Universal Health Care Commission's Finance Technical Advisory Committee meeting

March 19, 2026

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Washington State Health Care Authority

Tab 1

Washington State Health Care Authority

Universal Health Care Commission's
Finance Technical Advisory Committee (FTAC)

Agenda

March 19, 2026
2–4:30 p.m.
Zoom meeting

Members		
☐ Christine Eibner	☐ Kai Yeung	☐ Robert Murray
☐ Eddy Rauser	☐ Matthew Morrissey	☐ Roger Gantz
☐ Esther Lucero	☐ Pam MacEwan	☐ Sarah Huling
☐ Hiroshi Nakano		

Time	Agenda items	Tab	Lead
2:00–2:10 (10 min)	Welcome, roll call, review of meeting minutes	1	Pam MacEwan, FTAC Lead
2:10–2:25 (15 min)	Public comment	2	Mary Franzen, HCA
2:25–2:30 (5 min)	Workplan update	3	Mary Franzen, HCA
2:30–2:40 (10 min)	Universal Health Care Commission meeting report out	4	Pam MacEwan, FTAC Lead
2:40 – 2:55 (15 min)	OIC proviso funding	5	Jenn Scott, HCA
2:55-3:40 (45 min)	Proposed interim solution: description and discussion	6	Jane Beyer, OIC
3:40–3:50 (10 min)	**BREAK**		
3:50 –4:30 (40 min)	Provider reimbursement	7	Harrison Fontaine, HCA
4:30	Adjournment		Pam MacEwan, FTAC Lead

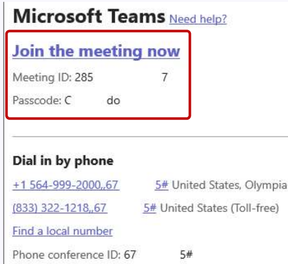
Microsoft Teams Meeting Quick Start Manual

Washington State Health Care Authority

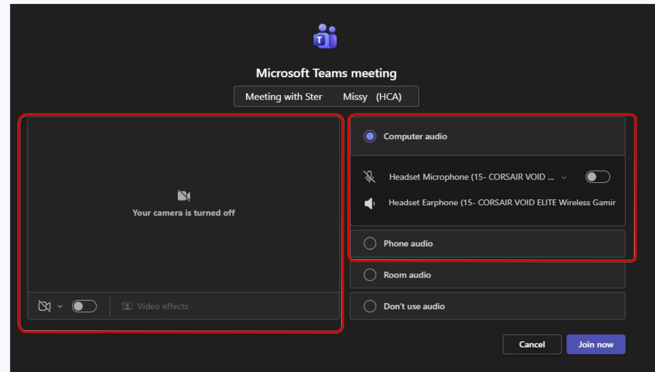
Updated: 12/17/2025

GETTING STARTED

1. Open the meeting invitation, review the body. Click the link **Join the meeting now**, or if you have the ability type in the Meeting ID and Passcode manually.



2. Before joining:
   - Confirm your audio preferences.
   - Confirm your video preferences.

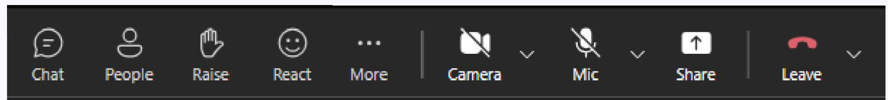


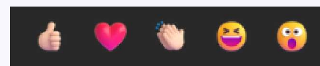
PARTICIPATION & ENGAGEMENT

*If you're calling in **only**, this section does not pertain to you.*

1. You may be asked to name yourself. If not, the software will use the name of your profile. *Government Employees will display their profile name, visitors and guests who do not have a Teams account will name themselves.*

2. Each HCA meeting or webinar is different, take a moment to **review the meeting menu toolbar**. Depending on the settings, this can be found in the upper right-hand corner, or bottom-center of your window. *Note*: You may have less options than the following visual.

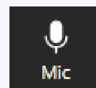




Muted

3. Primary controls include:
   1. Camera | The webcam
   2. Mic | The microphone
   3. Share | Share screen or content

   *When a line is through the camera and mic they are **disabled**. To speak, you will need to "unmute", click the mic button until it is solid*

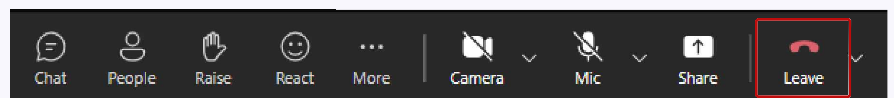


Unmuted

4. To engage and react:
   - Raise | Raise-hand
   - React | Reactions, inclusive of "Thumbs-up", "Heart", "Clap", "Laugh", and "Surprise"

LEAVE A MEETING

1. When the meeting is done, click the "Leave" option in the meeting menu toolbar. Please ensure you leave completely, and the window is closed.



Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting minutes

January 15, 2026

Virtual meeting held on Zoom from 2–4:30 p.m.

Note: The meeting materials packet and a full recording of this meeting can be found on the **Commission's FTAC page**.

All votes made during this meeting are highlighted throughout in blue.

DRAFT

Members present

Christine Eibner
Roger Gantz
Sarah Huling
Pam MacEwan
Matthew Morrissey
Robert Murray
Hiroshi Nakano
Eddy Rauser
Kai Yeung

Members absent

Esther Lucero

Call to order

Ross Valore, Board and Commission Director at HCA, called the meeting to order at 2:03 p.m. There were enough members for a quorum, so the committee could hold votes.

Agenda items

Welcoming remarks

Valore welcomed everyone to FTAC's 19th meeting and shared announcements about FTAC membership and roles. Two new members joined FTAC for their first meeting: Sarah Huling and Hiroshi Nakano. Both were approved by the Universal Health Care Commission at the Commission's December 11, 2025 meeting. Valore also shared that member Pam MacEwan will take on the role of FTAC Liaison to the Commission.

Washington State Health Care Authority

Meeting minutes

Committee members approved the November 2025 meeting minutes by majority vote, with the two new members abstaining.

Public comment

The following members of the public provided comments:

- **Maureen Brinck-Lund**, Health Care is a Human Right
- **Thomas Kennedy**, Whole Washington

Public comment topics included:

- Recommendation to apply OIC proviso funding to a topic related to funding a universal health care system
- Request to seek out and emphasize cost savings when designing and promoting a universal system

Find full testimonies in the **meeting recording (time stamp 11:36)**.

Workplan update

Mary Franzen, HCA

Mary Franzen, Coverage Strategies Manager at HCA, presented a revised 2026 workplan that had previously been shared with the Commission. FTAC will take on provider reimbursement and financing, which remains unchanged from the previous plan. The revised plan assigns the following three design elements – enrollment, infrastructure, and governance – to the Commission.

In response to a question from an FTAC member, Franzen relayed information from the Commission about FTAC's future. The Commission would like FTAC to continue even after it wraps up work on design elements, perhaps with a reduced meeting schedule, to continue its advisory role to the Commission.

Find the full presentation and discussion in the **meeting recording (time stamp 17:06).**

Universal Health Care Commission meeting report out

Ross Valore, HCA

Ross Valore provided an overview of the Commission's December meeting including

- An overview of robust public comment in December
- Commission vote to expand FTAC to "up to 10 members" (previously nine) and approve applications from Sarah Huling and Hiroshi Nakano
- Presentation by Vishal Chaudhry, chief data officer at HCA, about health care cost growth in Washington

Find the full presentation and discussion in the **meeting recording (time stamp 25:54).**

Provider reimbursement & participation: draft guiding principles

Harrison Fontaine, HCA

Harrison Fontaine, Senior Health Policy Analyst at HCA, led members in a discussion about the draft guiding principles for provider reimbursement. An earlier draft document had been circulated among FTAC members, and comments shared via email were incorporated into the slides shared during the meeting and Appendix A in the meeting packet.

FTAC members discussed the proposed revisions but did not reach full agreement or vote on the draft. Much of the discussion focused on the appropriate level of specificity for guiding principles, acknowledging that adopting a framework that is too prescriptive could constrain future options. Member Pam MacEwan noted the Commission has not made certain design decisions, and flexibility may be appreciated. Member Hiroshi Nakano

DRAFT

noted that not all providers are prepared for certain types of reimbursement schemes, which could affect long-term sustainability. Member Roger Gantz stressed that all enrollees should be treated "in like fashion," regardless of the eligibility category that brings them into the system.

HCA staff will synthesize comments and pose clarifying questions to the Commission to guide further development of the guiding principles.

Find the full presentation and discussion in the **meeting recording (time stamp 38:10)**.

Provider reimbursement & participation: draft proposal outline

Mary Franzen, HCA

Mary Franzen reviewed past work that informed a draft outline for a provider reimbursement proposal. FTAC members agreed on the approach to recommend small-scale changes, with an eye toward refining and expanding a given approach. Members suggested adding general recommendations about data collection as hospitals and providers adapt to a new payment mechanism, noting that data could lead to refinements in the payment system.

Find the full presentation and discussion in the **meeting recording (time stamp 1:11:16)**.

OIC proviso funding

Jenn Scott, HCA

Jenn Scott, Senior Health Policy Analyst at HCA, led a discussion about funding that is available to the Commission from the Office of the Insurance Commission. A proviso in the current state budget provides $250,000 from the Insurance Commissioner's regulatory account to fund "economic, actuarial, or other modeling related to the design of a universal health care system." Scott noted the final deliverable of such a study would be used to inform design decisions, and the topic should be related to an outstanding design element.

FTAC members suggested various areas of focus, including hospital global budgets, different cost containment mechanisms, an inventory of the state's revenue sources, and incentives for private employers to opt into a universal system. Members also discussed applying different reimbursement frameworks to actuarial analysis performed by Milliman in 2025.

HCA staff will reach out to FTAC and Commission members for further input.

Find the full presentation and discussion in the **meeting recording (time stamp 1:57:11)**.

Closing comments and adjournment

The meeting adjourned at 4:34 p.m.

Next meeting

Thursday, March 19, 2026 from 2–4:30 p.m.

The meeting will be held on Zoom

DRAFT

Tab 2

Public Comment

Universal Health Care Commission's
Finance Technical Advisory Committee
Written Comments

- Written comments submitted via e-mail (received January 2 – March 5):
  1. F. Yancy
  2. S. McEvoy
  3. C. Currie
- Oral comments received during the January FTAC meeting
- Public comments can be provided orally during the meeting's public comment period or in written form at any time to FTAC's inbox at **HCAUniversalFTAC@hca.wa.gov**.

Question/ Suggestion

From Fred Yancey <fyancey@comcast.net>
Date Fri 1/9/2026 4:16 AM
To HCA Universal FTAC <HCAUniversalFTAC@hca.wa.gov>

External Email

There has been a lot of work on the issue seeking affordable healthcare and I am just barely understanding the breadth of work to date. However, I am concerned over the apparent failure to address the Medicare population. If I understand the issue correctly, currently Medicare restricts participation in efforts to control costs. A waiver would need to be sought and then granted. I believe seeking such should be one of the guiding principles outlined in future plans. The costs to Seniors for medical and prescription care are onerous and adversely affect the quality of their lives. Please address this area.

Thank you,
Fred Yancey

Sent from my iPad

Fw: Public comment submission to FTAC

From HCA Universal HCC <HCAUniversalHCC@hca.wa.gov>
Date Mon 1/12/2026 3:12 PM
To HCA Universal FTAC <HCAUniversalFTAC@hca.wa.gov>

From: Shari Mcevoy <smcevoy2222@gmail.com>
Sent: Monday, January 12, 2026 2:05 PM
To: HCA Universal HCC <HCAUniversalHCC@hca.wa.gov>
Subject: Public comment submission to FTAC

External Email

Hello my name is Sharon mcevoy arnp nurse practitioner. I volunteer on two universal healthcare committees to educate myself and insist that we implement drastic measures to insure health care for all.

I support universal healthcare
We are and have been in a healthcare crisis now it will be a horribly preventable disaster if we don't ACT.
As representatives to wa state residents we need you to strongly form coalitions either state legislators to fix what is holding up the passage of universal healthcare bills.
Please promote now and for the entire session:
SB5387 corp practice of healthcare must end.
Sb 5949 tax insurance providers
SB5981 an essential bill to protect access to discounted meds for the public.
SB5967 prev care access protection
hb2242 no cost prev care
HB2283 A medical loss ratio for health insurance must be established and penalized if no transparency or does not meet goal.
HB2283, HB2106,HB2105,HB2182,hb2100,HB2385,
Thank you please don't wait to require studies. They've been done in other states.
Let's move on our goal and not stop. Our patients are literally dying waiting for action!
Sincerely
Shari

Sent from my iPhone

From: Cris <criscurrie22@gmail.com>
Sent: Wednesday, January 21, 2026 3:06 PM
To: HCA Universal FTAC <HCAUniversalFTAC@hca.wa.gov>
Subject: Public Comment

External Email

RE: DRAFT Provider Reimbursement Guiding Principle #6. **Reduce waste and improve the quality of care provided.** The reimbursement system should incentivize providers to improve the quality of care as measured through quality metrics and reduce unnecessary or harmful care.

I'm very concerned about proposed guideline #6 because I do not believe that the reimbursement system is the place to incentivize professionals to reduce unnecessary care. The word "incentivize" has come to mean monetary rewards and punishments for meeting or not meeting prescribed quantitative financial goals. As such it is far too narrow and insulting to the vast majority of health care professionals whose primary incentive has always been seeing the health of their patients improve as a result of their interventions. While most are aware that their pay fluctuates, they don't have the time or the interest in correlating those fluctuations with the financial outcomes of their work.

As with factory workers, most physicians and nurses now have their hourly productivity tracked by relative value unit formulas and unfair value-based payment schemes, and they are constantly pressured to work faster, on top of requirements for lengthy prior authorizations. They are pushed to discharge patients sooner, order more highly profitable testing and procedures than are necessary, and required to spend no more than the most minimal amount of time with each patient. They are encouraged to think in terms of "product lines" and "returns on investment." Proprietary electronic medical records systems that are designed for billing, rather than for quickly finding clinical information, fragment care, require inordinate amounts of time, and distract providers from listening to their patients, while chronic understaffing, forced transfers, and resignations add substantially to the daily stress. Hospital and insurance networks require referrals within their own systems, even when it would be more appropriate to refer outside. The widespread availability of superficial patient satisfaction scores, misleading medication advertising, and the constant threat of litigation can inhibit physicians from discussing bad news with patients and can lead to overtreatment to keep patients satisfied and be sure "everything" is being done. In other words, they are forced to abandon their commitment to put their patients first in order to keep their jobs. When these are the conditions under which most clinicians practice, it is no wonder that there is so much waste and oversight in health care.

The best way to truly "incentivize" professionals is to support and facilitate their reliance on traditional medical ethics and the fundamental reasons why they originally entered their profession. Correcting the problems listed above will go a long way toward reducing burn out and moral injury. Developing an EMR that facilitates best practices research and tracks prescribing trends and then widely publicizing the results in journals, seminars, grand rounds, and even embedded in the EMR itself, will also greatly reduce unnecessary procedures, increase professional satisfaction, and improve outcomes, all of which are desperately needed. Determining best practices retrospectively, as is done in Canada and other countries, rather than through preauthorization and denial will also facilitate higher quality care.

I would therefore recommend that the guideline be changed to: **Seek to improve health care outcomes by supporting and facilitating the practice of traditional medical ethics among all healthcare professionals.**

I would further encourage members to review Subchapters 56.2 What's Wrong with Value Based Payment Schemes? 39.1 How Can Unnecessary Procedures Be Avoided? and 45.1 What is Moral Injury in Healthcare? in my book, A Medicare for All Q &A.

Cris M. Currie, RN, MA Spokane, WA

Microsoft Teams meeting tools

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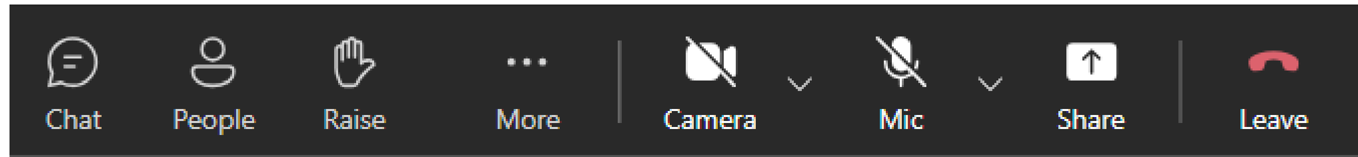

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- Mute / Unmute
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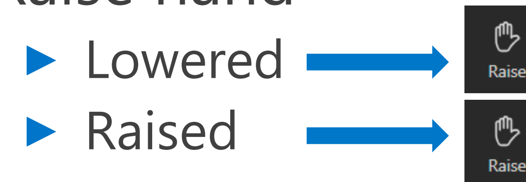


Note: You will be highlighted for the host when hand is raised.

Tab 3

Workplan update

Finance Technical Advisory Committee

Overview

- Workplan status
- “What we’re working on” web page

Universal Health Care Commission

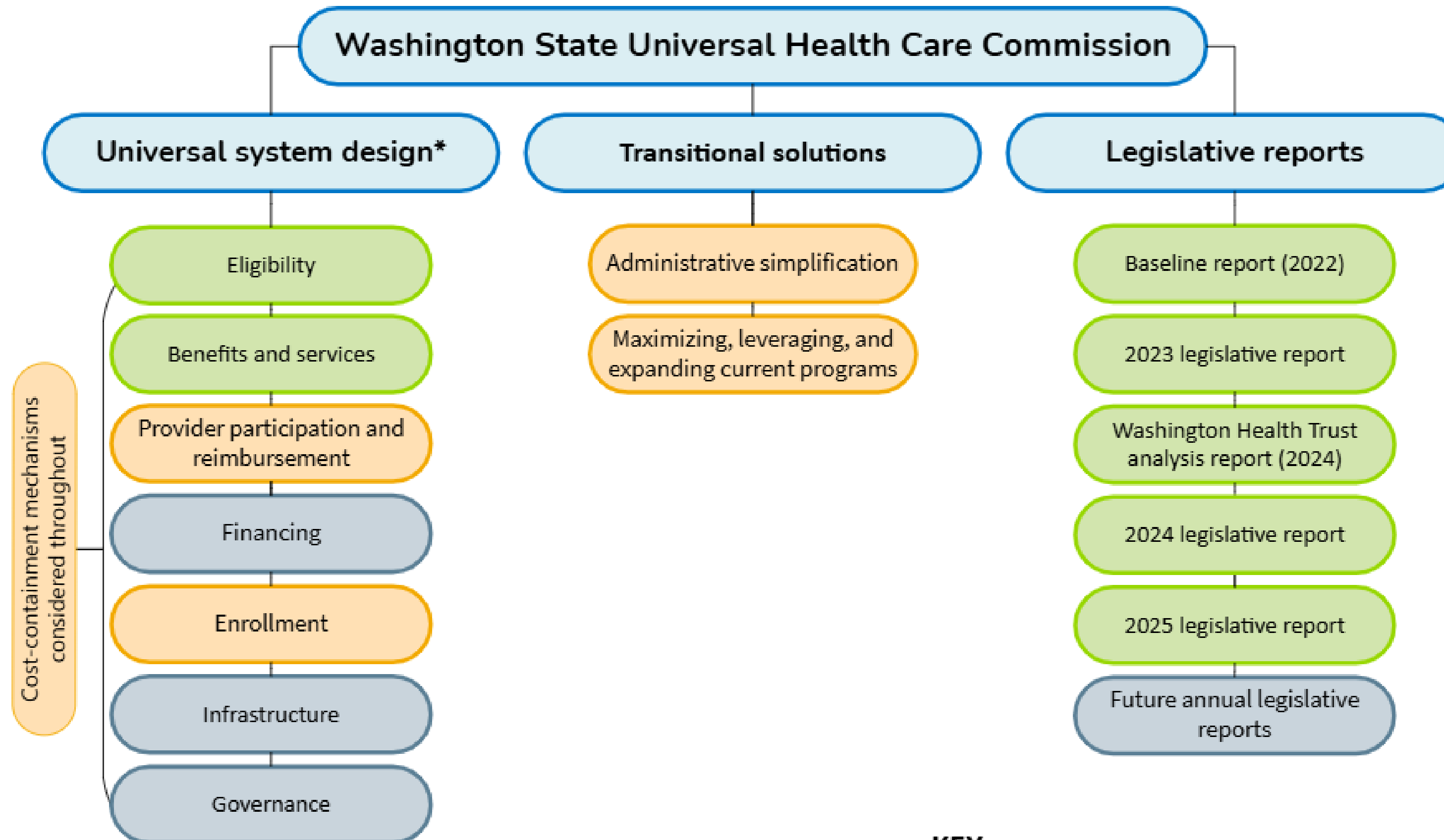
- As directed by the Legislature (RCW 41.05.840), the Commission must:

Transitional solutions

"…create immediate and impactful changes in the health care access and delivery system in Washington and to prepare the 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 necessary federal authority has become available."

Universal system design

Workplan status



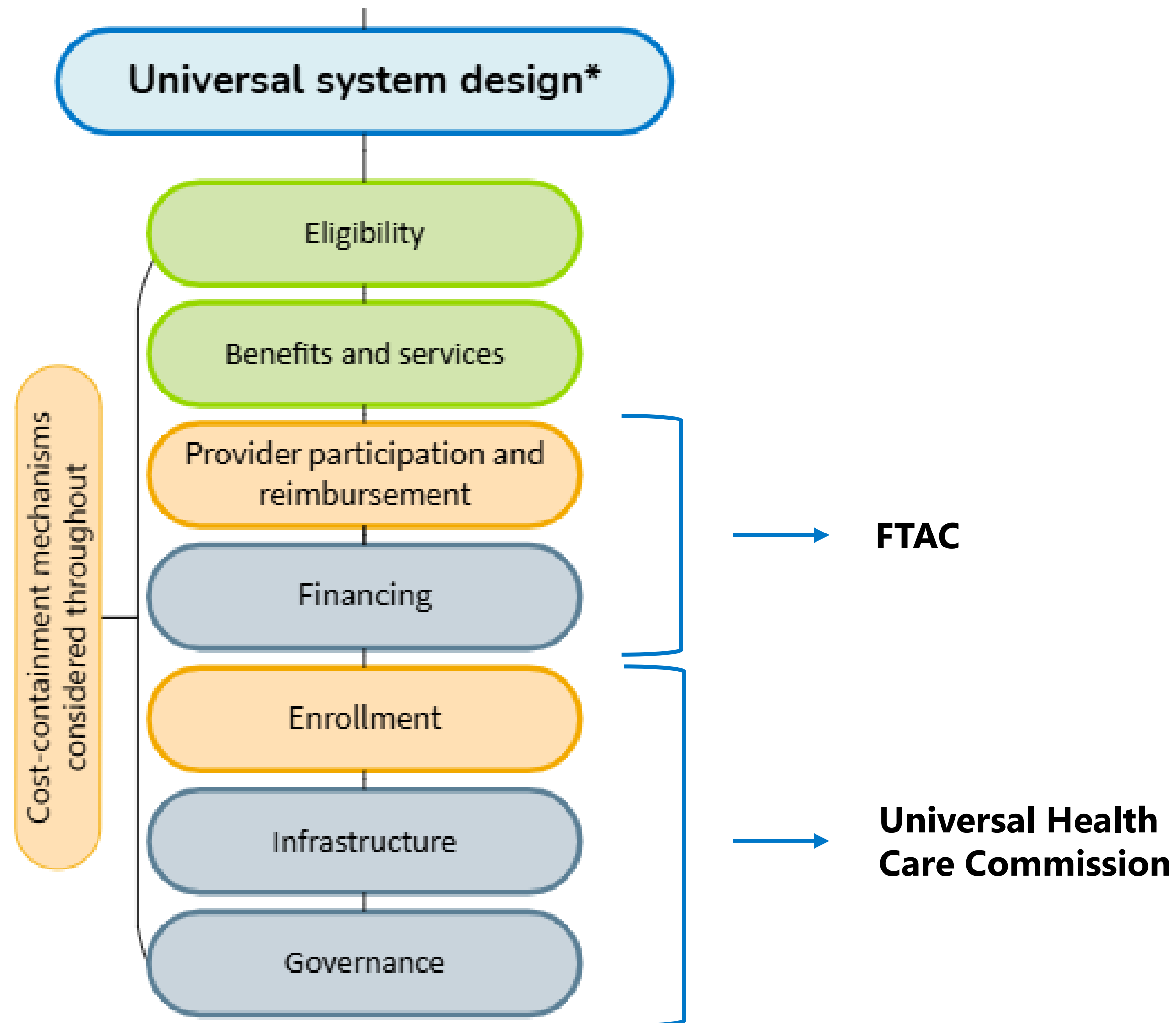
*Health care quality, health equity, and health disparities will be discussed and considered during each of the core universal system design components.

KEY

- Completed/straw proposal adopted
- In progress/ongoing
- Not yet started

Last updated February 2026

Universal system design



FTAC

Universal Health Care Commission

On today's agenda:

- Provider participation and reimbursement
  - Guiding principles
  - Draft proposal
  - Roadmap

“What we’re working on” web page

New web page that tracks Commission’s progress on key design elements, along with other information

Home > About HCA > Who we are > Universal Health Care Commission > What we’re working on

Drafts for design elements

We have eight design elements, and we’ve completed design drafts for two.

Completed

- Eligibility — who can be part of a universal system
- Benefits and services — the health care services a universal system would cover

In progress

- Cost-containment mechanisms — ways to keep health care from costing too much
- Provider reimbursement and participation — how health care providers are paid for their work and included in a universal system
- Enrollment — how people join a universal system

Not started

- Financing — how to collect, manage, and move money in a universal system
- Infrastructure — underlying base that supports a universal system
- Governance — who runs a universal system

https://www.hca.wa.gov/about-hca/who-we-are/universal-health-care/what-we-re-working

Questions?

Tab 4

Universal Health Care Commission update

February UHCC meeting recording & materials

Overview

- Public comment
- Provider reimbursement
  - Proposal and guiding principles
  - Roadmap for various options
- Enrollment, infrastructure, and governance
- OIC proviso funding

Public comment

- In-person and online comments
  - Critical need for universal care and support for bills pending in Washington legislature
  - Personal experiences with fragmented care
  - Examples of existing universal systems in the United States, such as care for veterans
  - Suggestion to apply OIC proviso money to a study related to financing a universal system
  - Encouragement to simplify enrollment processes in commercial and public coverage
- Response to earlier request to make written comments available to members between meetings. Staff is exploring options.
- Staff created a SharePoint page accessible to workgroup members where we can share public comments relevant to the work.

Provider reimbursement

- Commission members reviewed draft guiding principles and offered feedback
  - Reflected on version included in today's packet
- Overview of provider reimbursement proposal
  - Commission members suggested a reimbursement system that puts primary care and outpatient behavioral health at the center
  - Accepted offer of a roadmap that recommends incremental steps toward reimbursement system
- Commission members are aware that current proposals represent interim, incremental changes to the reimbursement system, not the final recommendation for a unified system

Enrollment, infrastructure, and governance

- Dr. Miriam McDonell of the Oregon Universal Health Plan Governance Board shared Oregon’s experiences
  - Dr. McDonell noted that some large design decisions that are open questions in Washington were mandated by the Oregon bill that created its board
- Commission members considered some larger structural questions related to Washington’s design
  - Single v. multi-payer system?
  - Who is the risk bearing entity?
  - Are insurance carriers involved in any way?
  - **Next steps: Staff is further defining elements and exploring key questions.**

OIC proviso funding

- Ideas for application of $250,000 of proviso funding to support economic, actuarial, or other modeling
- Commission supports use of funds for a topic related to provider reimbursement or financing

Tab 5

OIC Proviso Funding

February UHCC meeting recording & materials

Washington State Health Care Authority

OIC Proviso: Overview

- $250,000 of the insurance commissioner's regulatory account …to support "economic, actuarial, or other modeling related to design of a universal health care system."
- Funds must be spent by June 30, 2027
- Related to one of the outstanding design elements
- Final deliverable will provide guidance for making a recommendation, not the recommendation itself

Commission decision on element of focus

Question: Which of the outstanding design element(s) should the modeling work focus on?

Answer: Provider reimbursement or financing

Potential analyses proposed by FTAC & others

- Hospital global budgets
- Explore more aggressive cost containment mechanisms
- Inventory of state’s revenue sources
- Incentives for private employers to opt into a universal system
- Apply different reimbursement frameworks to Milliman’s 2025 actuarial analysis
- Actuarial sensitivity testing of reimbursement scenarios for rural, critical access, and safety-net providers to identify participation and sustainability thresholds
- Model the costs of different administrative structures, potentially drawing from experiences of other states
- Model the cost of state-administered, managed fee-for-service Medicaid

Commission suggestions for the OIC proviso funds

- Consider a study that could produce a range of outputs based on the interaction of varied inputs, such as the balance between administrative simplification and financing.
- Asked if focus should be on the entire population or a sub-population.
- Model a system similar to managed fee-for-service Medicaid, but for a broader population, and examine whether cost savings could be used to better fund primary care and behavioral health services. (Transitional solution)

Next steps

- Staff will:
  - Synthesize ideas and develop proposal(s) for FTAC and Commission consideration
  - Start the contract process

Questions?

Tab 6

Proposed interim solution

Finance Technical Advisory Committee

Overview

- Background
- Proposal overview
- Discussion

Background

- Idea proposed during February Commission meeting as a possible transitional solution to be pursued by the Commission
- Through the Health Care Cost Transparency Board and other entities, Washington has set a target of 12 percent of health care expenditures going to primary care
- Today, we are looking for questions and feedback from FTAC as the proposal takes shape
- Ultimately, the Commission will decide whether and how to proceed with this proposal as a transitional solution

Proposal overview

- Create a universal benefit package for primary care
  - Primary care would be paid for and delivered distinct from health insurance coverage
  - Health insurance wraps around and coordinates with primary care providers to cover all other services
  - Build on evidence-based primary care models, such as UW AIMS Center Collaborative Care model, integrating behavioral health, primary care, and advanced primary care
- Payment goes directly to provider or provider organization—preferably on a pre-paid basis
- Insurance carriers provide supplemental coverage for other services
- System could be a platform for expanding universal coverage to other services

Discussion

- What are some key considerations the Commission should keep in mind as it makes its decision?
- Are there finance-specific factors the Commission should consider?

Questions?

Finance Technical Advisory Committee meeting

We are currently on a short break

Tab 7

Provider reimbursement workgroup

Finance Technical Advisory Committee

Provider reimbursement overview

- Work products and background
- Proposal draft review and feedback
- Implementation roadmap framework review and feedback
- Guiding principles review and vote

Work products

- Provider reimbursement work products:
  - Guiding principles: key values to inform the proposal and future regulatory decisions
  - Design element proposal: set of recommendations that could be implemented on a smaller scale, then broadened
  - Implementation roadmap: recommendations for potential pathways to universal care that place payment mechanisms in order and describe how mechanisms could be broadened

Provider reimbursement proposal

- **Current sections:**
  - Background
  - Payment mechanisms
  - Phased approaches
  - Oversight and data collection
  - Provider incentives
  - Alignment with ongoing work

Provider reimbursement sections for review

- **Payment mechanisms**
  - Price setting (RBP)
  - Hospital global budgets
  - Revising fee schedule
  - Out of network price caps
  - Competitive, selective contracting
  - Direct, universal PC payment

- **Implementation approaches**

  Applying mechanism to:
  - Additional market segments
  - Additional set of providers
  - Additional care settings
  - Additional services
  - Increasing proportion of budget

- Should additional mechanisms or approaches be included?

Draft proposal outline: questions to consider

- Should the background section explain why the proposal focuses on transitional solutions rather than universal design?
- Should an identified benefit (e.g., direct, universal primary care) be included with other payment mechanisms?

Proposal: proposed schedule

January	February	March	April	May	June
FTAC Input and feedback on proposal outline	Revised drafts circulated to FTAC WG members for feedback	**FTAC** Reviews and revise draft proposal	**UHCC** First review of draft proposal Direction and feedback to FTAC	**FTAC** Revised draft based on UHCC feedback Potential vote to approve	**UHCC** Potential vote to approve proposal

Ongoing incorporation of feedback and preparation of revised drafts
FTAC workgroup and staff

Provider reimbursement roadmap

- In scope:
  - Provider reimbursement mechanisms and implementation approaches described in the proposal
  - Implementation pathways/options towards provider reimbursement universal design
    - Brief description of advantages/disadvantages for each approach
    - Additional dependencies, if any
- Are there additional sections that should be included?
- Should options be evaluated against criteria other than those outlined in the guiding principles?

Guiding principles

- Review and potential vote on guiding principles.
- Background:
  - FTAC reviewed guiding principles on January 15 and returned to workgroup for minor revisions
  - Principles 1,4 and 6 have been revised based on FTAC, workgroup, and public comment input
  - Draft guiding principles are in Appendix A

Revised guiding principles

Draft principle 1	Draft principle 4	Draft principle 6
Create uniform and consistent reimbursement systems across all providers and payers The reimbursement system should use consistent reimbursement designs and rates for all enrollees (regardless of income, race, or source of coverage) in the universal financing system.	**Maintain and improve fairness and equity of the reimbursement system** The reimbursement system should promote equity, including paying providers consistent rates for the same services (e.g., consistent rates with flexibility to adjust payments for rural and medically underserved areas).	**Reduce waste and improve the quality of care provided** The reimbursement system should incentivize providers to improve the quality of care and reduce unnecessary or harmful care.

Potential vote

- Note revisions, if any
- Potential vote:
  FTAC approves the draft guiding principles for provider reimbursement [as revised] and will submit them to the Universal Health Care Commission for their consideration.

Questions?

Thank you for attending the Finance Technical Advisory Committee meeting

Appendix A

Health Care Authority
Universal Health Care Commission

Provider participation and reimbursement

DRAFT

Notes

Committee: Finance Technical Advisory Committee (FTAC)
Commission/committee lead(s): Roger Gantz, Pam MacEwan, Bob Murray, and Eddy Rauser.
FTAC initial review: March 19, 2026

Commission review: [Month Day, Year]

Commission adopted: [Month Day, Year]

Proposal ID: 2026-03
Core design element/milestone: Provider Reimbursement and Participation

Summary

This proposal includes recommendations for provider reimbursement and participation under a universal health care delivery system in Washington state. Creating a universal health care delivery system in the state will require development of various state-regulated provider reimbursement models to constrain costs driven by growth in provider prices, administration, and overall spending. Accordingly, the development of mandatory (required and enforced by state law) payment mechanisms is essential in advance of and during the implementation of a universal system. In parallel, the state should strengthen and leverage its purchasing power to take the lead in transitional cost-containment strategies.

It will take time for the state to sort out the key components of a universal system. In the meantime, it is vitally important that the state continue to pursue the implementation of regulated healthcare price and spending models. This will make health care more affordable in the short term and improve long term prospects for universal financing. Cost containment has been woven throughout the Commission's design of a universal system and is a key guiding principle for provider reimbursement design[1]. The initial recommendations in this proposal fall within the realm of transitional solutions – part of the Commission's charge – and will inform later design decisions for a universal system.

[1] Provider reimbursement guiding principles

DRAFT

Regardless of the specific payment mechanisms chosen, this proposal recommends a gradual approach to implementation. Large-scale changes implemented simultaneously could prove too disruptive to the health care system. Rather, the Commission recommends implementing new payment mechanisms incrementally, with gradual application to different provider settings, services, or patient populations.

Background

The Commission was established, "to prepare the state for the creation of a health care system that provides coverage and access for all Washington residents through a unified financing system" once federal authority is granted. Provider reimbursement and participation design is one of the key elements required to prepare the state.[2]

Since its inception, the Commission and FTAC have closely followed efforts throughout the United States to alter and improve reimbursement mechanisms. The Commission closely follows proposed and enacted changes in Washington law related to provider reimbursement, and other states have generously shared their experiences and results.

Beginning in late 2025, the Commission and it Finance Technical Advisory Committee (FTAC) formally began work on provider reimbursement as a core design element both leading up to and under a universal system in Washington. The Commission adopted a set of guiding principles (Appendix A) on DATE.

Recommendations

As noted in the proposal summary, the Commission recommends implementing gradual changes that can be evaluated over time, adjusted as necessary, and expanded as appropriate. This approach helps ensure sustainability by avoiding sudden, large-scale changes that could disrupt care. It also creates opportunities to refine and improve an approach before recommending large-scale adoption and/or making final recommendations for a universal system. The Commission recommends that participation be mandatory for the included providers and care settings.

Payment mechanism

The Commission first looks to an initiative already in place in Washington as both a possible payment mechanism and an example of how to begin a phased approach. Beginning in January, 2027, under RCW 41.05.028, payment rates for certain public employees at most hospitals[3] in Washington will be based on a percentage of Medicare reimbursement rates.

That payment mechanism, known as Reference-Based Pricing (RBP), could also be applied to payments to non-hospital-based providers. In addition, as noted in Principle #5[4], a payment structure could rebalance payments toward traditionally under-resourced services and settings (e.g., primary care, behavioral health care, and rural or underserved areas, among others). In this

[2] RCW 41.05.840
[3] RCW 41.05.028 contains exemptions for certain care settings, including pediatric and rural hospitals.
[4] Provider reimbursement guiding principles

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regard, a key issue both in Washington and nationally relates to distortions embedded in the Medicare fee-for-service physician fee schedule that result in underpayment for primary and preventive care services. This fee schedule is also the basis for non-hospital provider payments from Medicaid, Medicare Advantage and most commercial insurers[5]. The state could consider developing a revised physician fee schedule or applying adjustments to correct distortions. Such an adjustments could conceivably be first accomplished in the context of the state's public and school employees program, just as Washington is attempting to do by modifying hospital, primary care, and behavioral health payment for these programs per RCW 41.05.028

A payment approach that may be implemented as a progression from RBP is Out-of- Network (OON) payment caps for hospital care provided to all commercially insured patients. The use of RBP caps (tied to a percentage of Medicare payments) for OON hospital services in the state could address the issue of surprise hospital bills for patients. More importantly for cost containment, OON price caps is a low-intensity way of creating limitations on hospital prices paid by commercial insurance companies. Price caps for OON hospital services for the commercially insured would confer additional pricing leverage to commercial insurers in their negotiations with hospitals and health systems by moderating the consequences of the health system leaving the network. Effectively, this would cap in-network prices at or below the OON price cap. This approach could provide the state with an interim step in extending aspects of the current RBP mechanism[6], without imposing RBPs on all hospital services in the state, while still imposing significant pressure on commercially negotiated hospital prices.

Another payment approach that may be considered for these progressive steps is hospital global budgets (HGBs). This mechanism establishes a predetermined amount paid to hospitals for all inpatient and outpatient services. In contrast to RBP or OON price caps, this mechanism expands the reimbursed bundle of services to avoid cost-containment issues with fee-for-service payment models. Budgets established should be mandatory for all payers but may be phased in by category of hospital or proportion of hospital budget. Small and rural hospitals that serve more isolated communities are the first candidates for this type of payment model because HGBs can be structured to pay predictable annual amounts regardless of fluctuations in patient volume. HGBs for small rural hospitals can be used to preserve access to needed services in rural markets, while giving time to transition less needed hospital capacity to meet key local service needs. If HGBs for small/rural hospitals are successful, the state can consider extending this payment model to all hospitals in the state.

To leverage the role of the state purchasing to advance cost containment goals, the state could expand its purchasing power to increase the impact of competitive, selective contracting. Under this mechanism, the state establishes contract specifications (e.g., quantity, quality), then seeks competitive bids from licensed carriers. Carriers respond to the invitation and are selected to provide coverage for a period of time based on the price they offer. The state retains policy control over the service, while the market produces the service under public oversight. Critically,

[5] An American Medical Association (AMA) survey of 127 public and private payers found that 77% use the Medicare RBRVS to set their payment rates. (American Medical Association. *Medicare RBRVS: The Physicians' Guide 2013*. Chicago, IL: American Medical Association; 2013)

[6] RCW 41.05.028 sets OON rate caps for most hospitals that are out of network for public and school employees.

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the state's purchasing leverage may be expanded and linked[7], improving the prospects of cost containment with contracted carriers.

Phased approach

Regardless of the payment mechanism selected, the Commission recommends starting with an identified population and/or care setting before applying that mechanism to additional enrollees or care settings. Lessons learned from initial implementation will inform and refine future initiatives. Before recommending the expansion of any approach, the Commission will ensure that the mechanism supports a system with unified financing and promotes equitable access to care.

Possible ways to expand a given approach include, but are not limited to:

- Consolidating and extending state purchasing power. [8]
- Applying the mechanism to an additional set of providers
- Applying the mechanism to additional care settings
- Applying the mechanism to additional services
- Apply mechanism to a greater proportion of provider budget
- Others

The phased implementation of specific reimbursement mechanisms may follow a stepwise progression, where earlier progress facilitates implementation of subsequent mechanisms. Sequencing transitional solutions is considered in Appendix B[9].

Data collection and oversight

The Commission recommends that the governing body that oversees the universal system collect data from payers and providers as different reimbursement mechanisms are implemented. This governing body should establish principles for patient centered governance that further accountability, transparency, and public trust. Such principles may address data ownership/access, consent, secondary use, and individual rights.

Data collected could be used to:

- Inform rate setting, priority-setting, benefits design, payment models, and resource allocation.
- Determine whether elements of a payment mechanism, such as base rates, need to be adjusted, (e.g., risk adjustment, rate cell analysis).
- Adjust identified elements accurately and fairly.
- Determine appropriate expansion of a payment mechanism.
- Determine whether entities that fall under a reimbursement mechanism are shifting care or altering billing practices to avoid cost containment measures.

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[7] See footnote 8 and Provider reimbursement roadmap

[8] The state purchases healthcare coverage for some 2.7 million persons, approximately 2/3 of which is through risk-based contracts. The state could begin by consolidating purchasing for state and school district employees, followed by consolidation by state-purchased coverage for those on the Health Benefit Exchange. Finally, state purchasing for these groups could be linked with purchasing for Medicaid beneficiaries.

[9] See Provider reimbursement roadmap

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- Gather other information as appropriate to oversee payment system, including payment variation and its sources, (e.g., management of high-need/cost members, detection of waste/ fraud/ abuse).
- Support analytics for waste/fraud/abuse detections, high-cost/high-need member management, and evaluation of reform.
- Assess variation in payment, cost, access, utilization, quality.
- Identify the need for exceptions or modifications to preserve access to quality care.
- Evaluate and set health system performance measures goals for public reporting.

Provider participation incentives

Reimbursement systems should be designed to make billing and payment processes as simple, consistent, and transparent as possible. Eventually, in a universal system, the Commission envisions a standardized process that will reduce administrative burden on providers. The eventual system may also include incentives to provide quality care.

Beyond administrative simplification, potential advantages include greater stability in rural and underserved areas, predictable and prospective payments, and targeted support for primary care and preventive services that improve access and continuity of care.

Mandatory payment models are necessary to achieve cost containment in most contexts. The history of payment initiatives and Value Based Payment models has demonstrated that voluntary payment initiatives (such as ACOs or other VBP strategies) have not been effective in controlling the growth of provider prices and spending. This is because providers with the highest prices and spending are allowed to opt out. Thus, voluntary models do not have the ability to enforce limits on price and spending growth in a comprehensive way.

Alignment with ongoing work

The Commission will continue to monitor and learn from other ongoing initiatives related to provider reimbursement, health care costs, and delivery models. Those efforts include

- Health Care Cost Transparency Board
- Prescription Drug Affordability Board
- Rural Health Transformation Program
- Medicaid Transformation Project (Washington's Medicaid 1115 waiver)
- Traditional Health Care Practices waiver
- Value-based Purchasing
- Office of the Insurance Commissioner
- Washington Health Benefit Exchange
- Washington All-Payer Claims Database State Agency Coordinating Committee
- Other states' past and current experiences with cost boards, universal health care commissions, and alternate payment models including Massachusetts, Vermont, Oregon, Maryland, and California.

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Draft Review History

[The work group's recommendations.]

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Appendix B

DRAFT Provider reimbursement guiding principles

1. **Create uniform and consistent reimbursement systems across all providers and payers**
   The reimbursement system should use consistent reimbursement designs and rates for all enrollees (regardless of income, race, or source of coverage) in the universal financing system.

2. **Improve affordability of the health care system**
   The reimbursement system should improve and sustain affordability by promoting cost containment and increasing efficiency.

3. **Maintain and improve access to needed care**
   The reimbursement system should promote the availability of needed and appropriate care for all enrollees, with a particular focus on people in rural and medically underserved areas.

4. **Maintain and improve fairness and equity of the reimbursement system**
   The reimbursement system should promote equity, including paying providers consistent rates for the same services (e.g., consistent rates with flexibility to adjust payments for rural and medically underserved areas).

5. **Rebalance payments to support traditionally underfunded care**
   The reimbursement system should rebalance provider reimbursement to promote access to traditionally underfunded care and enhance population health (e.g., primary, preventive, and outpatient behavioral health services.

6. **Reduce waste and improve the quality of care provided**
   The reimbursement system should incentivize providers to improve the quality of care a and reduce unnecessary or harmful care.

7. **Standardize key aspects of payment administration**
   The reimbursement system should have single standardized systems for eligibility verification, prior authorization, billing and claims processing, and post-service and follow-up administration.

8. **Assure reimbursement system transparency and accountability**
   The reimbursement system should make appropriate data publicly available to demonstrate that regulating agencies, providers, and payers are meeting key policy goals.

9. **Assure reimbursement system stability and predictability**
   Implement gradual and incremental changes in reimbursement policies to promote the overall

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predictability and stability of the payment/financing system.

10. **Ensure that payment policy aligns with capacity policy**
    Integrate and coordinate payment and health care capacity and staffing policies to ensure adequate access to affordable care.

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Appendix C

March 10, 2026

TO: FTAC Members
HCA Staff

FROM: Roger Gantz, FTAC Member

RE: INCREASEING PRIMARY CARE PAYMENTS

I understand our March 19, 2026, Finance Technical Advisor Committee (FTAC) meeting will include a session on transitional reimbursement options. This will include increasing primary and preventive care payments to improve health outcomes and reduce the need for more expensive specialty care. This strategy was discussed at the, Universal Health Commission's (UHCC) February 12, 2026, meeting discussion on the use of the Office of the Insurance Commissioner's (OIC) $250,000 (ESSB 5167, Sec.145(17)) donation to the UHCC to "… *support economic, actuarial, or other modeling related to design of a universal health care system.*"

The following memo is intended to provide background information on the "standard" model used to reimbursement for primary care, payment inequities in that payment system, and options to increase primary care through a "rebalancing" of this system. It is important to understand that primary care payments rebalancing options can be accomplished within either a managed care organization (MCO) or fee-for-service (FFS) delivery system.

It is also important to note that increasing payment for primary care does not require the introduction of new money into the health care system. As our colleague, Bob Murray, has well-articulated, there is already more than sufficient "money" in the United States' health care system to accomplish this goal. To illustrate, United States spends more per-capita than another county. Analysis by FFS and Peterson Institute found that United States health care spending was 38% greater per-capita than the next highest country and 82% more per-capita than the average for 10 EU counties and Japan (see Attachment A). According to World Bank data, the United States had the third highest health care expenditures as a percent of gross domestic product (GDP) among some nearly 200 counties. The point to be made is that undervalue of primary care is not due to an absence of money in our health care system.

Importance of Primary Care.

As outlined in their 2025 report to the legislature, Washington's Health Care Cost Transparency Board (HCCTB) stated,

> *Extensive research shows that a strong high-quality primary care system leads to better health outcomes, greater equity in access and outcomes, and higher patient satisfaction with care. Utilization of primary care services as the foundation of the health care system leads to lower per capita health care costs as primary care is much less expensive than care provided in emergency departments and hospitals. Despite its importance, research shows that the U.S. has lower utilization of primary care than other high-income countries, with U.S. adults being among the least likely to have a regular doctor or regular place they go for care. Patients with a long-term relationship with a primary care doctor are less likely to go to the emergency department and more likely to seek care in a less expensive setting.* [1]

Their report goes on to note that in the United States, there is an imbalance between primary care and specialty care. Thirty-nine percent of actively practicing physicians work in primary care compared to over 60% working in specialty areas. The HCCTB report further states,

> *Experts suggest that the U.S. has underinvested in primary care for many years, leading to current challenges, such as the declining number of physicians and market consolidation. In Washington, as in other states, primary care services are reimbursed at lower rates than most specialty services and primary care practices often lack the infrastructure to support population-based payment arrangements.*[2]

Both HCCTB and Washington's Legislature have recognized the imbalance in primary care compensation. HCCTB's 2024 recommendations included setting a target rate increase for primary care expenditure as a ratio of total health expenditures to increase by one percentage point annually until Washington achieves a primary care expenditure ratio of 12 percent. Of note, their 2025 reported stated that slightly more than 4.0 percent in 2023. They also recommended that the Legislature should increase Medicaid reimbursement for primary care to no less than 100 percent of Medicare by 2028.

The other example of state efforts to increase primary care reimbursement was included in the adoption of reference-based pricing for public (PEBB) and state (SEBB) healthcare coverage (E2SSB 5083). In addition to placing price-caps for hospital payment rates, the legislation directed that reimbursement for in-network primary care services or non-facility-based behavioral health services be no less than 150 percent of the total amount Medicare would have reimbursed for the same or similar service.

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[1] Washington Health Care Cost Transparency Board, "Annual Report", (December 2025), page 19.
[2] Ibid, page 19.

Resource-Based Relative Value System

A key contributor to the "underinvested" in primary care has been the widespread adoption of the Medicare Resource-Based Relative Value System (RBRVS) for physician related services. First adopted by Medicare in 1992, it is now used by all state Medicare program. An American Medical Association (AMA) survey of 127 public and private payers found that 77% use the Medicare RBRVS to set their payment rates. Attachment B provides an overview of the RVRBS system and terms used in this memo.

The RBRVS has been subject to significant review and consternation (see Attachment B). The net result of these weaknesses is the Resource Value Unit (RVU) weights create prices that reward high-volume, high-intensity services over comprehensive care and underfund rates for primary care,

Transitional Primary Care Payment Options

Given that most Washington payers use an RBRVS payment system, there are several pathways to increase primary care payments. One adjustment would be to have Medicare, Medicaid and other payers should recognize and pay for Current Procedure Terminology (CPT) codes for immunization administration, non–face-to-face services, and adult and children screening services.

Another set of transitional options are to "rebalance" the RBRVS to more appropriately reward primary care, including:

1. The RVU values for CPT codes could be rebalanced to better reflect the complexity of both cognitive and procedural physician work, comprehensive practice expense, and professional liability insurance expense in providing primary care. While a worthy focus, it may be outside the scope of Washington State and would require a national effort through CMS.

- A simpler approach would be for Washington's state agencies to use and require their contracted carriers use a higher specified conversation factor (CF) for primary and preventive care and behavioral health services. As an example, Washington's Medicaid program adopted pediatric primary care enhancement in 2018. The state pays an enhanced rate for evaluation and management (E&M) codes and vaccine administration for clients aged 20 and younger. In 2021, Washington instituted "Medicaid-Medicare parity" for pediatric primary care, meaning pediatricians were paid at rates equivalent to or slightly better than Medicare rates.

2. Another approach is to require Washington's state agencies set a primary care payment floor. As noted above, the legislature has directed that PEBB/SEBB payments be not less than 150 percent of Medicare. This floor or a higher floor could be applied to Medicaid, PEBB/SEEB and the Health Benefit Exchange plans.

Two issues arise under these "rebalancing options. One is at what level should primary care payment rates be set at? The revision of RVU values to more accurately reflect primary care would provide an analytic guide. Another approach using Medicare as a benchmark would be a comparison of what commercial payers are paying specialist and other provider type, such as inpatient and outpatient hospital services, as a percentage of Medicare payments and use that ratio to adjust existing primary care payments through a CF adjustment.

A second issue is how are these increased payment rates to be financed. Again, there are several pathways to increase primary care rates with requiring new funding, including:

1. One option that has been suggested is to move the state purchased health coverage from managed care organizations (MCO) to a fee-for-service (FFS) delivery system and use a portion of administrative saving to increase primary care rate. Washington's Medicaid MCOs and large group market carriers currently operate with a 90 percent medical loss ratio (e.g., 10 percent administrative charge). A portion of the MCO administrative load could then be used to increase primary care rates.

2. Another option would be to rebalance the RBRVS system by increasing the CF for primary and preventive care and outpatient behavioral health services and reducing the CF for specialty services by a corresponding amount to maintain payment neutrality. This approach could be used within both MCO and FFS delivery systems.

ATTACHMENT A

2023 Health Care Expenditures as %GDP		
Rank	Country Name	%GDP
1	United States	16.7%
2	Germany	11.7%
3	Switzerland	11.7%
4	France	11.5%
5	Canada	11.2%
6	Austria	11.2%
7	Sweden	11.2%
8	United Kingdom	11.0%
9	Belgium	10.8%
10	Japan	10.7%
11	Finland	10.5%
12	Australia	10.4%
13	New Zealand	10.1%
14	Portugal	10.0%
15	World	10.0%
16	Denmark	9.6%
17	Spain	9.2%
18	Italy	8.4%
19	Greece	8.4%
20	China	5.9%
SOURCE: World Bank Data		

2023 Per-Capita Health Care Expenditures		
Country	Per-Capita	Ratio to Country Average
United States	$13,432	182%
Switzerland	$9,688	131%
Germany	$8,441	114%
Austria	$7,811	106%
Netherlands	$7,737	105%
Sweden	$7,522	102%
Belgium	$7,380	100%
France	$7,136	97%
Canada	$7,013	95%
Australia	$6,931	94%
United Kingdom	$6,023	81%
Japan	$5,640	76%
Comparable Country Average	$7,393	100%
SOURCE: KFF analysis of OECD Health Statiistics database.		

ATTACHMENT B

Resource-Based Relative Value System [3]

A key contributor to the "underinvested" in primary care has been the widespread adoption of the Resource-Based Relative Value System (RBRVS) for physician related services. First adopted by Medicare in 1992, it is now used by all state Medicare program. An American Medical Association (AMA) survey of 127 public and private payers found that 77% use the Medicare RBRVS to set their payment rates.

The RBRVS is based on Current Procedure Terminology (CPT) codes created by the AMA to standardized the reporting of medical services, procedures and treatment. There are currently more than 11,000 CPT codes in use.

The RBRVS assigns a value to every CPT code based on three Relative Value Units (RVUs):

- **Physician Work (51%):** Accounts for the time, technical skill, mental effort, and stress involved in the service.
- **Practice Expense (45%):** Covers the cost of clinical and non-clinical resources, such as office rent, equipment, and supplies.
- **Professional Liability Insurance (4%):** Reflects the cost of malpractice insurance premiums.

The Center for Medicare & Medicaid Services (CMS) makes the final determination and assignment of RVUs to CPT codes. Their assignment is based on recommendations from the Relative Value Scale Update Committee (RUC). RUC is an AMA panel of 32 physicians and health professionals. RUC relies on voluntary surveys from professional societies.

For Medicare, CMS calculates the final payment by adjusting these units for local economic conditions and converting them into a dollar amount:

1. Geographic Adjustment: Each RVU component is multiplied by a Geographic Practice Cost Index (GPCI) to account for variations in costs across different regions.
2. Conversion Factor: The total adjusted RVU is then multiplied by a fixed dollar amount, known as the Conversion Factor (CF), to determine the final reimbursement.

[3] MedPac, "Physician and Other Health Professional Payment System", (November 2025)

For Medicare, CMS calculates the CF through formula that takes into account the overall state of the economy of the United States, the number of Medicare beneficiaries, the amount of money spent in prior years, and changes in the regulations governing covered services.
It is important to note that Medicaid programs and private health carriers calculate their own CF, which is often based on a percentage of the Medicare CF.

The RBRVS payment system has been subject to significant criticism, including:

- **Undervaluation of Evaluation and Management (E/M) Services**: Primary care and cognitive services (E/M) are not accurately captured by CPT codes, leading to lower compensation for complex, time-intensive, non-procedural work compared to surgical services.[4]

- **Conflicts of Interest in the RUC Process**: The Specialty Society Relative Value Scale Update Committee (RUC) relies on voluntary, potentially biased surveys from professional societies. Experts, including the original designer of the RBRVS, William Hsiao, have described the update process as "highly political" rather than based on independent, objective data.

- **Low-Quality Data and Selection Bias**: GAO reports have noted that RUC surveys often have low response rates, small sample sizes, and significant estimation errors, which can lead to data that does not accurately reflect the true time and effort required for services.

- **Systemic Mispricing and Overvaluation**: The RBRVS often fails to adjust for efficiencies in new technologies, leading to high reimbursement for certain procedures even as they become faster and easier to perform.

- **Failure to Keep Pace with Costs:** The Medicare Physician Fee Schedule (MPFS) updates have not kept pace with the inflation of medical practice costs.

- **Inadequate Practice Expense Valuation**: There are concerns that overhead costs for certain services are not adequately calculated, potentially hindering access to care if reimbursement fails to cover operational expenses.

The net result of these weaknesses is the RVU weights create prices that reward high-volume, high-intensity services over comprehensive care and underfund rates for primary care,

[4] Skopec, Laura and Berenson, Robert," Why the Medicare physician fee schedule misvalues fee levels and how to fix it", Health Affairs Scholar (October 1, 2025)