‘Triple-A’ Initiative for Primary Care in Oregon

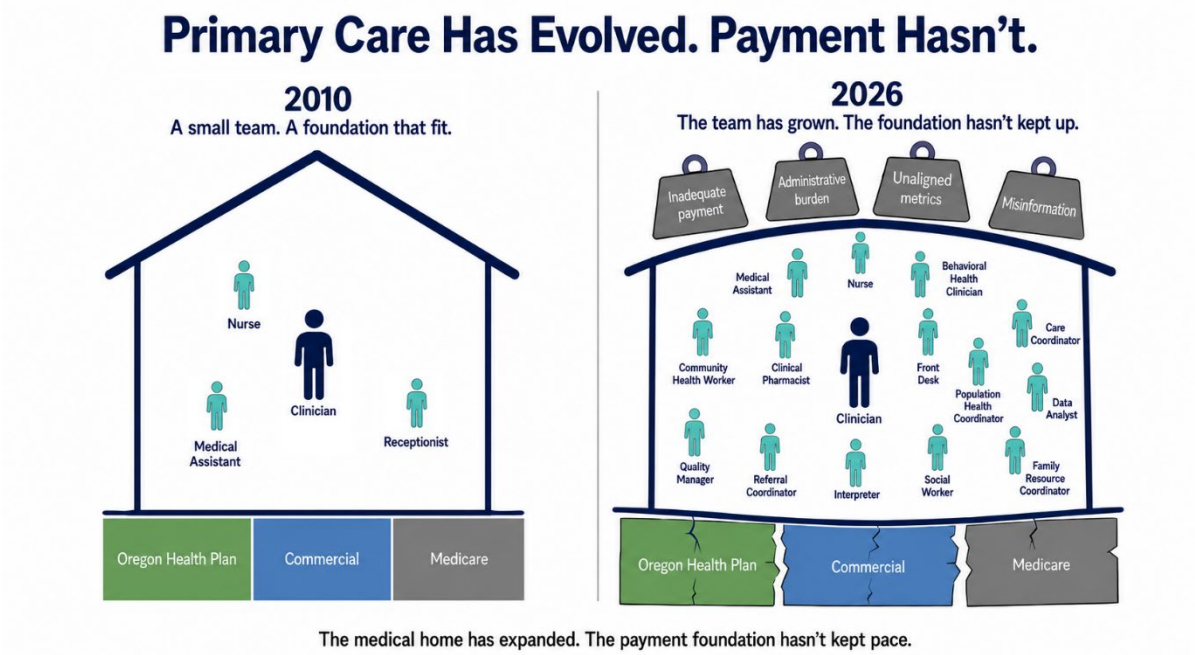
1. Executive Summary

Oregon’s health care delivery system is facing a structural collapse driven by federal funding contractions under HR 1, expanding primary care deserts, acute workforce burnout, and escalating access delays. Piecemeal solutions will no longer suffice. To stabilize the system, Oregon must urgently transition its primary care infrastructure from a volume-driven, administrative-heavy model into a predictable, universally accessible public utility.

We propose the Primary Care "Triple A" Initiative: Access, Administrative Simplicity, and Aligned Payment. This comprehensive framework provides an immediate, budget-neutral stabilization strategy for the state by eliminating systemic administrative waste, expanding team-based clinical capacity, and structurally aligning multi-payer investments across public and private markets.

2. Where We Are Today — Current State

The foundation of Oregon's health care has been compromised due to five acute, interacting structural failures that have progressed from chronic to critical:



Courtesy Dr. Doug Lincoln and Deborah Rumsey, Children’s Health Alliance

- **Inadequate Reimbursement Models:** Oregon has more than a decade of data showing a $13-to-$1 return on investment for care provided through a patient-centered primary care home, and yet most primary care payments still come from traditional fee-for-service (FFS) reimbursement methods. Such a payment structure rewards quantity over quality, mandating high-volume/low-impact one-on-one office visits between a clinician and patient. This outmoded system fails to

provide reliable capital to support evidence-proven delivery models like patient-centered, team-based care for chronic disease prevention and management. Promising efforts to care for parents with behavioral health or substance use disorders with an eye to supporting the family are not permanently resourced.

- **Administrative Waste:** Fractured funding arrangements among dozens of commercial and public payers require levels of data management and contract navigation sophistication that independent, rural, and safety-net clinics cannot sustain, forcing clinics to focus on insurers rather than patients and driving consolidation. Meanwhile, continuous expansion of process-heavy reporting, redundant credentialing paperwork, and duplicative prior authorization rules divert precious clinical resources directly away from frontline patient care, adding billions in pure systemic drag.
- **Unaligned Quality Metrics:** A proliferation of reductionist, disease-specific quality measures exists without clear evidence of clinical effectiveness or multi-payer alignment, creating immense operational fatigue across clinical teams.
- **Unrealized Transformation:** Oregon is a national leader in health care innovation - from the Oregon Health Plan to the Patient-Centered Primary Care Home Program to the 12% primary care spend initiative. Yet our approach lacked mechanisms to enforce those policies, and so innovation remains under-funded and at risk of regression, while substandard practices still dominate our system.
- **Compounding Workforce Collapse:** An aging clinician workforce is accelerating toward early retirement, while medical school graduates actively turn away from primary care fields due to an average educational debt exceeding $300,000 and low pay relative to procedure-based specialties; new clinicians pursue less-than-full-time clinical roles.[1] Training capacity constraints for nursing and physician professions, including community preceptorship capacity, limit Oregon's ability to close the existing gap or prevent it from getting worse.

The status quo has led to a system overburdened by administrative waste and box-checking rather than one providing high-quality/high-value care to all Oregonians.

3. What the Future Looks Like — Ideal Future State

The successful implementation of this state-level strategy will establish an advanced, resilient primary care ecosystem characterized by the following systemic outcomes:

- **Universal Access & Continuity:** Every Oregonian is guaranteed a stable, reliable, and continuous primary care medical home (PCPCH) accessible to them for preventive care, integrated behavioral health care, chronic disease management, and minor acute care needs. Patients are insulated from care disruptions during sudden changes in employment, income, or insurance coverage. Technology such as telemedicine is used to expand and augment access to care teams through virtual visits, rather than displace them. Appropriate artificial intelligence and other emerging technology is deployed safely, focusing on administrative tasks rather than replacing clinical staff.
- **Sustained Team-Based Care:** Capital flows predictably to fund comprehensive, multi-disciplinary care teams, including functions such as integrated behavioral health professionals and access to resources such as OPAL-A and OPAL-K, clinical pharmacists, care coordinators and traditional

[1] More doctors where they're needed: Reforming Medicare's GME formula. Niskanen Center. Retrieved July 7, 2026 from https://www.niskanencenter.org/more-doctors-where-theyre-needed-reforming-medicares-gme-formula/

health workers—unlocking downstream savings, improving care, and expanding total clinic capacity. Care pathways that facilitate patient transitions between specialty behavioral health care and primary care are created and fully resourced. Technical support and professional development programs (e.g., Project ECHO) are sustainably funded.

- **Radical Administrative Simplicity:** Primary care clinics operate under a single, streamlined payment methodology and are evaluated with a unified set of measures that require minimal administrative drag, reducing system fatigue and returning clinicians to the primary joy of direct patient care.
- **Workforce is Actively Growing:** Training programs for all necessary clinicians and team members have appropriate public support; multi-sector financial collaboration helps fund educational loans and new-practice start-ups. Programs matching older clinicians with part-time or *locum tenens* opportunities help relieve system strain.
- **Oregon's Primary Care Scorecard Tells the Story:** Across critical indicators, Oregonians and policymakers can track the health of this sentinel part of the health care system.

4. The Strategy — "Swim Lanes" of Activity

The strategy is organized into three core "Swim Lanes," sequenced across four policy cycles for a deliberate, manageable progression from initial remedies to a comprehensive public utility model:

Horizon	Access	Administrative Simplicity	Aligned Payment
Horizon 1 2026-2027 Immediate and Short-term Actions	• Establish the Primary Care Registry of clinics and clinicians. 🏛 $ • Fund the Oregon Wellness Program to support clinicians. 🏛 $ • Fully fund the Vaccine Access Program. 🏛 $ • Refine the definition of primary care: setting aside urgent care, OB, and psych; include pharma in denominator. 🏛 • Modernize, harmonize, and consolidate workforce incentive programs. 🏛 • Modify census methods and create a statewide provider directory. 🏛 $ • Launch the Primary Care Scorecard using existing baseline metrics. ⚙ • Restore funding for family medicine residency technical assistance and support 🏛 $	• Support the OHPB Primary Care Committee in its work to advance legislative fixes to improve the flow of non-claims funding. ⚙ • Pursue radical simplification of quality metrics via the CCO Metrics & Scoring Committee or regulatory change ⚙ • Pause REALD/SOGI data collection in clinical settings for 3 years to redesign. ⚙ • Exclude independent clinics from Cost Growth Target penalties; pause on reporting requirements for primary care. 🏛 $ • Update DCBS statutory authority over commercial insurance lines. 🏛 $ • Reduce the administrative burden of PCPCH attestation. ⚙	• Preserve or restore 2025-6 CCO Quality Incentive Pool (QIP) funds strictly for clinic support; direct future funds to primary care 🏛 $ • Enforce mandatory, transparent action plans for payers falling short of the 12% spend target. 🏛 • Restore value-based payment contract targets for CCOs for 2027. ⚙ • Re-engage PEBB and OEBB boards for VBP and investment alignment. ⚙ • Preserve 2026 QIP funding streams; ensure sustainable funding going forward. ⚙ • Require absolute telehealth payment parity. 🏛 $ • Mandate quarterly or faster quality incentive distribution. 🏛 • Initiate legislative discovery for the Primary Care Trust. ⚙
Horizon 2 2028 Medium-Term Actions	• Pursue preceptor and targeted faculty incentive structures. 🏛 $ • Convene workgroup on public-benefit infrastructure investment partnerships. 🏛	• Implement efficient, timely payment strategies post-prior authorization reporting. 🏛 • Draft legislation for a unified common credentialing system under DCBS. 🏛 $ • Draft legislation to unify health insurer oversight in one agency. 🏛 $	• Require health plans to spend their 12% allocation directly within PCPCH medical homes. 🏛 • Increase the statewide primary care spending target to a mandatory 15%. 🏛 $
Horizon 4 2029 Long-Term & Beyond	• Fund and resource a public-private Primary Care Center of Excellence for capacity financing. 🏛 $ • Partner with OHA on Rural Health Transformation workforce funds. ⚙	• Pursue multi-state licensure compacts to ease clinical friction while protecting clinician autonomy. ⚙	• Pass comprehensive Universal Primary Care legislation enabling a unified payment model. 🏛 $ • Increase target 1% each year to reach a 17% target. 🏛 $ • Deploy the State-as-Payer model for the uninsured using a Hospital Community Benefit Set-Aside (HB 3076 from 2019). 🏛 $

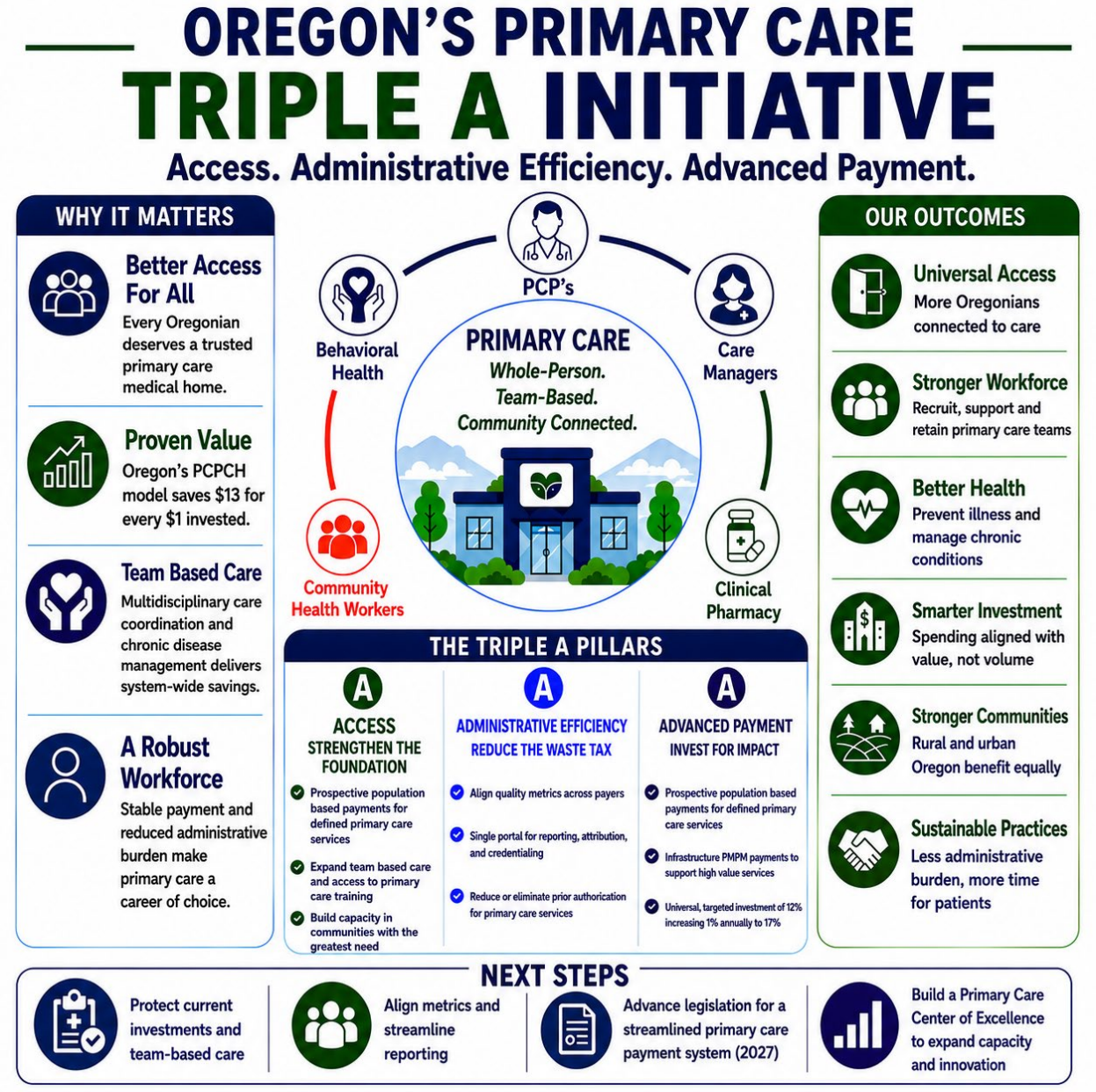
Key: 🏛 = requires legislation ⚙ = administrative or regulatory action only 🏛 $ = requires legislation and funding

5. Advanced Payment Core (Primary Care VBP Architecture)

Independent evaluations confirm that Oregon's Patient-Centered Primary Care Home (PCPCH) program delivers profound system-wide cost savings, and a 2024 Congressional Budget Office analysis found that lower emergency department visits and avoided high-cost care would offset a significant portion of primary care investment.[2] To protect this baseline, traditional fee-for-service is entirely replaced by a hybrid payment structure once the long-term Trust is established:

- **Prospective Population-Based Payments (PBP):** A predictable monthly capitation payment distributed directly to clinics for a defined set of core primary care services that represent a preponderance of spending and are prone to overuse in FFS models.
- **Fee-for-Service (FFS) Payments:** Retained selectively only for specific frontline services that are prone to underutilization or performed inconsistently, such as home visits, prenatal care, and after-hours triage.
- **Infrastructure PMPM Payments:** A base per-member-per-month payment tied directly to a clinic's PCPCH tier, with additional designated capital for high-value integrated teams (behavioral health, clinical pharmacists, and traditional health workers).
- **Performance-Based Incentive Payments:** Meaningful financial rewards based on an aligned, high-level primary care scorecard, with total eligible incentives equaling at least 10% of annual projected service payments, distributed no less frequently than quarterly.
- **The Budget-Neutral Financing Model:** Restructures care without expanding the deficit. The model preserves front-end insurance premium financing from employers and individuals. The transformation occurs entirely on the backend by pooling existing primary care allocations into a single public trust fund via a uniform assessment on health plans. To seamlessly capture self-insured corporate lines under federal jurisdiction, the model leverages the state's constitutional business taxing power, automatically crediting or waiving the assessment when the employer routes their primary care allocation into the Common Fund.

[2] Hiding in Plain Sight: Investing in Primary Care Can Heal Our Dysfunctional Health Care System. The Primary Care Collaborative. Retrieved July 7 from https://thepcc.org/wp-content/uploads/2024/06/Hiding-In-Plain-Sight-Investing-in-Primary-Care-6.2024_0.pdf



Contextual Note:

We recognize that the time horizon for these proposals overlaps the time horizon for the finalization and potential launch of Oregon's Universal Health Plan. With the exception of the concept of Universal Primary Care, the interventions mentioned here would have applicability to the resulting transformed system. Importantly, the UHPGB has founded its work heavily on an assumption of prioritizing primary care access and working to a 15% primary care spending target.

The passage of HR 1 in 2025 has added, and will continue to add, enormous pressure to the health care system in Oregon and across the state. While dollars are scarcer than ever, the most recent data we have (which predates any cuts to Medicaid enrollment or expenditures triggered by HR 1) is indicating a decline in primary care spending due to accelerated overall health care spending.

Triple-A' Initiative for Primary Care – Appendix: Glossary

Primary Care Practice & Clinician Registry/Directory
A statewide inventory of primary care community practices and the clinicians who provide primary care, designed to accurately measure the location, composition, and capacity of Oregon's primary care workforce.

Why it is needed: Oregon lacks a consistent method to identify where primary care exists and who is delivering it. A comprehensive registry would enable more accurate workforce planning, identify communities with insufficient capacity, and inform policies and investments to strengthen primary care.

Oregon Primary Care Strategy Committee

First convened in May 2026; this subcommittee of the Oregon Health Policy Board (OHPB) is tasked with identifying challenges and solutions pertaining to the delivery of primary care in Oregon. In summer 2026 it voted to send a legislative concept to the OHPB that would modify the statutory definition of primary care, and make changes to payer requirements related to timing and levels of non-claims financial support for primary care.

Oregon Wellness Program

A confidential psychological help line for licensed health professionals of all types. Callers can be connected with up to three no-cost visits with mental or behavioral health professionals skilled at working with health care professionals; the service is not reportable to the Oregon Medical Board. The program is proven to reduce burnout and prevent workforce loss.

Quality Incentive Pool Funds

Percentage of the Oregon Health Authority Medicaid budget that is distributed to CCOs proportionally based upon their performance on quality measures selected and benchmarked by the OHA Metrics & Scoring Committee. Most CCOs distribute these funds to clinics; for some CCOs, they flow substantially to primary care clinics. Total funds for performance year 2025 were reduced from 3.48% to 3%. The fund was reduced to 2% for 2026.

Streamlined/Universal Primary Care

Pursuing this policy would unify the coverage and payment for primary care for all Oregonians under a single trust funded for this purpose. This proposal does not supersede Universal Health Care, but rather could be pursued as a steppingstone on the path to coverage and access for all.

Primary Care Center of Excellence

This entity would exist to drive policy, to consult on matters related to primary care delivery and payment, and to finance investment in primary care clinics through low-interest loan programs. This organization might be modeled on the Primary Care Development Corporation. This entity could also be the organization that operates the trust to administer the state's streamlined primary care system.