Draft | April 2026

OREGON HEALTH AUTHORITY

Oregon Primary Care Strategy Framework

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About

In 2025, the Oregon Health Policy Board (OHPB) established the Primary Care Strategy Committee (PCSC) to lead a coordinated effort to stabilize, strengthen and align Oregon's primary care system with the goal of increasing access to equitable, affordable, high-quality patient care.

The Committee will develop and drive actionable strategies that unify policy, funding and performance goals across payers, providers, consumers, purchasers and state programs — ensuring a coherent, equitable and sustainable system that delivers responsive, community-centered care statewide. The Committee will promote innovative solutions in three key, interrelated areas—workforce, delivery system, and payment and affordability—that are essential for a strong primary care system:

- Workforce: Primary care is experiencing significant recruitment and retention issues due to, for example, administrative burden that leads to burnout
- Delivery system: Primary care is often unable to support whole-person, team-based care, such as integrating behavioral and oral health care and leveraging technology.
- Payment and affordability: Resources are insufficient to support the expectations of the primary care system.

The Committee will develop strategies that can inform legislative concepts or recommended changes to primary care programs or processes that don't require legislative action in support of a strong primary care system across Oregon.

The Oregon Health Authority (OHA) has prepared this draft framework to help guide PCSC conversations and strategy development. The Primary Care Strategy Framework is intended to make the landscape of potential primary care policies and initiatives more manageable by providing the following:

- Topical groupings for types of policies (payment and affordability, workforce, and delivery system).
- Information on where Oregon has already or partially implemented primary care policies, and where there are opportunities to improve or enhance primary care policies for the state.
- Considerations for acting on each strategy, including, but not limited to, cost and legislation.

Strengthening primary care requires a dual approach: **short-term solutions** to alleviate immediate workforce shortages and burdens, and **long-term strategies** to tackle systemic issues impacting access, the workforce and payment and affordability. Policy recommendations will strike a balance of short- and long-term solutions; the Primary Care Strategy Framework includes both.

The Primary Care Strategy Framework was created by synthesizing input gathered from OHA partners and recommendations from organizations, other states, academic research and advocacy groups on how to strengthen primary care. The Primary Care Strategy Framework is intended to be flexible and a living document — if PCSC members and others identify additional policies not currently included, the Framework can be expanded.

In many cases, implementing new activities and expanding existing activities will require financial resources. This document does not include details on the sources of funds that may be required. However, a possible short-term funding source for some aligned activities could be the Oregon Rural Health Transformation Program (RHTP), which was included in H.R. 1, is a one-time, five-year program that makes funding available to states for health-related activities supporting rural communities and rural health system transformation. Oregon is receiving $197.3M in 2026 for Budget Year 1. If approved for a similar amount in subsequent years, Oregon will receive an estimated $1B over the five-year grant period. Oregon's five RHTP initiatives include a strong focus on strengthening primary care systems and supports, and addressing workforce challenges in rural communities. Awards in Phase 1 (Years 1-2) will build a foundation for more transformation in Phase 2 (Years 3-5). There is a strategic opportunity for PCSC to help establish a future vision for the primary care system in Oregon that can help refine the Phase 2 RHTP work in the coming years.

Finally, it is important to note that decreasing providers' administrative burden is essential for strengthening Oregon's primary care system. Instead of including one section on strategies related to this goal, the Primary Care Strategy Framework includes strategies throughout that would contribute to a less administratively burdensome system for providers.

Contents

Primary Care Strategy Framework

This table reflects the three interrelated primary drivers that are essential to achieve the goal of a strong primary care system across Oregon: workforce, delivery system, and payment and affordability. Secondary drivers that support the primary drivers are in the summary table below. ach secondary driver is included later in the document with policies and efforts that have been or could be implemented in Oregon to advance the strategy. For each strategy where there is an opportunity to expand or create new programs, considerations of the resources needed to achieve the strategy are included. The secondary drivers are not listed in priority order.

This table reflects the three interrelated primary drivers that are essential to achieve the goal of a strong primary care system across Oregon: workforce, delivery system, and payment and affordability. Secondary drivers that support the primary drivers are in the summary table below. ach secondary driver is included later in the document with policies and efforts that have been or could be implemented in Oregon to advance the strategy. For each strategy where there is an opportunity to expand or create new programs, considerations of the resources needed to achieve the strategy are included. The secondary drivers are not listed in priority order.

Goal: A strong primary care system across Oregon

Primary Drivers	Workforce	Delivery system	Payment and affordability
Secondary Drivers	• Measure and report on workforce • Expand recruitment and retention pathways • Increase provider wellness and resiliency • Increase provider diversity • Reduce credentialing, privileging and enrollment barriers	• Support whole-person team-based care • Integrate behavioral health • Integrate pharmacy services • Integrate oral health • Enhance care coordination • Continued educational opportunities	• Measure and report on investment • Adopt flexible payment models • Require minimum expenditures on primary care • Pay for whole-person team-based care • Implement site neutral payments

	• Simplify quality metrics	• Leverage technology-enabled care • Coordinate interoperable and shared technology • Share data across payers and providers • Reform prior authorization	

Measure and report on the health of primary care in Oregon

An overarching strategy to support primary care is following the example of several states that have developed dashboards or reports that measure the health of primary care in five domains: 1) spending and investment for primary care services, 2) performance focused on quality, 3) access to insurance and services, 4) capacity focused on workforce and pipeline, and 5) equity focused on assessing inequities in the primary care system. State examples with this information include the Massachusetts Primary Care Dashboard, the Virginia Primary Care Scorecard and the Health of Primary Care in California Annual Snapshot.

Comprehensive "Health of Primary Care" dashboard

Oregon has components of a "health of primary care" dashboard that could be added to, strengthened, and collected into one interactive tool.

1. **Spending and investment for primary care services**: The annual OHA Oregon Primary Care Spending Dashboard reports the percentage of medical spending allocated to primary care by health care payers (coordinated care organizations [CCOs], commercial, and Medicare Advantage) against the statewide target of 12 percent set by the legislature in 2017. There isn't agreement on the methodology used to measure primary care investment in this dashboard.

    - Opportunity: Convene partners to agree on a new methodology. *(Consideration: Legislation)*

2. **Performance focused on quality**: The Oregon CCO Quality Incentive Program rewards exceptional care and continuous quality improvement by CCOs, which serve over one million Oregonians on the Oregon Health Plan (Medicaid). The CCO

Quality Metrics Dashboards and Reports summarize the performance of CCOs on a variety of quality metrics, including many related to primary care. (Note that data on commercial and Medicare Advantage payers is not included in the report.)

- Opportunity: Add data on commercial and Medicare Advantage payers. *(Considerations: Legislation and cost)*

3. **Access to insurance and services**: The Oregon Health Insurance Survey (OHIS) Coverage Dashboard reports on a variety of data related to health coverage, including insurance types, rates by different demographics, and reasons people are uninsured. There is no report showing utilization of primary care services.

   - Opportunity*:* Develop a report on primary care service utilization. *(Considerations: Legislation and cost)*

4. **Capacity focused on workforce and pipeline**: Oregon's Health Care Workforce Needs Assessment is a biannual report developed by OHA on health care workforce needed to meet the needs of patients and communities throughout Oregon, including primary care providers (PCPs). OHA has heard from providers and patients that in some cases the report does not reflect the situation they are experiencing.

   - Opportunity: Ensure the report more accurately reflects provider and patient experience, which may include identifying additional data sources. *(Considerations: Cost and data availability)*

5. **Data focused on assessing inequities in the primary care system**: While all reports noted above, except for the Oregon Primary Care Spending Dashboard, include some data on health equity, some are not integrated or comprehensive.

   - Opportunity: Integrate the reports and identify additional data. *(Consideration: Cost)*

Policies to support the workforce

Measure and report on workforce

The need for, and success of, policies to revitalize the primary care workforce to sustainably deliver care in an interprofessional team-based model depends on accurate measurement of the clinicians and practice staff truly functioning as providers of comprehensive, longitudinal primary care, and accountability among stakeholders for achieving national and regional workforce goals.[1]

OHA Health Care Workforce Reporting Program

- Collects survey data from health care professionals licensed in Oregon every time they renew their licenses. The survey includes questions about providers' demographics, the care they provide, and their plans for the future.
- Produces an annual dashboard presenting supply trends, demographics and practice patterns of licensed health care professionals in Oregon.
- Provides data included in a biennial assessment of the health care workforce needed to meet the needs of patients and communities throughout Oregon.

OHPB Health Care Workforce Committee

- Coordinates efforts to recruit and educate health care professionals and retain a quality workforce.
- Produces a biennial assessment of the health care workforce needed to meet the needs of patients and communities throughout Oregon.
- Produces a biennial evaluation of state-funded health care provider incentives designed to grow Oregon's workforce, which informs efforts to increase access to culturally responsive care in urban and rural underserved areas of the state.

Provider directory

- Oregon does not have a common provider directory to allow one location to update provider information to help ensure information is updated and accurate.
    - Opportunity: Create a common provider directory. *(Considerations: Unsuccessful previous attempt, cost, legislation, technical feasibility, national provider directory may be created in 2026/2027)*

Expand recruitment and retention pathways

Having a sufficient and well-functioning health workforce is crucial for reducing the burden of disease and premature death. However, it is well-documented that significant challenges face the workforce providing this care.[2] These include shortages and maldistribution of PCPs, low compensation compared to other health occupations, increasing burnout and job dissatisfaction, and an aging workforce.[3]

State-funded incentives: Health Care Provider Incentive Program

- Loan repayment programs for primary care, behavioral health, and oral health professionals provide tax-free loan repayment funds for eligible providers with a

three-year service commitment at qualifying practice sites in rural and underserved areas.

- Rural Medical Practitioners Insurance Subsidy provides partial payments directly to authorized medical professional liability insurance carriers. This incentive support reduces the financial burden on health care providers in rural areas who would otherwise pay the full cost of malpractice insurance.
- Primary Care Loan Forgiveness provides financial support to students enrolled in approved rural training tracks by offering loan forgiveness during their education in exchange for a service commitment in a rural area of Oregon.
- Scholars for a Healthy Oregon (SHOI) provides full tuition and fees to OHSU students in four clinical programs (Doctor of Medicine [MD], Doctor of Medicine in Dentistry [DMD], Master of Physician Assistant Studies [MPAS], Doctor of Nursing Practice [DNP]) in exchange for a service commitment at a qualifying practice.
- Health Care Workforce Scholarship incentives provide funding for health professional training programs at institutions of higher education.
- Health Care Interpreter Retention incentives fund continuing education training of health care interpreters to renew certification and remain in the field.
- Behavioral Health Retention incentives fund Mental Health and Addiction Certification Board of Oregon (MHACBO) for registration and advanced exam costs.
- Health Care Workforce Career Pathways funds Oregon's secondary education, Career and Technical Education (CTE), training programs, and other health-related workforce programs to provide 8th–12th grade students with career exposure, mentorship and certifications.

State-funded incentives: Healthy Oregon Workforce Training Opportunity Grant Program (HOWTO)

- HOWTO expands health professional training within the state to address current and future shortages in the health care workforce in rural and medically underserved areas of Oregon. The program supports community-based training initiatives that address local health care workforce shortages and expand diversity of the health professional workforce. HOWTO supports workforce development programs in primary care, such as family medicine residences and other graduate medical education programs, integration of behavioral health and oral health care, traditional health worker programs, and community health center-based workforce centers.

Federal incentives: Primary Care Office

- Supports federal loan repayment and scholarship programs offered by the U.S. Health Resources and Services Administration, such as National Health Service Corps (NHSC) and Nurse Corps, for qualifying primary care professionals in exchange for a service commitment.
- Supports federal shortage designations — Health Professional Shortage Areas (HPSAs) — to identify areas and population groups that are experiencing a shortage of primary care professionals, which are used to distribute federal resources to improve access to care.
- The Physician Visa Waiver Program (also called the J-1 Visa Waiver Program, Conrad Program and Exchange Visitor Program) allows international medical graduates who have completed a residency or fellowship in the United States to remain in this country to practice in federally designated shortage areas in exchange for a service commitment. Each state may submit up to 30 waivers per federal fiscal year that are approved by the U.S. Department of State.

Federal funding programs: Teaching Health Centers

- Supports existing and proposed teaching health center residency programs, particularly in rural areas.

Opportunities to increase primary care career pathways *(Considerations: Cost and legislation)*

- Create an interagency (across OHA, Higher Education Coordinating Commission, Area Health Education Center, Oregon Department of Education, etc.) plan with recommendations for primary care career pathways to grow and diversify the primary care workforce. Recommendations could include a grantmaking program that addresses local workforce shortages and increases culturally responsive care.
- Develop a low-interest loan or housing program.
- Pay salary supplements for primary care clinicians who opt to work in Community Health Centers (CHCs), public hospitals or rural areas.
- Offer state tax credits or other incentives for preceptors to supervise primary care trainees.

Increase provider wellness and resiliency

Burnout is increasingly recognized as a threat to the stability of the U.S. primary care workforce, with evidence linking it to reduced clinical productivity, diminished patient access, and higher provider turnover. Family physicians, one type of PCP, suffer from

significantly higher rates of burnout than physicians in many other specialties with 51% of family physicians reporting being burned out in 2022 (most recent data available).[4]

Oregon Wellness Program

- Provides physicians, nurses, advanced care practitioners, dentists and other health care professionals within Oregon access to mental health support that is non-reported, urgently available and complimentary.
    - Opportunity: Expand to serve other licensing boards. *(Considerations: Cost)*

Opportunities to increase understanding of and strategies to address burnout

- Expand collection of data from providers on burnout by practices and health systems. *(Considerations: Cost and data collection concerns)*
- Create a multi-organization partnership to create a statewide health care employer recognition program that recognizes and rewards employers that take steps to understand their employees' needs related to supporting provider burnout and implement wellness programs to address them. *(Considerations: Cost)*

Opportunities to increase use of artificial intelligence (AI)

- Expand use of AI to support charting and other functions. *(Considerations: Cost)*

Increase provider diversity

In the United States, health access and outcomes remain inequitable by race, ethnicity, gender, disability, language and other characteristics.[5] These health inequities are present in Oregon as well; for example, the rate of deaths before age 75 from preventable causes is 328 per 100,000 for Black Oregonians and 206 per 100,000 for white Oregonians.[6] In addition to disparities based on race and ethnicity, individuals with physical disabilities or cognitive limitations have higher prevalence of poor physical and mental health outcomes compared with their nondisabled peers.[7] Given the continuing health inequities and historical barriers that have made entry into the health care workforce difficult for some people of color and have created vast labor disparities among those who have entered the workforce, it is important to put in place efforts to increase a workforce that is culturally and linguistically representative of the communities it serves.[8]

OHA Health Care Provider Incentive Program

- Engages students from diverse backgrounds in health care professions.

- Prioritizes diversity of student/provider applicants when making awards, including loan repayment, loan forgiveness and scholarship incentives.

- Supports provider diversity for all incentives, including loan forgiveness, repayment and scholarship incentives.

OHA HOWTO Grant Program

- Supports grants that address culturally responsive and specific workforce by developing career pathways and creating local partnerships to address workforce development and retention in rural and medically underserved areas of the state.

Other education, training and workforce development programs

- Other state agencies and commissions have workforce development programs that prepare people for entry-level positions (for example, medical assistants), fund wraparound services (for example, childcare, transportation and financial assistance) that remove barriers to training and employment, and provide career coaching and employment support.

- Oregon's universities and colleges have career pathways, clinical education, and workforce development programs aimed at diversifying and strengthening Oregon's health care workforce.

Opportunities to support provider diversity

- Increase prioritization of provider types participating in loan repayment/forgiveness incentives in alignment with Areas of Unmet Health Care Needs (AUHCN) and primary care provider diversity data. *(Considerations: Cost and data availability)*

- Implement additional strategies to engage students and practicing professionals from diverse backgrounds (such as developing a unified strategy across OHA and other state agencies to create a culturally responsive health care workforce and increase faculty and preceptor demographic diversity). *(Consideration: Cost)*

- Require payers to pay a differential for bilingual primary care staff. *(Considerations: Cost and legislation)*

Reduce credentialing, privileging and enrollment barriers

Credentialing, which is the process of verifying credentials and assessing qualifications, is the first of three distinct phases required of all health care providers to practice medicine. The second is privileging, which gives providers permission to perform specific services at an institution based on credentials. The third is enrollment with payers, such

as Medicare, Medicaid and commercial insurance, which allows providers to bill and be paid for those specific services. This full process may take up to 180 days and must be completed for each payer.[9]

Support for credentialing

- OHA convenes the Advisory Committee on Physician Credentialing (ACPCI), which was established by House Bill 2144 (1999) to develop the uniform applications used by hospitals and health plans to credential and recredential practitioners in Oregon.
- State statute requires payers to respond to providers with a credentialing decision on their application within 90 days of receipt of a complete credentialing application.
- House Bill 4083, which passed in 2026 and is currently being implemented, requires OHA to adopt a uniform process for credentialing behavioral health providers for use by behavioral health providers and coordinated care organizations.

Opportunities to reduce barriers

- Create a common credentialing program that 1) requires timely review of credentialing documentation and payment for new providers to begin upon application submission; 2) allows for a simplified process to credential when provider changes location or provider group but is already credentialed; 3) requires the same/similar information for each health plan; and 4) uses one platform for all health care providers. *(Considerations: Unsuccessfully previously pursued, cost, legislation, technical feasibility)*
- Connect clinics to payer information to easily verify eligibility of patients, including co-payments and deductibles, allowing timeline knowledge of in-network services and reduction in denials. Explore expanding payer participation (some Oregon payers already participate) in the single sign-on service through Washington's One Health Port where clinics can verify eligibility for multiple health plans in one place.. *(Considerations: Cost, legislation, and technical feasibility)*

Simplify quality metrics

The burden of quality metric reporting is high for primary care practices, especially for practices that have multiple payer contracts and value-based payment (VBP) models, such as pay for performance. PCPs provide services that address a wide range of patient needs and conditions; as a result, PCPs face greater quality measure reporting requirements than specialists do.[10] Practices struggle to keep up with variation across

models, payers, programs and technology. Documentation and usability issues in electronic health records (EHRs) also contribute to administrative burden among primary care teams. During PCPRC meetings and Patient-centered Primary Care Home (PCPCH) Program site visits, practices have told OHA that in aggregate, they are tracking and reporting on many quality metrices, routinely over 50. Additionally, each payer requires practices to use their unique portal for metrics reporting and to close care gaps. Note that some of the strategies below are relevant for all payers, whereas others apply only to CCOs.

Simplified measure sets

- OHA measures CCOs on a specific set of metrics that have remained relatively stable over time.
- A limited set of metrics are included in the 2023 Primary Care Payment Reform Collaborative VBP model.

Opportunities to simplify quality metrics

- Identify and require all payers to use a limited common set of metrics and specifications that considers the impact of incentive measure requirements on primary care. *(Consideration: Legislation)*
- Systematically consider administrative burden placed on primary care when identifying quality incentive metrics for Medicaid and other programs. *(Considerations: Process for metrics selection by Metrics and Scoring Committee, Public Employees Benefit Board (PEBB)/Oregon Educators Benefit Board (OEBB) metrics selection, and the Oregon Health Insurance Marketplace metrics)*
- Reduce manual documentation requirements for all quality measures. *(Consideration: Payers' metrics selection processes)*
- Consider using PCPCH tier as a single quality measure for quality incentive payments. *(Consideration: Payer process)*
- Where possible, shift CCO metric reporting burden to CCOs instead of PCPs. Upstream and home-grown measures, such as Meaningful Language Access and Social Determinants of Health (SDOH) Screening and Referral, are part of the CCO measure set. Providers report these metrics as complex and requiring more reporting work for practices compared with claims-based measures. The home-grown metrics put greater burden on the providers than the CCOs. *(Consideration: Legislation)*

- Pause requirement for practices to collect race, ethnicity, language and disability (REALD) and sexual orientation and gender identity (SOGI) data that could be collected by OHA or CCOs and other payers. *(Consideration: OHA guidance)*

Policies to support the delivery system

Support whole-person team-based care

High-quality primary care provides whole-person, integrated, accessible and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families and communities.[11]

OHA Patient-Centered Primary Care Home (PCPCH) Program

- Recognizes practices that meet care delivery standards that are developed in partnership with providers, patients, payers, people from community-based organizations and other partners.
- Develops and hosts webinars, learning collaboratives and other educational opportunities focused on the PCPCH program standards.
- Is reducing administrative burden for primary care practices participating in the PCPCH program — in response to provider feedback — by streamlining the application and renewal process, reducing the amount of documentation to be submitted for a site visit (audit) and shortened the site visit to a half day.
- Has conducted evaluations on the impact of the PCPCH Program on cost, utilization and patient outcomes.

Opportunities to support whole-person team-based care

- Provide educational opportunities on topics beyond the PCPCH Program standards, such as clinic leadership and management, administrative processes like billing for services, team-based care, and how to ensure providers can serve at the "top of their license." *(Consideration: Cost)*
- Require payers to adequately reimburse practices to support staff capacity and technology for screening and referral of patients for health-related social needs. *(Consideration: Cost)*
- Practices have reported that many CCOs do not reimburse for using interpreters with only national health care interpreter certification for Medicare compliance. This can be a barrier to providing timely, patient-centered interpretation. *(Considerations: Legislation)*

Integrate behavioral health

Behavioral health integration (BHI) in primary care is the coordination of mental health, substance use and behavioral health services within primary care settings to provide whole-person, team-based care. It can involve embedding behavioral health screening, treatment and follow-up into routine primary care workflows so patients receive timely, coordinated support for both physical and behavioral health needs in a single care setting. This care could be provided by a PCP or behavioral health provider. This approach ensures patients receive timely, connected support for both their physical and behavioral health needs in one integrated care environment. [12]

Models of integration and support

- PCPCH Standard 3.C has four measures by which primary care practices can demonstrate they are meeting the behavioral health care needs of their patients, including substance use disorders. One of these measures (3.C.3) is the integration of a licensed behavioral health clinician in the primary care practice, which aligns with the evidence-based Primary Care Behavioral Health (PCBH) model.

- Some practices have implemented one of two behavioral health integration models: 1) the PCBH model and 2) the Collaborative Care Model (CoCM). In CoCM a primary care provider consults with a contracted psychiatrist and provides the care needed, and the practice manages the patient's behavioral health care. Care management is typically provided by a medical assistant or care coordinator who has been trained in the CoCM model. They are not usually behavioral health providers themselves.

    - Opportunity: Expand these models to other practices. *(Considerations: Cost and workforce)*

- Fifteen Certified Community Behavioral Health Centers (CCBHCs) integrate limited physical health into behavioral health care settings, including screening, care coordination, physical health history, and labs related to behavioral health medications to monitor physical health impact.

    - Opportunity: Develop additional CCBHCs. *(Considerations: Cost and workforce)*

- The Oregon Psychiatric Access Line (OPAL-A about adults and OPAL-K about kids) provides free, same-day, Monday through Friday child and adult psychiatric phone consultation to PCPs.

- Some practices have implemented tele-behavioral health and/or AI-enabled therapy tools.

    - Opportunity: Expand the tools to other practices. *(Considerations: Cost and workforce)*

Payment

- Primary care practices contracted with CCOs and OHA can bill for peer support specialist services provided in primary care without a Certificate of Approval.
- All payers are required to pay telehealth at parity with in-person care, including for behavioral health.
- Some payers pay higher reimbursement rates to cover costs of behavioral health services not covered by billing codes.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*

Integrate pharmacy services

Pharmacists in primary care settings can take on a variety of roles. Most commonly, pharmacists and pharmacy technicians work with primary care teams to improve chronic disease management, evaluate the appropriateness of medications, assist with prior authorizations for medications, educate patients, monitor patient outcomes, and assist with transitions of care. Pharmacists may be co-located at these practices or offered in a centralized manner through telehealth and referral. This approach ensures patients receive timely, connected support for both their physical health and pharmacy needs in one integrated care environment.[12]

PCPCH standards

- PCPCH Standard 4.B. for pharmacy services, including medication management, to be provided by a pharmacist in the primary care practice.

Integration models in use

- Some practices, including Federally Qualified Health Centers (FQHCs), have integrated pharmacy services.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*
- Some practices have integrated off-site pharmacy.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*
- House Bill 4131, which was passed in 2026 and is currently being implemented, allows pharmacy services to be delivered via mobile clinics.

Opportunities for integration

- Centralized pharmacy services for sharing across multiple practices. *(Consideration: Cost)*

- Pharmacy consulting model that supports consultations between providers and pharmacists. *(Consideration: Cost)*

Integrate oral health

Oral health integration (OHI) in primary care refers to coordinating oral health within primary care settings to deliver whole-person, team-based care. It includes embedding oral health services — such as cleanings, fluoride treatments, extractions, screening, treatment, and follow-up — into routine primary care workflows. This approach ensures patients receive timely, connected support for both their physical and oral health needs in one integrated care environment.[13]

Support for providers

- The OHA Health Care Provider Incentive Program provides loan repayment/forgiveness opportunities for dentists (DMDs/DDSs), dental therapists, expanded practice dental hygienists (EPDHs) and dental assistants (DAs) who provide services in rural or medically underserved, integrated primary care practices.

Opportunities for integration

- Some practices, including FQHCs with the capacity and administrative bandwidth, have integrated oral health.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*
- Some CCOs and dental care organizations (DCOs) have provided virtual training to PCPs on properly conducting oral health assessments.
    - Opportunity: Expand to other payers and practices. *(Consideration: Cost)*

Enhance care coordination

Care coordination — which is an ideal role for primary care — involves deliberately organizing patient care activities and sharing information among all the participants involved in a patient's care to achieve safer and more effective care. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means the patient's needs and preferences are known and communicated at the right time to the right people, and this information is used to deliver safe, appropriate and effective care.[14]

PCPCH standards

- Care coordination is prioritized in the PCPCH Standards since "coordination" is designated as one of the six core PCPCH attributes, which means care coordination is integrated throughout the standards. For example, PCPCH Standard 5.C. provides a framework for practices to coordinate the health care needs of their complex patients.

Payer support

- Some payers use data-driven approaches, dashboards and health navigators to engage patients, close care gaps and coordinate referrals.
    - Opportunity: Expand to all payers and align to reduce administrative burden for practices. *(Considerations: Cost and legislation)*
- CCOs have the option of investing in health information technology for their contracted providers that meets flexible services criteria, including EHRs, health information exchanges (HIEs), population health tools, hospital event notification systems, and some care management platforms. OHA's Flexible Services and HIT guidance includes more information.
- Some payers provide grants or resources to support technology for care coordination (for example, EHR, HIE, community information exchange [CIE], care management platforms and population health tools) and technology upgrades.
    - Opportunity: Expand to other payers. *(Consideration: Cost)*

Reform prior authorization

Prior authorization (PA) is a utilization management (UM) tool used by health plans and risk-bearing medical groups to discourage inappropriate, low-value, or unsafe care and ensure patients receive services that are covered by their benefit plan and delivered by a contracted provider. Despite the important role PA plays in the health care system, there is widespread consensus that the processes by which it is carried out add to providers' administrative burden and warrants significant improvement.[15]

Limited PA reform and support

- HB 3134, passed in 2025, requires insurers 1) report annual 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 Prior Authorization Application Programming Interface (API) as part of the CMS Interoperability and

Prior Authorization Final Rule (CMS-0057-F), which will enable primary care providers to submit PA requests and receive payer decisions in a specified timeframe within their EHR systems.

Opportunities *(Consideration: Cost)*

- Eliminate the use of automatic PA denials.
- Implement a gold card program that exempts physicians who earn an exemption from future PA requirements for common services within their practice or patient population.
- Require specialists, rather than the PCP, to submit needed information (CPT codes, diagnosis, etc.) once the referral is made.
- Implement an efficient process to approve standard and effective medications.

Continued education opportunities

Educating PCPs to manage complex patients involves training in multidisciplinary team collaboration, enhanced communication, and structured, patient-centered care models.[16] Participating in case- or simulation-based learning provides PCPs the opportunity to learn how to meet patient care needs for issues the PCP has referred out for in the past. Individual consultations with specialists also support this goal.

Oregon Project ECHO

- Project ECHO is an interactive educational and community-building experience that allows health care professionals throughout Oregon to create a case-based learning environment through the convenience of video connection. It includes programs on a variety of clinical issues that could be addressed in primary care. Project ECHO is supported by some payers and health systems.

Opportunities for ongoing educational support

- Require payers to support ongoing communities of practice for key needs such as treatment of substance use disorder, and other behavioral health concerns. *(Consideration: Cost)*

Leverage technology-enabled care

To manage costs and increase quality of care, many organizations are leveraging technology to extend reach and reduce staffing needs. Telehealth and other strategies can have a positive impact on patient care, including enabling diagnosis and treatment in communities rather than secondary care; improving integration; and encouraging community engagement.[17]

Telehealth

- All payers are required to pay telehealth at parity with in-person care.

Remote patient monitoring

- Some practices use remote patient monitoring, which extends the reach and reduces synchronous workload if data systems are integrated.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*

Asynchronous visits

- Some practices use asynchronous visits, which allow patients and providers to communicate at different times via secure messaging, email or questionnaires.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*

E-consults

- Some practices use e-consults, which enable clinicians to communicate asynchronously, allowing access to specialty expertise without the need for a face-to-face consultation.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*
- Some payers pay for e-consults, which allow PCPs to obtain specialist input asynchronously via EHR or synchronously via telephone or video, improving access and avoiding unnecessary referrals.
    - Opportunity: Require of all payers. *(Considerations: Cost and legislation)*

Use of AI

- Some practices use AI to support charting and other functions.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*

Coordinate interoperable and shared technology

While health IT certification promotes interoperability and information blocking is forbidden, health information remains siloed. Clinicians frequently cannot access all of a person's health information in real time at the point of care, or the process to access and review the information is cumbersome and time consuming. Patient information remains a competitive advantage for both health systems and technology vendors, which can further inhibit information sharing for clinical care.[18]

HIE with hospitals

- The EDIE/PointClickCare platform is a data infrastructure and software program that delivers real-time hospital event notifications to clinics to support care coordination and population health management. This is free for clinics serving Oregon Health Plan members.

HIE with other practices

- Reliance eHealth Collaborative, a health information exchange organization in Oregon, offers a community health record, which is an aggregated view of patient information across regional sources.
- Many practices are connected to nationwide query-based networks, allowing them to query unaffiliated clinics and organizations for clinical summary documentation information about their patients.
    - Opportunity: Expand to other practices. *(Consideration: Cost)*

Community information exchange

- Some primary care providers in Oregon leverage CIE technology to support sharing patients' social needs information to help address them and make referrals to services to meet those needs.
    - Opportunity: Expand adoption and integration into electronic health records (EHRs). *(Consideration: Cost)*

Population health

- Develop a statewide common or interoperable population health or shared care plan technology platforms to support quality improvement and VBP.
    - Opportunity: Some regionally adopted solutions in place could be expanded. *(Considerations: Cost, legislation, technical feasibility)*

Share data between payers and providers

Data sharing between payers and providers involves exchanging clinical (medical records, labs) and administrative (claims, eligibility) data to improve patient care, close care gaps and automate processes like prior authorization. Payer-provider clinical data exchange plays a critical role in payer and provider operations. Near-real-time data-sharing partnerships give practices timely access to utilization, cost and quality data for population health management and proactive patient outreach.[19]

CCO data sharing

- CCOs are currently implementing a federally mandated Provider Access API as part of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), which will make payers' patient health data available to primary care providers for care coordination purposes using a standard data-sharing process and format. (This is also referenced in the prior authorization reform section above.)
    - Opportunity: Establish state-level expectations and technical assistance for its adoption and use. *(Considerations: Cost and legislation)*
    - Opportunity: Expand to other payers. *(Consideration: Cost)*

Other data sharing

- Some payers and providers, including primary care practices, are in near-real-time data-sharing partnerships.
    - Opportunity: Expand to other payers and practices. *(Considerations: Cost and legislation)*

Policies to support payment and affordability

Measure and report on investment

Investing in primary care works. Research finds that when states invest more in primary care, their residents have better health outcomes and fewer visits to emergency departments and hospital admissions. An evaluation of the Oregon PCPCH Program between October 2011 and September 2019 found that total health care expenditures per person were reduced by 6.3% or approximately $76 per person per quarter. Nearly $12 in savings in other services were created, including emergency department and inpatient care, for every $1 increase in primary care expenditures related to the PCPCH program.[20]

Reporting on investment

- The annual Oregon Primary Care Spending Dashboard reports the percentage of medical spending allocated to primary care by health care payers (CCOs, commercial and Medicare Advantage) against the target of 12 percent set by the legislature in 2017. There isn't agreement on the methodology used to measure primary care investment in this dashboard. (This is also referenced in the comprehensive "health of primary care" dashboard section above.)
    - Opportunity: Convene partners to agree on a new methodology. *(Consideration: Legislation)*
    - Opportunity: Develop mechanisms to enforce the 12 percent target. *(Consideration: Legislation)*
    - Opportunity: Track costs and revenues for advanced primary care services separately from general primary care budgets to support accountability, sustainability and payer negotiations. *(Consideration: Legislation)*

Adopt flexible payment models

Effective primary care will require higher levels of predictable payment that allow patients to build, maintain and access long-term relationships with integrated care teams. Such relationships are formed in different clinician settings based on patient circumstances, and payment should be flexible to support all of them.[11]

Payment models

- The PCPRC developed a VBP model to be used across payers. The model's aligned primary care measure set balances minimizing the reporting burden for primary care providers while sufficiently demonstrating quality. The model includes eight measures for adults or children to help align and simplify tracking at the practice level. Some payers have implemented the PCPRC VBP or another aligned VBP model.
    - Opportunity: Expand the PCPRC VBP model to all payers. *(Consideration: Legislation)*
- Alternative Payment and Advanced Care Model (APCM) is an alternative payment model (APM) for FQHCs, rural health centers, and Indian Health Services administered in partnership between OHA and the Oregon Primary Care Association. Implemented in 2013, participating clinics receive a per member per month (PMPM) payment for a roster of patients in exchange for flexibility in how care is provided (quality metrics and patient satisfaction are measured).

    - Opportunity: Develop a common total cost of care shared savings VBP model. *(Consideration: Cost)*

- Some payers have implemented payment models that support programs to address their members' health-related social needs through, for example, social risk adjustment.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- CCOs and payers covering PEBB and OEBB members are required to implement a PMPM payment to support PCPCHs. Some commercial payers also do so voluntarily.
    - Opportunity: Expand to all payers. *(Consideration: Legislation)*
- Some payers pay for all primary care providers who provide primary care services, including those provided by traditional health workers (THWs), quality mental health providers (QMHPs) and licensed clinical social workers (LCSWs).
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- Some payers support small, independent, rural and resource-limited practices with tailored VBP contracting models, recognizing differences in capacity and infrastructure.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*

Payment amount and timing

- Some payers have implemented prospective, quarterly quality incentive payments.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- Require payers to maintain practices' payment rates when increasing quality incentive payments.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*

Support for practices

- Some payers provide technical assistance to support provider participation in VBP.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- Opportunity: Measure if funding designated for primary care within health systems reaches frontline primary care practices. *(Considerations: Cost and legislation)*

Pay for whole-person team-based care

Any effort to implement high-quality primary care must begin with a commitment to pay for primary care teams, not only doctors, to deliver services. To improve payment for primary care to better meet people's needs, payment should be increased to reflect the needs of supporting a primary care team. The payment should be sufficiently flexible so practices can meet the specific needs of the population they serve.[11]

Payment models

- Oregon's APCM for FQHCs, rural health centers and Indian Health Services supports expanded team-based care across the clinic (including physical infrastructure to keep teams physically engaged) and increased patient-centered services like cooking and exercise classes to support whole-person health.
- CCOs and payers covering PEBB and OEBB members are required to implement a PMPM payment to support PCPCHs. Some commercial payers also do so voluntarily.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*

Payment amounts

- Some payers pay sufficiently to support team-based care.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- Some payers pay Medicare Advanced Primary Care Management and Behavioral Health Integration codes. When these codes are paid, they should be classified as preventive services to reduce the co-pay burden on patients with medical complexity.
    - Opportunity: Expand to all payers. *(Considerations: Cost and legislation)*
- Increase Medicaid payment rates to at least 100% of the Medicare rates. *(Considerations: Cost and legislation)*
- Study the true cost for providers to deliver whole-person team-based care. *(Considerations: Cost and legislation)*

No-cost primary care visits

- ORS 743A.310, enacted through Senate Bill 1529 (2022), mandates that fully insured individual and group health plans provide at least three primary care visits per plan year — including behavioral or physical health — without any cost-sharing (no copays, coinsurance or deductibles).

Require minimum expenditure on primary care

Underinvestment in primary care has perpetuated a system that in most cases is unable to provide high-quality primary care. Lack of investment restricts the ability of interprofessional teams to address the whole-person health needs of individuals and families they serve.[11]

- Senate Bill 934 (2017) set a target primary care spending of 12 percent for all payers.
    - Opportunity: Develop mechanisms to enforce the 12 percent target. *(Consideration: Legislation)*

Implement site-neutral payments

The goal of site-neutral payments is for payers to pay the same rate for the same service, whether it is provided in a hospital outpatient department, ambulatory surgical center, or freestanding physician office, subject to patient safety and quality safeguards.[21]

- Opportunity: Require payers to pay the same regardless of location of a primary care practice. *(Considerations: Cost and legislation)*

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