Primary Care Strategy Committee

Legislative Concept Ideas: Details and Committee Feedback

June 18, 2026

Background

Primary care practices are under significant strain, caused in part by increased demands on primary care providers and lack of sufficient funding to support approaches — such as expanding the primary care "team" — to help address these demands and meet patients' needs. The Oregon Health Authority (OHA) has heard about challenges the primary care system is facing in multiple public forums from primary care partners throughout the state, including Oregon Health Policy Board (OHPB), the Primary Care Payment Reform Collaborative, the Health Care Workforce Committee, the Oregon Rural Health Conference and Oregon Health Forum events.

Legislative Opportunity

OHPB has the opportunity to introduce legislation during Oregon legislative long sessions, and there is an OHPB primary care legislative concept (LC) "placeholder" for the 2027 legislative session. The expectation is that the Primary Care Strategy Committee (PCSC) will recommend language to be included in this LC placeholder, which will then be shared with OHPB for their consideration. The goal is for PCSC to have draft LC language by the end of the June 18 meeting, which will allow OHPB to meet the Executive Branch timeline for the 2027 legislative session.

Legislative Concept Ideas: Source

As noted at the April 28 PCSC meeting, OHA presented the committee with three ideas to be considered for inclusion in its LC placeholder. These ideas came from provider feedback that's been shared with OHA for years, primarily from providers on the Primary Care Payment Reform Collaborative (PCPRC). The PCPRC was a legislatively required body, per SB 231 (2015) and SB 934 (2017), that included a broad mix of members, including providers, payers, consumers, clinic administrators, and statewide organizations representing primary care. Legislation required PCPRC focus on: increase investment in primary care, moving primary care payment from fee-for-service to value-based payment, and align payment methods. After meeting for 10 years, the PCPRC ended late last year.

Together the three ideas increase primary care payment amount and sustainability, impacting the highest-prioritized strategy by PCSC members of increasing payment to primary care practices. These ideas also address, either directly or indirectly, all three

committee focus areas: increasing payment and affordability (direct impact), and supporting the workforce and improving the delivery system (indirect impact).

Legislative Concept Ideas: Collective Impact

Together the three ideas increase primary care payment amount and sustainability, impacting the highest-prioritized strategy by PCSC members of increasing payment to primary care practices. In addition, these ideas address, either directly or indirectly, all three committee focus areas: increasing payment and affordability (direct impact), and supporting the workforce and improving the delivery system (indirect impact).

Legislative Concept Ideas: Details

This document presents the following:

- Description of each LC idea
- Problem the idea aims to solve
- Proposed solution
- Impact the solution would have on primary care
- Potential concerns about the idea
- Potential approaches to address the concerns that could include changes to the LC

Per Member Per Month Payments for Patient Centered Primary Care Homes

Problem

Per member per month (PMPM) funds paid to Patient-Centered Primary Care Homes (PCPCHs) — which are practices certified by OHA, via a legislative program, for delivering high-quality care — can provide primary care practices with funds to hire staff such as Traditional Health Workers or Behavioral Health Providers that are essential to team-based primary care. While current coordinated care organization (CCO) and Public Employee Benefit Board/Oregon Educator Benefit Board (PEBB/OEBB) contract language includes a requirement to provide PMPM funds paid to PCPCHs, not all payers are required to make these PMPM payments.

Proposed Solution

All payers would be required to pay a PMPM to PCPCHs in their network to sustain PCPCH practices through, for example, being able to hire additional staff for the primary care team. The PMPM would be tiered based on the PCPCH practice's tier-status (tier 3, 4, or 5 determined by the total point value of the measures that they attest to) and required to be sufficiently meaningful to support primary care. Via its focus on PCPCHs, this approach would ensure that PCPCHs benefit from the savings stemming from the PCPCH model (as demonstrated in a 2023 PCPCH evaluation). PMPM payments are common to many VBPs

and support practices by providing flexible funding for work that is not billable. The proposed solution will not legislate a recommended PMPM amount that payers should provide to PCPCHs in their network.

Potential Concerns	Potential Approaches
A payment floor is needed to ensure sufficient payment.	• Could recommend amounts based on research. However, there likely wouldn't be sufficient time for this to occur for the 2027 legislative session, as it would require thorough research and robust input from PCSC. In addition, it would be challenging to implement for Medicaid given the state budget situation and the need to go through CMS for approval. • Payment parameters could be added in future legislation.
Overall compensation to primary care could remain static if payers reduce rates.	• Require payers to attest to not decreasing rates through rate review process (Massachusetts uses this approach). • Educate practices about the requirement to not decrease rates and encourage them to report to OHA/DCBS if rates are decreased.
May limit innovation in value-based payments (VBPs) unless flexibility is allowed.	Payers can continue to innovate in other components of their VBP models.
Could result in duplicative payments with existing VBPs.	Payers could decouple the PCPCH PMPM from the rest of VBP and/or make an additional PCPCH PMPM on top of existing VBP.
Will increase member premiums.	The funding can instead come from reducing non-primary care rates.
Lack of enforcement mechanism.	Enforcement via the DCBS rate review process could be added to the LC.
Increased administrative burden for payers.	Should not be significant. Payers have many different payment models already.

Payment is not ensured to go to practices.	Restrictions on how payment is spent could be added to the LC.

Stabilizing Primary Care via Timely Value-Based Payment Funding

Problem

While the flexible funding associated with VBP can provide primary care practices with funds to hire staff — such as traditional health workers or behavioral health providers — that are essential to team-based primary care, there is often a significant delay in practices receiving these dollars.

Proposed solution

Create a more sustainable cashflow for primary care practices by requiring all Oregon payers prospectively disburse VBP-related quality measure performance payments on a quarterly cadence at a minimum (with a retroactive adjustment if needed). The payments should equal at least 50% of what a practice is eligible for during the payment timeframe (for example, if payments are being made on a quarterly basis, the practice would receive half of what it would be eligible for during each quarter, and the other half at the end of the contract period).

Ensuring timely disbursement of VBP quality measure payments is one strategy primary care providers and provider representatives sitting on the PCPRC frequently suggested to support primary care providers. In addition, the Collaborative's recommended primary care VBP model guidance notes: "*Incentive payments should be made as proximate to the practice's actions to achieve rewards as possible.*"

Potential Concerns	**Potential Approaches**
Increases administrative burden for practices, especially if metrics aren't aligned across payers.	• Impact could be offset by sustainable cashflow. • The LC could be changed to a requirement to offer to practices, versus being required for practices to adopt.
Doesn't address concerns about number and complexity of quality metrics.	Could be addressed in the future, including legislation if needed.
Increases administrative burden for payers.	Impact could be offset by supporting financial health of practices. Many payers already administer complex VBPs.
Clawbacks are financially challenging for practices.	Metrics and benchmarks could be set at a level that would ensure most practices

	achieve 50%, so clawbacks would be unneeded.
Implementation will be impacted by data lag and attribution issues, especially for measures that are inherently annual (for example, well-child visits), and increased churn as a result of HR1.	At least 50% of eligible dollars could be based on metrics that could be calculated on an ongoing basis, thus not requiring year-end calculations.
Lack of funding source for CCOs.	Since the prospective payment is 50% of current VBP quality payments, no new funds would be required.

Changes to the Primary Care Spending in Oregon Report

Problem

The annual *Report on Primary Care Spending in Oregon* presents how much money most major public and private health insurance payers spend on primary care each year. OHA has heard from many partners they do not use the report for its intended purpose because they do not agree with 1) the restrictive, outdated definition of primary care that is written in statute and 2) the exclusion of prescription drugs from the total medical expenditures. The statute also prescribes a report deadline that does not align with the OHA's data collection and processing timeline.

Proposed Solution

- Move the definition of primary care from statute to administrative rule, which would support a more robust community engagement process to create the definition; and allow the definition to be changed over time.
- Remove from statute the exception for prescription drugs from total medical expenditures, which would support a more robust community engagement process to inform the methodology, and allow the methodology to be changed over time.
- Shift the Report deadline from February 1 to September 30 to align with the data processing timeline.

Accurately measuring primary care spending is essential to improving health care delivery and outcomes. Only by measuring investment is it possible to objectively compare primary care spending over time and across payers and to focus attention on the financial support primary care receives. However, to ensure trust in the data, all interested parties must participate in defining primary care and the methodology to be used.

Potential Concerns	Potential Approaches
Advocates could overly influence the definitions resulting in a weakened report.	Definitions will be developed through rulemaking by a multi-partner group to represent all perspectives.
The public will not be sufficiently engaged.	The public will have the opportunity to provide input on the proposed definition and methodology through a rule-making process.
Definitions could shift in the future.	This is expected and would be addressed through periodic rule updates.
Changes in definitions and methodology will impact longitudinal comparability.	OHA could rerun data for prior years using new methodology.