CareOregon
Primary Care Payment Model

2026 Provider Network Program Guide
Metro Region

Please email Payment Model for all PCPM program inquires: **paymentmodel@careoregon.org** The centralized inbox serves as the primary channel for provider communications to ensure timely responses and optimal support.

PCPM 2026 Executive Summary

The PCPM 2026 program has been comprehensively redesigned with the primary objective of reducing administrative burdens on our provider network and enhancing the overall provider experience. Key changes are summarized below. Any further noteworthy updates or clarifications will be integrated into this program guide and communicated accordingly.

Annual Reporting: Unlike prior years, which divided each program year into multiple reporting periods, the 2026 program will follow a single annual reporting and evaluation period covering the full calendar year (January–December). While certain metrics will continue to require quarterly data submission, overall 2026 performance will be evaluated based on full-year results. Data will be submitted throughout the year via claims and quarterly eCQM/Postpartum Care files, with final evaluation occurring in Q2 2027. As a result, CareOregon will not issue workbooks to collect data retroactively.

Unified Measure Set: The program no longer maintains separate tracks for pediatrics, family medicine, and internal medicine. Instead, a unified measure set has been implemented. Individual clinic measures are now determined based on their patient population (denominators), program guidelines, and selected preferences.

Standardize Metrics: The program has been aligned with standardized CareOregon metrics to promote consistency and equity across all value-based incentive programs. These metrics include measures implemented by the state and nationally recognized standards such as Oregon Health Authority (OHA) CCO and HEDIS metrics. The goal is to ensure providers are evaluated using widely accepted measures, many of which they are already actively engaged with through existing quality improvement activities. PCPM adheres to the standard measure specifications and no longer supports metric customization requests or data adjustments.

Score Methodology: Clinics will earn a per-member-per-measure-per-month (PMPMPM) payment based on the number of measures for which they meet their targets, replacing the previous system of varied scores for different focus areas.

Target Methodology: A simplified approach to setting targets has been implemented to align with standard practices and improve clarity. See the target setting section for details.

PCPM Dashboard: A dashboard will be available to monitor PCPM progress. Providers will be able to download their assigned member list, and members not currently meeting a metric (gap lists) throughout the year. The dashboard is expected to launch in spring of 2026. The dashboard will be the official data source for final score calculations, replacing the process of manually distributing workbooks as in the past. These dashboards are sometimes referred to as “FIDO” dashboards, which is the name of the software application that hosts and presents them.

Data Submission: PCPM 2026 focuses on metrics supported by data available from claims, EHR-based eCQMs, Alert IIS, and other administrative sources—reducing provider burden and leveraging standardized measures. Providers submitting eCQM data are required to report via OCHIN or once per quarter per established processes.

Supplemental data: Supplemental data will only be accepted for the postpartum care measure, which includes a supplemental data component (chart review) for its calculation. All other measures are based solely on data from claims, eCQM files, ALERT IIS, or other administrative sources.

ShareFile: The PCPM Program will no longer require a workbook submission via ShareFile. Clinics will continue to use ShareFile for the postpartum care metric supplemental data only.

Data Validation and Appeals Process: Throughout the year, providers are expected to review their data to identify and address any inconsistencies. Requests for data corrections must be submitted through the designated data validation and appeals channels.

- For validation or appeals related to member assignments, providers must submit the required forms to Provider Relations, following their established process. See Program Support section for contact information.
- For corrections or appeals related to claims, providers must engage directly with Claims, in accordance with their procedures.

Score Calculation Process: For 2026, clinics will be assigned a Payment Level (PL) based on their assigned risk level and their 2025 performance. Each Payment Level directly relates to a monthly PMPM (Per Member Per Month) payment.

Low denominator: Denominators must meet the minimum threshold of 20 members at the time of measure selection. If the denominator falls below 20 members during the measurement period, PCPM will still score the metric using available data.

Streamlined Points of Contact: All inquiries and requests are to be submitted to the appropriate contact, as indicated below, for efficient handling and resolution. This process helps streamline communication and ensures that providers' needs are addressed effectively.

When to contact	Contact
Program participation, contract, metric-related operations, site admin access & payments	VBP Team paymentmodel@careoregon.org
Program Dashboard Access	Clinic Site Administrators specified at each clinic
Member Assignments & Claims Inquiries	Provider Customer Service 1-800-224-4840 option 3

Contents

Program Overview

The Primary Care Payment Model (PCPM) program is an optional pay for performance program to promote both better health outcomes for our members and financial stability for CareOregon and our primary care provider network. This voluntary performance-based incentive challenge program is designed to reward providers with bonus funds for demonstrating improvements in quality, ultimately benefiting CareOregon members.

CareOregon's PCPM program is in alignment with Health Care Payment Learning and Action Network (LAN) framework, a nationally accepted methodology. Additional information on this state and national work can be found on the OHA's value-based payment website.

Contained within this program guide is a comprehensive overview of the criteria and expectations for successful participation in the PCPM incentive program. It serves as a guide to help participants understand their obligations, key milestones, and performance standards required to achieve program goals.

Program Dates

Date	Program Activity
1/1/26	Contract active
2026 Early Q2	2026 Measure Elicitation
2026 Late Q2	PCPM dashboard available to providers
4/15/27	Performance results delivered
4/15/27 to 5/20/27	Providers to review final score calculations
May 2027	2026 Performance finalized

Note: The PCPM dashboard is refreshed quarterly with the most up to date information.

Program Supports

Providers have access to a wide range of resources designed to support them throughout their participation in the PCPM program.

Program Support Reference Table

When to contact	Contact
Program participation, contract, metric-related operations, site admin access & payments	VBP Team paymentmodel@careoregon.org
Program Dashboard Access	FIDO Site Administrators specified at each clinic
Member Assignments & Claims Inquiries	Provider Customer Service 1-800-224-4840 option 3

CareOregon VBP Team – Payment Model

The VBP team is here to support all your contract and metric specification needs and can be reached through the centralized Payment Model inbox (paymentmodel@careoregon.org). Messages sent to this inbox are routed directly to the appropriate support teams, helping us provide timely and effective assistance.

To keep communication clear and ensure an efficient workflow, we kindly ask that all PCPM-related emails be directed to the centralized inbox rather than to individual VBP team members. Team members will wait to respond until messages come through the shared inbox so we can maintain a consistent and organized process.

Following this approach helps us serve you more efficiently and ensures that every request receives the right level of support.

Provider Network Emails

Providers should ensure that relevant staff are subscribed to the PCPM provider network email list to receive important updates and key program information. To be added to the provider distribution list, contact paymentmodel@careoregon.org.

Provider Sessions

Periodic meetings provide essential updates for all participating staff. Each organization is expected to have at least one representative attend each session. To be added to the meeting invitations, contact paymentmodel@careoregon.org.

CareOregon Regional Team

The Regional Team serves as a key resource for providers, offering support for questions, feedback, and guidance related to the program. The Regional Team works closely with the provider network to facilitate seamless navigation of the CareOregon system and ensure effective program implementation. Regional leadership collaborates to guide operational decisions related to the program, including the selection and structure of performance metrics. Providers are encouraged to reach out to the Regional Team for clarification, troubleshooting, or best practices to ensure successful participation.

CareOregon PCPM Governance Committee

The PCPM Governance Committee holds decision-making authority for the program. It is responsible for setting strategic direction, including metric selection and the structure of performance evaluation. While the committee makes final decisions, it actively considers input from key stakeholders—including partner organizations, the Regional Teams, and other contributors—particularly regarding operational aspects of the program. This collaborative approach ensures that decisions are informed by diverse perspectives and practical insights.

Program Eligibility Requirements

Eligibility requirements must be met at the time of CareOregon PCPM application deadline of December 10th, 2025.

Member Thresholds
Each Metro Provider clinic must have 750 or more active members.

PCPCH Designation
Providers must be designated as PCPCH Tier 3.

Open to Assignment
Providers must be open to member assignments for a minimum of nine (9) months per calendar year.

Measure Eligibility
Providers must be eligible for at least three quality measures at the time of application. Measure eligibility is outlined in the measure selection structure. This determination will be made by the CareOregon program team and communicated to the Provider.

Program Participation
Provider must participate and meet requirements as described in this Program Provider Guide.

Application

Providers must submit an application by December, 10, 2025 to participate in the 2026 PCPM Program. The application is found here: **2026 PCPM Program Application**

Providers accepted into the 2026 PCPM Program will receive notification by December 31, 2025.

Contract

Exceptions to contracts or change requests must be submitted to the contracting team via PaymentModel@careoregon.org during designated review periods. Additional information and timelines will be provided in advance of these review periods. Mid-year or mid-reporting period changes are not permitted.

Dashboard Access

Providers must coordinate with their designated Site Administrator to gain access to their PCPM dashboard. If a clinic is unsure who their Site Administrator is, or has not yet established one, they may contact paymentmodel@careoregon.org for support.

Clinic Changes and Closures

To meet program participation requirements and ensure the continued validity of contracts, we ask that Providers promptly notify CareOregon of any changes to clinic status—such as mergers, splits, closures, relocations, or name changes. These notifications should be made within 30 days via email notification to PaymentModel@careoregon.org and to your regional PRS team:

Metro PRS	MetroPRS@careoregon.org

Program Quality

PCPM 2026 Measures

Measure type	Measure Name	Eligibility
Required Measure	Primary Care Engagement	All clinics participate
CCO Measures	Initiation of SUD Treatment (IET-I) Engagement of SUD Treatment (IET-E) Postpartum Care Rate* Screening for Depression and Follow-up** Child Well-Care Visits Pediatric Fluoride Varnish ages 1 -5 Social Emotional Issue-Focused Services Childhood Immunizations Immunizations for Adolescents Glycemic Status Assessment for Patients with Diabetes	Clinics participate in up to six (6) measures or as few as two (2), depending on denominator eligibility
Additional Measures	Breast Cancer Screening Colorectal Cancer Screening Controlling High Blood Pressure** Lead Screening in Children	Available to clinics who have selected five (5) CCO measures and want an Additional Measure as their 6th

*Supplemental data submission required
**eCQM data submission required

Expanded Primary Care Engagement Definition

Primary Care (PC) Engagement is a required metric in the 2026 PCPM Program. Beginning in 2026, CareOregon is expanding the definition of PC Engagement to include additional approved rendering provider types.

Expanded Engagement Definition

Percent of members with at least one qualifying Primary Care billed/paid service at their assigned primary care system in the measurement period.

Qualifying PCP service criteria (must meet all):

1. Performed by an **approved rendering provider specialty type**
2. **Billing Provider** and/or **Service Facility** location are set in CareOregon's claims processing systems to allow billing as a PCP specialty type
3. Medicaid member receiving the service is assigned to the clinic-system

List of approved rendering provider specialty types (refers to the provider's primary taxonomy code which indicates their role and expertise):

Rendering Provider Specialty Types
Adolescent Health
Behavioral Health (e.g. services delivered in primary care setting by LPC, LCSW, social worker, SUD counselor, CADC, mental health professional, psychologist)
Dentist
Family Practice
General practice – Doctor
Geriatrics
Gynecology
Internal medicine
Midwife
Naturopathic Medicine
Nurse Practitioner (e.g. FNP, PMHNP)
Obstetrics
Pediatrics
Pharmacist
Preventive Medicine
Registered Dietician
Women's Health
Physician Assistant (for specialty types above)
Alternative Care (e.g. Community Health Worker; Federally Qualified Health Center – no formal definition from OHA, but observed primary use case is for specific programs, such as recuperative care, operated within primary care scope and delivered by PCPs)

Terminology

National Provider Identifier (NPI) identifies individual healthcare providers (Type 1) and organizations (Type 2/Global).

Rendering provider is the specific healthcare professional or organization who personally performs, delivers, or supervises medical services for a patient and is identified on billing claims. NPI listed in Box 24J on 1500 professional claim form.

Rendering provider specialty type refers to the provider's primary taxonomy code which indicates a provider's role and expertise. Not specific for specialists, but all providers. These codes are used on NPI application, enrolling with the OHA, submitting claims, verifying credentials, and more. Code list is from the National Uniform Claim Committee (NUCC). To look up what taxonomy code is associated with an NPI go to NPPES NPI Registry See table 1 for approved types.

Billing provider identifies who is being paid. The entities (groups, hospitals, clinics) that submit claims and receive payments. Box 33a on 1500 professional claim form.

Service facility is the physical location where the patient actually received care. Field 32a on 1500 professional claim form. For example, if rendering provider & billing provider is a type 2/Global organizational NPI then would specify the service facility location.

Measure Determination

Clinics must meet the criteria to qualify for metric participation. The metric qualifications assume program eligibility is met. Eligibility for measures will be determined when baseline is calculated and set for the 2026 program in the spring.

Denominator Requirements

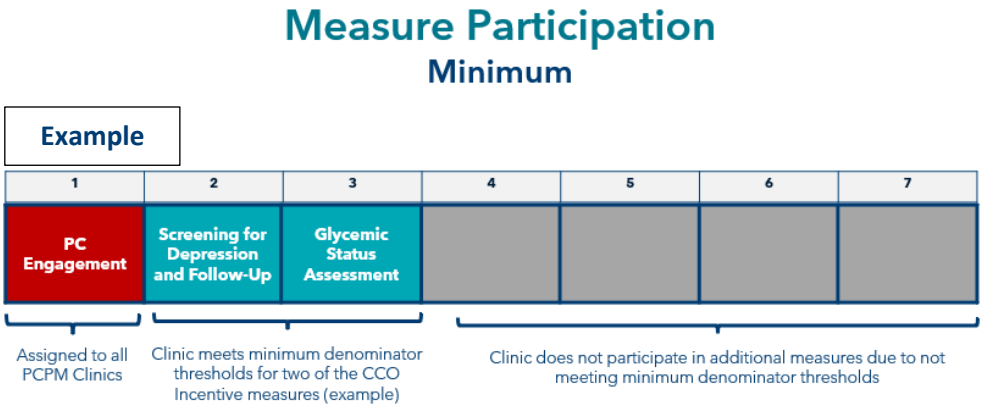
- Each measure must have a minimum denominator of 20 to be considered viable for that clinic.
- If the clinic cannot meet the minimum denominator requirements for the minimum of three (3) measures, then the system roll-up can be used.
- If the denominator for a selected measure falls below 20 at the time of final scoring, the measure will still be scored using the available numerator and denominator data.

Measure Eligibility

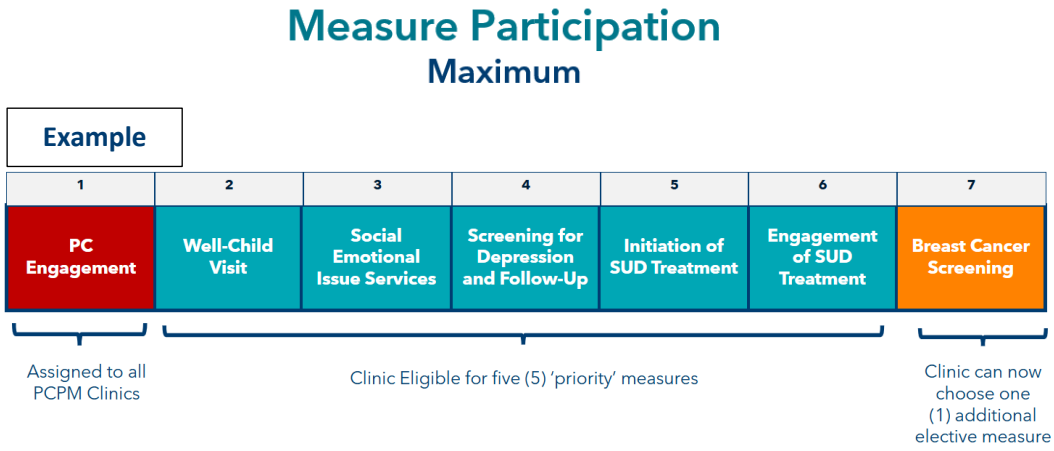
- In addition to Primary Care Engagement, clinics that qualify for six (6) measures or fewer are encouraged to participate in every measure for which they meet denominator eligibility.
- Clinics that are eligible for seven (7) or more measures may choose from the measures for which they meet denominator eligibility as outlined in the Measure Participation guidelines below.

Measure Participation

- **Minimum**
    - Clinics must qualify for at least two (2) CCO Incentive Measures to be eligible for the 2026 PCPM Program. The minimum measure participation is three (3) measures: Primary Care Engagement + two (2) CCO Incentive Measures



- **Maximum**
    - After selecting the required Primary Care Engagement Measure and five (5) CCO Incentive measures, clinics may choose one (1) additional measure from either the CCO Incentive measure set or the additional measure set (depending on eligibility and preference).



Finalized Measure Sets

- Measure Determination will take place in the spring of 2026 via an electronic survey for eligible clinics. Additional details will be provided as the determination period approaches.
- A clinic's Measure Set is final and cannot be modified once the determination period closes.

Data Submission

PCPM program leverages automated data processes. Automation improves data exchange and communication between CareOregon and providers, while reducing the administrative burden to providers. To that end, PCPM metrics are limited to data generated by submitted claims, captured by ALERT IIS, and submitted as EHR-eCQM files**.** The one exception is the postpartum care measure, which includes a supplemental data component (chart review) for its calculation.

Claims

Claim-based measures are assessed using provider-submitted data and are codified in the data warehouse using Current Procedural Terminology (CPT) codes. Providers should ensure they use the correct CPT codes for their services and understand how those codes are included in the measure specifications. It's also recommended that Providers communicate relevant workflows and coding details to their clinicians and billing staff to support accurate reporting.

CareOregon as Secondary

For members with dual coverage where CareOregon is secondary, Providers should bill CareOregon as secondary, reporting the payments and payment adjustments made by the primary payer, even if there is no expected payment from the secondary payer.

- There is no need to add a claim line with a penny charge if the services provided are on the original claim.
- If you are adding a quality metric that was not included on the claim that was sent to the primary payer (such as a CPT II code), that can be added to the secondary claim.
- We do not require that you associate a charge to the claim, but we understand some practice management systems require a charge to be added.

CPT II Coding

You may add CPT II codes to any existing encounter when billing CareOregon as primary or secondary, as well as additional encounter types (not an exhaustive list):

- Lab encounters
- Telephone (and telehealth)
- Transitional Care Management (including medication reconciliation)
- Administrative / Nurse visits (e.g., blood pressure checks)

Direct Data Entry

For clinics who have difficulty submitting claims with a zero (or nominal) charge via their EHR, direct data entry is available through CareOregon's provider portal, HealthTrio

- HealthTrio allows direct data entry of Professional (CMS 1500) claims
- Providers using the VisibilEDI portal for direct entry may continue to do so

Additional Claims Notes

- Secondary claims can be submitted within 365 days; however, for any quality reporting, all claims need to be submitted by March 1st at the latest to support prior year quality performance.
- Always consult with your billing / coding department for guidance and final determination on submitting claims.
- For further questions related to submitting claims, please contact CareOregon Provider Customer Service at 1-800-224-4840 option 3

ALERT IIS

Vaccinations are recorded and transmitted through the ALERT IIS system. The PCPM program uses data from ALERT IIS to calculate immunization measure performance.

EHR-eCQM Data

Most Providers already have a system in place to send EHR-eCQM data to CareOregon and should continue to use their current process through the 2026 reporting year.

- There are two metrics in the 2026 PCPM measure set that require eCQM data submission:
    - Screening for Depression and Follow-up; and
    - Controlling High Blood Pressure
- Providers whose data is currently submitted via OCHIN must continue to report eCQM numbers through OCHIN.
- Providers who do not automatically send eCQM data must submit row-level data at least once per quarter per established processes. Quarterly data is due by the 12th of the month following the end of each quarter. Please see 2026 eCQM File Submission Dates below.
    - Providers are required to submit data in CSV file format.
    - Files not submitted in the required format will be rejected.

For assistance on how to submit eCQM data via workbooks to CareOregon, contact paymentmodel@careoregon.org. Providers must submit a complete 12 months of 2026 data to be eligible for the metric. Partial or incomplete data will not be scored.

Please **do not send any files or documentation to the Payment Model** team, as they are not able to process changes related to this data. Data files should be submitted via ShareFile .

Submitting eCQM files after the Q1-Q3 due date does not affect 2026 payment or overall performance; however, it may delay updates to your clinic's PCPM Dashboard. Because the dashboard is refreshed quarterly, data submitted after a quarterly deadline will be reflected in the subsequent update. The final Q4 data is required by the due date to be eligible for final performance calculations and payment.

2026 eCQM File Submission Dates

Timeframe	Rolling 12-month Data Timeframe	Provider Submission Due By
Baseline	2025-01-01 to 2025-12-31	Jan 12, 2026
Q1 2026	2025-04-01 to 2026-03-31	Apr 12, 2026
Q2 2026	2025-07-01 to 2026-06-30	Jul 12, 2026
Q3 2026	2025-10-01 to 2026-09-30	Oct 12, 2026
Q4 2026	2026-01-01 to 2026-12-31	Jan 12, 2027

Supplemental data

Supplemental data can be submitted during designated times for the Postpartum Care metric. Supplemental data includes any items to assist CareOregon in the final score for this metric. To have supplemental data considered, it must be submitted on time in the format requested via established processes. Data lacking all necessary information requested may not be considered.

Member rosters will be available via the PCPM Dashboard. The first Provider submission of supplemental data will be due four (4) weeks after the dashboard is published.

Timeframe	Data Timeframe	CareOregon Sends Roster by	Provider Submission Due by
Q2 2026	1/8/2026 to 4/7/2026	When dashboard available	4 weeks after Dashboard available
Q3 2026	4/8/2026 to 7/7/2026	Sep 12, 2026	Oct 12, 2026
Q4 2026	7/8/2026 to 10/7/2026	Dec 12, 2027	Jan 12, 2027

*Rosters will include any prior submitted chart review data, where applicable.

Performance Evaluation

The PCPM Dashboard will be the central resource where Providers can access and track their own performance across PCPM measures. It will be refreshed quarterly with all available data.

Data Validation

Providers are encouraged to routinely review their data over the course of the year to identify and resolve any inconsistencies. Conducting periodic reviews ensures that needed adjustments can be made before performance scoring, generally 90 days from the service date. Adhering to these practices helps ensure that issues are addressed at their point of origin.
Requests for data corrections must be submitted through the designated data validation and appeals channels:

- For validation or appeals related to member assignments and claims, providers may contact Provider Customer Service. See Program Support section for contact information.

Note, some metric specifications require that a specific provider type deliver the care to meet the measure. Providers must ensure the billed services match the metric guidelines, as appropriate.

Data Adjustments

PCPM uses standard measure specifications to ensure consistency across all providers. As a result, we're not able to offer metric customization or data adjustments.

Data Rounding

PCPM program will round performance to the nearest **tenth.**

Examples:

- Performance = 37.82% rounded to 37.8%
- Performance = 37.85% rounded to 37.9%

Member Attribution

Members are attributed to clinics based on their CareOregon primary care assignment, with the exception of the Initiation and Engagement of Substance Use Disorder Treatment (IET) measures. For the IET measures, attribution is determined by the clinic that established the substance use disorder (SUD) diagnosis, regardless of the member's assigned organization.

Specific requirements regarding the timing of patient assignment and the duration of assignment within the clinic system are outlined in the measure specifications, which will be provided during the measure selection process in the spring.

HOP and Bridge

OHA metric specifications are expanded to include Healthier Oregon Program (HOP) and Bridge members. This inclusion ensures all CareOregon members receive the highest quality care, regardless of coverage type. HOP and Bridge members are also included in PMPM payment calculation.

Improvement Targets

Improvement targets will be determined based on each CCO region's baseline performance, in relation to benchmarks. For CCO metrics, targets are established by OHA for each CCO region. For non-CCO metrics, targets are calculated using OHA methodology for each CCO region, based on either the specified percentiles or CMS 4-star cut points as benchmarks for these measures.

Measure Thresholds & Benchmarks

The table below presents how targets will be calculated using established thresholds and benchmarks available at the time of writing. These thresholds and benchmarks will be reviewed and updated in spring 2026, following the release of updated metric information from governing bodies (e.g., OHA and CMS). This update will align with the establishment of program baselines. Once finalized, the threshold and benchmark values will remain fixed for the duration of the program performance year and will only be subject to revision in the event of catastrophic, unforeseen circumstances that materially impact program execution.

Measure Target Reference

Metric	Threshold	Benchmark
Primary Care Engagement	TBD% floor	90th pctl PCPM
Initiation of SUD Treatment	2.0% floor	75th pctl Nat'l Medicaid
Engagement of SUD Treatment	2.0% floor	75th pctl Nat'l Medicaid
Postpartum Care	2.0% floor	75th pctl Nat'l Medicaid
Screening for Depression and Follow-up	2.0% floor	90th pctl CCO
Child Well-Care Visits (Ages 3-6)	no floor	90th pctl CCO
Child Fluoride Varnish (Ages 1 -5)	TBD% floor	90th pctl PCPM
Social Emotional Issue-Focused Services	0.5% floor	90th pctl CCO
Child Immunizations	no floor	75th pctl Nat'l Medicaid
Adolescent Immunizations	no floor	75th pctl Nat'l Medicaid
Glycemic Status Assessment for Members with Diabetes (lower is better)	1.0% floor	90th pctl CCO
Breast Cancer Screening	TBD% floor	75th pctl Nat'l Medicaid
Colorectal Cancer Screening	TBD% floor	75th pctl Nat'l Medicaid
Controlling High Blood Pressure	TBD% floor	CMS 4 Star Cutpoint
Child Lead Screening	TBD% floor	75th pctl Nat'l Medicaid

Baseline Performance

Clinic baseline performance for their selected CY2025 measure will be calculated in the spring of 2026 to allow for sufficient claims run-out and ensure data completeness. This baseline performance will then be compared to established thresholds and benchmarks to determine the clinic's metric-specific targets.

2026 Payment Rates

Payment Levels

Clinics will be assigned a Payment Level (PL) based on their assigned risk level and the number of measures passed. Each Payment Level directly relates to a monthly PMPM (Per Member Per Month) payment. Please see the *Payment Level (PL) Table* and *2026 Payment Level PMPM Table* below to see how payment rate per measure accumulates at each risk level.

2026 Payments

Each clinic's 2026 Per Member Per Month (PMPM) will be determined as follows: The 2026 rate setting methodology will rebase the 2025 reporting performance to the 2026 measure set. To achieve this, performance will be cross walked by the proportion of 2025 measures met.

For newly participating clinics, if CareOregon has sufficient historical 2025 performance data to establish a PMPM based on that data, the 2026 PMPM will be set accordingly, based on clinic risk score. If sufficient data is not available, the 2026 PMPM will be set at the midpoint of the potential payment range, based on clinic risk score.

Payment Level (PL) Table

	Number of Measures Passed							
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Risk 1	PL 0	PL 1	PL 4	PL 7	PL 10	PL 13	PL 16	PL 19
Risk 2	PL 0	PL 2	PL 5	PL 8	PL 11	PL 14	PL 17	PL 20
Risk 3	PL 0	PL 3	PL 6	PL 9	PL 12	PL 15	PL 18	PL 21

2026 Payment Level PMPM Table

Payment Level	PL 0	PL 1	PL 2	PL 3	PL 4	PL 5	PL 6	PL 7	PL 8	PL 9	PL 10
PMPM	$0.00	$1.36	$1.63	$2.71	$2.72	$3.26	$5.42	$4.08	$4.89	$8.13	$5.44

Payment Level	PL 11	PL 12	PL 13	PL 14	PL 15	PL 16	PL 17	PL 18	PL 19	PL 20	PL 21
PMPM	$6.52	$10.84	$6.80	$8.15	$13.55	$8.16	$9.78	$16.26	$9.52	$11.41	$18.97

PMPM Payment Examples

Clinic A passes seven (7) measures and is assigned **Risk Level 3**. According to the Payment Level Table, Clinic A falls into **PL 21**. The 2026 PMPM payment associated with PL 21 is **$18.97**. Therefore, based on performance and risk adjustment, the clinic will receive a payment of **$18.97 PMPM**.

Clinic B passes two (2) measures and is assigned **Risk Level 2**. According to the Payment Level Table, Clinic B falls into **PL 5**. The 2026 PMPM payment associated with PL 5 is **$3.26**. Therefore, based on performance and risk adjustment, the clinic will receive a payment of **$3.26 PMPM**.

Risk Adjustment

CareOregon reviews and adjusts clinics' collective assigned population level risk on an annual basis for the PCPM Program. Risk adjustment methodology is based on risk scores and rate codes used by OHA. This method uses the Chronic Illness & Disability Payment System plus Medicaid Rx (CDPS+Rx) risk model. Within the PCPM Program, each clinic's average risk score is compared to all other participating clinics in the 2026 Program. Clinics are then grouped into three Risk Levels based on their relative position in the cohort:

- **Risk Level 1:** Clinics in the bottom 45%
- **Risk Level 2:** Clinics in the middle 45%
- **Risk Level 3:** Clinics in the top 10%

This distribution helps ensure all participating clinics fit within CareOregon's available 2026 program budget.

Distribution of Average Risk Scores for all PCPM Participating Clinics

← Clinics with Lower Average Risk Scores — Clinics with Higher Average Risk Scores →

Ratio of Measures Met in 2025	2026 PMPM Rates	Risk Level 1 (Lower 45%)	Risk Level 2 (Middle 45%)	Risk Level 3 (Top 10%)
1		$1.36	$1.63	$2.71
2		$2.72	$3.26	$5.42
3		$4.08	$4.89	$8.13
4		$5.44	$6.52	$10.84
5		$6.80	$8.15	$13.55
6		$8.16	$9.78	$16.26
7		$9.52	$11.41	$18.97

Change Log

Update	Location	Date
Removed ClaimsHelp as contact; replaced with Provider Customer Service	Pg. 13	4/3/2026
Expanded information regarding eCQM submission	Pg. 14	4/3/2026
Updated Supplemental Data Submission due dates	Pg. 15	4/3/2026
Expanded information regarding Risk Levels	Pg. 20	4/3/2026
Added to clarity to 2026 Payment Rates	Pg. 19	4/3/2026
Changed 'required' to 'encouraged' in Measure Eligibility	Pg.12	4/3/2026
Expanded information regarding claims submission	Pg. 13	4/3/2026
Expanded information regarding Primary Care Engagement Definition	Pg. 10	4/3/2026