



OREGON
HEALTH
AUTHORITY

Primary Care Strategy Committee

September 17, 2026

Oregon Health Policy Board
Health Policy and Analytics Division

Welcome to the Primary Care Strategy Committee meeting

- The meeting will begin shortly.
- This meeting is being recorded.
- Please mute yourself when not speaking.
- The chat is public.
- If you'd like to provide public comment, please send a message using the chat function on your Teams toolbar by 12:15pm, the time set aside in the agenda for public comment.
 - Public comments are limited to 2 minutes.



Welcome

Agenda

- Agenda review, meeting goals, consent agenda
- Public comment (12:15 p.m.)
- Health System Sustainability Group primary care recommendations
- Break (12:45 p.m.)
- Objective: Understanding administrative burden
- Objective: Big, bold solutions
- Possible products
- Next steps

Review draft meeting minutes

A draft summary from our August meeting is included in the materials for today's meeting.

The Committee doesn't have to vote to approve, but please review and flag any needed changes.



Draft revised guiding principles

A primary care action should...

1. Support patient access in all areas of the state.
2. Protect and support primary care's ability to provide whole person care, including preventative care, across all areas of the state.
3. Increase workforce wellbeing for all members of the primary care team.
4. Decrease administrative burden for providers.
5. Be aligned with other efforts to improve primary care.
6. Have the greatest impact on the health of the most people in their own environment.
7. Not increase complexity for patients.
8. Increase investment in team-based primary care.
9. Not increase the cost of care for patients and ideally lower the cost of care.

PCSC timeline

Month	Activities
April	<i>Clarified charge; established group agreements and decision-making process; discussed leadership roles; approved a process for prioritization; learned about legislative concept (LC) and possible ideas</i>
May	<i>Agreed on vision and objectives; conducted initial discussion on the straw proposal, focused on the LC</i>
June	<i>Decide on ideas to include in the LC; begin discussing guiding principles</i>
July	<i>Possibly refine LC based on OHPB feedback and finalize LC for OHPB 8/4 meeting vote; finalize guiding principles; supporting a strong, local, team-based workforce</i>
Aug	<i>Objective(s) presentations</i>
Sep - Dec	Objectives presentations; develop actions

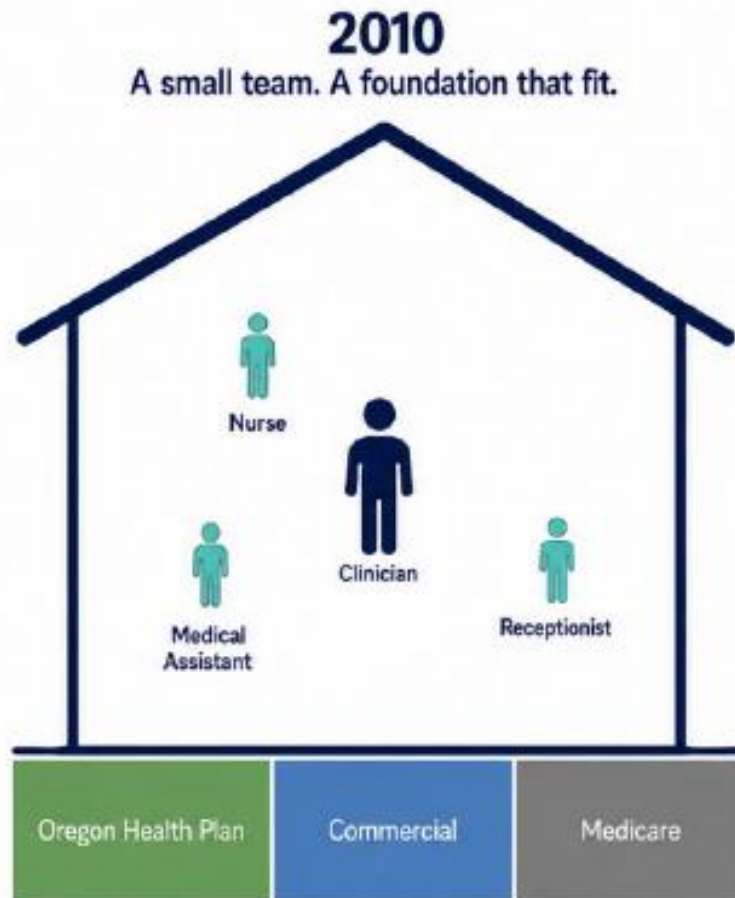


Public comment



Health System Sustainability Group primary care recommendations

Primary care has evolved. Payment hasn't.



The medical home has expanded. The payment foundation hasn't kept pace.

What primary care looks like...

Current state



Too many Oregonians have no usual source of care



Inadequate reimbursement models don't pay for all the care we know is best



Administrative waste



Unaligned quality metrics



Unrealized transformation



Compounding workforce collapse

Ideal future state



Universal access & continuity



Sustained team-based care



Radical administrative simplicity



Workforce is actively growing



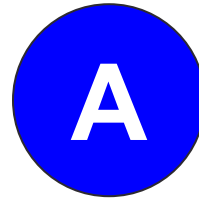
Oregon's primary care scorecard tells the story

THE TRIPLE A PILLARS



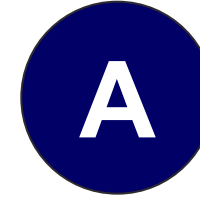
ACCESS **STRENGTHEN THE** **FOUNDATION**

- Prospective population-based payments for defined primary care services
- Expand team-based care and access to primary care training
- Build capacity in communities with the greatest need



ADMINISTRATIVE **EFFICIENCY** **REDUCE THE WASTE TAX**

- Align quality metrics across payers
- Single portal for reporting, attribution, and credentialing
- Reduce or eliminate prior authorization for primary care services



ADVANCED PAYMENT **INVEST FOR IMPACT**

- Prospective population-based payments for defined primary care services
- Infrastructure PMPM payments to support high value services
- Universal, targeted investment of 12%, increasing 1% annually to 17%

Immediate and short-term activities (2026-2027)

Access

Establish the Primary Care Registry of clinics and clinicians

Modernize, harmonize, and consolidate workforce incentive programs

Launch the Primary Care Scorecard

Administrative Simplicity

Pursue radical simplification of quality metrics

Exclude independent clinics from Cost Growth Target penalties

Update statutory authority of DCBS over commercial insurance

Aligned Payment

Preserve 2026 QIP funding streams; ensure sustainable funding

Enforce action plans for payers falling short of the 12% spend target

Require absolute telehealth payment parity

Medium-term activities (2028)

Access

Pursue preceptor and targeted faculty incentive structures

Convene workgroup on public-benefit infrastructure investment partnerships

Administrative Simplicity

Implement efficient, timely payment strategies post-prior authorization reporting

Draft legislation for a unified common credentialing system under DCBS

Aligned Payment

Require health plans to spend their 12% allocation directly within PCPCHs

Increase the statewide primary care spending target to a mandatory 15%

Long-term activities (2029+)

Access

Fund and resource a public-private Primary Care Center of Excellence for capacity financing

Administrative Simplicity

Pursue multi-state licensure compacts to ease clinical friction while protecting clinician autonomy

Aligned Payment

Pass comprehensive Universal Primary Care legislation enabling a unified payment model

Scale spend annually by 1% to reach a mature 17% statutorily indexed target

Advanced Payment Core (Primary Care VBP Architecture)

- **Prospective Population-Based Payments (PBP):** A predictable monthly capitation payment distributed directly to clinics for a defined set of core primary care services that represent a preponderance of spending and are prone to overuse in FFS models.
- **Fee-for-Service (FFS) Payments:** Retained selectively only for specific frontline services that are prone to underutilization or performed inconsistently, such as home visits, prenatal care, and after-hours triage.
- **Infrastructure PMPM Payments:** A base per-member-per-month payment tied directly to a clinic's PCPCH tier, with additional designated capital for high-value integrated teams (behavioral health, clinical pharmacists, and traditional health workers).
- **Performance-Based Incentive Payments:** Meaningful financial rewards based on an aligned, high-level primary care scorecard, with total eligible incentives equaling at least 10% of annual projected service payments, distributed no less frequently than quarterly.

Next steps



Protect current investments and team-based care



Align metrics and streamline reporting



Advance legislation for a streamlined primary care payment system (2027)



Build a Primary Care Center of Excellence to expand capacity and innovation

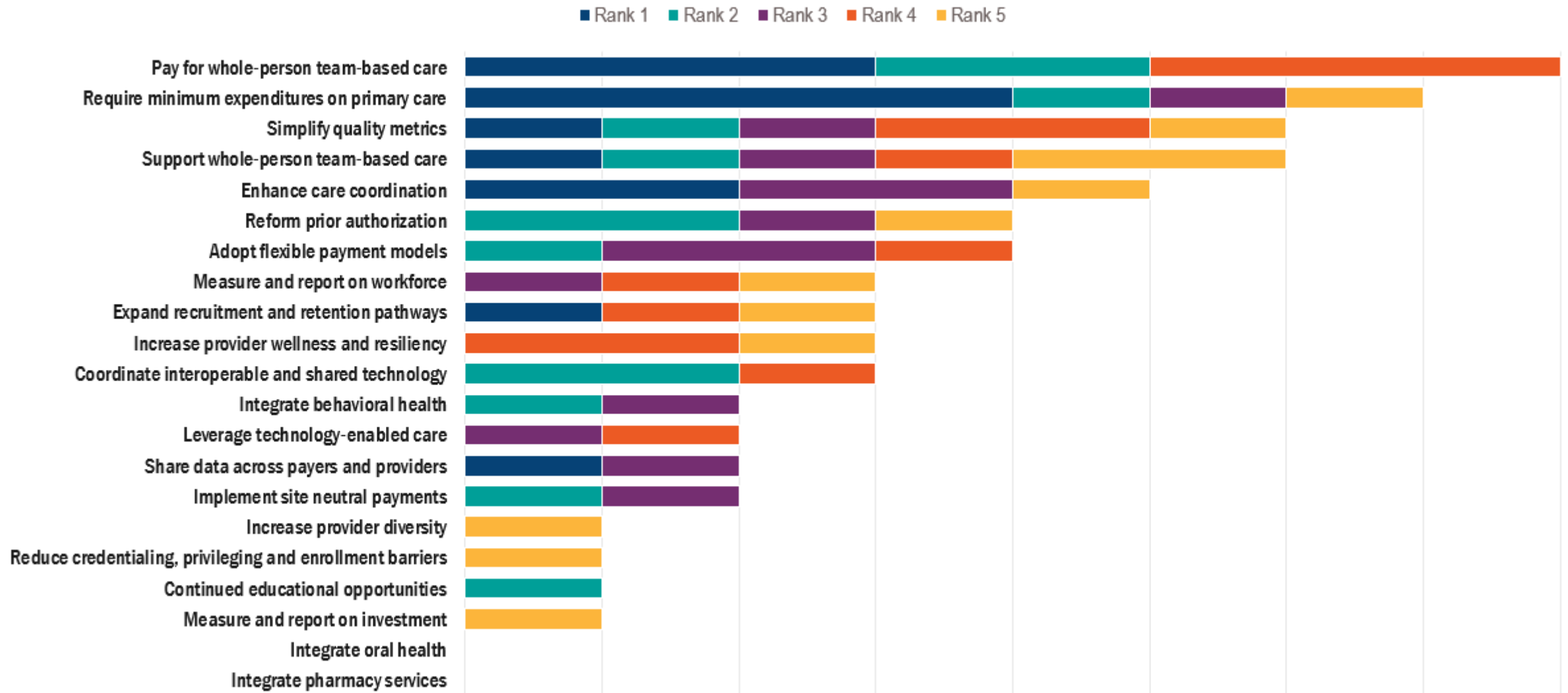


Objective: *Understanding administrative burden*

Background: What is administrative burden?

- Electronic health record (EHR) documentation
- Inbox
- Prior authorization
- Annual changes to formularies
- Quality reporting
- Risk adjusting patients

Number of times each strategy was ranked by the committee



How much administrative burden is there in quality metrics?

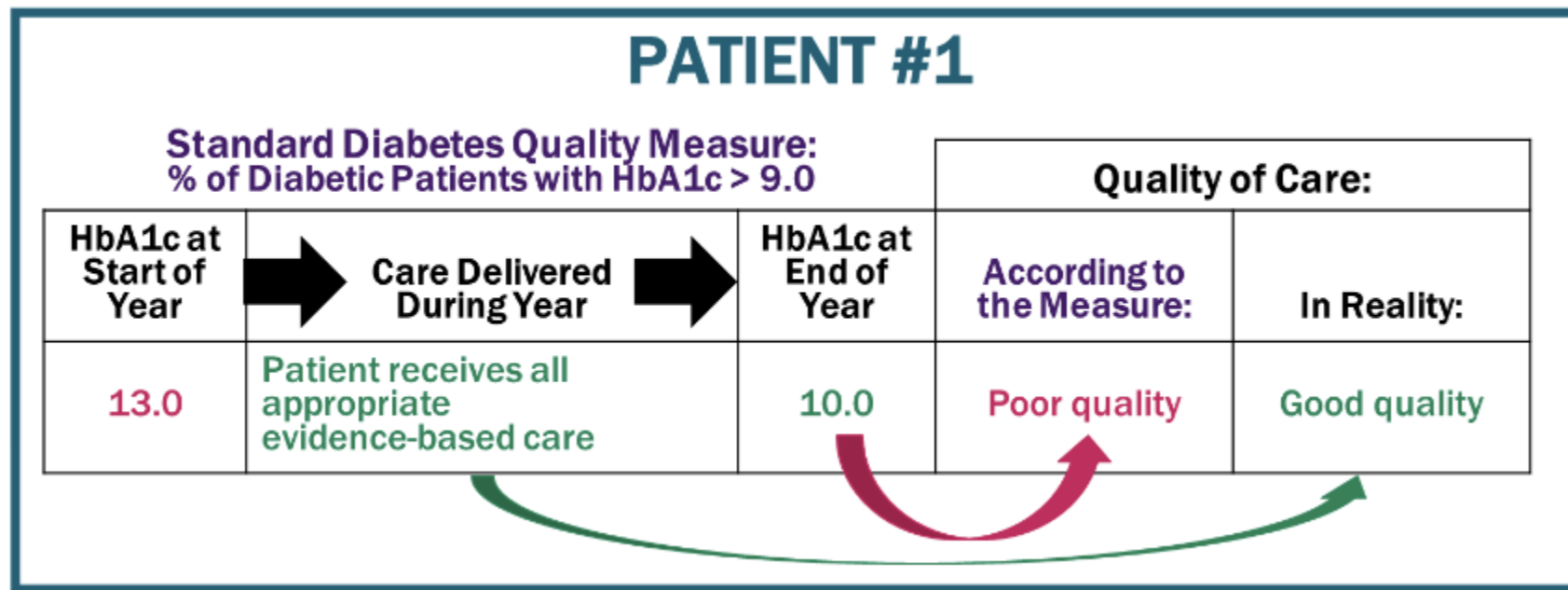
- The sheer number of measures has exploded as we've moved towards value-based payment (VBP).
- By adding in VBP on top of fee-for-service (FFS), we've added in administrative complexity without subtracting anything.
- For example: In 2024, Centers for Medicare and Medicaid Services (CMS) reported 26 quality programs with 492 unique measures.
- Providence reports that an average primary care physician faces meeting 57 different quality measures each year from eleven different payers.

The cost

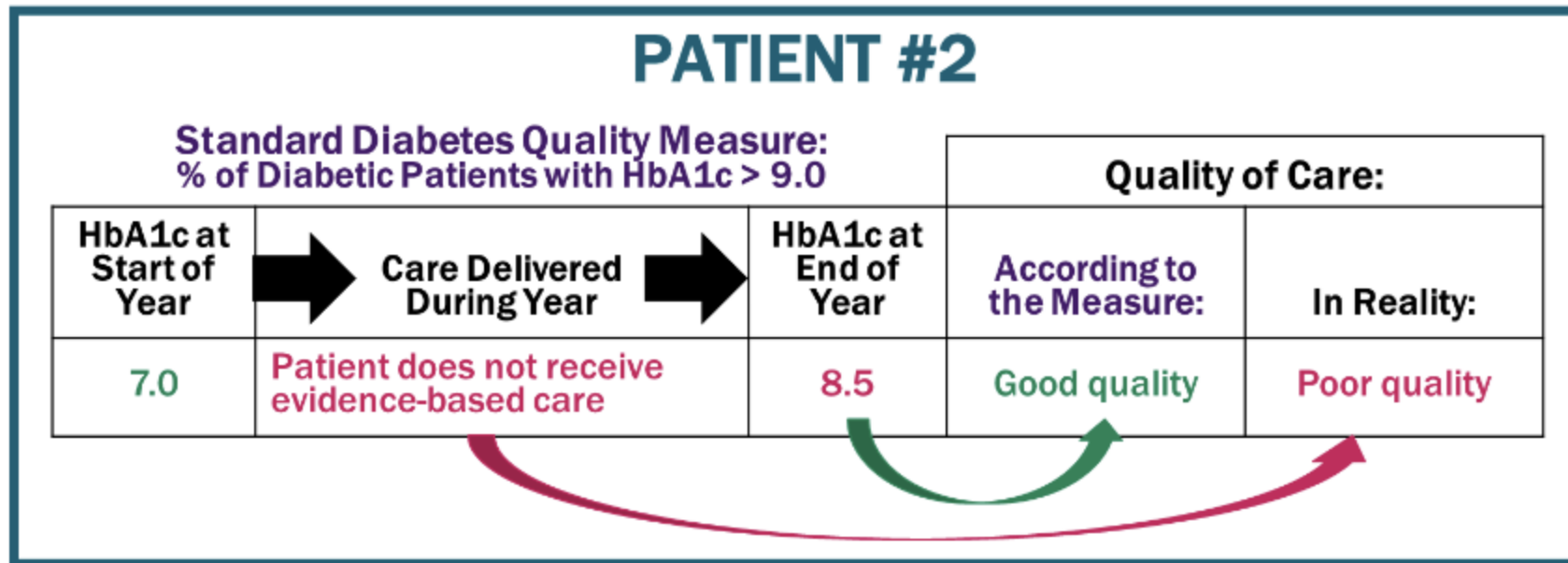
- Administrative burden overall contributes considerably to the overall cost of care.
 - Some studies cite that primary care providers spend upwards of 50% of their day on admin tasks
 - Spend roughly \$20 in admin for every \$100 in reimbursement
 - Overall, administrative spending accounts for 15-30% of total US health care spending
 - Contributes to burnout and decline of new physicians entering primary care
- Quality metrics in particular are costly.
 - Contributes to the loss of small practices
 - CMS Merit-based Incentive Payment System (MIPS) alone imposed a 1.3 billion dollar burden on the health care system

What is the problem with quality metrics? (1 of 4)

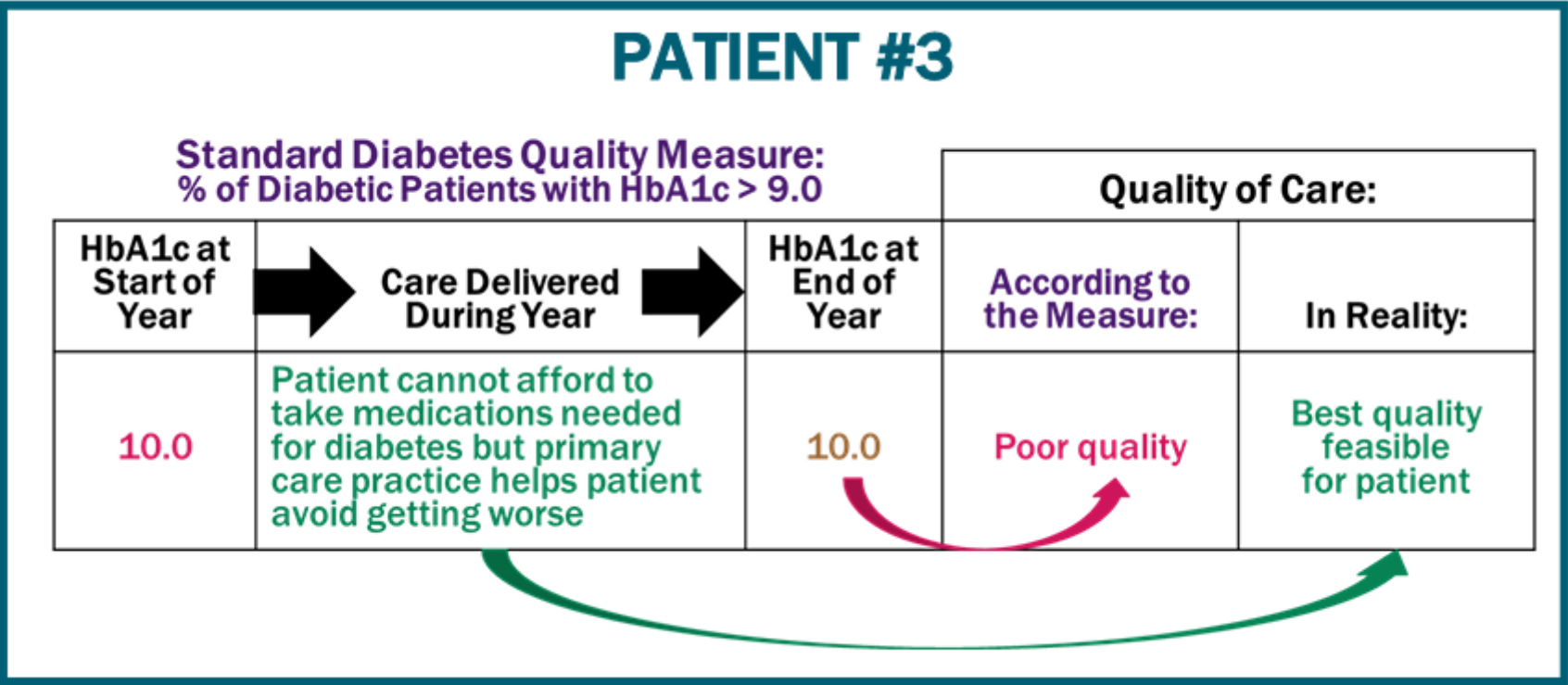
Next several slides are taken from a [paper](#) from the Center for Health Quality and Reform



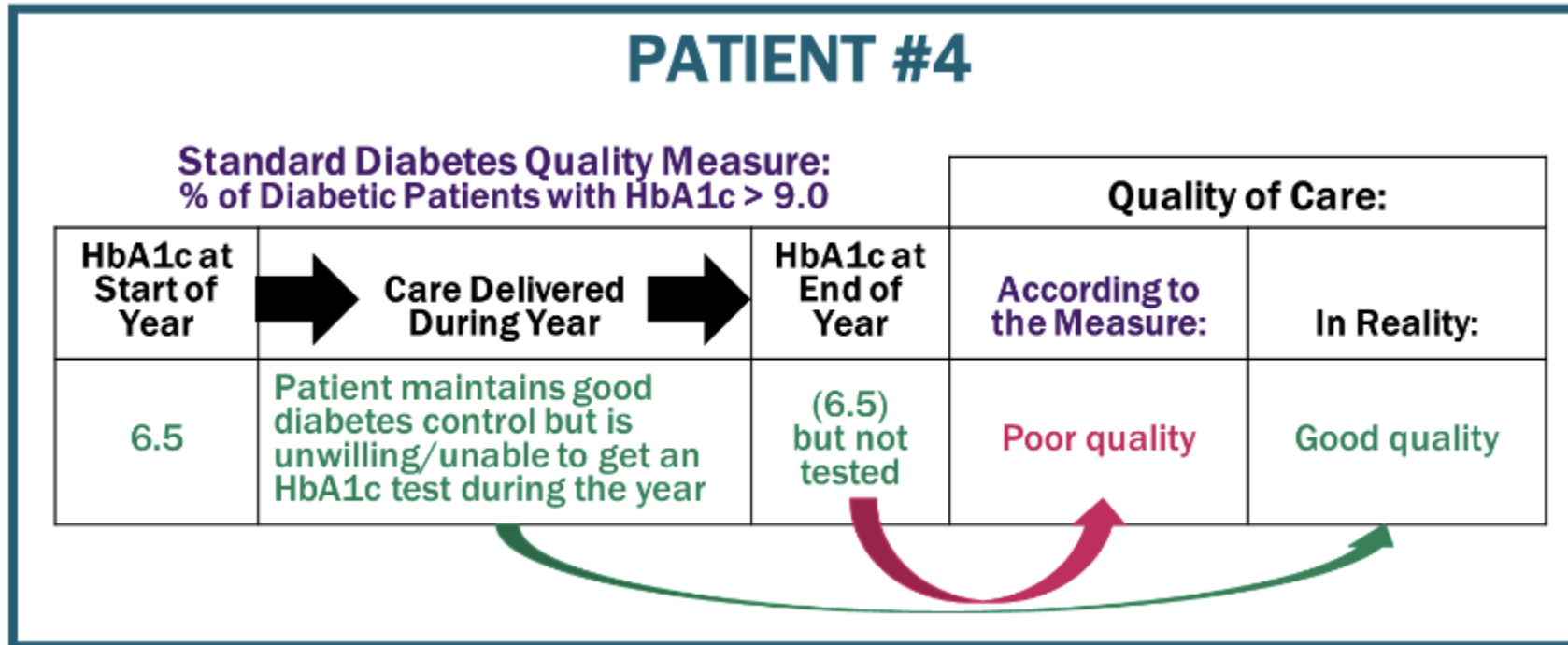
What is the problem with quality metrics? (2 of 4)



What is the problem with quality metrics? (3 of 4)



What is the problem with quality metrics? (4 of 4)



Why is this bad?

- Can steer patients to low-value practices
- Can increase health disparities
- No accountability for payers for their role in negative outcomes
- Little evidence that process-based measures (screenings) improve patient centered outcomes (reduction of mortality, improvement of quality of life)

Many other examples

- [Journal of the American Medical Association \(JAMA\) Internal Medicine article](#) evaluating the unintended consequences of a hypertension measure
- [American Academy of Family Physicians \(AAFP\) article](#) evaluating the evidence base for depression screening
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) actually has some data that it improves outcomes
 - Tracking of the current OHA measure on this is onerous
 - Lack resources for positive screens
- Social determinants of health screening
 - Unclear benefit when we lack resources for positive screens
 - Provider direction not necessary

How can we measure quality?

- Care should be based on up-to-date guidelines individually tailored and patient centered.
- Measures should focus on outcomes.
- Track negative outliers rather than requiring onerous reporting from all.
 - Focus on avoidable spending/care.

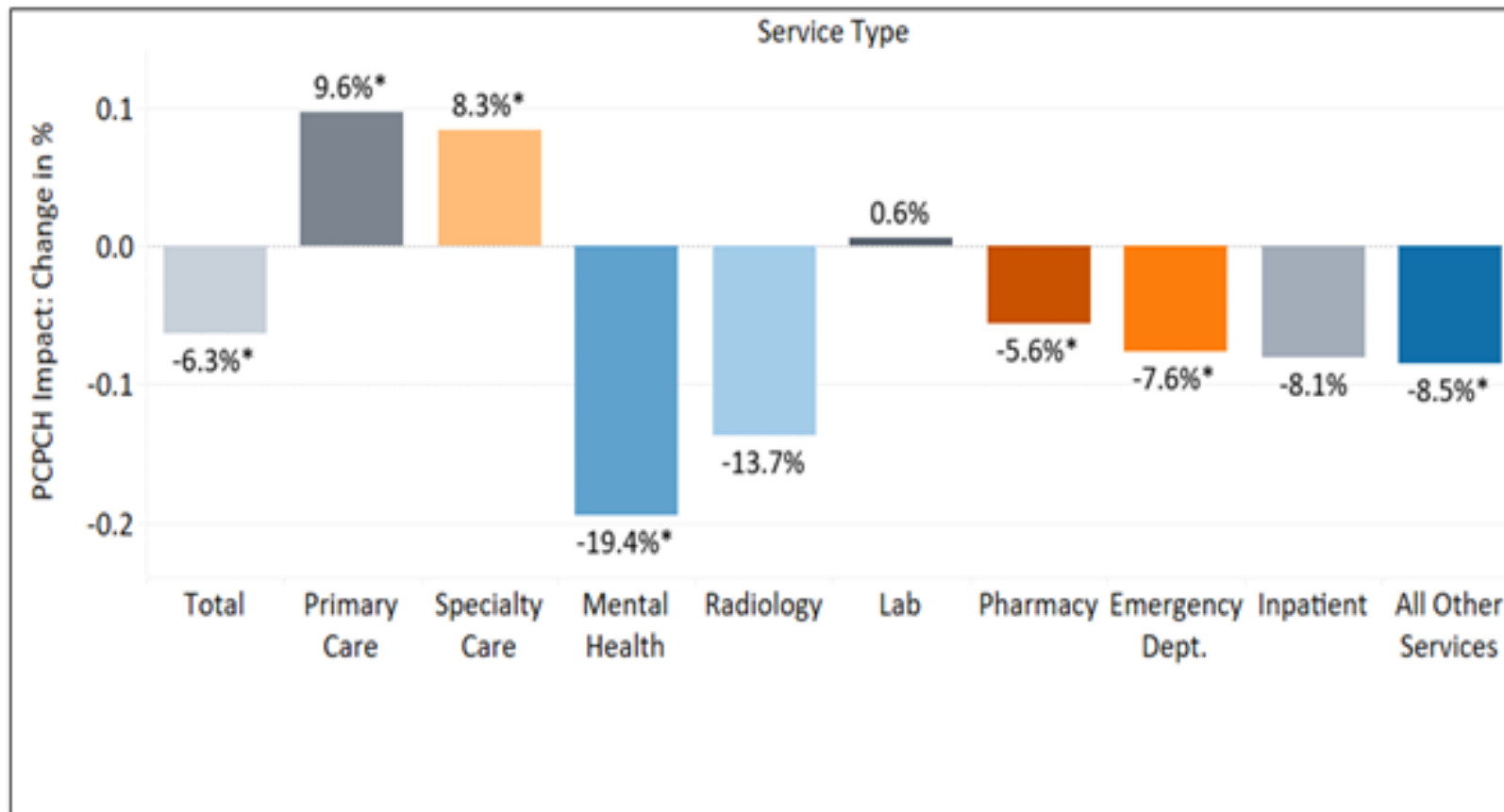
Paying for quality: focus on whole person care

Patient Centered Primary Care Home (PCPCH) program

- Clinics attest to standards regarding
 - Access to Care
 - Accountability
 - Comprehensive whole person care
 - Continuity of Care
 - Coordination and Integration
 - Person and Family Centered Care

Fiscal impacts of PCPCH program

PCPCH Impact on Quarterly Expenditures per Person



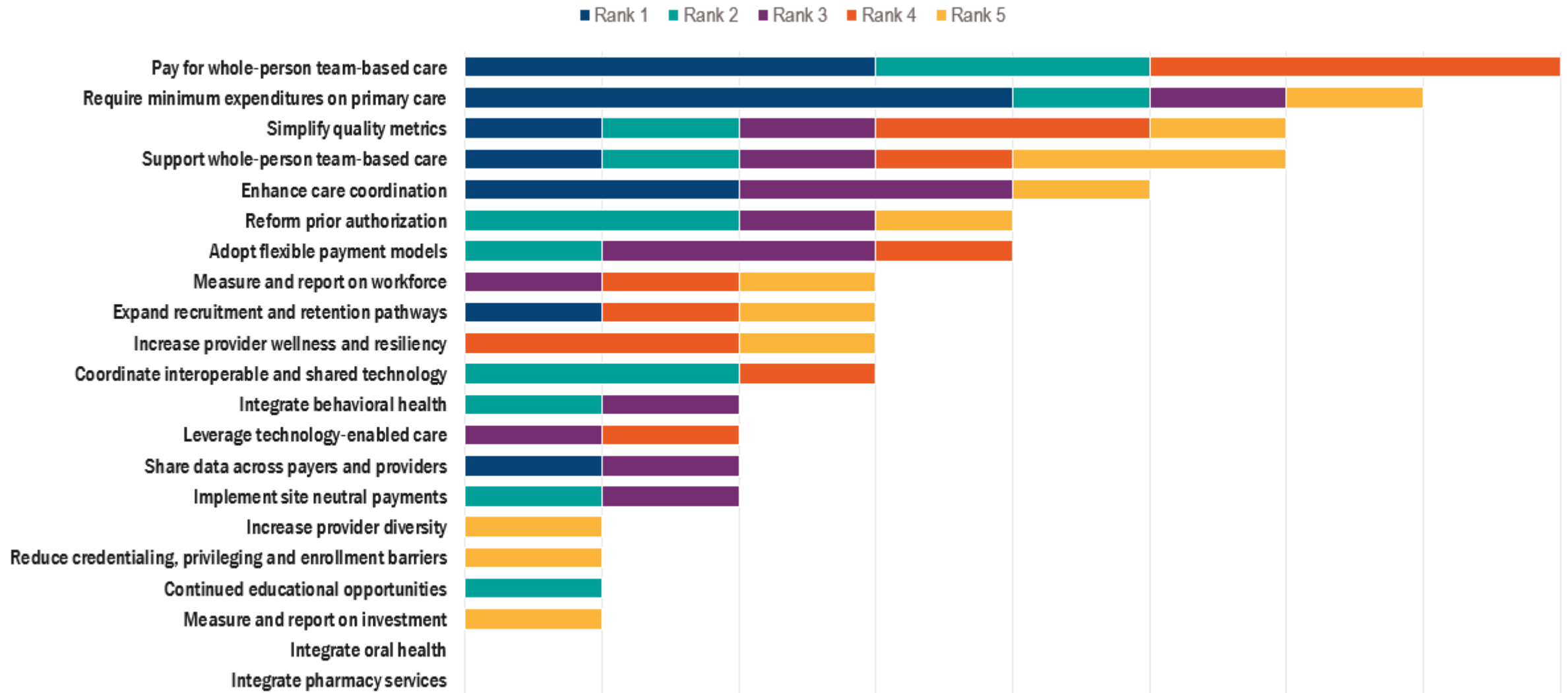
Value based payments are another lever to improve quality

- Primary care has been the main focus
 - Quarterback role
 - Intent from many is to pay for whole person care
- So far, mixed results at best
 - Has added to administrative complexity which is expensive
 - Shared risk formulas can benefit the insurer at the expense of the practice
 - Many different payers have many different ways of measuring value, and clinics must meet all
 - Has often resulted in shuffling of payment rather than a true increase

What is Oregon doing already doing to decrease administrative burden?

- A limited set of metrics are included in the [2023 Primary Care Payment Reform Collaborative VBP model](#).
- The PCPCH program is reducing administrative burden for primary care practices participating in the program.
- [HB 3134](#), passed in 2025, requires insurers 1) report annual prior authorization (PA) approvals and denials (to be published by the Department of Consumer and Business Services), 2) not require PA for an additional or related health care procedure that is identified during an authorized surgical procedure, and 3) streamline the PA process for necessary care.
- CCOs are currently implementing a federally mandated PA Application Programming Interface which will enable primary care providers to submit PA requests and receive payer decisions in a specified timeframe within their EHR systems.

Number of times each strategy was ranked by the committee



Opportunities: *administrative burden*

Big, bold solutions

- Pursue radical simplicity of quality measures and go all in on the PCPCH program. Require all payers to participate and hold accountable payers that add on additional measures.
 - Adjust the PCPCH program as needed
- Pay for primary care with true value-based contracts that prioritize reduction of avoidable spending and unplanned care with appropriate risk sharing. No individual quality measures set by outside entities. Completely move away from fee for service.
 - PCSC should support any ongoing national efforts to repeal MIPS.

Sources

- Agarwal and Lang [Is Questionnaire-Based Screening for Depression Worthwhile in Primary Care? No: Current Evidence Does not Demonstrate Improved Patient Outcomes](#)
- Boon and Robicesek [Evaluating the Consequences of a Hypertension Management Incentive](#) Jama Internal Medicine 2026;186;(8):965-973
- O'Malley et al [Administrative Burden in Primary Care, Causes and Potential Solutions](#) The Commonwealth Fund Issues and Briefs October 2025
- Center for Health Quality Payment and Reform, [Why Quality Measures Don't Measure Quality](#)

Sources (cont.)

- Wallace, Neal and Joyner, Candace [Evaluation of Oregon's Patient Centered Primary Care Homes on Expenditures and Utilization from 2011 to 2019](#) Submitted to OHSU/Portland State School of Public Health January 31, 2023
- White et al, [Reforming Medicare Quality Measurement](#), Journal of Health Affairs September 30, 2025
- [Providence News Team New data: Average primary care physician faces meeting 57 different quality measures each year](#)
- [Center for Healthcare Quality and Payment Reform Creating Successful Alternative Payment Models](#)

Discussion: *administrative burden*

Questions about the content?

What additional information would be helpful?

Thoughts on the strategies and opportunities?

Any additional strategies and opportunities?





Break



Objective: *big bold solutions*

Background

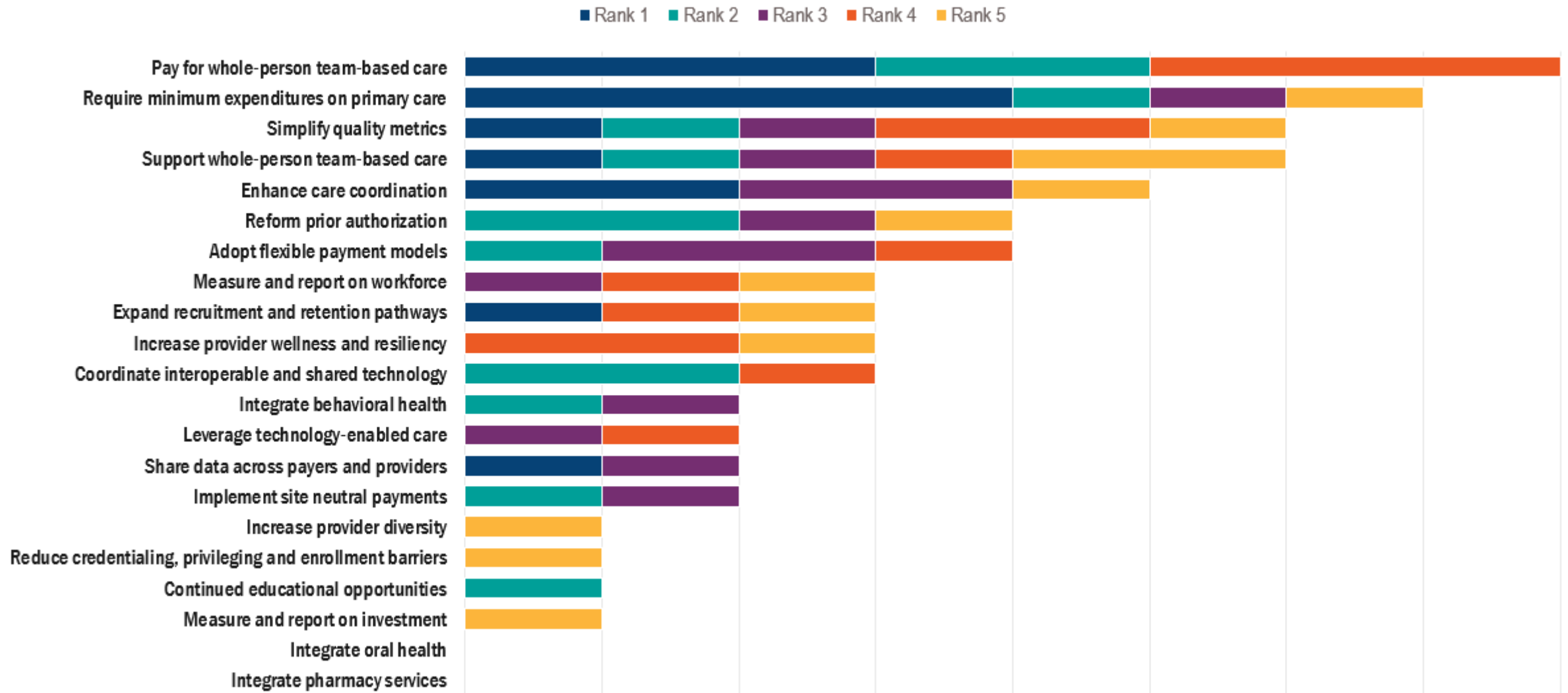
- We started our work in May.
- Much of our work thus far has focused on refining and recommending three ideas to be included in the Oregon Health Policy Board (OHPB) legislative concept (LC).
- We have also been working on group learning about committee objectives, strategies, and opportunities.

Background (cont.)

Thus far, we've learned about:

- Workforce
- Financial sustainability
- Administrative burden, focusing on quality metrics

Number of times each strategy was ranked by the committee



Takeaways

- We think that whole person care is the heart of what great primary care is. Great primary care should be accessible to all.
- We want to pay for it.
- We want to support it.
- We want to simplify it.

Opportunities: *big, bold solutions*

Share screen to view tables of opportunities regarding paying for whole person care and administrative simplicity.

Regulatory barriers

- When looking at these tables we see the same thing again and again.
- Unless we can implement these opportunities across the board we risk adding to administrative complexity.
- The sheer number of payers adds to administrative complexity and makes meaningful increases in primary care investment difficult.
- Authority to regulate insurers is fragmented in Oregon.
 - Oregon Division of Financial Regulation under Department of Consumer and Business Services (DCBS) regulates commercial payers – mostly the insurance exchanges.
 - Oregon Health Authority has some regulatory authority over the Oregon Health Plan (OHP) as does CMS.
 - CMS regulates Medicare.

Primary care is under resourced

- Traditional fee-for-service models undervalue primary care.
- Administrative burden is expensive and not fully paid for by those adding to it.

Big, bold solutions (1 of 4)

Many payers, one standard

- Update DCBS statutory authority over commercial insurance lines.
- Draft legislation to unify health insurer oversight in one agency (DCBS or other).
- Ensure that paying for whole person primary care is a core principle of this one agency.
- Ensure that an explicit founding principle of this one agency is the pursuit of administrative simplicity.

Big, bold solutions (2 of 4)

Many payers, one standard

- The standard should include:
 - Primary care spending targets with enforcement power.
 - Direct payments for whole person care, a minimum PMPM payment.
- Value based contracts w/ flexible payments - capitation, with rates set by a central authority.
- Very streamlined quality metrics - such as use PCPCH as one unifying quality indicator and scrap individual measures.

Big, bold solutions (3 of 4)

Many payers, one standard

- In this situation, all payers share the savings from stronger primary care and better health.
- These savings should be re-invested into the healthcare system as much as possible, and/or drive cost reduction overall.

Big, bold solutions (4 of 4)

Another option: Reduce the number of payers

- Pass comprehensive Universal Primary Care legislation enabling a unified payment model.
- Involves many of the solutions on the previous slide, main difference is who pays.

Discussion: *big, bold solutions*

Questions about the content?

What additional information would be helpful?

Thoughts on the strategies and opportunities?

Any additional strategies and opportunities?





Possible products

Possible products to advise OHPB

Recommendations for policymakers, (legislators, OHA, DCBS) and other partners, including, but not limited to, commercial payers, coordinated care organizations (CCOs), and employers:

- Fact sheets
- Short reports
- Statewide primary care goals as required in the PCSC charter:
 - Establish and Monitor Statewide Goals: Define statewide primary care goals for payment and affordability, workforce, and the delivery system, including integrating behavioral and oral health. Monitor and publicly report progress toward these goals, including workforce and investment indicators.
- Roadmap for achieving goals

Next meeting

Thursday, October 15, 2026

Noon–2 p.m.

[Primary Care Strategy Committee](#)

Alternate format and contacts

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Primary Care Strategy Committee at OHPB.PrimaryCare@oha.oregon.gov or 503-753-9688. We accept all relay calls.

Oregon Health Policy Board
Primary Care Strategy Committee
OHPB.PrimaryCare@oha.Oregon.gov
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Primary-Care-Strategy-Committee.aspx>

