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Tuesday, March 3, 2026

Re: Written Opposition to HB 5204 Due to Cuts to the Quality Incentive Program (QIP)

Co-Chairs Girod and Nosse and members of the Capital Construction Subcommittee of Ways and Means,

Thank you for the opportunity to express the concerns of the many independent providers from Southwestern Oregon. The cut embedded in the January OHA rebalance has significant policy implications for Oregon's 15-year effort to transform health care away from a fee-for-service system to one that rewards preventive, upstream care.

We are also concerned that this policy change will significantly impact Oregon's ability to leverage federal Medicaid dollars back into the state. Cutting the Quality Incentive Program from 4.25% down to 2% reduced General Fund spending by approximately **$63 million**, but because Medicaid funding draws federal matching dollars, that reduction triggers a loss of roughly **$147 million in federal funds**. In total, this policy results in a $210 million reduction to Oregon's Medicaid program.

To put the scale of this cut in perspective, the entire statewide General Fund reductions suggested during the 2026 legislative session totaled approximately $128 million. [SOURCE: https://www.oregonlive.com/politics/2026/03/despite-earlier-alarms-oregon-programs-services-can-proceed-largely-unscathed-in-wake-of-trump-tax-and-budget-cuts.html]

Below are the concerns we have about how this policy change will significantly impact OB/GYNs, primary care providers, and pediatricians across our state.

Why the Quality Incentive Program (QIP) Matters for Oregon — and How CCOs Are Using It to Strengthen Primary Care and Prevention

The Quality Incentive Program (QIP) is one of the most important structural tools Oregon has to align Medicaid financing with its core goals: maintaining access to preventive care, improving long-term outcomes, and transitioning the delivery system away from volume-driven fee-for-service toward value-based, outcome-oriented care.

At its core, the QIP redirects a portion of CCO funding into payments tied explicitly to quality and performance metrics rather than simply reimbursing the number of services delivered. This makes it one of the few mechanisms in the Oregon Health Plan that systematically rewards prevention, early intervention, and coordinated care—activities that are essential to population health but historically undervalued in traditional fee-for-service (FFS) payment models.

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Protecting and Expanding Access to Preventive Care

Preventive care is often undercompensated in volume-based systems because it does not generate the same immediate billable revenue as acute or procedural services. The QIP directly counteracts this structural imbalance by tying funding to measures such as well-child visits, immunizations, cancer screenings, chronic disease management, and behavioral health integration.

This creates a financial incentive for CCOs and providers to invest in outreach, care coordination, and early intervention. The result is a system that encourages proactive engagement with patients before conditions worsen, supports investments in care teams and community health workers, and helps stabilize provider participation—particularly in rural and underserved areas.

Many of Oregon's CCOs operationalize this model by using QIP dollars to enhance payments to high-performing providers—especially primary care practices—that meet or exceed key preventive and quality benchmarks. In practice, this means primary care providers delivering strong preventive care and population health management are paid more than they would receive under a straight encounter-based payment structure. This additional support helps ensure clinics can invest in prevention-focused workflows and maintain access for Medicaid members who rely on consistent, longitudinal primary care.

Without this type of incentive structure, the system naturally drifts toward reactive care—treating illness only after it becomes acute—rather than preventing disease in the first place.

Driving the Transition from Fee-for-Service to Value-Based Care

One of Oregon's long-standing policy goals has been to move away from fee-for-service reimbursement, which rewards the quantity of services, and toward value-based payment models that reward better outcomes and more efficient care. The QIP is a central bridge in that transition.

Under fee-for-service, providers are paid more when more services are delivered, regardless of whether those services improve health. This creates incentives for fragmented, episodic care rather than coordinated, outcome-focused care. The QIP begins to flip that incentive by paying for results—improved chronic disease control, higher screening rates, better maternal and child health outcomes, and reduced avoidable utilization.

Importantly, this transition cannot happen overnight. Providers need predictable, performance-based revenue streams before they can fully move away from fee-for-service dependence. The QIP provides that glide path by layering outcome-based payments on top of global budgets, allowing the system to gradually reorient incentives without destabilizing provider finances.

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Why Value-Based, Outcome-Oriented Care Is Better Long Term

Moving toward value-based care is both a clinical and fiscal necessity for the long-term sustainability of Oregon's Medicaid program. A system dominated by fee-for-service inevitably experiences higher utilization growth, fragmented care delivery, and rising costs without proportional improvement in outcomes.

In contrast, value-based models supported by the QIP incentivize prevention and early treatment, encourage coordination across physical, behavioral, and social needs, and reward providers for keeping patients healthy rather than only treating them when they are sick. Over time, this leads to better population health outcomes and more predictable cost growth—aligning directly with Oregon's broader strategy of global budgets for CCOs and total cost-of-care accountability.

Many CCOs' use of QIP dollars to enhance payments for primary care and preventive services exemplifies this approach. Preventive care and longitudinal management often produce substantial downstream savings by reducing emergency department visits and hospitalizations. By reinvesting QIP funds into the front end of the care continuum, CCOs support the very activities that generate the greatest long-term health gains and cost moderation.

System Stability and Provider Engagement

Another critical function of the QIP—particularly in periods of financial pressure—is that it keeps providers engaged in the Medicaid delivery system. Performance-based incentive payments provide flexible funding that CCOs can use to reward high-performing providers, support value-based payment arrangements, and offset the limitations of traditional base rates—especially for primary care and behavioral health providers whose work is foundational to preventive care access.

Thank you for hearing our concerns about the significant impact of this this policy and funding change to the Oregon Health Plan and Providers who take care of OHP members.

Sincerely,

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