

Primary Care Strategy Committee

Legislative Concept Ideas Details and Committee Feedback

May 21, 2026

The Oregon Health Policy Board (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 legislative concept placeholder, which will then be shared with OHPB for their consideration. The goal is for PCSC to have draft legislative concept language by the end of the June 18 meeting, as this will allow OHPB to meet the Executive Branch timeline for the 2027 legislative session.

As noted at the April 28 PCSC meeting, the Oregon Health Authority (OHA) has three ideas for consideration by the committee to include in this LC placeholder. These ideas came from provider feedback that’s been shared with OHA for years, including from the Primary Care Payment Reform Collaborative which sunset late last year.

Legislative Concept Details

Per Member Per Month Payments for Patient Centered Primary Care Homes

Problem: 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. OHA has heard about strain to the primary care system in multiple public forums from primary care partners throughout the state, including the Oregon Health Policy Board, the Primary Care Payment Reform Collaborative, the Health Care Workforce Committee, the Oregon Rural Health Conference and the Oregon Health Forum events. Per member per month (PMPM) funds paid to primary care practices such as 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. PCPCHs are recognized by OHA based on a tier-level system. Their tier level (Tier 3, 4, or 5) is determined by the total point value of the measures that they attest to.

Proposed Solution: The concept requires all payers 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 tier-status of the PCPCH clinic. Via its focus on PCPCHs, this would ensure that PCPCHs benefit from the

savings stemming from the PCPCH model (as demonstrated in a 2023 PCPCH evaluation). Proposed solution will not legislate a recommended PMPM amount that payers should provide to PCPCHs in their network.

Other: CCO and PEBB/OEBB payer contract language includes a requirement to provide PMPM payments to PCPCHs.

Stabilizing Primary Care via Timely Value-Based Payment Funding

Problem: The primary care system is currently 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. 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).

Other: Ensuring timely disbursement of VBP quality measure payments is one strategy primary care providers and provider representatives sitting on the Primary Care Payment Reform Collaborative have frequently suggested to support primary care providers. In addition, the [PCPRC’s recommended primary care VBP model guidance](#), (within the “Value Incentives and Rewards” section) notes: “*Incentive payments should be made as proximate to the practice’s actions to achieve rewards as possible.*”

Changes to the Primary Care Spending in Oregon Report

Problem: The annual *Report on Primary Care Spending in Oregon* presents how much money health insurance payers spend on primary care each year. The Report contributes to state-wide initiatives to increase investments in primary care in Oregon and decrease disparities in primary care access. 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 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.

Committee Member Feedback

OHA asked for questions and input on the three ideas for discussion at the PCSC May 21 meeting. Below are questions and input from PCSC members.

1. All payers would pay a per member per month (PMPM) payment to in-network Patient-Centered Primary Care Homes. Note that this is currently required, per contract, for coordinated care organizations (CCOs) and payers who participate in the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB).
 - What is the PMPM floor or methodology?
 - Would risk adjustment differ by patient risk, geographic adjustment, Patient-Centered Primary Care Home (PCPCH) tier?
 - Need to know if dollars pass through directly to PCPCH practices or can be absorbed by systems.
 - Interaction with existing value-based payments (VBPs)/ avoiding duplicative payments.
 - Enforcement mechanism for non-Medicaid payers (the current DCBS filing process has little bite).
 - May limit innovation in VBPs unless flexibility is allowed.
 - ERISA preemption and uniform benefit design issues.
 - Administrative burden and the need for phasing or exemptions.
2. All payers prospectively, quarterly disburse value-based payment quality performance payments.

- Need to address how prospective payments would be reconciled if quality targets are not met, including avoiding year-end clawbacks that destabilize practice finances.
 - One strategy is to make current year payments based on prior year performance, though it doesn't necessarily tie the dollars to the improvement work you're doing that same year.
 - 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.
 - Alignment across payers to avoid increased administrative friction for practices.
 - Clarifying whether this replaces QIP and, if so, what the new funding source and risk design look like.
 - Balancing statewide expectations with CCO flexibility.
3. Methodology changes to the Primary Care Spending in Oregon Report, which was created to track payers' progress in meeting the Oregon Senate Bill 934 (2017) requirement that payers invest 12% of total medical expenditure in primary care. The proposal is to move from statute to administrative rule the primary care definition and exclusion of prescription drugs from total medical expenditures, which OHA has heard would increase trust in the report data.
- What stakeholder structure governs rule changes? Who will be involved? Does PCSC have?
 - Is there a public comment cycle and some sort of sunset or periodic review to prevent definitional shifts down the road?
 - How does the state maintain longitudinal comparability if definitions change?
 - Will this increase transparency, flexibility, and consistency?
 - How will CCOs be involved in ongoing methodology refinement?

Additional LC topics for consideration

- A 15% primary care spending target by 2030.
- Real enforcement mechanisms for commercial carriers, comparable to CCO contractual oversight.
- Funding that supports full care teams (behavioral health providers, community health workers, pharmacists, care managers), with mechanisms ensuring dollars reach practices.
- VBPs with meaningful financial weight, not token PMPMs.
- Workforce pipeline investments and support for rural/independent practices.

- Statewide multi-payer quality metric and administrative alignment at the practice level (for example, an Oregon Master Quality Contract Addendum) that practices can choose. Clearly defined metrics and APM floors, regulated through OHA for CCOs and DCBS for commercials.