE6yPf6rm2g

Public comments received since June 30th through the deadline for comments for the August meeting (August 2nd)

Submitted by Kelly Powers

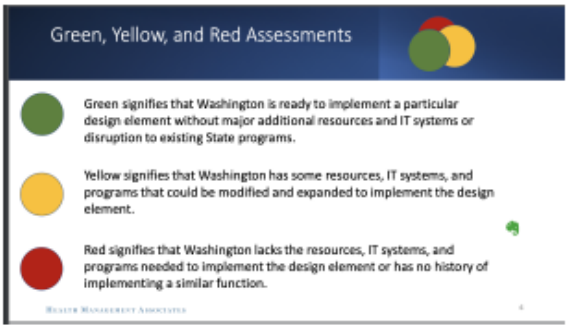
7/6/2022

Proposal: Alternatives for Communicating System Design Analysis

Dear UHC Commission Members,

After watching the June16th UHC Commission meeting, the progress and discussion among Commissioners is very encouraging. A lot of important considerations were raised by Commission members.

Like several others who mentioned it in the public comments, I am also concerned about using the Red, Yellow and Green stoplight system for analyzing the key design elements appearing in any report.

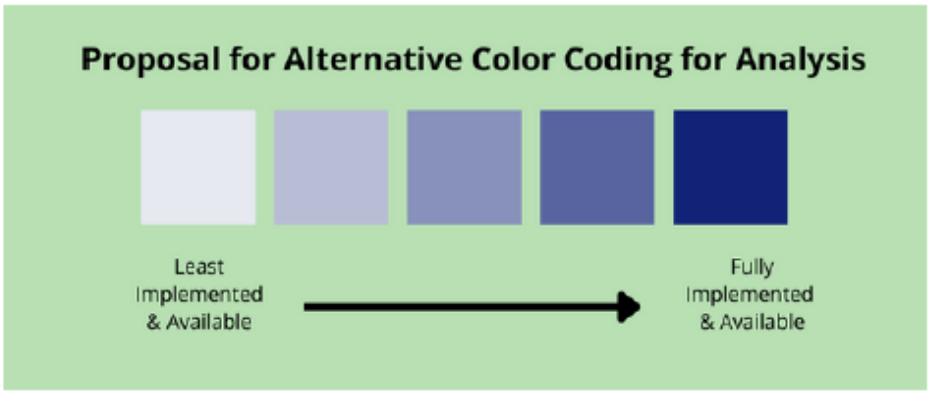


It may seem like a small detail, but in our culture, Red means STOP, Yellow means Slow Down and Green means Go. Just by using the visual it communicates those messages. The consultants did explain the coding during the June UHC Commission meeting, but they won't be there as the legislators and the Governor, and staff read the report. **The visual is so powerful that even explaining it in writing before using it won't be enough to overcome the impact.**

Wouldn't it be more useful to adopt a different system that doesn't require an explanation and avoids that cultural baggage that works on a subliminal level?

Below are a couple of suggestions that are derived from system design methodology. Both options emphasize incremental change and defining what is possible at each step.

PROPOSAL 1: COLOR or GRAY SCALE GRADIENT
Provides a little more nuance as to the preparedness level, and avoids the cultural bias. Shows progress is possible, and can be defined at each step as the design progresses.



PROPOSAL 2: CRAWL, WALK, RUN, FLY MODEL

It is inspired by Rev. Martin Luther King, Jr.'s famous quote:

This method provides a realistic, structured, phased approach that propels an organization to focus, respond to feedback, and improve – keep moving forward.

For example Data Integration. From what we learned in the June Commission meeting, it seems fair to say that WA's data integration is currently CRAWLING because of dozens of fragmented, silo-ed systems.

This system gives the Commission members an opportunity to flesh out what the next steps/transition might look like. For this data integration example:

Walking might look like – PEBB, SEBB, Medicaid and ACA Marketplace data are integrated
Running might look like – Medicare data and various other public databases folded in
Flying might look like – All health care data public and private would be integrated and accessible

Thank you for considering! Communication is crucial to the successful reception of the Commission's proposals.

Thank you for considering these ideas for improving the final report due in November.
Kelly Powers

Submitted by Valerie Luongo

7/13/2022

To Whom It May Concern:

I have missed the deadline to be able to give my comments orally, so I am emailing them to you instead.

My sister and I moved to Washington a few years ago from Southern California and bought a home in the 98577 zip code. At the time, we were both covered by Kaiser Permanente.

When we moved, we were told by Kaiser that we would be covered in WA State. Unfortunately, we learned a different reality. In Washington state, Kaiser qualifies people by their zip code. So, we are unable to have Kaiser as our provider, even though we are perfectly willing to drive the hour and a half to Olympia to get health care.

We live in rural Pacific County where the choices for quality health care are slim to none. I don't know why or what mechanisms are in place that prevents Kaiser from offering their services to anyone in Washington that is willing to drive to them, but it would be of great service to everyone to remove whatever barriers exist that prevent it.

In addition, I am now on Medicare and am unable to sign up for no or low-cost Medicare Advantage plans where I live because they are not offered in Pacific County, and I am left with only Medigap choices at much higher premiums. This is a complete mystery to me as to why Medicare Advantage plans are not offered in our County.

We are completely in favor of Universal Health Care. We would absolutely love to be able to have Kaiser as our provider, no matter the drive.

I look forward to hearing positive news from your committee in the very near future.

Thank you for the opportunity to express our thoughts and concerns.

Valerie Luongo

Lebam, WA 98577

Submitted by Cris Currie

7/13/2022

UHCC:

Here is my July comment for the Universal Health Care Commission.

Fee for Service (FFS) is not the problem and Value Based Payments (VBP) and Accountable Care Organizations (ACOs) are not the solution. For decades insurance companies have claimed, without proof, that paying physicians by FFS is the cause of out of control prices because if physicians are paid for quantity, they will just provide more to make more money. While this may be somewhat accurate to a small extent, it is certainly not the cause of the highest administrative healthcare costs in the world. VBP seeks to treat this misdiagnosis and reduce costs by reimbursing for value, a vague, poorly defined mixture of low cost, high quality, and improved health, about which very little data has ever been collected. Since the latter two are difficult to measure, cost has become the primary focus. However, this overemphasis on cost and provider risk sharing has led medical practice down the path of cherry-picking and lemon-dropping patients, rushed exams, overwhelming needless paperwork and administrative complexity involving *higher* costs, inappropriate algorithmic treatment protocols, higher death rates, and much higher rates of resentment and burnout among practitioners to which I can personally attest.

A better system would be to return to the far simpler, cheaper FFS, but with a better quality improvement process focused on safety. Defining and measuring the harms from which a patient must be protected can be used as one measure of success. Critical to this system is a universal, open-source, accurate and complete Electronic Medical Record designed for clinical data collection as opposed to the disastrous proprietary systems like Epic and Cerner that are designed primarily for insurance billing. The VA has used such a system for many years with high practitioner satisfaction. Called VistA, it could be updated and modified for broader use. The Chesapeake Regional Information System for Patients in Maryland (CRISP) is another example of a current system with promise. Regardless of the software, complete clinical data on every patient must be accessible to any qualified clinician and researcher so that a full written history is always on the platform, and true best practices can be studied, tabulated and made readily available. Doctors (the vast majority of whom truly want to provide the best, cost-effective services possible), will be able to monitor how well they do in actual care. This will truly increase safety and quality while improving results and reducing costs. Please see James F. Burdick, Talking About Single Payer, p. 87-105 for more detail. Thank you.

Cris M. Currie, RN (ret.) Mead, WA

Submitted by Sarah Weinberg

7/13/2022

Dear UHCC Members:

Let's focus on the word "cost".

"Cost" is an important part of creating a state universal health care system, but the word means different things in different contexts. Some examples:

- Actual cost of providing a given service
- Actual cost of producing a given object (like a drug or device)
- Cost of administering a program
- Out-of-pocket cost for a patient receiving health care services
- Cost of running a medical practice or a hospital

So when we talk about "reducing costs" we need to be careful to specify which costs and what other effects occur as a result. In creating a universal health care system, the goal is to save some costs by pooling resources, simplifying administration, and regulating payments. The goal is to pay the costs of providing high quality health care to each state resident as needed, while spreading the payment for those costs fairly across the entire population.

The UHCC should focus on costs borne directly by patients, as many studies have shown that such cost burdens reduce necessary care at least as much as unnecessary care – a penny-wise and pound-foolish approach when patients' care costs more when they are sicker due to skipped earlier care.

On the other hand, experience in other wealthy nations shows that simplified administration of a unified system would cut costs in the U.S. dramatically.

Remember, the focus of a universal health care system is first and foremost on each patient's needs. After all, sooner or later, we will all be patients.

Sarah K. Weinberg, MD

Retired pediatrician

Mercer Island, WA 98040

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Washington State Health Care Authority

Provider Rates and Finance Technical Advisory Committee

Tab 4

Washington Universal Health Care Commission

Liz Arjun, Senior Consultant - HMA
Gary Cohen, Principal - HMA
Jon Kromm, Principal - HMA

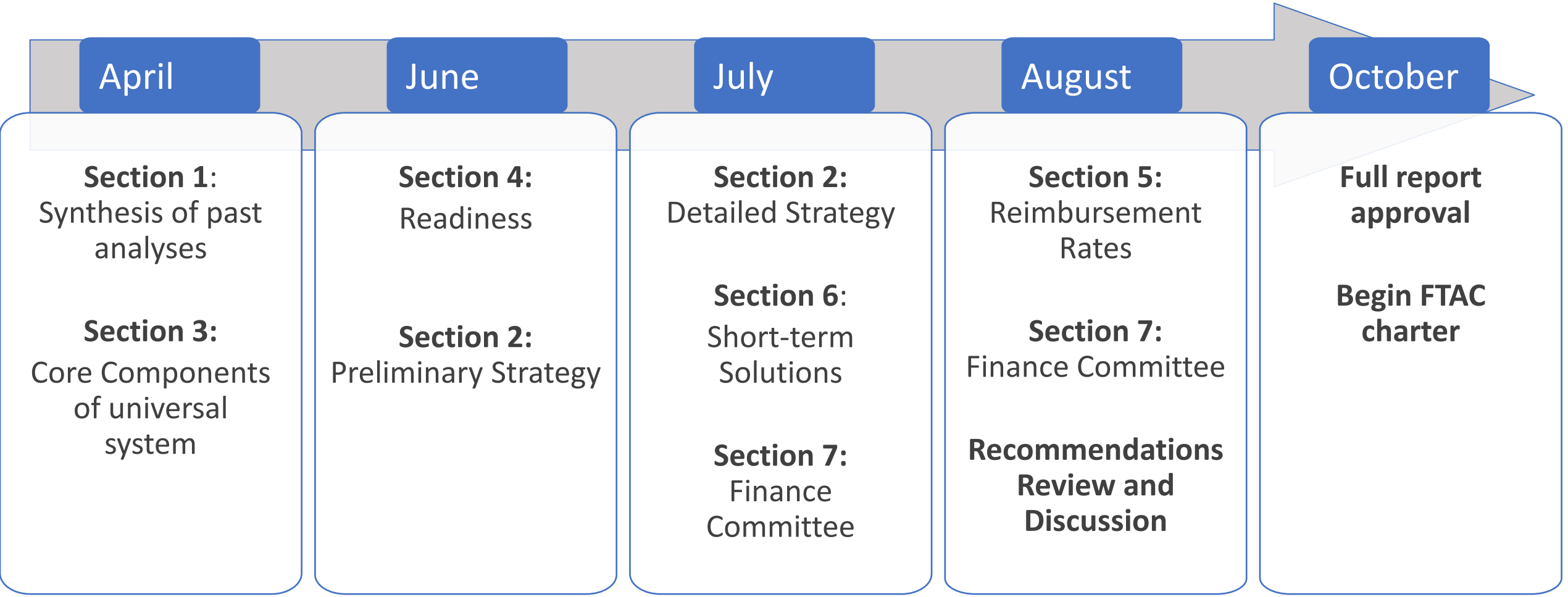
Presentation to the Universal Health Care Commission

August 16, 2022

Agenda

- Timeline
- Goals for Today
- Section 5:
  - Apple Health Provider Rates
  - Discussion
- Recommendations for Consideration:
  - Strategy for the work ahead
  - Establishment of Finance Technical Advisory Committee (FTAC)
  - Transitional Solutions
  - Apple Health Provider Rate Increase
- Next Steps

Report Development Timeline



Today's Goals

1. Learn and discuss options for an Apple Health provider rate to 80% of Medicare.
2. Gather opinions from Commission members about proposed recommendations to include in the legislative report:
   - A strategy for future Commission work to design a universal health care system.
   - Establishment of the finance technical advisory committee.
   - Transitional solutions that move Washington further towards a universal health care system.
   - Pathways to Apple Health provider rate increases.

Section 5: Medicaid Provider Rates and Potential Pathways to Increases as Directed by the Legislature

Background on This Request

Why is the Commission being asked to explore how to get to Medicaid rates that are no less than 80% of Medicare?

- This request was an amendment offered in the House (SB 5399, 2021).
- Increasing Medicaid provider payment may increase provider participation and improve access to care.
- This could be a transitional strategy for making immediate and impactful changes in the current health care system to increase access to quality, affordable health care.

Understanding Medicaid Payment Rates in Washington

- There are two Medicaid payment structures:
  - Fee-For-Service (FFS): Providers are paid directly for each covered service received by a beneficiary.
  - Managed Care: Comprehensive benefits provided through Managed Care Organizations (MCOs) who receive a capitated payment to provide services.
- Medicaid has the lowest payment rates of any payer.
- In Washington, Medicaid rates are on the average 71% of Medicare across all services and 65% for primary care.[1]
- Medicaid payment rates have not kept pace with the cost of services over the last 10 years.[2]
- There have been several legislative efforts to increase Medicaid payment rates.

1. Kaiser Family Foundation, 2016
2. During the COVID-19 pandemic and public health emergency, federal matching for Medicaid programs has increased by 6.2%. Prior to the pandemic, the federal matching rate in Washington was 50%.

Impacts of Rates on Provider Participation

Exhibit 1: Impact of Rates on Physicians Accepting New Patients by Coverage Type, 2014-15

Specialty	Medicaid	Medicare	Private insurance
Total	**70.8%**	**85.3% ***	**90.0% ***
General/family practice	68.2	89.8 *	91.0 *
Pediatrics	78.0 ǂ	32.8 *	91.3 *
General surgery	88.4 ǂ	99.0 *	92.4
Obstetrics and gynecology	81.1 ǂ	87.9	92.9 *
Psychiatry	35.7 ǂ	62.1 *	62.2 *

Additional Impacts

- Less likely to accept new patients with Medicaid than new patients with Medicare or private insurance (Exhibit 1).
- Low payment rates relative to other payers cited as being the most important factor affecting the decision to participate in Medicaid.[1]
- Physicians in states that paid above the median Medicaid-to-Medicare fee ratio accept new Medicaid patients at higher rates compared to states that pay below the median. [2]

1 Health Care Authority Report to the Legislature. December 1, 2028. Enhancement of Primary Care Access for Medical Assistance Clients ESSB 6032.
2 Median ranges from .66-.72. Acceptance rates increased by .78% for every percentage point increase in the fee ratio. Health Affairs, 2019

Payment Rate Modeling

- In 2022, HCA analyzed the fiscal impact of increasing Medicaid rates to 80% of Medicare.
- The following challenges are associated with implementing increased rates:
  - Difference in the respective payers' case mix.
  - Difference in payment methodology.
  - Some services covered under Medicaid are not covered by Medicare.

State Fiscal Year 2023	
State Impact (GSF)	$ 271 million
Total*	$ 864 million

**Ratio of Medicaid to Medicare (71%) based on a 2016 report published by the Kaiser Family Foundation.*
**Expenditure amounts were based of Fiscal Year 2023 projected costs.*
**Including additional federal contributions for physical health services only, with some exclusions.*

Pathways

Increasing **all** Medicaid rates to 80% of Medicare would cost the state an additional $271 million/year in GSF spending.

- State funds would be matched with federal funding.

Transitional Options:

- Increase adult primary care rates to match pediatric primary care rates.

- Increase behavioral health rates not included in recent legislative behavioral health rate enhancements.

Primary Care Current Rates

Adult Primary Care

- Current rates average approximately 67% of Medicare

Pediatric Primary Care

- Current rates average approximately 80% of Medicare

Primary Care Option

Adult Primary Care

Enhance rates to match pediatric rates

- Eliminates the need for two separate fee schedules
- Reduces provider confusion
- Reduces administrative waste
  - ➢ Time and costs

Also:

- Matching adult and pediatric primary care payment rates works toward achieving goals of a universal health care system
  - ➢ Reduction in administrative complexity and waste
  - ➢ Health equity
    - Improved access to care
    - Increased provider rates

Behavioral Health

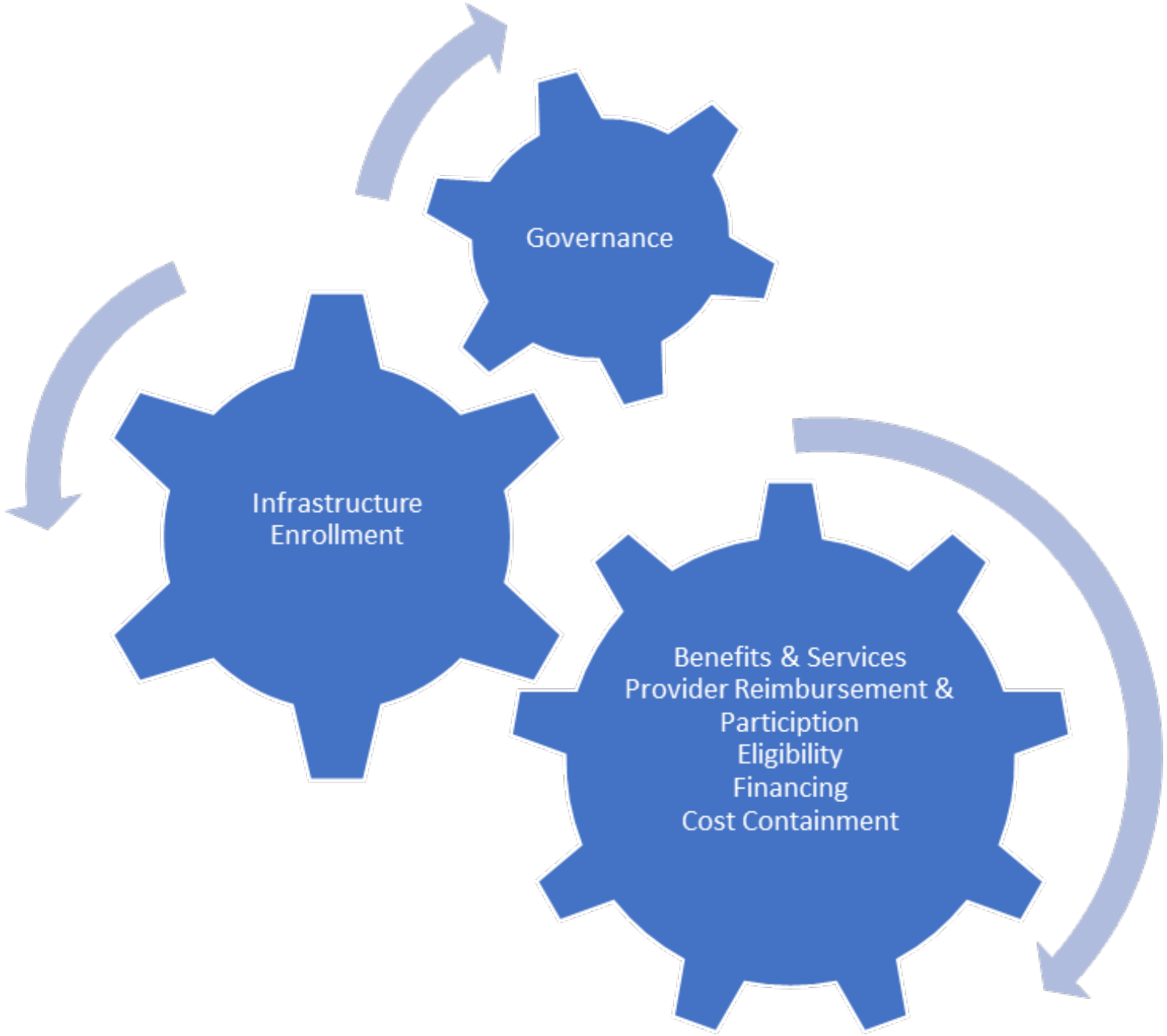
Behavioral Health

Increase behavioral health rates not included in recent legislative rate enhancements.

- Fee-for-service
- Behavioral health services not included in recent legislative rate enhancements

Recommendation #1: A Proposed Strategy for the Work Ahead

Prioritize Foundational Decisions



Recommendation #1: A Three-Phase Strategy

The Universal Health Care Commission recommends a three-phase strategy to move forward on the pathway to a universal healthcare system

Phase 1: Gather information on and offer direction focused on foundational components that underpin the design of a universal healthcare system including:

- Eligibility
- Benefits and services
- Provider Reimbursement and Participation
- Cost containment elements
- Financing

Phase 2: Evaluate and consider core components to operationalize and implement the system design including:

- Establishing the infrastructure to implement these components of a universal healthcare system
- Developing an enrollment system that allow Washingtonians to opt into the system

Phase 3: Offer direction to the Legislature about components related to governance and oversight of the system.

Recommendation #2: Establishment of the Finance Technical Advisory Committee

Finance Technical Advisory Committee (FTAC)

Create a finance technical advisory committee (FTAC) to provide subject matter expertise and advise the Commission on the development of a financially feasible model to implement a unified health care financing system.

FTAC Questions

1. Is 7 the right number of FTAC members?
2. What kind of guidance from FTAC would be most helpful?
   - Option based with pros and cons?
   - Reach consensus? Or come with a diversity of opinions?
3. Would the Commission like a recommendation regarding FTAC applicants?

Recommendation #2: Establishing the FTAC

The Commission recommends establishing a Finance Technical Advisory Committee that will support the work of the Commission. This work will be directed by the Commission and may include the following activities **as directed by the Commission**:

- FTAC may provide guidance for the system design framework, including eligibility, benefits and other services, and needed core operational and implementation components.
- FTAC may investigate and provide guidance on ways to reduce the underlying cost of health care.
- FTAC may investigate and provide guidance on how health care services will be paid in a uniform financing system, including alternative payment methods to fee-for-service and risk-bearing arrangements.
- FTAC may provide guidance on sources of revenue to replace premiums and co-pays in a universal health care system with a uniform financing system.

FTAC VOTE

Does the Commission vote to establish a Finance Technical Advisory Committee to support the work of the Commission?

Recommendation #3: Transitional Solutions

Identified Options for Transitional Solutions

The Commission has discussed measures that would expand coverage for currently uninsured individuals:

- Establishing a sustained funding source for the new coverage solutions being implemented for individuals without federally recognized immigration status will ensure long-term coverage for a key uninsured population.

- Implementing the Cascade Care Savings program that may make coverage more affordable for some uninsured individuals currently eligible to purchase QHPs.

Recommendation #3: Transitional Solutions

The Commission recommends transitional solutions that support goals of universal coverage including enrollment options, eligibility systems, access to care, quality improvement and increased equity including:

- **Align Current Coverage Programs:** State-run public programs (Medicaid, Exchange, PEBB/SEBB) should align to the greatest extent possible with respect to the following areas:
  - Benefits
  - Quality standards
  - Networks
  - Payment structures
- **Enhance Available Coverage:** Funding programs for those currently uninsured and underinsured
- **Initiate Components of Needed Infrastructure:** Implementing the Integrated Eligibility and Enrollment Modernization Roadmap to advance the State's technology infrastructure readiness
- **Initiate Federal Discussions on Options:** Explore with the federal government opportunities for inclusion of Medicare and Self-funded ERISA plans in the uniform financing system

Recommendation #4: Apple Health Provider Rate Increase

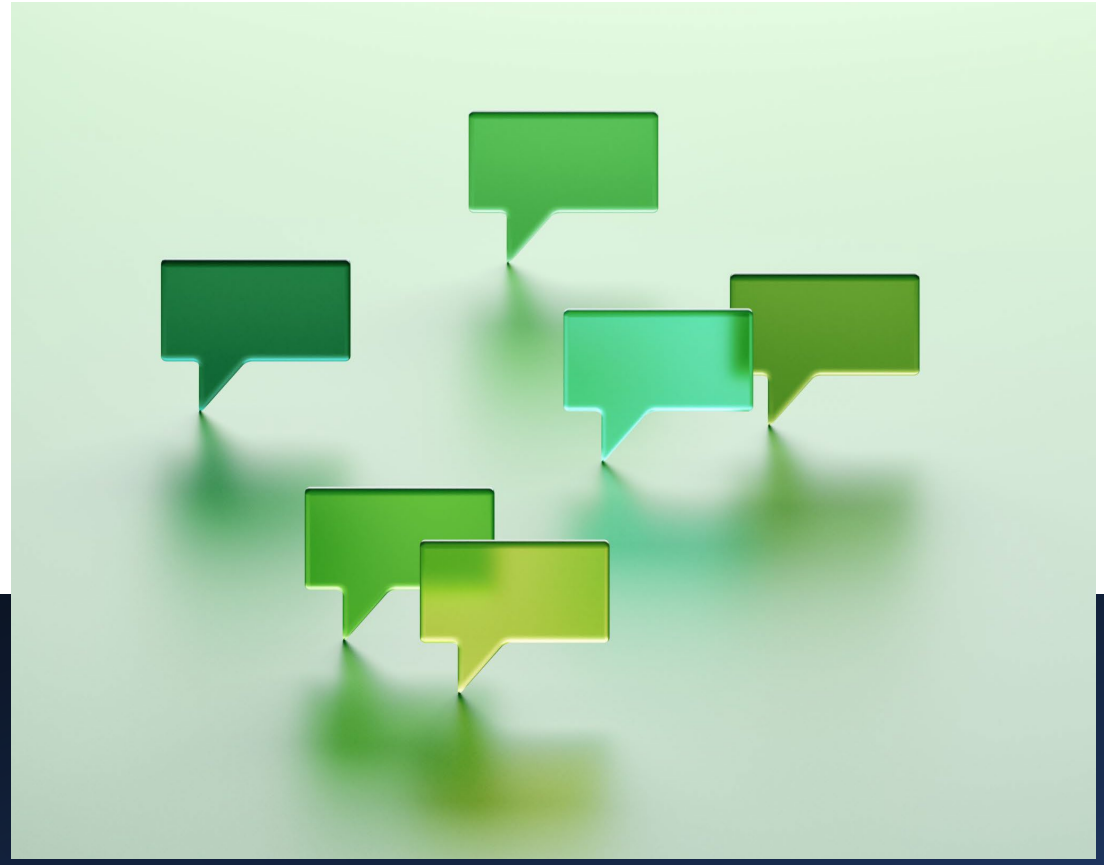
Recommendation #4: Apple Health (Medicaid) Provider Rate Increase

The Commission recommends:

An Apple Health provider rate increase focused on improving access to primary care and behavioral health care services.

- Such rate increases could help to lay the foundation for many of the goals of a universal health care system with a unified financing system including increased access, improved quality, and lowered costs.
- This recommendation includes support for resources to model the costs associated with these rate increases while maximizing federal matching opportunities available through Medicaid.

Discussion/Q&A



What's Next

ACTIVITY	DATES
Commission final reviews of sections 4 and 6	August 17
Commission final reviews of sections 5,7, and FTAC materials	August 23
Report sections consolidated with recommendations	August 23 – September 1
Commission review period	September 1 – September 12
Revisions & HCA review	September 13 – October 5
Final report sent to Commissioners	October 6
Commission begins FTAC charter	October 13 (UHC meeting)
Commission approves report	October 13 (UHC meeting)
2023 workplan development	October – December

Washington State Health Care Authority

Report to the Legislature – Draft Section 5

Tab 5

Section 5.

Report Requirement: Recommendations for implementing Medicaid rates at 80% of Medicare.

Overview

Engrossed Second Substitute Senate Bill 5399 directs the Universal Health Care Commission to make recommendations for implementing reimbursement rates for health care providers serving Medicaid enrollees a rate that is no less than 80% of the rate paid by Medicare for similar services.[1] Under a universal health care system, the way people currently covered by Medicaid receive services may be significantly different than is the case today. However, increasing Medicaid payment rates may improve provider participation in Medicaid, which could improve access to care for Medicaid beneficiaries in the interim.

This section will provide a summary of current Medicaid reimbursement structures, the impact of relatively low reimbursement rates on provider participation in Medicaid, as well as the impact of low payment rates on health care access and equity, and some of the legislative efforts to increase Medicaid rates in Washington. This section will also share the results of financial modeling done by the Financial Analytics Division at the Health Care Authority to determine the cost to the state and federal government of increasing all Medicaid rates to 80% of Medicare.[2] Finally, the Commission will share recommendations for potential pathways to achieving enhanced Medicaid reimbursement rates.

Background

Before the passage of the ACA, Medicaid was generally unavailable to non-disabled adults under age 65 unless they had minor children. Even then, the income caps to qualify as a parent/caretaker were very low. However, a provision in the ACA called for the expansion of Medicaid eligibility in order to cover more low-income Americans. Under the expansion, Medicaid eligibility would be extended to adults up to age 64 with incomes up to one 133% of the federal poverty level (FPL) (plus a 5% income disregard).[3] States seeking to adopt Medicaid expansion could do so using Section 1115 waiver authority. Washington extended Medicaid coverage to non-elderly adults up to 133% FPL under the waiver beginning January 1, 2011.[4] The decision and action to adopt early expansion effectively reduced the uninsured rate in Washington. In 2013, the uninsured rate in Washington was 14.1% which dropped to

[1] Engrossed Second Substitute Senate Bill 5399 https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5399-S2.SL.pdf?q=20220404085215

[2] Modeling made several assumptions and most services with some exceptions.

[3] Patient Protection and Affordable Care Act. 2014. https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

[4] Medicaid expansion under the 1115 demonstration waiver was extended to nonelderly adults up to 133% FPL who were previously enrolled in the state-funded Basic Health Plan or the state Alcohol and Drug Addiction Treatment Support Act programs. Under the waiver, enrollment was capped, and enrollees were subject to cost-sharing which exceeded traditional Medicaid limits. When expansion under the ACA became effective in January 2014, enrollees under the waiver were transitioned to traditional Medicaid coverage. *The Kaiser Commission on Medicaid and the Uninsured. 2014. The Washington State Healthcare Landscape.* https://www.kff.org/wp-content/uploads/2014/06/8599-the-washington-state-health-care-landscape2.pdf

5.4% by 2016, representing an overall rate decrease of 60%. Over the next several years, the uninsured rate increased slightly and hovered around 6.7% prior to the COVID-19 pandemic.[5]

In 2020, the Public Health Emergency (PHE) declaration and subsequent Families First Coronavirus Response Act allotted states' Medicaid programs a temporary 6.2% Federal Medical Assistance Percentage (FMAP) increase in response to widespread unemployment and loss of health coverage. This increase was conditioned on states maintaining Medicaid members' enrollment, including for those newly eligible during this period. As result of these protections, the uninsured rate as of November 2021 was the lowest since the implementation of the ACA at 4.7%.[6]

Medicaid expansion coupled with federal protections from Medicaid disenrollment amid the COVID-19 pandemic have helped to significantly lower the uninsured rate. Since Medicaid expansion, Washington has sought to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program.

However, physician participation in Medicaid is voluntary and physician participation in Medicaid is lower than in the commercial insurance market and in Medicare, particularly among specialists. This shortage of providers has long been associated with low Medicaid payment rates. In fact, physicians cite low rates as the primary barrier to participating in Medicaid.[7] In Washington, Medicaid provider reimbursement rates are not competitive with either commercial plans or Medicare, with Medicaid rates in 2016 at 71% of Medicare averaged across all services and 65% for primary care.[8] Additionally, Medicaid payment rates have not kept pace with the cost of services and there has been no sustained ongoing rate increase for Medicaid services in over 10 years.[9] While recent legislation successfully increased some Medicaid payment rates, provider rates largely remain stagnant.

Medicaid Fee-for-Service and Managed Care

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or a combination of both. In Washington, Medicaid enrollees are automatically enrolled into managed care and can choose which plan best fits their needs. Some groups, including Medicare eligible individuals, American Indians, and Alaskan Natives, are exempt from auto-enrollment in Medicaid managed care but may choose to opt into a managed care plan. Some groups can also opt out of coverage under managed care, such as Foster Care Alumni. Some services are always provided on an FFS basis such as long-term care and dental care.

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[5] The state's uninsured rate increased sharply during the COVID-19 pandemic. At the height of the pandemic lockdown in May 2020, the uninsured rate reached 11.9%. OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

[6] OFM microsimulation model of Washington's unemployment claims during the COVID-19 pandemic and associated health coverage changes. Washington State Office of Financial Management. 2021.

[7] Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

[8] Medicaid-to-Medicare Fee Index. 2016. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[9] Health Care Authority, 2019, Barriers to Primary Care Access in Apple Health. Senate Health and Long Term Care Committee. https://www.hca.wa.gov/assets/program/senate-hltc-barriers-primary-care-access-011619.pdf

Fee-for-Service Payment

Under Medicaid FFS, providers are paid directly for each covered service received by a beneficiary. Federal rules allow states broad flexibility in determining FFS provider payments on the condition that payments help to safeguard against unnecessary utilization, and be consistent with access rules, efficiency, economy, and quality of care.[10] Washington uses a provider fee schedule to establish base payment rates, or standardized payment amounts, for Medicaid FFS.[11]

Managed Care Payment

Managed Care provides comprehensive benefits through Managed Care Organizations (MCOs), which receive a capitated payment to provide services. Federal Medicaid rules allow states to enter into contracts requiring MCOs to adopt minimum fee schedules for network providers that provide a particular service under the contract.

Impact of Payment Rates on Provider Participation in Medicaid

Providers have long cited Medicaid's low payment rates as the primary barrier to participating in Medicaid. A provision of the ACA intended to encourage primary care physicians to participate in Medicaid required states to temporarily increase Medicaid primary care rates to 100% of Medicare in 2013 and 2014.[12] After raising Medicaid rates during this period, Washington's Medicaid reimbursement returned to pre-ACA levels.[13] The temporary nature of the Medicaid one-time fee bump resulted in limited improvements in provider participation.[14] Several studies investigating the effect of increased rates during this same period noted that the limited duration and design of the payment increase may have not been enough to incentivize providers to participate despite the increase in payment rates.

HCA funded a study by the University of Washington Center for Health Workforce Studies to assess the impact of the 2013-2014 Medicaid payment increase on primary care providers' willingness to serve Medicaid patients in Washington State. [15] This study found that the lack of sustainable funding from the

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[10] Compilation of the Social Security Laws. State Plans for Medical Assistance. https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

[11] The Centers for Medicare & Medicaid Services (CMS) assesses the adequacy of FFS payments when it approves FFS payment methodologies.

[12] The two-year rate enhancement was funded solely by the federal government. Health Care and Education Reconciliation Act of 2010, Section 1202. https://www.govinfo.gov/content/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf

[13] The Health Care Authority models Medicaid rates annually, ensuring budget neutrality. After the ACA temporary rate increase period, Medicaid rates in Washington State returned to the rate that would have followed 2012 rates modeling.

[14] Decker, S. Lipton. B. 2017. Most Newly Insured People In 2014 Were Long-Term Uninsured. https://pubmed.ncbi.nlm.nih.gov/28069842/

[15] Pattterson DG, Andrilla CHA, Skillman SM, Hanscom J. The Impact of Medicaid Primary Care Payment Increases in Washington state. Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington, Dec 2014. http://depts.washington.edu/uwrhrc/uploads/WA%20Medicaid%20Incentive%20Final%20Report%20Dec%201%202014.pdf The study consisted of two surveys in fall 2014. The first sampled 15 Washington counties and captured the perspectives of 230 primary care physicians in solo and small group practices of 50 physicians or fewer. Physicians sampled had to have reported providing direct patient care in Washington since January 1, 2013, and have a main practice site that was not an Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), as these facilities were not eligible for the payment increase. Survey two was directed at leaders of the state's 13 largest healthcare organizations, with a response rate of 53.8%. Provider awareness of the temporary increase varied, where respondents from large healthcare organizations or in private practice were

one-time fee increase was not incentive enough for some providers to participate in Medicaid and would not impact decisions to accept or continue care for Medicaid patients for most providers. Most providers noted that increasing reimbursement rates, as well as other strategies such as streamlining payments and administrative processes, may encourage them to continue seeing or accepting new Medicaid patients.

A 2019 Health Affairs Study reviewed the effects of provider payment rates, Medicaid expansion, and managed care on physician acceptance of new Medicaid patients.[16] Neither Medicaid expansion nor managed care played a significant role in increasing provider participation. However, higher provider payment was associated with higher acceptance rates of Medicaid patients by providers. Further, physicians in states that paid above the median Medicaid-to-Medicare fee ratio (ranging from .66-.72) accepted new Medicaid patients at higher rates than those in states that pay below the median.

Impact of Provider Rates on Health Equity and Access

Health and health care disparities disproportionately impact individuals and communities of color. For instance, private insurance, primarily employer-sponsored insurance, is the largest source of health care coverage across racial and ethnic groups. However, structural racism has largely shaped employment trajectories for people of color, where compared to their White counterparts, people of color are less likely to be privately insured and are less likely to be employed with employers that offer health insurance.[17] People of color are also less likely to report having a personal doctor or health care provider compared to their White counterparts. [18]

People of color are overrepresented in Medicaid compared to other forms of insurance. As of 2020, Medicaid covered about three in ten Black, American Indian and Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) nonelderly adults and more than two in ten Hispanic nonelderly adults, compared to 17% of their White counterparts. For children of color, Medicaid and CHIP (Children's Health Insurance Program) play an even larger role, covering over half of Hispanic, Black, and AIAN children and nearly half of NHOPI children, compared to 27% of White children.

In their 2022 Quarterly Opinion, Millbank stated that relatively low provider payment rates contribute to access barriers for Medicaid enrollees. Millbank cited the 2019 Physician Acceptance of New Medicaid

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more aware of the Medicaid payment increase compared to primary care physicians in smaller practices. Primary care and large healthcare organizations were polled on the amount of influence primary care physicians had on whether to accept Medicaid patients and who in large healthcare organizations makes this decision. 82.1% of primary care physicians in smaller practices reported that they had "some" or "a great deal" of influence. 42.9% of primary care physicians in large healthcare organizations reported that their primary care physicians had "some" or "a great deal" of influence. 71.4% of large healthcare organizations reported that leadership made the decision. 46.3% of rural primary care physicians, compared with 72.8% of urban primary care physicians, reported they had "a great deal" of influence. Primary care physicians in private practice were 66.9% more likely to perceive they had "a great deal" of influence (76.6% vs. 9.7%). Self-employed primary care physicians were more than three times as likely as other primary care physicians to report having a great deal of influence (86.1% vs. 24.6%).

[16] Holgash, K. Heberlein, M. 2019. Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. Health Affairs. https://www.healthaffairs.org/do/10.1377/forefront.20190401.678690/full/

[17] Medicaid and Racial Health Equity. 2022. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/

[18] Breakdown by race/ethnicity: AIAN: 33.5%, Asian/HOPI: 25.6%, Black: 28%, Hispanic: 38%, White: 17.8%. Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity. Kaiser Family Foundation. 2020. https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Patients[19] report by the State Health Access Data Assistance Center (SHADAC) to the Medicaid and CHIP Payment and Access Commission (MACPAC). Of providers accepting new patients, 70.8% were accepting new Medicaid patients, compared to 85.3% accepting new Medicare patients and 90% for private insurance. For specialty providers such as psychiatrists, only 35.7% were accepting new Medicaid patients, compared to 62.1% accepting Medicare and 62% accepting private insurance. However, SHADAC found that every 1%-point increase in the Medicaid-to-Medicare fee reimbursement ratio was associated with a 0.78%-point increase in provider acceptance of Medicaid patients.[20]

Millbank stated that advancing the goal of health equity and improving access to care for Medicaid enrollees may require closing provider pay gaps that make Medicaid less attractive to providers.[21] One suggestion to improve care access was to increase Medicaid fees or benchmark Medicaid fees to Medicare where with such a rate increase, the supply of services to Medicaid could increase access and reduce health care disparities.

Other studies support an association between increased Medicaid provider rates and improved access to care. In 2019, the National Bureau of Economic Research assessed the impact of provider rates on adults covered by Medicaid and found that improvements in access to care can have large implications for disparities.[22] Compared to those who were privately insured, Medicaid-covered adults were twice as likely to report difficulties finding physicians willing to accept them as new patients. Medicaid-covered adults were also nearly three times as likely to report being in fair or poor health. The study found that Medicaid enrollees in states with larger increases in Medicaid provider payments saw greater improvements in access, frequency of office visits, and overall health.

The study also assessed the impact of provider payments on children and found that Medicaid-covered children were twice as likely to be chronically absent from school.[23] However, improvements in health care access resulting from increased payments for physicians lead to improvements in both self-reported health and reductions in school absenteeism due to illness and injury. Most school absences, particularly among young children, are attributable to acute conditions commonly treated in a primary care setting and school absenteeism may be responsive to changes in access to primary care.

Just as Medicaid enrollees may face barriers to accessing primary care due to low payment rates, the mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Though Medicaid enrollees are more likely to experience mental health

[19] The Physician Acceptance of New Medicaid Patients report by State Health Access Data Assistance Center (SHADAC) to the Medicaid and Chip Payment Access Commission (MACPAC) assessed state policies that could affect acceptance of new Medicaid patients. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

[20] After adjusting for state demographic characteristics.

[21] Allen H, Golberstein E, Bailey Z. Eliminating Health Disparities Will Require Looking at How Much and How Medicaid Pays Participating Providers. *Milbank Quarterly Opinion.* February 23, 2022. https://www.milbank.org/quarterly/opinions/eliminating-health-disparities-will-require-looking-at-how-much-and-how-medicaid-pays-participating-providers/

[22] Alexander, D. Schnell, M. National Bureau of Economic Research. 2019. The Impacts of Physician Payments on Patient Access, Use, and Health. Working Paper 26095. http://www.nber.org/papers/w26095

[23] Chronic absenteeism is linked to low academic achievement, including test scores, test score growth, and on-time graduation rates.

disorders compared to privately insured patients, [24] nearly a quarter of Washingtonians will struggle with mental health or addiction at some point in their lives. However, as of 2018, there was just one mental-health provider for every 360 residents.[25] Further, by county, the ratio of behavioral health providers ranges from one for every 262 people to 1 for every 3,378 people.

Despite state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths continue to rise. Prior to the pandemic, 22.8% of adults with any mental illness in Washington reported having Medicaid coverage in the past year. In 2021, 33.5% of Washingtonians reported symptoms of anxiety and/or depressive disorder, surpassing the national rate of 31.6%. Though Washington's rate of drug overdose deaths per 100,000 population falls below the national average (22.4% compared to 28.3% respectively), opioid overdose deaths in 2020 increased by nearly 30% compared to 2019.[26]

According to the Centers for Medicare and Medicaid Services (CMS), states that expanded Medicaid have seen improved access to behavioral health and substance use disorder services. However, gains in insurance coverage under Medicaid expansion may not guarantee access to office-based treatment. Though a broad range of behavioral health and substance use services are covered under Medicaid, behavioral health providers, particularly specialists, accept Medicaid patients at significantly lower rates compared to Medicare and private insurance.

State and federal efforts have aimed to address access issues and workforce shortages in behavioral health and primary care, especially during the COVID-19 pandemic. However, short-term investments such as one-time payment increases have been shown not to improve provider participation in Medicaid or improve access for patients. Securing permanent rate increases for primary care and behavioral health providers may be an impactful step to improving access to care and health equity for Medicaid enrollees in the current system, as well as in the transition to a universal health care system.

Legislative Efforts to Increase Medicaid Provider Rates

Washington aims to continue to improve the Medicaid program by improving access to care and improving provider participation in the Medicaid program. Though Medicaid provider rates have largely stagnated for over ten years, several pieces of legislation recently passed that increased provider payment rates for certain services in order to increase access to care for Medicaid enrollees. The next section will highlight some of the recent legislative efforts to increase Medicaid payment rates.

Pediatric Primary Care Reimbursement Enhancement, 2018

As stated previously, the ACA provided for an increase in Medicaid provider rates to Medicare rates for certain providers (2013 and 2014). In Washington, evaluation and management (E&M) services and vaccines for Medicaid covered children were codes for which providers could receive enhanced rates

[24] Bergamo, C, MD. 2016. Association of Mental Health Disorders and Medicaid with Emergency Department Admissions for Ambulatory Care Sensitive Conditions https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4837066/#:~:text=Adult%20Medicaid%20enrollees%20are%20more,Care%20Sensitive%20Conditions%20(ACSC).

[25] Access to Behavioral Health Providers. 2018. Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/1000//SHA-AccesstoBehavioralHealthProviders.pdf

[26] To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap. 2021. CMS. https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap#_ftn16

during this period.[27] In the years since, the Washington State Legislature tried to increase reimbursement for the same codes, but such an effort was considered too costly and was not funded until 2018.

However, Engrossed Second Substitute Senate Bill 6032 (Operating Budget, 2018) appropriated funds for the HCA to increase primary care provider rates for pediatric E&M and vaccine services. These enhanced rates would match the rates under the ACA temporary rate enhancement.

HCA provided a one-time report to the Governor and the Legislature in November 2019, in response to the requirements in ESSB 6032, which detailed the following:

1. How the funds were used to increase provider rates.
2. What percentage increase was provided for pediatric primary care provider evaluation and management (E&M) rates.
3. What percentage increase was provided for pediatric vaccine rates.
4. How utilization changed within each category.
5. How rate increases impacted access to care.

However, there was difficulty in trying to assess the impact of this rate increase on E&M and vaccination services in the short reporting period. While the utilization of E&M and vaccination services did not seem positively impacted, it was difficult to conclude what effect the rate increase may have had if the number of children in the caseload remained more stable, and if this was a sufficient enough rate increase to stimulate better utilization of these services. The correlating decrease in the number of children in the caseload masked the opportunity to reach any compelling conclusions about how utilization was impacted. [28] It was determined that a longer evaluation period would be required to further assess the impact on the utilization of these services.

Primary Care Access Study, 2018

ESSB 6032 also tasked HCA with coordinating a study and subsequent report to the Legislature due December 2018, to identify strategies and provide recommendations for enhancing access to primary care for Medicaid enrollees. The study was to the extent possible:

1) Review the effect of the ACA temporary rate increase on:
    a. The number of providers serving medical assistance clients.
    b. The number of medical assistance clients receiving services.
    c. Utilization of primary care services.
2) Identify client barriers to accessing primary care services.
3) Identify provider barriers to accepting medical assistance clients.
4) Identify strategies for incentivizing providers to accept more medical assistance clients.

[27] There are some codes for E&M visits for children ages 19-20 that were not covered under the enhanced rates, though these codes are already reimbursed between 80-83% of Medicare. The E&M codes 99201-99215 are for office visits only and must be billed for professional providers such as physicians (or nursing staff under a physician's supervision), Advanced Registered Nurse Practitioners (ARNPs), and Physician Assistants (PAs).

[28] During this reporting period, the number of children ages 0-20 years in the case load dropped by 1.4%. The majority of this reduction was in the 0 to 6 age group. This is notable this is the age when children receive the most E&M and vaccination services, and this change in caseload numbers likely contributed to the decrease in utilization of E&M visit codes and vaccinations administered.

5) Prioritize areas for investment that are likely to have the most impact on increasing access to care.
6) Strategically review the current Medicaid rates and identify specific areas and amounts that may promote access to care.

HCA analyzed changes in access to primary care for Medicaid enrollees between 2012 and 2017. Data was used from 2012 (before the passage of the ACA), 2013 and 2014 (the years that the Medicaid reimbursement rate increased), and 2015 to 2017 (when reimbursement rates returned to pre-ACA levels).[29] Between 2012 and 2017, the 30% increase in primary care providers was outpaced by a 50% increase in Medicaid enrollment. Despite growth in the number of Medicaid providers during this period, declining HEDIS[30] and CAHPS[31] performance illustrated a negative impact on members' timely and needed access to care.

Providers reported the following as primary barriers to Medicaid participation:

- Payment rates have not kept pace with increasing costs of services.
- Administrative complexity in clinical criteria, claims submission, and payment.
- Challenges in meeting members' complex needs and time requirements.

Rate increases remain an important strategy to improving provider participation in Medicaid, particularly in primary care where reimbursement is lower than for specialty care. Further, primary care providers report that in addition to positively impacting access to care for new and current Medicaid enrollees, rate increases are the most successful strategy to encourage providers' willingness to participate in Medicaid. Based on these findings, the following recommendations were provided to the Legislature:

1) Increasing primary care rates.
2) Exploring opportunities to improve timely primary care provider payment.
3) Streamlining the administrative process.
4) Identifying options to reduce the financial risk of value-based payment arrangements for primary care providers and critical access services in underserved and rural areas.

Primary Care and Behavioral Health Reimbursement Enhancement, 2021-2023

The Operating Budget for the 2021-2023 biennium (Engrossed Substitute Senate Bill 5092) allotted funds for Fiscal Years 2022 and 2023 for HCA to implement enhanced Medicaid reimbursement rates in an effort to maintain and increase access for primary care services for Medicaid-enrolled patients. The rate increases apply to both fee-for-service and managed care and are consistent with the temporary rate increase provided under the ACA in 2013 and 2014. The statute directs that:

1) Medicaid payments for adult primary care services be at least 15% above rates that were in effect on January 1, 2019.

[29] HCA Report to the Legislature. December 1, 2028. Enhancement of Primary Care Access for Medical Assistance Clients Engrossed Substitute Senate Bill 6032, Section 213(eee); Chapter 299; Laws of 2018. https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCA%20Report%20-%20Enhancement%20of%20Primary%20Care%20Access%20for%20Medical%20Assistance%20C..__b77842c4-60b1-4c74-8c97-8f2b355d60a9.pdf

[30] Healthcare Effectiveness Data and Information Set.

[31] Consumer Assessment of Healthcare Providers and Systems.

2) Medicaid payments for pediatric primary care services be at least 21% above rates that were in effect on January 1, 2019.
3) Medicaid payments for pediatric critical care, neonatal critical care, and neonatal intensive care services be at least 21% above rates that were in effect on January 1, 2019.
4) Certain family planning codes at Title X clinics be increased by at least 162%.
5) A 2% increase for all services paid through the behavioral health portion of managed care capitation rates relative to the reimbursement levels in place as of April 1, 2021. [32]

Rate Enhancement for Behavioral Health, 2021-2023 Supplemental Operating Appropriations (2022)

Engrossed Substitute Senate Bill 5693[33] allotted funds to implement a 7% increase to Medicaid reimbursement for community behavioral health providers contracted through managed care organizations (MCOs) to be effective January 1, 2023. The rate increase must be implemented to all behavioral health inpatient, residential, and outpatient providers contracted through the Medicaid MCOs. HCA must employ mechanisms such as directed payment or other options allowable under federal Medicaid law to ensure the funding is used by the MCOs for a 7% provider rate increase as intended and verify this pursuant to the process established in chapter 285, Laws of 2020 (EHB 2584).[34]

Payment Rate Modeling

In 2022, HCA analyzed the fiscal impact of raising Medicaid rates to 80% of Medicare. Due to previous analyses of the impact of increased rates on provider participation, there is an expectation that access to care and utilization would increase as a result of a rate increase. While it may seem relatively simple to increase Medicaid provider rates to a percentage of Medicare rates, there is great complexity and difficulty in matching rates due to the difference in the respective payers' case mix[35], as well as differences in payment methodology. Additionally, several services provided under Washington's Medicaid do not have Medicare equivalent rates, which can range from a few codes in a program, to an entire program.[36]

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[32] *MCO contract subsection 5.20.5: The Contractor will increase provider reimbursement rates by two 2 percent effective April 1, 2021, for providers that deliver contracted Behavioral Health services as described in subsections 17.1.2, 17.1.4.3, 17.1.4.4, 17.1.4.5, 17.1.4.6, 17.1.14, 17.1.15, 17.1.16, 17.1.41, and 17.1.42 of the contract. The Contractor will pay providers that provide Behavioral Health services to patients in primary care settings at a rate no less than those published by HCA for its FFS Mental Health and Psychology Services. The Contractor will also pay providers that provide the following services at a rate no less than those published by HCA for its FFS Physicians Services: 90832, 90833, 90834, 90837, H0004, H0036, H2015, H2021, H0023, 90836, 90838, 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 90845, 90846, 90847, 90849, 90853, 90785, 90791.*

[33] Engrossed Substitute Senate Bill 5693. 2022. Section 215(58) https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5693-S.PL.pdf?q=20220311101341

[34] Engrossed House Bill 2584. 2020 https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2584.SL.pdf?q=20220405103230

[35] Case mix is a measure used by the Centers for Medicare and Medicaid Services (CMS) to determine hospital reimbursement rates for Medicare and Medicaid enrollees and reflects the diversity, complexity, and severity of patient illnesses treated.

[36] Hospitals are paid differently in Medicare than Medicaid. Medicare uses Medicare Diagnosis Related Groups (MS-DRG), which provides a means of relating a hospital's patient case mix to the costs incurred by the hospital. Medicaid uses All Patient Refined – Diagnosis Related Groups (APR-DRG), which expands the basic DRG structure, but also address patient differences relating to severity of illness and risk of mortality in addition to resource utilization. For facility outpatient services, Medicare uses Ambulatory Patient Classifications (APCs), whereas Medicaid uses the Enhanced Ambulatory Patient Group (EAPG). Changes to rates would reportedly affect supplemental payments received by hospitals currently.

Methodology

The analysis did not include Medicaid services provided by State agencies other than HCA. [37] Expenditure amounts were based off Fiscal Year 2023 projected costs.[38] The report estimated the average ratio of Medicaid to Medicare to be 71%, which was assumed a reasonable approximation for this high-level estimate. [39]

Findings

The analysis found that the total fiscal impact for State Fiscal Year 2023 would be approximately $864 million for increasing physical health services rates only, with some exclusions. [40] The General Fund - State (GF-S) portion of the impact was estimated to be about $271 million.

Potential Legislative Pathways

As demonstrated by the results of financial modeling by HCA, the costs associated with increasing Medicaid rates for most physical health services, not including dental, long-term care, or behavioral health, covered by Medicare to 80% of Medicare would cost the state an additional $271 million GSF.

Efforts aimed to improve provider payment equity as well as access to care for Medicaid enrollees require a long-term strategic approach. Research shows that temporary rate increases do not translate to improved provider participation in Medicaid or improved access to care. Additionally, attracting more providers to the Medicaid program may require both payment rate increases and administrative simplification.

The Universal Health Care Commission recognizes the difficulty in implementing increased Medicaid payment rates across the board for all providers and services. However, it may be more feasible to continue with the Legislature's selected areas of focus to develop approaches to achieving the long-term goal of increasing Medicaid payment rates that are 80% of Medicare, such as increasing adult primary care rates and behavioral health increases.

Continue Enhancing Primary Care by Increasing Adult Primary Care Rates to Match Pediatric Primary Care Rates

Primary care emphasizes health promotion and prevention and is proven to be an equitable, cost-effective, and efficient approach to improve mental and physical health as well as social well-being.[41] The goals of primary care also align with those of universal health coverage; to ensure equitable access to affordable, high-quality care for everyone. However, primary care is drastically underfunded in the U.S., limiting the potential of primary care to achieve cost savings and quality improvements.

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[37] The analysis did not include the amounts spent on services provided to Medicaid enrollees by the Department of Social and Human Services (DSHS) or the Department of Corrections (DOC), for example, long-term care services provided by DSHS.
[38] Health Care Authority. Financial Services Division. February 2022 Expenditure Forecast, version D05 M01.
[39] The ratio of Medicaid to Medicare was based on a 2016 report published by the Kaiser Family Foundation.
[40] The following forecast services were excluded: Pharmacy related forecast services; Dental Services; Durable Medical Equipment; Transportation Services. Community Behavioral Health (CBH) services were excluded from this analysis because many of these services are not currently covered by Medicare. Medicaid payment rates are often higher than Medicare for those outpatient behavioral health services that are covered by both payers.
[41] Primary Health Care. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/primary-health-care

In Washington, Medicaid rates for pediatric primary care services under both FFS and managed care currently average 83% of Medicare.[42] However, adult primary care rates for the same services average just 67% of Medicare. Payment rates differ depending on a patient's age necessitates having two different provider fee schedules, often leading to confusion for providers as well as administrative complexity and waste.

Increasing rates for adult primary care to identically match the rates for pediatric primary care would ensure that all primary care rates average at least 80% of Medicare. However, it is important to secure permanent rate increases for these important services, as research shows that temporary rate increases have not translated to improved provider participation in Medicaid or improved access to care for Medicaid enrollees.

Matching rates for adult and pediatric primary care aligns with the goals of a universal health care system in two ways. First, this streamlines health care administrative processes and reduces administrative waste. Matching rates will eliminate need for two separate provider fee schedules, which may reduce administrative costs, complexity, and waste, and may help to avoid confusion for providers. This also increases the likelihood that more primary care providers will participate in Medicaid, as providers cite administrative complexity, as well as low payment rates, as barriers to their participation. Second, increased primary care provider rates may improve health equity for patients. With permanent rate enhancements for these important services, providers may be more likely to accept new Medicaid patients, likely improving access, and potentially health outcomes, for Medicaid enrollees. ***Estimates pending**[43]

Continue Advancing Behavioral Health by Increasing Behavioral Health Rates for Services Not Included in Recent Legislative Rate Enhancements

Washington's mental health system has struggled to meet the demand for services, particularly amid the COVID-19 pandemic and opioid crisis. Despite recent state efforts to promote access to behavioral health providers and care, rates of mental illness and overdose deaths continue to rise.

Though behavioral health and mental health rates were recently enhanced by the Legislature, some services were not included in the rate enhancements. For instance, the Applied Behavior Analysis (ABA) program is a covered benefit for Medicaid clients diagnosed with Autism Spectrum Disorder (ASD). However, the ABA program was not included in the recent legislative rate enhancements and rates have not been increased for these services for some time.

While the Legislature also recently increased managed care rates, FFS behavioral health services were not included in rate increases.[44] Matching Medicaid FFS behavioral health rates to managed care rates aligns with the goals of a universal health care system by reducing barriers to provider participation in Medicaid and increasing the likelihood that providers will not choose to provide services to managed care enrollees over individuals enrolled in Medicaid FFS. Providing parity between FFS and managed care behavioral health services may increase equitable access to services for Medicaid enrollees and advance the goals of a universal health care system.[45] With permanent

[42] HCA estimated rates.

[43] Estimates from this analysis may be available by the time the Commission votes on the final report. If these estimates are not available by this time, it will be noted in the final report that estimates are forthcoming.

[44] Fee-for-service behavioral health care rates for higher acuity care.

rate enhancements for these important services, providers may be more likely to accept new Medicaid patients, likely improving access, and potentially health outcomes, for Medicaid enrollees. ***Estimates pending**[46]

Conclusion

The COVID-19 pandemic exposed health and health care disparities stemming from past and enduring inequitable policies and practices within and external to the health care system. Enhanced federal Medicaid funding and enrollment protections under the Public Health Emergency have helped to improve access to care by expanding and protecting Medicaid coverage and reducing the number of uninsured in Washington. Improving access to primary care and behavioral health services are particularly important to building upon this coverage expansion, improving health equity, and laying a foundation for universal health coverage.

The Legislature recently targeted Medicaid adult and pediatric primary care as well as behavioral health managed care for enhanced payment rates to increase provider participation and improve access to care. This has been a successful strategy and continuing these efforts may be an interim pathway toward increasing all rates. Building upon the Legislature's strategy to prioritize primary care and behavioral health may be an impactful strategy to improving access to care and health equity for individuals and families covered under Medicaid.

[46] ***Estimates from this analysis may be available by the time the Commission votes on the final report. If these estimates are not available by this time, it will be noted in the final report that estimates are forthcoming.***

Washington State Health Care Authority

Report to the Legislature – Draft Section 7

Tab 6

Section 7.

Report Requirement: Recommendations for the creation of a finance committee to develop a financially feasible model to implement universal health care coverage using state and federal funds and materials considered by the Commission regarding financing.

Background

In their 2021 report to the legislature, the Universal Health Care Work Group noted that the health care system's current financing model has grown increasingly costly and fragmented with no governance structure. Further, pricing of health care products and services is not transparent, and prices for prescription drug and hospital prices can exceed the rate of inflation.

Though Washington continues to make payment and purchasing reform efforts, the current system's increasing annual costs outpace wages and the rate of inflation, which widens gaps in access to health coverage and care. Multiple economic analyses, including analysis conducted by the Universal Health Care Work Group, demonstrate that a universal system can improve health equity and access to care, decrease costs, and will produce billions in savings per year, all while providing universal coverage to residents.[1]

As described in earlier sections, the Universal Health Care Work Group developed three (3) universal health care models with which Washington could achieve universal coverage. These universal coverage models will be considered including Model A and Model B, as well as unified financing models utilized in other countries, to develop the right approach for Washington. The unified health care financing system will be dependent on the universal health care model developed for implementation. Further, transitioning the state to a unified financing system is dependent on foundational programmatic, legal, financial changes and approval from the federal government.

There are multiple sources of funding that pay for health care in Washington and there are many challenges associated with pooling those funding sources to finance a universal health care system. This section of the report will outline other potential financing considerations which may help inform the design of Washington's unified health care financing system.

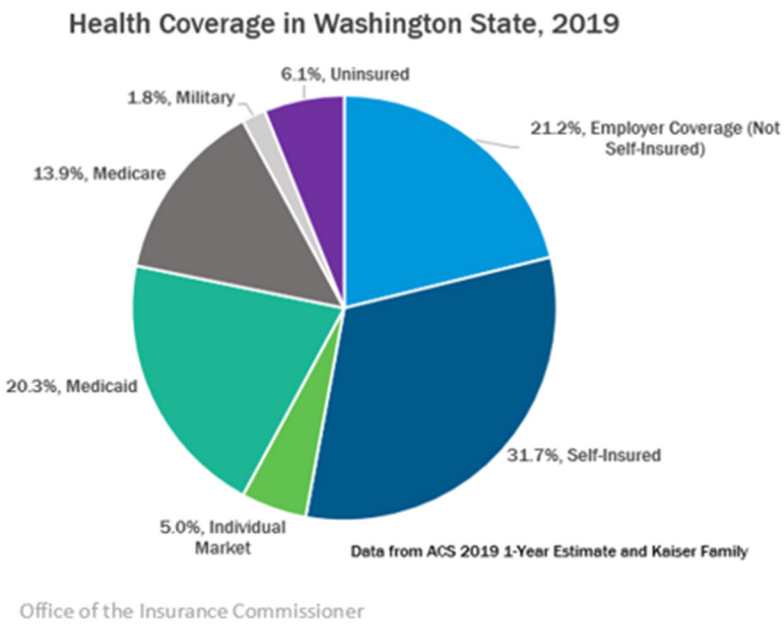
This section will also summarize the financing landscape of the current health care system and will provide a brief overview of single-payer models in other countries, including the role of government and how universal coverage is financed. Several financing models will be outlined that may inform Washington's unified health care financing system, including: 1) a universal purchasing program currently used in Washington, 2) all-payer rate setting and global budgets used in the state of Maryland, and 3) evaluations of single-payer proposals by other states. Finally, the Commission recognizes that the subject matter expertise of a finance committee will be essential to informing their planning and decision making. As such, the Commission will consider the creation a finance technical advisory committee to explore the various barriers and solutions to implementing a sustainable and equitable unified financing system in Washington.

[1] Senate Bill 5399 https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Senate%20Passed%20Legislature/5399-S2.PL.pdf?q=20220223093553

Current Health Care Financing Landscape

The U.S. health care system funds and delivers care through a mix of public and private insurers and health care providers (See Table 1). Employer-sponsored insurance, including by self-insured and non-self-insured employers, is the dominant form of coverage in Washington[2], followed by Medicaid and Medicare.

Table 1



Health Care Systems

The following section will outline components of the publicly funded health care system, including governmental insurance programs and other health systems, including Medicaid, Medicare, Indian Health Services, and the Veteran's Health Administration.

Medicaid Financial Overview

The Medicaid program is administered by states and the Centers for Medicare and Medicaid Services (CMS) and is jointly funded by states and the federal government. The federal government pays states a Federal Medical Assistance Percentage (FMAP) for qualified Medicaid expenditures. FMAP rates are based on each state's per capita income and have a statutory minimum of 50% and a statutory maximum of 83%.[3] In Washington State, the FMAP is 50% (which temporarily increased to 56.2% during the COVID-19 Public Health Emergency declaration).[4]

States have some flexibility in deciding how to fund their share of Medicaid expenditures. Washington uses state general and other funds to cover the non-federal share of Medicaid funding. [5] In 2020, Medicaid accounted for 25% of the state's total budget. [6]

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[2] Pre-COVID-19 pandemic estimate. Health Insurance Coverage of the Total Population 2020. Kaiser Family Foundation. https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] Matching Rates. CMS. https://www.macpac.gov/subtopic/matching-rates/

[4] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, 2022. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] Other state funds and revenue sources can include local funds and provider taxes (as defined by the Centers for Medicare and Medicaid Services). Congressional Research Service. Medicaid Financing and Expenditures. 2020. https://sgp.fas.org/crs/misc/R42640.pdf

[6] Medicaid Expenditures as a Percent of Total State Expenditures by Fund. 2020. Kaiser Family Foundation. https://www.kff.org/medicaid/state-indicator/medicaid-expenditures-as-a-percent-of-total-state-expenditures-by-fund/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Medicare Financial Overview

Medicare is funded solely by the federal government through two Medicare designated trust fund accounts. The Hospital Insurance (HI) Trust Fund covers Medicare Part A (hospital insurance) and is funded through payroll taxes, interest earned on trust fund investments, Social Security taxes, and Medicare Part A premiums.[7] The Supplementary Medical Insurance (SMI) Trust Fund covers Medicare Parts B (medical insurance) and D (drug coverage), and Medicare Program administration. The SMI is funded through enrollee premiums and interest earned on trust fund investments. The Medicare employment tax paid by employers and employees also supports federal funding for Medicare. Payment policies and provider payment rates are set by CMS.

Indian Health Services

American Indians and Alaska Natives (AI/ANs) are eligible to participate in all public, private, and state health programs and have treaty rights to federal health care services though the Department of Health and Human Services (DSHS). The Indian Health Service (IHS) is a division operating within DSHS and provides health services to members of federally recognized tribes and Alaska Natives as part of the government-to-government relationship between Indian tribes and the federal government.[8] IHS revenues are contingent on third-party billing, including Medicaid, Medicare, and private insurance, as well as discretionary one-year appropriations by Congress.

Veteran's Health Administration

The Veteran's Health Administration (VHA) is the largest integrated health system in the US and is funded through general taxation as well as through appropriations by Congress. The federal government sets provider rates and negotiates drug prices. Veterans have little to no out-of-pocket costs for services and prescription drugs.

Private Health Care

As described in earlier sections, the majority of insured Americans receive health care coverage through private insurance. The private insurance market includes the group market (including large and small group) and the individual market. The group market is primarily made up of employer-sponsored insurance. The individual market includes health plans purchased directly from a private health carrier. The following section will outline components of the private health insurance market.

Employer Sponsored

The ACA requires employers with fifty or more full-time equivalent employees to provide health coverage to at least 95% of its full-time employees and their dependents and that coverage must meet minimum affordability and value standards. Employers in noncompliance are issued fines and penalties by the Internal Revenue Service (IRS).

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[7] Premiums apply only to individuals who are not eligible for premium-free Medicare Part A. Centers for Medicare and Medicaid Services. Original Medicare (Part A and B) Eligibility and Enrollment
https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol

[8] The federal government's provision of health services is derived from federal statutes, treaties, court decisions, executive actions, and the Constitution. Congressional Research Service. 2016. The Indian Health Service (IHS): An Overview.
https://crsreports.congress.gov/product/pdf/R/R43330

Compared to public programs, private health plans reimburse at a significantly higher rate. In 2020, The RAND Corporation (RAND) report entitled, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* documented the variation in professional and facility prices for the commercially insured population.[9] Between 2016 and 2018, the rate at which private insurers and employers reimbursed for services increased by 23%. In 2018, across all inpatient and outpatient hospital services, private insurers and employers paid 247% above what Medicare would have paid at the same facilities for the same services. Spending for employer-sponsored health insurance has also accelerated for both employers and employees and reflects the increase in national health care spending.

Federal Employees Health Benefits (FEHB) Program

The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored group health insurance in the US and provides health care coverage to federal employees, retirees, and their dependents. Over 131,000 Washingtonians are insured through the FEHB Program.[10] The statute governing FEHB specifies that the federal government and employee or retiree share the cost of health insurance, including premiums, with the federal government contributing the majority (72-75%).[11] The Office of Personnel Management administers the program and contracts with private health carriers to deliver comprehensive health care services. [12]

Public Employee Benefits Board (PEBB) Program and School Employee Benefits Board (SEBB) Program

The Public Employee Benefits Board (PEB) Program provides health care coverage to state employees, retirees, and their dependents, covering over 300,000 Washingtonians.[13] The School Employee Benefits Board (SEBB) Program provides health care coverage to approximately 150,000 employees and dependents of Washington's school districts and charter schools, and represented employees of Washington's educational service districts. PEBB and SEBB lie within the Health Care Authority (HCA), the largest purchaser of health coverage in the state. Under HCA, PEBB purchases benefits from private health carriers within the funding approved by the State Legislature. PEBB also approves premium contributions for employees, sets eligibility requirements, and approves benefits of all participating health plans. SEBB authorizes premium contributions and approves plan specifications and carrier selection to leverage efficient purchasing through coordination with PEBB.

Individual Coverage and Washington's State-based Exchange

[9] Using data from 2016 to 2018, the study evaluated hospital spending from self-insured employers, health plans, and state-based all-payer claims databases from 49 states.

[10] Health Coverage in Washington State. 2017 data provided by the Washington State Office of Financial Management. Economic Opportunity Institute. 2020. http://www.opportunityinstitute.org/research/post/health-coverage-in-washington-state/

[11] Employees of the United States Postal Service have their share of premiums collectively bargained. Blom, K. Cornell, A. Federal Employees Health Benefits (FEHB) Program: An Overview. Congressional Research Service. 2016. https://sgp.fas.org/crs/misc/R43922.pdf

[12] OPM coordinates the administration of FEHB with federal agencies, manages contingency reserve funds for the health plans, and applies sanctions to health care providers according to federal regulations.

[13]Health Coverage in Washington State. 2017 data provided by the Washington State Office of Financial Management. Economic Opportunity Institute. 2020. http://www.opportunityinstitute.org/research/post/health-coverage-in-washington-state/

The ACA requires each state to establish a health insurance exchange where consumers are able to shop for private health insurance plans through a virtual marketplace.[14] Washington adopted a state-based exchange, making the state generally responsible for performing marketplace functions. Through legislation in 2011, the Health Benefit Exchange was established as a "public-private partnership separate and distinct from the state" to operate the state-based exchange (Senate Bill 5445). Approximately 215,000 individuals receive coverage through Washington's Exchange.

Cascade Care

The Legislature passed Senate Bill 5526 in 2019, establishing Cascade Care standard plan coverage options on the state-based exchange, beginning in 2021. The goal of Cascade Care's standard benefit design is to make care more accessible by lowering deductibles, making cost-sharing more transparent, and providing more services before the deductible as well as enabling consumers to compare plans more easily. Senate Bill 5377, passed by the Legislature in 2021, made improvements to Cascade Care and also directed the Health Benefit Exchange to establish a state premium assistance program for Cascade Care.

Washington's Public Option

Public Option plans, or Cascade Select, first became available on the state's exchange in 2021 following the passage of Senate Bill 5526 in 2019. Cascade Select provides health insurance coverage options to the individual market through Washington's Healthplanfinder (offered by the Washington Health Benefit Exchange (HBE). Cascade Select is a multi-agency effort involving HBE, HCA, and Office of the Insurance Commissioner (OIC). The goals of Cascade Care Select are to increase the availability of quality, affordable health care coverage in the individual market, and ensure residents in every Washington county have a choice of qualified health plans. As of 2022, 6,335 residents selected Public Option plans. For Plan Year 2023, Public Option Plans will be available in thirty-five (35) of thirty-nine (39) counties, up from 25 counties in 2022 and 19 counties in 2021. [15]

Public-Private Coverage

Medicare Advantage (Medicare Part C)

Medicare pays private health plans a capitated payment to provide all Medicare-covered services to individuals who choose to enroll in Medicare Advantage. These plans may be subject to premiums, copays/coinsurance, deductibles, and other out-of-pocket costs. Medicare Advantage plans have grown increasingly popular amongst Medicare enrollees. In Washington, 510,026 Medicare beneficiaries were enrolled in Medicare Advantage plans accounting for approximately 36% of Medicare beneficiaries in 2020, up from 30% in 2016. [16] The federal government has also steadily increased spending on Medicare Part C. In 2019, the federal

[14] States have the option to develop and host their own exchanges, or let the federal government establish and run exchanges for them. Washington State manages its own exchange.
[15] Washington State Health Benefit Exchange. Effectuated Cascade Care Select Plans by Carrier and County. 3/31/2022.
[16] Compared to 370, 814 Medicare Advantage enrollees in 2016. Total Number of Medicare Beneficiaries. 2020. Kaiser Family Foundation. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22washington%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

government spent an additional $7 billion on Medicare Advantage plans, with an increase of $321 per person compared to beneficiaries in traditional Medicare in 2019.[17]

Unified Financing Models in Other Countries

The U.S. is the only high-income country that does not provide universal coverage to its residents.[18] Compared to the U.S., other high-income countries have reached universal coverage through a more unified financing system while achieving lower health care expenditures and generally better health outcomes. The following section will outline components of single-payer systems as well as regulated multi-payer systems.

Single-Payer

Senate Bill 5399 directs the Commission to prepare the state for the creation of a universal health care system through a unified financing system, including a single-payer financing system. In January 2022, the Washington State Institute for Public Policy (WSIPP) shared with the Commission findings from their 2019 study and final report to the Legislature entitled *Single-Payer and Universal Coverage Systems*. While a single-payer system would likely reduce overall spending on health care, the financing required would impose large new taxes, as is done in other countries, as the system shifts from a combination of public and private coverage to public coverage.

There are two primary models of single-payer systems. In either single-payer model, the government is the only insurer for a standard set of benefits.

1) The first is the Beveridge Model, which is used in Denmark, New Zealand, and the United Kingdom.[19] This model creates a national health service where benefits are standardized across the country and the government acts as the single-payer, eliminating competition in the market, and generally keeping prices low. The government is also active in controlling drug prices, whether through price negotiations with pharmaceutical companies, price caps, or drug formularies among others. Most physicians and other health care workforce are government employees, and clinics and hospitals are government owned. Care is usually free at point of service. A U.S. equivalent to this model of single-payer financing is the Veteran's Health Administration. In this single-payer model, there is still a role for private insurance which can be offered by employers or made available for individuals to purchase. In England's National Health Service for instance, private insurance typically offers better amenities, faster access to non-urgent care, or choice of specialists.[20] However, there may be health equity implications of supplemental private health insurance being available to purchase for more timely care and broader access to providers.

[17] $11,844 per person in Medicare Advantage compared to $11,523 in traditional Medicare in 2019. Polosky, C. 2021.Payments to Medicare Advantage Plans Boosted Medicare Spending by $7 Billion in 2019. Kaiser Family Foundation. https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019/

[18] Commonwealth Fund. 2021.U.S. Health System Ranks Last Among 11 Countries; Many Americans Struggle to Afford Care as Income Inequality Widenshttps://www.commonwealthfund.org/press-release/2021/new-international-study-us-health-system-ranks-last-among-11-countries-many

[19] Chung, M. Health Care Reform: Learning from Other Major Health Care Systems. Princeton Review. https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/

[20] About 11% of the population purchases supplementary coverage. Commonwealth Fund. 2020. International Health Care System Profiles. England. https://www.commonwealthfund.org/international-health-policy-center/countries/england#:~:text=Private%20insurance%20offers%20more%20rapid,emergency%20care%2C%20and%20general%20practice.

2) The second is the National Health Insurance Model, which is practiced in Australia, Canada, and Taiwan. This model establishes a national health insurance system with little cost-sharing. Providers are usually private and reimbursed through a tax-financed government plan. In this single-payer model, private insurance can be purchased to gain faster access to care, or improved choice in provider. In Canada's case, private insurance covers services excluded from universal coverage, such as vision, dental, or prescription drugs.[21] However, the option to purchase complementary private insurance may create inequitable access to services not included under universal coverage benefits. This finance model is similar to the Medicare program in the U.S. where enrollees may also purchase supplemental insurance in addition to their public insurance.

Multi-payer

Most multi-payer systems follow the Bismarck model, where health insurance is mandatory for residents. In this model, Statutory Health Insurance (SHI) is administered by nongovernmental insurers known as "sickness funds," and is funded through premiums. [22] Premiums are calculated as a percentage of income through compulsory payroll deductions by employees and are matched by employers.[23] Some countries have multiple competing insurers as is done in Germany, which helps contain costs by emphasizing managed competition among insurers. Regardless of the number of insurers, the government tightly controls prices for health services. [24]

In Germany, SHI funds are non-profit and must accept any applicant, regardless of preexisting conditions or health risk profile.[25] Individuals with higher incomes often choose to purchase complementary or supplementary insurance policies in addition to SHI for benefits nots covered under SHI, or for amenities such as private hospital rooms. Some groups are exempt from enrolling in SHI, including high-income individuals who meet a certain income requirement, civil servants, and those who are self-employed. Individuals in these groups may choose to purchase fully substitutive private insurance.[26] However, the federal government regulates private insurance including monthly premiums, as well as provider fees.

Health care providers in Germany are mandated to participate in both SHI and private insurance plans, helping to balance payments from public and private insurance. Out-of-pocket expenses in multi-payer systems vary, though in Germany, most patients enrolled in SHI pay very small co-pays for outpatient or inpatient prescription drugs, medical devices, and hospitalization.

Government Role in Single and Multi-Payer Universal Health Care Systems

[21]About 67% of Canadians have some form of private coverage, typically through an employer. International Health Care System Profiles. Canada. Commonwealth Fund. 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/canada

[22]In addition to compulsory wage contributions, income-dependent contributions are paid directly to an individual's sickness fund. Income-dependent contributions to sickness funds are determined by the government. In 2019, the average supplementary contribution rate was approximately 1%. International Health Care System Profiles. Germany. 2020. Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/countries/germany

[23] Employees' portion is withheld directly by the employer from the employee's gross salary. The employer is obliged to remit the total contributions to the health insurance carrier on a monthly basis. Working and Living in Germany. 2020. Deloitte. https://www2.deloitte.com/content/dam/Deloitte/de/Documents/tax/Deloitte-Working-Living-in-Germany-2020.pdf

[24] Sickness funds compete for patients namely through deductibles, bonuses, and issues of efficiency. Sickness funds' costs are controlled by prohibiting physicians from charging above a set price for services in the SHI benefit catalog, and by allowing the sickness funds to negotiate drug prices with pharmaceutical manufacturers. The Public-Private Option in Germany and Australia: Lessons for the United States. 2020. Millbank Quarterly Opinion. https://www.milbank.org/quarterly/opinions/the-public-private-option-in-germany-and-australia-lessons-for-the-united-states/

[26] Fully substitutive private insurance covers approximately 11% of population. Ibid.

In all universal health care systems, whether single or multi-payer, governments play an active role in the oversight and regulation of health care. Governments regulate insurers, which are non-profit insurers in most cases. Additionally, the governments typically determine the standardized benefits packages, provide subsidies for low-income residents, establish prices for drugs and procedures, influence contract negotiations between providers and insurers, set the health care policy agenda, and set health budgets. Fees are often determined at the regional or national level through negotiations between providers, insurers, and drug manufacturers. Some governments, including England, set a fixed amount of funding per year for hospitals, known as global budgets, to control health expenditures. Other countries broker collective agreements with providers and insurers to limit cost growth rates.

Taxation in Single and Multi-payer Systems

Universal health care systems are funded mostly through general taxation. Though, this is not to say that there are no premiums or other out-of-pocket costs paid by consumers.

The National Health Service single-payer model as utilized in the United Kingdom is funded through general taxation. There, the three (3) main sources of revenue include income tax (27.6%), National Insurance contributions (20%)[27], and sales tax (19.2%).[28] In Canada's single-payer system, national health insurance is funded through earmarked taxes, usually on earned income which account for approximately 30% of revenue.[29] Employers in Canada also pay a revenue-based Employer Health Tax which can vary by territory or province.[30]

Multi-payer systems are largely financed through payroll taxes with contributions from both employers and employees. In France's multi-payer system, social security payroll taxes account for the majority of funding (53%), followed by a national income tax on all earnings (34%), the pharmaceutical industry and private voluntary health insurance (VHI) (12%), and state subsidies (1%).[31]

Example of Models for Consideration When Transitioning to a Universal Health Care System

Section 3 of this report offered examples of the unique financing approaches utilized in the state of Maryland, including all-payer rate setting and hospital global budgets. Additionally, the Washington Vaccine Association demonstrates a successful purchasing program used to provide universal coverage of vaccines to children in Washington. The following section will outline the funding model behind the Washington Vaccine Association.

The Washington Vaccine Association

[27] National Insurance is a payroll tax paid by employers and employees.
[28] Other revenues include tobacco duty (1.3%), alcohol duties (1.7%), council tax (4.9%), business rates (4.2%), and all other taxes collected by Her Majesty's Revenue and Customs (21.1%). RAND Europe. Research Brief. Options for Funding the NHS and Social Care in the UK. https://www.rand.org/content/dam/rand/pubs/research_briefs/RB10000/RB10079/RAND_RB10079.pdf
[29] Canadian residents pay a provincial income tax in addition to the federal income tax. Rates and tax brackets may vary by territory or province. https://www.canada.ca/en/financial-consumer-agency/services/financial-toolkit/taxes-quebec/taxes-quebec-2/5.html
[30] Ontario Employer Health Tax. https://www.ontario.ca/document/employer-health-tax-eht#:~:text=Employers%20have%20to%20pay%20Employer,of%20the%20employer%20in%20Ontario
[31] International Healthcare System Profiles. France. Commonwealth Fund. 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/france

Washington began its Universal Childhood Vaccine Program in 1990 to provide vaccines to all children under the age of nineteen (19), regardless of income.[32] The program was jointly funded by state and federal funds until 2009 when the Legislature eliminated state funding for the program beginning in 2010 due to the state budget deficit. In the 2010 legislative session, then Governor Gregoire signed into law Second Substitute House Bill 2551 that preserved the state's universal vaccine purchase program and established the Washington Vaccine Association as a new entity.

The Washington Vaccine Association (WVA) is a non-profit consortium who collects funds from health carriers and third-party administrators through mandatory assessments to cover the cost of vaccines for all children under the age of nineteen (19). [33] With funds collected from the assessments, the State Department of Health is able to purchase vaccines from the US Centers for Disease Control and Prevention at volume rates and deliver them to providers at no cost.

The WVA Funding Model

1. Each month, the Washington State Department of Health (DOH) fulfills enrolled providers' vaccine orders.
2. Healthcare providers then submit dosage-based assessments to payers for vaccines administered to insured children, at no charge to patients.
3. Health plans, carriers, and third-party administrators then pay the Washington Vaccine Association dosage-based assessments for vaccines.
4. On a monthly basis, the Association remits the funds from assessments to DOH for pediatric vaccine purchases.

Benefits of the WVA's Universal Purchasing Program

1. Providers have no financing costs or risk of loss because they receive pediatric vaccines from DOH and can use their existing billing system to trigger WVA's collection of funding from payers.
2. Consolidating ordering, delivery, and storage improves efficiencies for providers.
3. Providers have a stable supply of recommended vaccines.
4. Healthcare savings resultant from bulk purchases by the DOH of all pediatric vaccines at federal contract rates.
5. Centralized vaccine management.
6. Reduced barriers to immunizations.

Single-Payer Financing Models Proposed by Other States

In recent years, the RAND Corporation evaluated proposals by both Oregon and New York to finance their respective health care systems through a single-payer financing approach. Though some of the nuances of their respective proposals differ, RAND determined that in either approach, the new tax structure should redistribute the burden of financing health care to higher-income earners. RAND noted in both evaluations that the redistribution of who pays for health care may impact the political feasibility of implementing a single-payer model. These proposed single-payer models and their evaluations offer additional considerations in designing a unified health care financing system.

[32]Washington Vaccine Association Financial Statements. Years Ended Jun 30,2021 and 2020. https://wavaccine.org/wp-content/uploads/2021/11/Washington-Vaccine-Association-Financial-Statements.pdf

[33] Pursuant to RCW 70.290.075, if the clients represented by the TPA offer private health plan or self-funded employer plan coverage that might include vaccine material being provided to patients under the age of 19, then both state based and out-of-state TPAs are required to register with the Washington Vaccine Association. https://wavaccine.org/faqs/

Oregon

In 2017, the Oregon Health Authority sponsored a research study and microsimulation by RAND[34] to review four (4) options for financing health care for state residents. One of the financing models evaluated was a single-payer option. The single-payer model as analyzed by RAND was a state-sponsored plan that would use public financing to provide privately delivered healthcare for all state residents, including individuals currently enrolled in Medicare and Medicaid, and undocumented immigrants. There would be no cost-sharing for those with income under 250% of the federal poverty level (FPL). For those with incomes above this level, 96% of expenditures (actuarial value), on average, would be covered.[35] There would be no premiums. This option would significantly redistribute the burden of financing health care to higher-income earners. Hospital, physician, and other clinical services payment rates would be 10% below the average rates in the Status Quo.[36]

The single-payer model would be financed through:

1. Income-based state and federal tax payments.
2. Pooling state and federal outlays for current public programs.
3. Employers with twenty (20) or more employees would no longer make tax-advantaged premium payments and would instead pay a new state payroll tax.

RAND determined that the single-payer approach would reduce public sector costs by 20-50% but that the results are sensitive to assumptions including 1) the insurance operations of PEBB (Public Employee Benefits), OEBB (Oregon Educators Benefit), and Oregon's Healthcare Marketplace are largely redundant,[37] 2) a 30% reduction in the combined administrative costs of public program operations, and 3) one or more administrative contractors would replace health plans, agencies, and contractors in program's administration, including claims processing, utilization review, and provider credentialing. RAND made recommendations to Oregon to effectively implement a single-payer plan:

1. Arrange discussions with the federal government on the feasibility of the necessary waivers or other federal authorities.
2. Seek legal counsel to navigate ERISA (Employee Retirement Income Security Act of 1974) challenges.
3. Review provider payment approaches with CMS and seek input from providers on how provider payment changes could be implemented to promote quality of care and maintain sufficient provider engagement. Value-based payment approaches while reducing unnecessary care should be explored.

New York

[34]White, C. Eibner, C. Liu, J. 2017. A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon. RAND. https://www.rand.org/pubs/research_reports/RR1662.html

[35] RAND simulated a variant on the Single Payer option in which households with incomes above 400 percent of the FPL were enrolled in a plan with 90% actuarial value (AV) rather than 96% AV. Reducing AV for higher-income individuals reduces total system costs by around $600 million and reduces the state financing requirement by around $1.2 billion.

[36] The costs of the Single Payer option vary depending on the generosity of provider payments and on the share of health care expenditures paid by the plan. To quantify the impact of provider payment rates, RAND simulated two variants of the Single Payer option: 1) A low-payment variant in which hospital and physician payment rates were set to equal traditional Medicare. Reducing provider payment rates to this level would exacerbate congestion but would reduce total system costs by nearly $3 billion, and 2) a high-payment variant in which hospital and payment rates were kept equal to the Status Quo. Maintaining provider payment rates at the level of the Status Quo would alleviate some congestion but would increase total system costs by over $2 billion.

[37] The Single Payer option would replace commercial health plans and integrate the Medicaid and Medicare programs, as well as the Marketplace, PEBB, and OEBB.

In July 2018, the New York Legislature considered the New York State Health Act (NYHA), a state-level single-payer health plan that would provide coverage to all state residents regardless of immigration status and transform the state's delivery and financing of health care. The health care system under the NYHA would shift financing away from premiums and out-of-pocket costs towards a tax-based system, significantly redistributing who pays for health care.

The single-payer system as proposed would be financed primarily through taxes including:

1. Financing through new trust funds from the federal government in lieu of federal financing for health programs already existing (waivers for Medicaid, Medicare, and ACA requirements subject to federal approval).
2. Current state funding for health care programs.
3. Revenues from two (2) new progressively graduated state taxes:
    a. A payroll tax paid jointly by employers and employees at 80% and 20%, respectfully.
    b. A tax on income not subject to the new payroll tax, such as capital gains, interest, and dividends.

RAND was commissioned by the New York State Health Foundation to assess near-term and long-term impacts of the plan on health care coverage, costs, and spending, among other outcomes. [38] RAND made several assumptions in its analysis, including a possible graduated tax schedule. Compared to the status quo, this schedule would substantially reduce health care payments for lower-income residents, with the highest-income residents paying more. [39]

In their analysis, RAND determined that the NYHA single-payer approach could potentially lower payments amongst most New Yorkers, but that the results are sensitive to assumptions regarding uncertain factors, including:

1) the implementation of the program.
2) whether the state could reduce administrative expenses.
3) whether the state is willing and able to negotiate or set price levels and payment rates with providers.
4) the response of high-income residents facing new taxes.
5) the approval of federal waiver, including those to allow for federal funds currently paid to the state and its residents to be redirected to the NYHA.
6) that provider payments would, at least initially, be made on a fee-for-service basis based on a fee schedule.

Advancing Health Equity Through a Unified Financing System

The Commission recognizes that financing and coverage policies and structures in current health care system have contributed to the discrimination and marginalization of low-income individuals and individuals of color. Further, the current system allows for an individual's coverage and access to care to be largely determined not only by the payer or financing source of that coverage.

[38] Liu, H. White, C. Nowak, A. 2018. An Assessment of the New York Health Act. A Single-Payer Option for New York State. Rand. https://www.rand.org/pubs/research_reports/RR2424.html

[39] The NYHA would add new progressively graduated payroll and nonpayroll taxes but does not specify the rates or the degree of progressivity. RAND's analysis assumes one possible tax schedule that would reduce payments for the majority of residents but could lead to tax avoidance and migration among a small number of high-income households facing large tax increases. https://www.rand.org/pubs/research_reports/RR2424.html

The development and implementation of a unified financing system may create the opportunity to examine these existing harmful structures and to establish a new system that ensures equity and wellbeing for all Washingtonians, including the healthcare workforce. In examining the implications of a unified health care financing system on health equity, it will also be important to consider the role, if any, of private health insurance. A unified financing system may help further advance an equitable and transparent finance and delivery system as the state can leverage purchasing power to eliminate price variation and inequitable access to care. [40]

Recommendations

The approach for Washington's unified financing system will depend on the universal health care model selected for implementation. Universal coverage models as proposed by the Universal Health Care Work Group will be considered including Model A and Model B, as well as unified financing models utilized in other countries, to inform an approach translatable to Washington.

The Universal Health Care Work Group identified, but did not significantly address, key barriers to Models A and B. One of the greatest challenges to implementing a universal health care model is the cost to establish and administer the model. Though Model A and Model B project cost savings, the cost to implement either model will create a material financial burden to the State.[41] Other barriers considered by the Work Group included approval via waivers from CMS to implement such a program for those eligible for federal programs currently, the impact of job loss in eliminating many healthcare functions from the private industry, provider reimbursement, and political opposition to such a change. These barriers and challenges will be focuses of the deliberations on designing a unified health care financing system.

Significant planning, analysis, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the statutory charge, the Universal Health Care Commission created a Finance Technical Advisory Committee to aid the Commission in developing a unified financing system for universal health care in Washington.

1. Creation of a Finance Technical Advisory Committee (FTAC)

The Commission created a Finance Technical Advisory Committee (FTAC). This Committee will provide subject matter expertise and advise the Commission in the creation of a unified health care financing system.

2. Goals

FTAC serves at the direction of the Commission. The goal of FTAC is to provide guidance to ~~advise~~ the Commission in their development of a financially feasible model to implement universal health care coverage. FTAC members will investigate evidence-based strategies to develop unified health care financing proposals for the Commission's consideration. In their work, FTAC will carefully consider the interdependencies between proposals for a unified financing system and other considerations before the Commission and may provide pros and

[40] Single-Payer and Universal Coverage Health Systems: Final Report. 2019.Washington State Institute for Public Policy.
[41] Model A is projected to save $5.6 billion annually, while Model B is projected to earn no steady state annual savings past the implementation year.

cons for each proposal. Finally, FTAC will provide guidance~~make recommendations~~ for what entity(s) will implement the unified health care financing system.

3. Roles and Responsibilities

HCA will provide the necessary staffing and resources to support FTAC. HCA staff will prepare meeting agendas, provide meeting summaries, support the creation of meeting materials, distribute meeting materials, and will assist with meeting coordination.

The Commission will appoint a Chair for FTAC. The FTAC Chairperson may also be a member of the Commission. The Chairperson will assist with meeting facilitation and must be available for all FTAC meetings, as well as for Universal Health Care Commission meetings. The Chair will serve as the liaison between the FTAC and the Commission and will share any relevant discussions or findings at Commission meetings.

The Commission will direct the work of FTAC. The Commission will develop a charter for FTAC, and the charter will be available to FTAC members before their first meeting.

4. Committee Qualifications

Anyone may nominate a qualified candidate for FTAC, and self-nominees are also welcome. The applicant should hold subject matter expertise in health care financing, which can include, but is ~~including but~~ not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; dental benefits costs and financing; vision benefits costs and financing; provider reimbursement; coverage and benefits; health care economics; single-payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; or pricing.

5. Subject Matter Expertise

HCA staff will consult with FTAC if additional subject matter expertise is needed and invite subject matter experts to present to FTAC. Subject matter experts can~~will~~ include, but are not limited to, those with knowledge regarding financing of health care services and programs in Washington, public and private health care expenditures in the state, taxation and other public revenue models, employer-sponsored health coverage, health care benefits, economics, public budgeting and financing, organizational financing, provider reimbursement, health care workforce, and behavioral health financing.

6. Committee Appointment

The opportunity to apply for FTAC consideration will be posted to the Universal Health Care Commission's web page. The call for applications will be shared by HCA through a GovDelivery announcement when the opportunity to is posted to the Commission's web page. Applicants will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC. Applicants will also include their most recent resume with their application. The posting and opportunity to complete an application will be available for thirty (30) days which may be extended to sixty (60) days, if needed to allow for additional applicants.

The Commission will appoint seven (7) nominees for FTAC membership, which includes one (1) consumer representative, and if possible, reserving at least two (2) spots for two (2) state agencies which include the Department of Revenue the Office of Financial Management. If more than thirty (30) applications are received, the thirty (30) most qualified applicants will be brought to the Commission for consideration.

7. Considerations Before the Finance Technical Advisory Committee

A primary goal of the Universal Health Care Commission is to develop a plan for a uniform financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. One of the main goals of FTAC will be to provide guidance to the Commission. The following areoffer some of the areas that could be assigned to FTAC by the Commission for guidanceinterdependencies of a unified financing system and the larger universal health care system, and may inform FTAC's recommendations:

- Revenue goals and projections
- Scope of coverage, benefits, and cost-sharing, including dental and vision
- Development of fee schedule
- Securing federal funds
- ERISA
- Tax structure, including the impact of the tax structure on equity
- Assessing how to include Medicare beneficiaries
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Administrative cost reduction
- Risk management
- Model development process
- Health equity in financing
- Level of reserves and methods of funding
- Cost sharing
- Workforce
- Provider reimbursement medical school, including behavioral health
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

Conclusion

Washington's current health care financing system is costly and complex. Further, the current financing system and delivery system are inextricably linked, where an individual's coverage and access to care are determined by the payer or financing source of that coverage.

One of the primary goals of the Commission is to develop a plan for a unified financing system that will lead to greater access, higher quality, and equity for all Washington residents. The approach for Washington's unified financing system will be dependent on the universal health care model considered for implementation.

There are multiple sources of funding that pay for health care under Washington's current health care system. The strategy for combining those funding sources will be critical to the implementation and success of the unified health care financing system. This and other various challenges associated with maintaining or increasing funding from each funding source will be key considerations before the Commission and FTAC.

The Commission determined that the subject matter expertise of a finance committee will be essential to informing decision making and planning. As such, the Commission has begun the process for the creation a Finance Technical Advisory Committee to explore the various barriers and paths to implementing a successful unified financing system in Washington. The Commission and its Finance Technical Advisory Committee will work together closely at the direction of the Commission to explore unified health care financing systems as proposed by the Universal Health Care Work Group and as practiced in other countries, as well as other feasible paths to implementing a unified financing system that provides equitable, affordable, high-quality care to all Washingtonians.

Washington State Health Care Authority

Draft Finance Technical Advisory Committee (FTAC) materials with member comments

Tab 7

Washington State Health Care Authority

Washington State Universal Health Care Commission

Finance Technical Advisory Committee (FTAC)

Significant planning, analyses, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the statutory charge, the Universal Health Care Commission may recommend the creation of a finance committee to aid the Commission in developing a unified financing system for universal health care in Washington.

Creation of FTAC

The Commission created a Finance Technical Advisory Committee (FTAC) is created with the goal to provide subject matter expertise to advise the Commission. FTAC will also assist the Commission with the development of a financially feasible model to implement a unified health care financing system.

Goals

FTAC serves at the direction of the Commission. The goal of FTAC is to provide guidance ~~to advise~~ to the Commission in their development of a financially feasible model to implement universal health care coverage. Members of FTAC will work with an equity lens to investigate evidence-based strategies to develop unified health care financing proposals for the Commission's consideration. In their work, FTAC members will carefully consider the interdependencies between foundational design elements ~~proposals~~ for a unified financing system and other considerations before the Commission and may provide pros and cons for each proposal. Finally, FTAC will provide guidance ~~make recommendations~~ for what entity(s) will implement the unified health care financing system.

FTAC Roles and Responsibilities

The Health Care Authority (HCA) will provide the necessary staffing and resources to support FTAC. HCA staff will prepare meeting agendas, provide meeting summaries, support the creation of meeting materials, distribute meeting materials, and will assist with meeting coordination.

The Commission will appoint a Chair for FTAC. The Chair of FTAC may also be a member of the Commission. The Chairperson will assist with meeting facilitation and must be available for all FTAC meetings, as well as for Universal Health Care Commission meetings. The Chair will serve as the liaison between FTAC and the Commission and will share any relevant discussions or findings at Commission meetings.

The Commission will direct the work of FTAC. The Commission will develop a charter for FTAC, and the charter will be available to FTAC members before their first meeting.

Subject Matter Expertise

HCA staff will consult with FTAC, if additional subject matter expertise is needed, and invite subject matter experts to present to FTAC. Subject matter experts can ~~will~~ include, but are not limited to, those with knowledge regarding financing of health care services and programs in Washington, public and private health care expenditures in the state, taxation and other public revenue models, employer-sponsored health coverage, health care benefits, economics, public budgeting and financing, organizational financing, provider reimbursement, health care workforce, and behavioral health financing.

Meetings

FTAC will meet between Commission meetings on a bi-monthly basis. FTAC will continue this schedule until the Commission deems it appropriate to revise FTAC's meeting schedule or FTAC completes all of designated tasks ~~its goals~~.

Appointment

The opportunity to apply for FTAC membership will be posted to the Universal Health Care Commission's web page. The call for applications will be shared by HCA through a GovDelivery announcement when the opportunity to is posted to the Commission's web page. Nominees will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC. Nominees will also submit their most recent resume. The posting and opportunity to complete an application will be available for at least thirty (30) days ~~sixty (60) days,~~ which may be extended to sixty (60) days~~,~~ if needed to allow for additional applicants.

All application materials will be shared with the Commission. If more than thirty (30) applications are received, the thirty (30) most qualified applicants will be presented to the Commission. The Commission will appoint seven (7) nominees for FTAC membership, which includes one (1) consumer representative, and if possible, reserving at least one (1) spot for the Department of Revenue and one (1) spot for the Office of Financial Management.

Qualifications

Anyone may nominate a qualified candidate for FTAC, and self-nominees are also welcome. The applicant should hold subject matter expertise in health care financing, which may include ~~including~~ but is not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; dental benefits costs and financing; vision benefits costs and financing; provider reimbursement; coverage and benefits; health care economics; single-payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; or pricing.

Considerations Before FTAC

A primary goal of the Universal Health Care Commission is to develop a plan for a uniform financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. One of the main goals of FTAC will be to provide guidance ~~make recommendations~~ to the Commission ~~for which entity(s) will be responsib~~le for implementing a unified health care financing system. The following ~~offer~~ are some of the areas that could be assigned to FTAC by the Commission for guidance:

- Revenue goals and projections
- Scope of coverage, benefits, and cost-sharing, including dental and vision
- Development of fee schedule
- Securing federal funds
- ERISA
- Tax structure, including the impact of the tax structure on equity
- Assessing how to include Medicare beneficiaries
- Administrative cost reduction
- Risk management
- Model development process
- Health equity in financing
- Level of reserves and methods of funding
- Workforce and Provider reimbursement
- Impact of payment model on care quality and equity
- Economic impacts of new taxes
- Care investments, including primary care, behavioral health, community health, and health-related social needs
- Financial forecast of changes in demand/utilization, etc.
- Authority and analytic capacity within a new or existing administering agency

Washington State Health Care Authority

Finance Technical Advisory Committee for the Universal Health Care Commission

Call for Applications

The Washington State Universal Health Care Commission is seeking qualified members for the new Finance Technical Advisory Committee.

Finance Technical Advisory Committee (FTAC)

The health care system's current financing model has grown increasingly costly. Though Washington continues to make payment and purchasing reform efforts, the current health care system's increasing annual costs outpace wages and inflation and widen gaps in access to health coverage and care. Multiple economic analyses, including analysis by Washington's Universal Health Care Work Group, demonstrate that a universal health care system can improve health equity and access to care, decrease costs, and will produce billions in savings per year, while providing universal coverage to resident.

The Universal Health Care Commission was created by Senate Bill 5399. The Commission is charged with making the health care system more accessible by increasing access to quality, affordable health care by preparing Washington state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system once the federal government approves the new universal health care system. The cost to establish and administer such a system will create a material financial burden to the state and will be one of the greatest challenges to implementing a unified financing system.

Significant planning, analyses, and evaluation will be required for the transition to and implementation of a unified health care financing system. Consistent with the Universal Health Care Commission's statutory charge, it has created a Finance ~~and Revenue~~ Technical Advisory Committee (FTAC) to aid the Commission in understanding design components that are foundational to developing a unified financing system for universal health care in Washington. The Commission will provide direction, including topics and questions to be addressed ~~a recommended agenda for~~by ~~the work of the~~ FTAC. The Commission will also provide direction about how the materials and information gathered and researched by FTAC will be presented to the Commission for consideration.~~, potentially developing reports and culminating in a final report and set of~~guidance ~~recommendations to the Commission~~on options for for their ~~Commission to consider~~ation~~.~~

Purpose

A primary goal of the Universal Health Care Commission is to develop a plan for a uniform financing system that will greatly simplify the system and lead to equitable, accessible, high-quality care for all Washington residents. FTAC serves at the direction of the Commission. The goal of FTAC is to advise the Commission in their development of a financially feasible model to implement universal health care coverage. Members of FTAC will consider and recommend design options and strategies for a universal health care system with a unified health care financing for the Commission's consideration. In their work, FTAC members will carefully consider the interdependencies between foundational elements ~~proposals~~ for a unified financing system and other considerations before the Commission, including the impact on the existing healthcare landscape and resources necessary for implementing the system.

Finally, FTAC will provide guidance ~~make recommendations~~ for what entity(s) will implement the unified health care financing system.

Appointment and Qualifications

The Commission will appoint seven (7) nominees for FTAC membership, including one (1) consumer representative, and if possible, reserving at least two (2) spots for two (2) state agencies which include the Department of Revenue the Office of Financial Management. Anyone may nominate a qualified candidate, and self-nominees are also welcome. Applicants will need to complete a basic application about the individual, their background/expertise to participate, and why they want to participate on FTAC, as well as attaching their most recent resume to the submission. The posting and opportunity to complete an application will be available for at least thirty (30) days with a possible extension to sixty (60) days if needed to allow for additional applicants. ~~.~~

The applicant should hold subject matter expertise in health care financing, including but not limited to: service delivery; pharmaceutical costs and spending; universal health insurance; rural health; behavioral health financing; dental benefits costs and financing; vision benefits costs and financing; provider reimbursement; coverage and benefits; health care economics; single-payer revenue models (including taxation and federal and state revenue); single-payer payment models (including Diagnosis Related Group (DRG), global budgets, value-based payment, capitation, directed payments); alternative payment models (including value-based payment); Medicaid financing; Medicare financing; federal waivers; cost sharing; cost containment strategies; ERISA; and/or pricing.

How to Apply

If you are interested in being considered for FTAC membership, please complete the Finance Technical Advisory Committee Application, available on the Universal Health Care Commission's webpage, and submit to HCAUniversalHCC@hca.wa.gov.

Applications will be accepted for 30 ~~60~~ days through ***TBD, 2022***. All application materials will be shared with and considered by the Commission. FTAC members will be appointed by the Washington State Universal Health Care Commission.

Additional Information

For more information about the Universal Health Care Commission, including past and upcoming meetings, please visit: https://www.hca.wa.gov/about-hca/universal-health-care-commission

You can also reach out to Mandy Weeks-Green, the Coverage and Marketing Strategies Manager at the Health Care Authority at HCAUniversalHCC@hca.wa.gov.

For more information about the Universal Health Care Work Group, please visit: https://www.hca.wa.gov/about-hca/universal-health-care-workgroup

If you would like to stay informed about the Universal Health Care Commission's work, please visit their webpage and/or sign up for email updates.

Washington State Health Care Authority

Report to the legislature draft of section 4 with member comments

Tab 8

DRAFT OF SECTION 4 OF UNIVERSAL HEALTHCARE COMMISION REPORT TO THE LEGISLATURE

Section 4: Readiness

Introduction

The Legislature directed the UHC Commission to provide an assessment of Washington's current level of preparedness to meet the elements of universal health care with a unified financing system, including, but not limited to a single-payer financing system. *Section 4* provides a preliminary readiness assessment of the state's current level of preparedness to implement a unified health care financing system as described in Model A and Model B of the UHC Work Group. It outlines the functions state agencies are currently performing and potential resources available to perform those functions under a unified health care financing system.[1] Additionally, *Section 4* compares the current health care system with a potential unified health care financing system and identifies the steps and considerations necessary to move from the current system to universal health care supported by a unified financing system.

Washington's readiness to transition will likely evolve as the Commission continues its work, as a complete readiness assessment is dependent on finalizing various design elements, including which model of universal health care is chosen. This preliminary assessment will, however, provide initial considerations that will help to inform the Commission's work and potential next steps. Throughout the course of the Commission's work, there will be revisions and expansions to the initial assessment as the unified health care financing system develops.

A readiness assessment survey tool was developed and provided to Commission Members to gather information and evaluate Washington's readiness.[2] Individual interviews were also conducted with state agency representatives participating on the Commission. The survey and interviews demonstrated that while Washington has significant resources that could be adapted and expanded to implement a unified health care financing system, major gaps exist. The assessment revealed important information for consideration, including identifying that state agencies have limited to no experience in directly performing important functions of the health care system. For example, state agencies have not historically performed utilization management functions whereas managed care organizations, private payers, providers, and others typically employ utilization management strategies to coordinate and manage care, to reduce wasteful, unnecessary care, and to contain costs. In some cases, this is done by private entities such as Medicaid Managed Care Organizations and commercial health plans on behalf of state agencies in public programs which the state agency administers (e.g., Apple Health, School Employees Benefits Board (SEBB), Public Employees Benefits Board (PEBB)).

The assessment of the seven core components of a universal health care system is summarized in Table 1 (*see below*). This table describes the state's readiness to move from the current system to the potential new model(s). For purposes of assessing Washington's level of preparedness in this report, Green signifies that the State is ready to implement a particular design element without major

[1] Washington is currently adopting policies and making budget allocations to achieve Model C.
[2] The survey and interview guide are included in Appendix X.

additional resources and IT systems or disruption to existing state programs; Yellow signifies that the state has some resources, IT systems, and programs that could be modified and expanded to implement the design element; and Red signifies that the state lacks the resources, IT systems, and programs needed to implement the design element or has no history of implementing a similar function.

Preliminary Readiness Assessment Findings	
Core Component	**Readiness Level**
1. Eligibility and Enrollment	**Yellow**
2. Benefits and Services	**Yellow**
3. Financing	**Red**
4. Provider Reimbursement and Participation	**Dependent upon Model Design**
5. Cost Containment Elements	**Model A: Red** **Model B: Yellow**
6. Infrastructure	**Model A: Red** **Model B: Yellow**
7. Governance	**Red**

Table 1: Summary of Readiness to Implement Core Components of a Universal Health Care System with a Unified Financing System

Core Component 1: Eligibility and Enrollment

The goal of universal health care is to enroll all eligible Washington residents to ensure that they have the best possible access to essential, effective, appropriate, and affordable health care services. In the current system, determinations about coverage eligibility and enrollment vary depending on the coverage source: public programs, employer-sponsored coverage, or the individual market.

There are several challenges to establishing universal eligibility and enrollment processes. Washington lacks a centralized source of information about individuals' existing coverage because the various information technology systems currently in use are not capable of interacting with one another. Similarly, there is no central database of uninsured individuals and families. As a result, systems will need to be developed to effectively transition individuals enrolled in any current system and the uninsured into the new health care system. This will ensure continuous care and will help an individual or family enroll in a unified health care financing system.

This work will vary depending on current coverage: people who have existing coverage will transition into the new system, and people who are uninsured will need to be enrolled into the system. Each of these coverage scenarios presents its own challenges.

DRAFT OF SECTION 4 OF UNIVERSAL HEALTHCARE COMMISION REPORT TO THE LEGISLATURE

Eligibility Readiness = Yellow

Under any universal health care system, eligibility determination is crucial. The nature and extent of the information needed depends to some extent on the design of the new system. However, under any model, residency status would need to be determined and verified. Residency requirements could include a waiting period or a minimum residency duration to establish eligibility. These requirements would have to be investigated to understand the limitations allowable given the federal right to interstate travel and receipt of public benefits. ~~.~~

Additional information will be needed to determine the eligibility criteria. For example, more information would be needed to determine eligibility for non-residents such as those eligible for health insurance offered by their Washington-based employer. Similarly, further work may be needed to identify the impacts of eligibility policies, processes, and procedures on specific populations (e.g., tribal members or persons who are incarcerated) and to ensure comprehensive collaboration with all partners such as community-based organizations that can assist with outreach and eligibility determinations.

Washington's robust system to determine eligibility for Apple Health and Qualified Health Plans (QHPs) could be modified to serve as the eligibility verification system for any universal health care. However, depending on the model chosen for the unified health care financing system, these modifications could be significant and costly. For example, if multiple coverage programs are maintained under the system (e.g., Apple Health, QHPs, PEBB, and SEBB), a unified eligibility platform would need to reconcile multiple sets of eligibility criteria to determine the most appropriate program and, if applicable, relevant subsidies.

Modifications may be more straightforward if all participants have the same eligibility criteria and receive the same benefits under the universal health care system. For example, under Model A, eligibility may presumably be determined based on state residency, with subsidy eligibility determined based on income. This is similar to the eligibility criteria employed by the Exchange in determining eligibility for QHPs and subsidies. Clear criteria and required documentation would need to be identified in the program design and operational implementation phases.

The current eligibility systems would need to be expanded to determine eligibility for the entire population, which will require planning and funding, including some lead time prior to enrollment for system builds and testing. Readiness for eligibility processes will require coordination with Medicare (if Medicare enrollees can be included in the universal health care system). It will also be important to consult with tribal leaders regarding the relationship between the tribal health system and the trust responsibility for the federal government to provided healthcare to American Indians and Alaska Natives and the unified financing system. Finally, additional resources would be needed for consumer outreach, education, and support during the eligibility application process.

~~). It will also be important to consult with tribal leaders regarding the relationship between the tribal health system and the unified financing system. Finally, additional resources would be needed for consumer outreach, education, and support during the eligibility application process.~~

Enrollment Readiness = Yellow

Once an individual or family is determined to be eligible for coverage under the new system, enrollment processes will be needed to place eligible individuals and families into coverage. The methods for enrollment and the complexity of the processes depend on the design of the universal system.

Commented [BJ(1]: It might be worth some legal research regarding allowable limitations, given the federal right to interstate travel, especially with respect to receipt of public benefits.

Commented [LA2R1]: Added language, review

Commented [VL3]: It is important that the federal government fund coverage for I.H.S. eligible Washingtonians to keep their treaty/trust responsibility. Especially in Washington State, the treaties signed between 1854 and 1856 all had a provision of healthcare for the ceded land.

Commented [LA4R3]: Agree with this comment, have accepted it

Commented [BJ(5]: Here, I would not the government to government relationship between Washington state and the tribes. In addition, the relationship relates not only to the tribal health system, but also to tribal members with respect to access to coverage and services.

Commented [LA6R5]: See above

Currently, Washingtonians often have a choice among health carriers or health plans for their coverage. For public programs and most employer-based coverage, selections are made after reviewing the available options. Occasionally, people are assigned or auto-enrolled into a plan.[3] The current process utilized to enroll Washingtonians into Apple Health, Qualified Health Plans and Cascade Care could be simplified to expand enrollment for a unified health care system envisioned by Model A. While there may be various approaches to Model B, the enrollment processes currently utilized for Apple Health and the Exchange could be expanded upon to enroll the entire eligible population which may streamline enrollment.

Core Component 2: Benefits and Services = Yellow

Benefits and services will be a critical component of the universal health care system. As discussed in *Section 3* of this report, two of the potential coverage models (A or B) will require the state to develop, administer, and assess the performance of covered benefits and services. The UHC Work Group recommended, as a starting point, that the ACA-mandated categories of services in the Essential Health Benefits (EHB) would be provided, with the possibility of additional service categories ~~benefits~~, including vision and hearing. Among the outstanding considerations is whether other benefits not included in EHB, such as long-term care and disability services, will be provided by the universal health care system.

Through its existing coverage programs, Washington manages distinct benefits and services packages for Apple Health, PEBB, SEBB, and Cascade Care. As a result, Washington is well positioned to engage stakeholders, develop options, and make decisions regarding the standard benefits and services covered under the unified financing system. However, in many cases, programs including Apple Health, PEBB, SEBB, and other programs offer benefits that are not included in the EHB. The ACA-mandated EHB may be a helpful starting point for a standard benefit package, though the difference in benefits between what currently exists under various programs will need to be reconciled. However, to effectively guide this development, it will be important to establish a process to define the specific services within the categories, but also an ongoing process to update the services over time that incorporates new clinical evidence and diverse stakeholder input.

Once the benefit package is developed, the benefits must be administered. Depending on the coverage model, the state could administer benefits directly, or through third-party administrators, or through contracted health plans. Currently, benefits under Apple Health, PEBB, SEBB, and Cascade Care are administered using a combination of the three methods. More investigation is needed to understand the scalability of each program's benefit administration capabilities. Further, to support the affordability, quality, and equity goals of the unified financing system, administrators must accommodate any complex eligibility rules, benefit management processes and value-based payment models as they currently exist or are revised in the future. As such, Washington's readiness to administer benefits is critically tied to decisions regarding the benefits package as well as provider reimbursement, consumer cost-sharing, and financing.

It will also be necessary to assess the performance of the standard benefits and services in advancing affordability, quality, and equity goals. Currently, several coverage programs and agency-housed programs such as the Health Care Cost Transparency Board (HCCTB) and the All-Payer Claims Database

Commented [BJ(7]: The EHB's are categories of services. Under the ACA, which specific services within each category are covered is linked to the designated EHB benchmark plan, which by statute in Washington state (RCW 48.43.715) is a Regence BlueShield small group health plan. A determination of covered benefits and services should build in a process to both define the specific services within categories, but also to update those services over time. Washington (and other states) have lots of experience with the "additional benefit defrayal" issue under the ACA. That experience reveals the importance of having some means to update covered services based upon development of new clinical evidence.

Commented [LA8R7]: Added some word clarity- take or leave and then below adding language about process to update the services

[3] This would occur in Apple Health when a person does not make a plan selection and employer-sponsored coverage when only one plan is offered.

(APCD) collect and analyze claims, encounter data, and other data. However, more assessment will be needed to determine readiness to support value-based benefit design within the universal health care system. This will be critical in ensuring that incentives are provided and that financial barriers are removed for greater utilization of high value services such as recommended preventive care.

Core Component 3: Financing = Red

Health care is currently financed through several different sources and in a variety of ways. Financing sources include direct payments by the federal and state governments for public programs, subsidies for the purchase of health coverage on the Exchange, premiums paid by employers and consumers, and out-of-pocket costs paid by consumers such as copays and coinsurance. The complexity and cost of the current system make financing one of the most challenging aspects of establishing a universal health care system. Consolidating and simplifying this system is one of the outcomes that supports establishment of a universal health care system. Another likely outcome is reduced financial burden on consumers and increased access to care.

Under either Model A or B, numerous, complex decisions will determine how the system would be financed, as described more fully in *Section 3* of this report. *This section of the report may be further revised or developed pending Commission discussions.*

Perhaps the most challenging and time-consuming task will be to obtain the federal waivers needed to utilize federal funds to help finance the unified financing system. This work cannot begin until the universal health care system design has been further explored. Significant time will then be needed for waiver drafting and the federal approval process, which could potentially involve both federal agency and Congressional action. The federal government may not agree to approve the entire request, which would require alternative sources of funding to be identified. In addition, further exploration is needed to determine how to raise state funds to replace the amounts currently paid by businesses and families in the form of premiums and copays. These decisions are likely to be a significant change from what Washingtonians are used to ~~controversial~~, and this work will be more efficiently conducted once the design of the universal health care system is further developed.

Commented [LA9]: Comment for word change from Vivki

Core Component 4: Provider Reimbursement and Participation = Readiness Assessment Dependent on Model Variables

Provider reimbursement is a critical element of any health care system. It must address financial solvency for providers, advance equitable access to affordable health care services, and drive person-centered, outcomes -based health care delivery. Implementation requires both the operational functions to administer payment and the analytic functions to assess provider performance against quality, cost, and equity targets. Washington's readiness to implement a provider reimbursement model in a unified financing system is greatly dependent on the overall universal health care system, and the methods of provider reimbursement selected for the model.

Commented [LA11R10]: Accepted the word change

Commented [VL12]: Do we define "value based" somewhere? It has a different meaning depending on your values. Dominant culture values should not continue to be used for people with different values and cultural beliefs.

Commented [LA13R12]: Appreciate this comment, we don't define value here, but this should be part of the framing about what outcomes are sought by the health care system- how about for here we change it to "outcomes-based" and added person-cnetered?

Depending on the provider reimbursement methods, the assessment reveals varying levels of readiness (green, yellow, or red). For example, if Washington chose to implement a direct provider employment model such as the National Health Service in the United Kingdom or the Veterans' Health Administration in the U.S., its readiness assessment would be red. Washington has little experience with such a system

and the challenges of contracting directly with all the health care providers in the state would be considerably more involved.

However, Washington's readiness to reimburse providers entirely on a fee-for-service (FFS) basis with a uniform rate structure, as suggested in the UHC Work Group Report, is assessed as green. HCA has experience in paying claims in FFS Medicaid. Until 2011, HCA also contracted directly with providers to establish the Uniform Medical Plan network for PEBB and SEBB. While the scale and scope of these capabilities would need to be greatly expanded, Washington has demonstrated its capacity for provider contracting and FFS claims payment. Moving to an entirely FFS method of paying providers may be inconsistent with the many efforts Washington, along with other states and the federal government, has made to reduce costs and improve the quality of care using managed, coordinated care models. This may mean moving away from use of value-based provider reimbursement, which may disrupt advances made in quality, equity, and cost containment under value-based provider reimbursement.

Washington's readiness to transition to a system that makes greater use of alternative payment models and provides incentives for higher value care is assessed as yellow. While Washington does not have a history of administering global budgets, it does contract with managed care organizations on a per member per month payment basis and third-party administrators to provide these functions for specific programs. This is similar to what could be done under a variation of Model B. However, the extent to which these capabilities can be scaled to support a universal system requires further assessment and is likely dependent on the specific reimbursement models selected for the financing system. For example, while a third-party administrator under Model B may be able to administer quality bonuses, capitated payments, or value-based contracts in the commercial insurance market, the third-party administrator may not be able to easily implement a global budget for an attributed population.

In addition to these analytic and operational considerations, provider reimbursement under Model A or B would require an agency to have authority to set and pay provider rates. While that authority exists today in limited programmatic contexts (e.g., Apple Health), a unified financing system would require significant expansions of authority for a governing agency to support provider reimbursement models.

Core Component 5: Cost Containment Elements = Readiness Assessment Red or Yellow, Depending on Model Variables

Improved cost containment is one goal of a unified health care financing system. Washington's readiness to implement cost containment in a unified financing system is assessed as red for Model A and yellow for Model B. One of the more problematic features of the current health care system is that incentives for payers and providers are not aligned to control costs. Though changes have been made to improve health care financing and cost control, much of the system relies primarily on fee-for-service payments that focuses and pays based on volume rather than value. Further, due to the different delivery models and markets, the current health care system is fragmented making it difficult to apply cost containment measures at scale.

Many different efforts to contain costs are underway in Washington, as more fully described in *Section 1* of this report. Various entities are currently responsible for managing costs and coordinating care, with various state or federal agencies regulating their activities. For example, HCA oversees Apple Health managed care plans, OIC regulates commercial insurers, and the federal Department of Labor regulates self-funded employers. The state and federal governments have not directly engaged in managing costs

and coordinating care to a large extent, with the Veterans' Health Administration being a notable exception.

Under Model A, Washington would need to develop new processes and obtain additional resources to carry out the functions of directly managing costs and coordinating care. The current efforts of cost and care management are tailored to the respective programs that provide health coverage and are not unified among the different entities implementing them. Under one version of Model B that uses carriers to provide health care insurance, the accountable agency administering the new system would need to align the contracted carriers' actions to provide consistent, effective cost containment measures to everyone covered by the system. This could include myriad uniform cost containment and care management approaches such as a common list of clinical guidelines and benefit exclusions, one standardized appeal process, and common prescription medication formularies.[4]

Reducing fraud, waste, and abuse is another strategy for cost containment that should be considered in the universal health care system.[5] Currently, the Health Care Authority employs strategies to reduce fraud, waste, and abuse in public health care programs. Further, as part of their regulatory and consumer protection mission, state agencies identify and prevent fraud, waste, and abuse in the provider and private payer markets. As the design of the universal health care system is developed, further assessment will be necessary to identify the readiness of these current agencies to support a fraud, waste, and abuse detection program, particularly if the financing system includes complex, value-based provider reimbursement models.

Core Component 6: Infrastructure = Readiness Assessment Red or Yellow, Depending on Model Variables

The capacity of the state's existing administrative infrastructure to scale and adapt to the new system is a key determinant of Washington's readiness to implement a unified financing system. The overall readiness of Washington's infrastructure supporting a universal health care system is assessed as red for Model A and yellow for Model B.

Technology and data platforms are some of the more important infrastructure considerations necessary to execute the universal health care system.[6] In administering existing coverage programs, Washington utilizes multiple call center and data management platforms for eligibility determinations, enrollment, and claims payment. However, most of the platforms currently in use are not compatible with other systems, making program integration a challenge. Further, given that platforms serving different programs have been developed to widely varying requirements, existing systems may not be well suited to support the unified financing system. However, there may be eligibility and enrollment platforms, such as the Apple Health and HBE's eligibility platforms, that could be repurposed for eligibility determination with modifications. Or, if utilizing work hours is a key determinant of eligibility, the PEBB and SEBB eligibility platforms could be modified and repurposed. As key design elements of the

[4] Many existing state initiatives would establish a foundation to support such approaches to better manage cost while improving quality as discussed in *Section 1*.
[5] Efforts to reduce fraud, waste and abuse were previously discussed in *Section 3.*
[6] As discussed in *Section 3.*

universal health care system are developed, each of the IT systems utilized in Washington will need to be evaluated for appropriateness and scalability to support the model selected.

Human resources and staffing are also critical areas of infrastructure readiness. Certain functions needed to implement a universal health care system are currently being performed by the private sector. For example, health insurance carriers currently contract with providers who care for their members. Carriers also help to coordinate and manage care delivered by providers in the community who may not be part of the same health care system. Additionally, carriers perform utilization management to determine whether particular health care services are medically necessary and appropriate. Under Model A, additional state workers may be needed to perform these functions, or in the alternative, enter into contracts with private entities with state workers managing those contracts. While each agency has a complement of staff to support existing programs, significant planning efforts must be authorized and funded to assess needs pertaining to staff training, management transitions, and integration, particularly for Model A. For example, many of the programs operate call centers to support clients with eligibility determinations, enrollment, and other services. However, call center staff are typically highly trained and expert in the rules and processes for one coverage program and may require additional training to support a unified financing system, even if many of the rules and processes are retained in the new model.

Another consideration for readiness is Washington's ability to support the transition for employees whose service may not be required if organizations ~~agencies~~ and programs (including state agency and private organizations that comprise the current health care system) can be consolidated to support the unified financing system. Training programs can help transition these employees to new employment opportunities, possibly within the universal health care system. Further assessment will be needed to determine whether an existing employment program could fulfill this need.

Commented [BJ(14): Is this sentence referring only to state agency employees, or is the intent to address employment across the health care system?

Commented [LA15R14]: Made word changes to address

Finally, assessing human resource needs may also identify needs for new personnel and skill sets that do not currently exist in the state's workforce. For example, provider rate setting in Washington has never been done comprehensively across all payers. Supporting that function under the unified financing system will require combining technical expertise from across all markets. Identifying these needs and developing training programs for employees in the current health care system wherever possible may help mitigate negative consequences of implementing a universal health care system, and ease employment concerns through the transition.

Core Component 7: Governance = Red

In this report, governance has been identified as a critical design element of the universal financing system. The primary consideration for establishing the governance structure is whether a single agency or multi-agency governance structure should be accountable for overseeing the operation of the universal financing system.

Currently, no single agency or entity performs all the functions necessary for operating a universal financing system or serves all populations and stakeholders that would be served by the system. Additionally, no agency or entity has the authority to operate, oversee, or regulate across the entire healthcare landscape. However, Washington does have a history of shared authorities and collaboration across agencies. For example, HCA, OIC, and WAHBE collaborate to implement Cascade Care as designated by the Legislature.

DRAFT OF SECTION 4 OF UNIVERSAL HEALTHCARE COMMISION REPORT TO THE LEGISLATURE

Once the accountable agency or agencies are decided, the governing entity is likely to need significant resources and expanded or new authority to oversee and operate the universal financing system. When this critical design element is established, a governance structure and needed resources will need to be reassessed.

DRAFT OF SECTION 4 OF UNIVERSAL HEALTHCARE COMMISION REPORT TO THE LEGISLATURE

Summary

The preliminary readiness assessment reveals several opportunities to build on existing functions, but also identifies some initial areas that will require greater resources and/or new authorities to be able to design and develop a universal health care system. It also helps to clarify a potential sequencing for how the Commission might approach the system design for these key elements according to those that are foundational, secondary, or tertiary as seen in Figure 1.

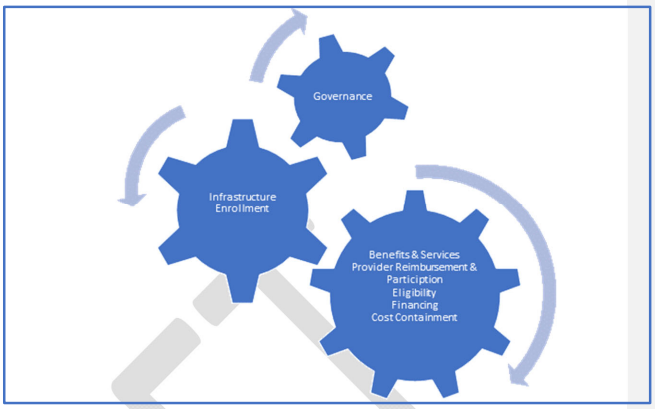

Figure 1: Potential Sequencing for Universal Health Care System Design

Washington State Health Care Authority

Report to the legislature draft of section 6 with member comments

Tab 9

DRAFT OF SECTION 6 OF UNIVERSAL HEALTHCARE COMMISION REPORT TO THE LEGISLATURE

Section 6

Introduction

Implementing a universal health care system is a long-term strategy for providing universal access to affordable and quality health care. The previous sections of this report describe the core design elements of a universal health care system and key considerations for their development and implementation. The Commission is also charged with developing intermediate recommendations for coverage expansion consistent with the goals of the universal health care system.

While Washington has made significant gains in reducing rates of uninsured, approximately four-point seven percent (4.7%) of the population remains without coverage as indicated in the most recently available data from the OFM. Notably, this does not capture the number of Washingtonians who are considered "underinsured" meaning that, "their insurance did not adequately protect them against catastrophic health care expenses".[1] Furthermore, disparities in coverage persist, particularly among Hispanic populations. As described in the first section of this report, Washington has already undertaken significant efforts and initiatives to expand access to coverage and improve the quality and affordability of health care for Washingtonians. This section incorporates those efforts and options for transitional improvements to the health care system.

This section also outlines a set of options that may expand coverage and improve the quality and affordability of health care in Washington. These options may also serve to lay a foundation for future efforts to establish the universal health care system and assist with short-term goals to improve the current health care system by increasing access and affordability:

- **Supporting~~Funding~~ new coverage solutions for individuals without federally recognized immigration status;**
- **Implementing the Cascade Care Savings program;**
- **Further aligning public coverage programs;**
- **Establishing a broader set of health care cost targets; and**
- **Implementing the Integrated Eligibility and Enrollment Modernization Roadmap**
- **Examining other transitional activities for alignment across coverage markets creating administrative simplification and potentially reducing costs**

Options for Expansion of Coverage and Subsidy Programs

Currently, the uninsured population in Washington includes individuals who, because of their immigration status, are prohibited from purchasing or enrolling in coverage options, as well as individuals for whom current coverage options are unaffordable. Efforts to expand coverage to these groups are currently in development in Washington.

Coverage Solution for Individuals without Federally Recognized Immigration Status

Under the ACA, only lawfully present immigrants can enroll in a qualified health plan (QHP). For those individuals who are not eligible to purchase QHPs, limited coverage programs are currently available (e.g., Apple Health is available for children and pregnant individuals and emergency medical coverage is

[1] "Insured But Not Protected: How Many Adults Are Underinsured." https://www.commonwealthfund.org/publications/journal-article/2005/jun/insured-not-protected-how-many-adults-are-underinsured.

Commented [BJ(1]: I think it's worthwhile to flag the issue of underinsurance here as well, maybe using the Commonwealth Fund definition. While we may not have a count of folks that meet this definition in Washington state, it still seems worth a mention.

Commented [LA2R1]: This is addressed further down- also added the CF definition here.

Commented [BJ(3]: Is there any value in considering a set of transitional activities related to looking at effectiveness of services, utilization management and payment methodologies? Any of this research could inform upcoming HCC decisions on key components, but could also potentially inform possible additional transition steps to be taken with respect to current programs. Here are some examples:

1.The Bree Collaborative has reviewed and developed care recommendations related to many types of health care services. Currently, these are recommendations and not binding. It seems worth it to explicitly incorporate their findings/recommendations into any consideration of both covered services and utilization management.

2.Same goes for the Health Technology Assessment Program, whose decisions are binding on Medicaid, PEBB and SEBB.

3. In prior years, there has been a focus on administrative simplification across payers. With the passage of SB 6404 in 2020, OIC has published 2 reports, with another due this year, related to carrier prior authorization practices, i.e. most common services subject to PA, approval rates, reversal of PA decisions upon appeal. It would be worth looking at any trends in carrier practices and what the research literature says about the impact of prior authorization, e.g. is the "sentinel effect" real. OIC has adopted rules requiring some base elements in carrier PA and UR practices (See WAC 284-43-2000 to -2060). It would be interesting to look at the extent to which states or other purchasers are legislating or directing the use of particular clinical standards or other common elements for UR activities, e.g. ASAM.

4.Washington state has a "sunrise review" process when the Legislature is considering adding a new health benefit mandate. Is it worth taking a look at what the results of those reviews have been over the years, whether the criteria in RCW 48.47.030 are appropriate criteria for the UHCC or other entities to use when considering what benefits to cover?

5.We are starting to develop a research base for value based payment model effectiveness. If the goal is t… [1]

Commented [UHCC4R3]: This has been added to the report.

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available for individuals with qualifying medical conditions). However, Washington has made significant progress in creating a program to cover individuals without federally recognized immigration status.

In May 2022, WAHBE and HCA applied for a 1332 Waiver to allow individuals without federally recognized immigration status to purchase QHPs on the Exchange without federal subsidies. Additionally, Cascade Care Savings will provide state-based subsidies for individuals earning under 250% FPL purchasing Silver or Gold standard plans regardless of their immigration status in order to further support the affordability of QHPs.

In 2022, legislation passed and dollars were allocated authorizing HCA to develop a coverage program to provide Medicaid look-alike coverage for individuals without federally recognized immigration status earning under 137% FPL. This coverage will be available in 2024 and will expand upon the current coverage options available for this historically underserved and underinsured group. Together, these changes would ensure that virtually all Washingtonians will be eligible for a coverage option regardless of immigration status with fully or partially subsidized coverage for lower-income individuals. While the Legislature has designated resources to design and build the program, resources have not yet been allocated to pay for the coverage itself.

Cascade Care Savings

Federal premium assistance for ACA Marketplace enrollees has been one of the primary strategies for increasing enrollment and expanding coverage through the Federal and State-based Marketplaces. The 2021 authorizing legislation directed the Exchange to establish Cascade Care Savings, a State premium assistance program that will begin providing financial assistance in 2023 to Washingtonians with incomes under 250% FPL purchasing a standardized health plan on Washington Healthplanfinder. The legislation appropriated $50 million in funding to subsidize premiums. Subsequently, an additional $5 million was appropriated to subsidize individuals not eligible for federal subsidies.

Options for Improving Affordability ~~and Quality of Coverage~~

Universal coverage and access are the primary goal of the universal health care system. As part of this goal, the Commission has discussed the need to address and support underinsured populations as the State progresses toward a universal health care system. Reducing underinsurance includes ensuring that affordable coverage meets the health and wellness needs of covered individuals. It also means that services are delivered equitably. In its future work, the Commission will consider short-term options for reducing underinsurance in Washington as a critical step toward universal health care.

However, it is important to recognize a critical step to reducing underinsurance is improving the affordability of existing coverage programs ~~as well as the quality of care delivered through existing coverage programs~~. The Commission has considered initial transitional solutions that advance affordability ~~and quality goals for~~of existing coverage programs and build capabilities that can be leveraged in the future universal healthcare system.

Further Align Public Coverage Programs

As described in Section 1 of this report, Washington has several ~~coverage~~ programs that finance care for a significant portion of Washingtonians including Apple Health, PEBB, SEBB, and Cascade Care. Each program has a unique design to serve the specific needs of the eligible population as well as to meet federal and state requirements. However, the programs also have many common functions that overlap with core design elements of a universal health care system as described in Section 3 and Section 4 of this report. At the same time, ~~For example,~~ each program manages these functions in slightly different ways either by directly performing~~ms~~, procuring~~es~~, or delegating ~~es~~ to ~~a~~ health plans for eligibility and enrollment, provider reimbursement, cost or utilization management, and quality improvement.

Commented [VL5]: Is it universal coverage or universal access? Coverage does not always equal access. The legislation talks about providing coverage **AND** access. I think it is important use those words together as much as possible to keep with the intent of the legislation.

Commented [LA6R5]: Accepted this edit

Commented [VL7]: What evidence are we using that the quality of care is poor? I don't remember this in anything we discussed. Are you trying to say that care is often culturally inappropriate? Access to care is certainly poor when it is too expensive.

Commented [LA8R7]: Striking the quality pieces here. Not sure it is relevant here, unless we want to add in the pieces that Jane is suggesting, but I realize these are your initiatives.

Commented [MB9]: This sentence seems slightly off but I can't quite figure out why? Perhaps a misplace comma? For instance, what does it mean that each program directly performs to a health plan eligibility and enrollment?

Commented [LA10R9]: I think this helps clarify Bidisha's issue

Currently, some of these functions align across programs. For example, several programs, including Apple Health and Cascade Care utilize measures for the Statewide Common Measure Set to help manage quality of care delivered and track health plan performance.[2] As an example of a common plan and benefit design, both the PEBB and SEBB programs utilize the Uniform Medical Plan (UMP), a self-insured plan managed by HCA.[3] This results in same benefits and networks available to employees served by both programs.

Continuing to align coverage programs may help to ensure consistent, equitable and ~~high~~ quality coverage across programs; reduce per beneficiary administrative costs for shared functions; enhance the purchasing power of the state when services are jointly purchased across programs; and make it easier for third-party vendors or health plans to participate in multiple coverage programs. Alignment also simplifies the consolidation of design elements as the State progresses toward implementing a universal health care system.

Commented [VL11]: Can we describe this differently than "high quality"? This is one of those phrases that gets used when a system that is structurally oppressive is being changed and there is an effort to cling to the old system because it is "high quality". Either remove the word "high" or maybe say: "consistent access to appropriate care across programs". What is quality health care will be different to different people.

Commented [LA12R11]: Accepted Vicki's suggestion and added equitable

Use Ongoing Cost Analyses to Establish Health Care Cost Targets

Section 1 described recent initiatives Washington has undertaken to analyze health care cost drivers including the Health Care Cost Transparency Board, the Prescription Drug Price Transparency Program, the Prescription Drug Affordability Board, Value-Based Purchasing, and the OIC's Report on Prior Authorization. While each of these initiatives has a different charge or purpose, they represent a growing analytic capacity within the State to identify costs across payers and to set costs targets.

In particular, the work and scope of authorities of the Health Care Cost Transparency Board and Prescription Drug Affordability Board could have the ability to analyze a broader range of health care costs and set targets for growth in health care costs in aggregate and per service or of drug prices. Cost growth targets can establish an analytic foundation for key design elements of a unified health care financing system. For example, as cost targets are developed, these can be used to set fee schedules or for developing value-based arrangements for providers participating in coverage programs. As an initial step, Washington could explore how to leverage the work of cost transparency initiatives such as the Health Care Cost Transparency Board can be used to develop a broader set of health care cost targets.

Commented [BJ(13]: Might want to clarify what "cost transparency initiatives" are being referenced here. Also, add some explanation as to how they can be used.

Commented [LA14R13]: Addressed this by adding HCCTB- but I think we are saying that the Commission should explore how to use them

Implement the Integrated Eligibility and Enrollment Modernization Roadmap

In 2021, Washington established a Health and Human Services Enterprise Coalition to review the patchwork of eligibility and enrollment technology platforms that serve the seventy-five (75) health and human services programs administered by the state.[4] The coalition developed the Integrated Eligibility and Enrollment Modernization Roadmap. This five (5)-year roadmap for implementing an integrated eligibility and enrollment platform in Washington would allow Washingtonians to apply to all available

[2] Washington Health Care Authority, Statewide Common Measure Set. https://www.hca.wa.gov/about-hca/washington-statewide-common-measure-set#what-is-statewide-common-measure-set

[3] Washington Health Care Authority, Uniform Medical Plan. https://www.hca.wa.gov/about-hca/uniform-medical-plan-ump

[4] Engrossed Substitute Senate Bill 5092. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5092-S.sl.pdf

programs in a single streamlined application, receive support through multiple channels, and provide a single eligibility record.[5]

Implementing an integrated platform would support an important infrastructure need for a universal health care system. It can also, as a short-term step toward universal health care, make it easier for Washingtonians to apply for coverage and receive financial assistance and other supports for which they are eligible while potentially reducing overall administrative costs. Implementing the Integrated Eligibility and Enrollment Modernization Roadmap may support short-term coverage goals as well as builds necessary long-term infrastructure.

Examining Other Transitional Activities

The Commission will consider transitional activities related to effectiveness of services, utilization management and payment methodologies. This research could inform possible additional transition steps to be taken with respect to current programs. The following are some examples for further consideration: the Bree Collaborative, the Health Technology Assessment Program, administrative simplification across payers, and value-based payment.

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Summary

The options discussed in this section could be initiated in parallel to the universal health care planning and development efforts of the Commission. Some options have potential to advance important capabilities that will be necessary for implementing a universal health care system. These transitional, short-term opportunities could expand or improve coverage within the current health care system while aligning with the core principles of universal health care.

[5] Integrated Eligibility and Enrollment Modernization Roadmap. https://www.wahealthplanfinder.org/content/dam/wahbe-assets/legislation/WA%20IEE%20Modernization%20Roadmap%20Report.pdf

Page 1: [1] Commented [BJ(3] Beyer, Jane (OIC) 7/29/2022 10:07:00 AM

Is there any value in considering a set of transitional activities related to looking at effectiveness of services, utilization management and payment methodologies? Any of this research could inform upcoming HCC decisions on key components, but could also potentially inform possible additional transition steps to be taken with respect to current programs. Here are some examples:

1. The Bree Collaborative has reviewed and developed care recommendations related to many types of health care services. Currently, these are recommendations and not binding. It seems worth it to explicitly incorporate their findings/recommendations into any consideration of both covered services and utilization management.

2. Same goes for the Health Technology Assessment Program, whose decisions are binding on Medicaid, PEBB and SEBB.

3. In prior years, there has been a focus on administrative simplification across payers. With the passage of SB 6404 in 2020, OIC has published 2 reports, with another due this year, related to carrier prior authorization practices, i.e. most common services subject to PA, approval rates, reversal of PA decisions upon appeal. It would be worth looking at any trends in carrier practices and what the research literature says about the impact of prior authorization, e.g. is the "sentinel effect" real. OIC has adopted rules requiring some base elements in carrier PA and UR practices (See WAC 284-43-2000 to -2060). It would be interesting to look at the extent to which states or other purchasers are legislating or directing the use of particular clinical standards or other common elements for UR activities, e.g. ASAM.

4. Washington state has a "sunrise review" process when the Legislature is considering adding a new health benefit mandate. Is it worth taking a look at what the results of those reviews have been over the years, whether the criteria in RCW 48.47.030 are appropriate criteria for the UHCC or other entities to use when considering what benefits to cover?

5. We are starting to develop a research base for value based payment model effectiveness. If the goal is to integrate VBP models fully, it seems worthwhile to have the most current information regarding the impact of models to date on quality, access, equity and cost.