

# Provider participation and reimbursement draft

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## Design draft notes

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**Committee:** Finance Technical Advisory Committee (FTAC)

**Commission/committee lead(s):** Roger Gantz, Pam MacEwan, Bob Murray, Eddy Rauser, and Sarah Hughling

**FTAC initial review:** March 19, 2026

**FTAC approved:** August 6, 2026

**Commission review:** April 30, 2026

**Commission adopted:** September 3, 2026

**Proposal ID:** 2026-03

**Core design element/milestone:** Provider Reimbursement and Participation

## Summary

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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 state-regulated provider reimbursement mechanisms 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. These strategies are exemplified in the recent enactment of reference-based pricing for certain public employees.

It will take time to sort out the key components of a universal system. In the meantime, the state should continue to pursue the implementation of regulated health care price and spending mechanisms. This will improve stability and affordability health care in the short term, while enhancing long term prospects for universal financing. Considerations of cost containment have been woven throughout the Commission's design of a universal system, and efforts to contain costs inform these recommendations as well.

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. These initial recommendations fall within the realm of transitional solutions—part of the Commission's charge—and will inform later design decisions for a universal system.

## Background

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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.<sup>1</sup>

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<sup>1</sup> RCW 41.05.840

Beginning in late 2025, the Commission and its Finance Technical Advisory Committee (FTAC) formally began work on provider reimbursement as a core design element of a universal system in Washington. The Commission adopted a set of guiding principles (Appendix A) on April 30, 2026. These guiding principles informed this proposal and may serve future regulatory decisions in a universal system. Recommendations are grouped by how provider payments are structured (payment mechanisms), and how to incrementally expand payment mechanisms to additional circumstances (implementation approaches). Specific pathways that detail how specific payment mechanisms may be implemented are included in the implementation roadmap (Appendix B).

## Recommendations

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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. Payment mechanisms described below may be first implemented in narrow market segments (e.g., state agency purchasing), allowing for 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 mechanisms

#### Price and payment regulation

A key issue both in Washington and nationally relates to distortions embedded in the Medicare fee-for-service physician fee schedule. These distortions result in underpayment for certain services and care settings (e.g., primary care, behavioral health care, and rural or underserved areas, among others). This fee schedule is also the basis provider payments from Medicaid, Medicare Advantage and most commercial insurers.<sup>2</sup> As noted in Principles 2 & 5, a payment system should rebalance payments toward traditionally under-resourced services and settings while improving affordability through cost containment.<sup>3</sup>

To achieve these goals, 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 in Washington will be based on a percentage of Medicare reimbursement rates.<sup>4</sup> That payment mechanism, known as reference-based pricing (RBP), can also be used to correct for underpayments by setting a floor for payments to other providers and settings. As [RCW 41.05.028](#) is implemented, Washington will utilize this feature as well by mandating a price floor for primary care payments in the state's Public Employee Benefit (PEB) and State Employee Benefit (SEB) programs.

A payment approach that may be implemented as a progression from RBP is out-of-network (OON) payment caps for hospital care or other services provided to commercially insured patients. The use of RBP caps (tied to a percentage of Medicare payments) for all OON hospital services in the state could address the issue of surprise hospital bills for patients. More importantly, OON price caps is a low-intensity way of creating limitations on hospital prices paid by commercial insurance companies. Price caps for all 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.

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<sup>2</sup> 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)

<sup>3</sup> See Appendix A: Provider reimbursement guiding principles for detail on goals of a payment system. Additional consideration for specific settings (e.g., rural and underserved regions) can be found in Appendix B: Provider reimbursement roadmap.

<sup>4</sup> RCW 41.05.028 contains exemptions for certain care settings, including pediatric and rural hospitals.

Effectively, this would cap in-network prices at or below the OON price cap.<sup>5</sup> This approach could provide the state with an interim step in extending aspects of the current RBP mechanism,<sup>6</sup> without imposing RBPs on all hospital services in the state, while still imposing significant pressure on commercially negotiated hospital prices.

To address volume-based incentives that impact traditional fee-for-service (FFS) mechanisms (including RBP and OON caps), payment mechanisms that expand the bundle of services being paid for – such as bundled payments and hospital global budgets (HGB) – should be considered. Bundled payments are structured to cover all services associated with a diagnosis or procedure over a specified period. Service bundles can vary in breadth and may cover services provided by an entire care team. This feature makes conditions that require care coordination, such as specialty psychiatric or maternal care, good first candidates for this type of payment.<sup>7</sup> Bundled payments for certain psychiatric and obstetric care services are currently implemented in Washington State.<sup>8</sup> Potential impacts of this payment mechanism, including on administrative complexity, patient selection, and the financial stability of low-resource providers, should be monitored during implementation.

Another payment mechanism that may be considered for these incremental steps is hospital global budgets (HGBs). Hospital global budgets establish a predetermined amount paid to hospitals for all inpatient and outpatient services. There are two different versions of HGBs:

- HGBs that are **largely fixed** and set both a hard cap and a hard floor on annual revenues charged and realized by a hospital
- **Flexible HGBs**, which make use of a volume adjustment system to reduce the incentives of fee-for-service payment systems that induce hospitals to increase volumes of care unnecessarily and fund hospitals' fixed costs when volumes decline

The State should consider the advantages and disadvantages of both HGB approaches. These budgets should be mandatory for all payers but certain types of hospitals may be exempt initially. Careful consideration should be made regarding criteria for base payment rates, which may be adjusted based on factors like actual patient volume. When implemented effectively, HGBs allow for prospective, predictable payments that can stabilize hospitals currently subject to unpredictable revenue, fluctuating patient volumes, and a wide range of prices.

## Leveraging state market power

To leverage the role of the state purchasing to advance cost containment goals, the state could expand its use of open competitive contracting. Unlike traditional, limited competition contracting where an organization invites only prequalified entities to submit a bid, under open competitive contracting, the state establishes specifications (e.g., quantity, quality), then seeks competitive bids from all licensed bidders. This mechanism can be used for a variety of health care management services, including managed care organization (MCO) procurement, where organizations respond to the invitation and are selected to provide coverage for defined period (often three to five years). The state retains policy control over the service, while the contractor produces the service under public oversight. Critically, the state's purchasing leverage may be expanded and linked, improving the prospects of cost containment with contracted carriers.

## Phased implementation 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

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<sup>5</sup> Robert Murray and Jack Keane, *Setting Caps on Out-of-Network Hospital Payments: A Low-Intensity Regulatory Intervention for Reducing Hospital Prices Overall* (Commonwealth Fund, May 2022). <https://doi.org/10.26099/tvdr-1w88>

<sup>6</sup> RCW 41.05.028 sets OON rate caps for most hospitals that are out of network for public and school employees.

<sup>7</sup> Jeroen N. Struijs et al., *Bundled-Payment Models Around the World: How They Work and What Their Impact Has Been* (Commonwealth Fund, Apr. 2020). <https://doi.org/10.26099/936s-0y65>

<sup>8</sup> See the Collaborative Care Model and Global Obstetrical Care in Apple Health billing guides.

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:

- Applying the mechanism to an additional set of providers
- Applying the mechanism to additional care settings
- Applying the mechanism to additional services
- Applying mechanism to a greater proportion of provider budget
- Consolidating and extending state market power.

## Provider participation

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.

Reimbursement changes and administrative simplification will incentivize some providers to participate in the aspects of the system where these changes are first implemented. Beyond administrative simplification, potential advantages to providers include greater stability in rural and underserved areas, predictable and prospective payments, increased reimbursement for currently underfunded services (e.g., primary care and behavioral health), and greater satisfaction among clinicians.<sup>9</sup> Ultimately, these incentives may increase participation and contribute to stronger provider networks, especially where services were previously underfunded.

While provider incentives may reinforce the effect of transitional payment mechanisms, mandatory provider participation in payment models is necessary to achieve cost containment in most contexts. The history of payment initiatives and value-based payment (VBP) models has demonstrated that voluntary payment initiatives (such as ACOs or other VBP strategies) have not effectively controlled the growth of provider prices and spending. This is because providers with the highest prices and spending are allowed to opt out. For this reason, voluntary models do not have the ability to enforce limits on price and spending growth in a comprehensive way.

## 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 people-centered data governance that furthers accountability, transparency, and public trust. Such principles may address data collection impact, ownership/access, consent, secondary use, and individual rights.

Data collection should be as complete as possible while minimizing impact on reporting entities. Currently, several separate and complementary data streams provide an incomplete picture of health care spending. Payment-relevant data currently collected by these separate systems should be incorporated into the universal system's all-payer claims database (APCD).<sup>10</sup> This additional data should include non-claims spending and more

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<sup>9</sup>Current provider reimbursement models can contribute to clinician burnout and moral injury, in part through overreliance on financial incentives to promote quality care.

<sup>10</sup>Payment-related data is currently distributed across multiple operationally distinct systems, none of which was designed for cross-payer analytic use. Realizing the full value of a universal APCD requires a data governance infrastructure that integrates these data streams into a single harmonizing source capable of supporting expenditure forecasting, rate-setting, research, and public transparency that could support the use cases enumerated in this section.

complete geographic, race, ethnicity, and language information for patients. A health care entity registry should be developed to analyze how spending accrues to relevant groups.

Data could be used to:

- Inform rate setting, priority-setting, benefits design, payment mechanisms, and resource allocation.
- Determine whether elements of the current payment mechanism, such as base rates, need to be adjusted.<sup>11</sup>
- Adjust identified elements accurately and fairly.
- Identify the need for exceptions or modifications to preserve access to care.
- 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.
- Oversee the payment system, including understanding the sources of payment and access variation.
  - Understand how critical measures (utilization, access, costs, outcomes, social determinants, commercial determinants, etc.) vary across payers, delivery systems, and services.
  - Integrate information across reporting systems to provide a comprehensive source for system evaluation.
  - Detect and manage high-need/-cost members and provider services, including instances of financial waste/fraud/ abuse.
- Evaluate and set health system performance measures goals for public reporting.

## 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](#)
- [Department of Health](#)
- Other states' past and current experiences with cost boards, universal health care commissions, and alternate payment models including Massachusetts, Vermont, Oregon, Maryland, and California.

## Draft review history

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### FTAC feedback | March 19, 2026

- Consider adding bundled payments to payment mechanisms
- Add a broad statement about why the memo—and aspects of others—focuses on transitional solutions
- Further explain and connect what is meant by payment mechanisms and implementation approaches
- Consider adding a standalone section describing the proposed universal, direct primary care transitional mechanism/approach

### UHCC feedback | April 30, 2026

- Concern that reference-based pricing or HGB could destabilize rural hospitals.
- Request to clarify how consolidating and leveraging purchasing power/open competitive contracting differs from existing strategies

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<sup>11</sup> E.g., risk adjustment and rate cell analysis.

- Request to clarify what consequences an opt out provision would have re: mandatory vs. voluntary provider participation
- Inclusion of what success looks like (evaluation criteria) for payment mechanisms
- Inclusion of contract durations and notification periods for provider predictability
- Review of unsuccessful related legislation to address issues related to provider reimbursement

## FTAC feedback| May 14, 2026

- Request to include other relevant data systems (e.g., Provider One) and how they may be integrated with the APCD.
- Concern that current draft suggests RBP is the singular solution to fee schedule distortions.
- Need to address how payment policies (especially in rural and low-volume settings) address problems and incentives with changing patient volumes. This can be done in the roadmap if the proposal is sufficiently clear and footnoted.

## FTAC feedback | August 6, 2026

FTAC voted to approve draft.

## Provider reimbursement guiding principles

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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. **Support clinicians to improve care**  
The reimbursement system should support clinicians in improving the quality of care and reducing 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 predictability and stability of the payment/financing system.
10. **Ensure that payment policy aligns with policy related to health system capacity and financing**  
Integrate and coordinate payment and health care capacity, staffing, and financing policies to ensure adequate access to affordable care.