

# PRIMARY CARE INVESTMENT

## Lessons Learned from Multi-Stakeholder Advisory Groups

### Abstract

The Primary Care Collaborative reviewed multi-stakeholder advisory groups in eight states that are measuring primary care spending, including how the groups relate to state government and the role they play in primary care measurement, investment, and health-system reform efforts. States utilize multi-stakeholder advisory groups in a range of roles—from expert advisers to influencers, to partners and implementers of new payment and care-delivery models. The studied states cluster around three distinct, but often overlapping, strategies for using primary care measurement to spur investment and care transformation:

1. Using data and public reporting to set expectations, targets, and monitor progress
2. Exercising state healthcare purchasing and contracting authorities
3. Leveraging regulatory and oversight authority over health insurers and providers

Using interviews, a written survey of stakeholders and state leaders, review of laws, executive orders, meeting minutes and agendas, and short case studies, we describe the roles, composition, and activities of multi-stakeholder primary care advisory groups. We then highlight characteristics and processes of more effective multi-stakeholder groups as reported by participants. This brief aims to generate discussion and assist states and stakeholders who are considering embarking on primary care investment initiatives and those making strides on the path to health-system transformation.

### BACKGROUND

As of December 2020, 10 states have measured statewide primary care spending, defined as the share of total healthcare spending going to primary care services and clinicians. The 10 states are: Colorado, Connecticut, Delaware, Maine, Massachusetts, New Hampshire, Oregon, Rhode Island, Vermont, and Washington. In 2020, the six New England states aligned measurement of primary care spending as part of a collaboration coordinated by the New England States Consortium Systems (NESCSO) and sponsored by the Milbank Memorial Fund. In addition, West Virginia has enacted legislation to measure primary care spending in Medicaid. The

governors of Connecticut and Pennsylvania issued executive orders in 2020 that commit to measuring primary care spending as part of a healthcare cost benchmarking process, similar to cost benchmarking efforts established or underway in Massachusetts, Rhode Island, Delaware, Oregon, and Washington.

Almost all states currently measuring primary care spending have formed multi-stakeholder advisory groups to advise state leaders on defining and measuring primary care spending. Many have also established multi-stakeholder groups to inform state leaders on broader primary care and health-system transformation strategies. This brief provides an overview of state approaches to leverage

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PRIMARY CARE COLLABORATIVE

### Who We Are

The Primary Care Collaborative is a national multi-stakeholder organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care. Our mission is to engage and unify diverse stakeholders from the public and private sectors in support of high-performing primary care. We convene stakeholders, disseminate evidence and best practices, and connect primary care leaders and advocates. Our work is guided by the Shared Principles of Primary Care that are person-and family-centered; continuous; comprehensive and equitable; team-based and collaborative; coordinated and integrated; accessible; and high-value. We are committed to evidence-based policies and practices.

the expertise, commitment, and influence of stakeholders whose engagement is necessary to increase primary care investment and drive successful primary care delivery reforms. It is noteworthy that all of the surveyed and interviewed states were recipients of State Innovation Model (SIM) grants from the federal Center for Medicare and Medicaid Innovation (CMMI).

### Report Methods

- The PCC reviewed legislation establishing primary care spending measurement efforts and other primary care payment or transformation task forces or collaboratives in states measuring primary care spending.
- We reviewed missions, charters, membership, and activities of multi-stakeholder groups, along with the role of state agencies that convene them.
- We conducted a written survey that was sent to 90 stakeholders participating in efforts in eight states (survey in appendix).
- We conducted 11 focused interviews (over Zoom) with stakeholders and state leaders and staff (at least one from each of eight states).
- We consulted with project advisers from states and the Milbank Memorial Fund.
- We limited our review to states currently engaged in primary care spending measurement and reporting, recognizing there are

## EXECUTIVE SUMMARY: LESSONS FROM EARLY ADOPTER STATES

### 1. Have a Strategy and a Roadmap for Primary Care Investment

The first state efforts to measure primary care spending began in Rhode Island in 2010, when the Office of the Health Insurance Commissioner (OHIC) in the Department of Insurance adopted affordability standards. By making primary care measurement in OHIC as foundational to its affordability mission, OHIC uses its rate-review authority to meet and monitor affordability standards through a broader strategy of care-delivery and payment reform. The multi-stakeholder Care Transformation Advisory Committee, made up primarily of health insurers and clinician and hospital organizations and charged with developing an annual primary care transformation plan, advises OHIC on how primary care transformation can help achieve its affordability standards. By adopting a broad approach to affordability, Rhode Island has been able to invest in comprehensive primary care delivery models while simultaneously monitoring hospital spending.

Other states, such as Oregon, Washington, and Vermont, have utilized federal Medicaid waivers and other federal demonstration opportunities to support their primary care investment and transformation strategies.

### 2. Form Multi-Stakeholder Groups to Fit Your Strategy

The purpose and role of multi-stakeholder advisory groups should follow from the primary care investment strategy. One phrase we heard frequently in interviews was **“the stakeholder group discussions are where we build stakeholder buy-in.”** We also heard that busy, passionate clinicians will volunteer their time for multi-stakeholder processes if they think it will influence decisions such as new care-delivery and payment models or help solve problems such as workforce shortages. Good facilitation was also identified by participants as helpful to productive meetings and staying on track.

**“States that set out to measure primary care spending need a theory of action. What is the intended outcome of the process? For Rhode Island, it was to make health care more affordable for state residents. [States should] think carefully about where in state government you put the mission of measuring primary care spending.”**

Cory King, Director of Policy,  
Rhode Island Office of Health  
Insurance Commissioner

## Major Themes: Roles of Multi-Stakeholder Primary Care Advisory Groups and Collaboratives

- Build buy-in and create political will
- Elicit passion, commitment, expertise, and influence of stakeholders
- Listen to the experiences and expectations of stakeholders
- Drive alignment around new payment and care-delivery models
- Monitor progress against targets and goals

## OVERVIEW OF STATE LAWS, EXECUTIVE ORDERS, AD HOC WORKGROUPS

State primary care spending reports have been authorized by legislation in seven states, with most to be conducted annually by specific state agencies. In one state (Rhode Island), the rate-review authority of the Office of the Health Insurance Commissioner is used to collect the data to measure primary care spending. In at least two states (Pennsylvania and Connecticut), primary care spending measurement has been authorized in executive orders. In all of the laws and executive orders reviewed, state agencies are directed to consult with stakeholders as they make decisions related to defining and measuring primary

care spending. In most cases, the legislation or executive order names the categories of stakeholders to be consulted.

In four states (Colorado, Delaware, Oregon, and Rhode Island), the same multi-stakeholder advisory group that serves to define and measure primary care spending also has a broader, ongoing mission to support primary care investment and health-system transformation. In most states, there are separate multi-stakeholder collaboratives or advisory groups addressing payment models, affordability standards, cost benchmarks, and targets for primary care spending (Washington, Oregon, Vermont, Delaware, and Rhode Island).

A table providing links to state primary care spending laws, executive orders, spending reports, and other resources can be found in the appendix.

Three distinct, sometimes overlapping, strategies emerged in the review of state primary care spending laws and executive orders and in surveys and interviews with stakeholders and state agency leaders. *Each strategy may require a multi-stakeholder advisory group to inform, align, and assist with implementing the strategy.*

**"I have a lot of confidence in the process. We just had a public hearing, in part, to get legislators engaged and be transparent with them. The Connecticut Office of Health Care Strategy laid out recommendations. They identified where they modified recommendations in response to our [stakeholder] feedback and where they didn't. That's important to the advocates—to see ourselves in the process."**

Tekisha Everette, Executive Director, Health Equity Solutions (Connecticut). Everette serves on the Stakeholder Advisory Board, which gives input to the Technical Team supporting a statewide healthcare cost growth benchmark as established by Gov. Ned Lamont's (D) 2020 Executive Order 5, which also includes a primary care spending target of 10%.

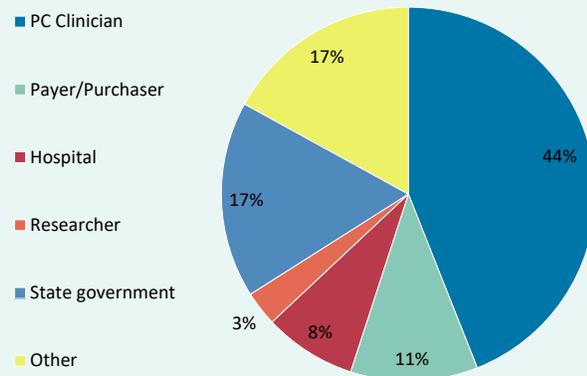
### Three Strategies for Primary Care Investment

Use authority to set standards, regulate, review rates	Leverage purchasing authority (Medicaid, public employees)	Measure, target, monitor with cost, quality benchmarks
Rhode Island Office of Health Insurance Commissioner	Oregon Health Authority	Connecticut Office of Health Care Strategy
Delaware Department of Insurance	Washington Health Care Authority	Delaware Health Care Commission
Colorado Department of Insurance	Vermont GMCB, Vermont AHS: All-Payer ACO	Washington Health Authority Cost Transparency Board
Vermont Green Mountain Care Board	Delaware DHSS, Office of State Employee Benefits	Oregon Health Authority
	Colorado Department of Health Care Policy & Finance	Rhode Island OHIC, EOHHS
		Pennsylvania Interagency Health Reform Council

### WHAT THE STAKEHOLDERS THINK: A SURVEY OF PRIMARY CARE ADVISORY GROUP MEMBERS

A survey was drafted to gather information from participants and state leaders about the multi-stakeholder groups’ roles, scopes, and impacts. The survey was sent (via Survey Monkey) to 90 advisory group members across eight states. We were limited by a lack of email addresses for some states but received 37 responses, with at least one response from each state. Forty-four percent of the respondents are clinicians, 17% work for state government, 11% are payers, 8% represent hospitals, and the remaining are from other stakeholder categories. Unfortunately, the voice of consumers is underrepresented in the survey responses; this may be reflective of the uneven inclusion and participation of consumers in multi-stakeholder advisory groups.

Stakeholders Represented in Survey



## SURVEY HIGHLIGHTS

### Scope and mission of primary care advisory groups:

- 62% of respondents said there are multiple groups discussing primary care investment in their state.
- Almost 80% report that the advisory groups that inform the primary care spending effort also discuss payment reform; 50% also discuss primary care workforce issues.
- 85% believe that a target for primary care spending is needed in their state.
- About 50% think their advisory group lacks sufficient resources or isn't sure.

### Stakeholders Represented

Only 16% of respondents thought their advisory group was missing important stakeholders. Two noted the absence of consumers in general and those from marginalized communities in particular. One identified major payers as missing, and one noted that the right stakeholders were participating but not from the right level of leadership in their organizations.

### Impact of Primary Care Spending Report

- 60% think the primary care spending report has influenced Medicaid in their state; only 30% think it is influencing commercial insurers and state employee benefits.
- 80% say they use the primary care spending report to educate stakeholders.
- 40% are not satisfied with their state's definition of primary care spending.

## Effectiveness of Primary Care Advisory Groups

Space was provided for respondents to identify barriers to effectiveness or factors in the success of primary care advisory group efforts to date. Below are some comments made:

- “the commitment to use regulatory authority has been important”
- “changing definitions of primary care have been difficult to manage”
- “powerful stakeholders are trying to prevent progress”

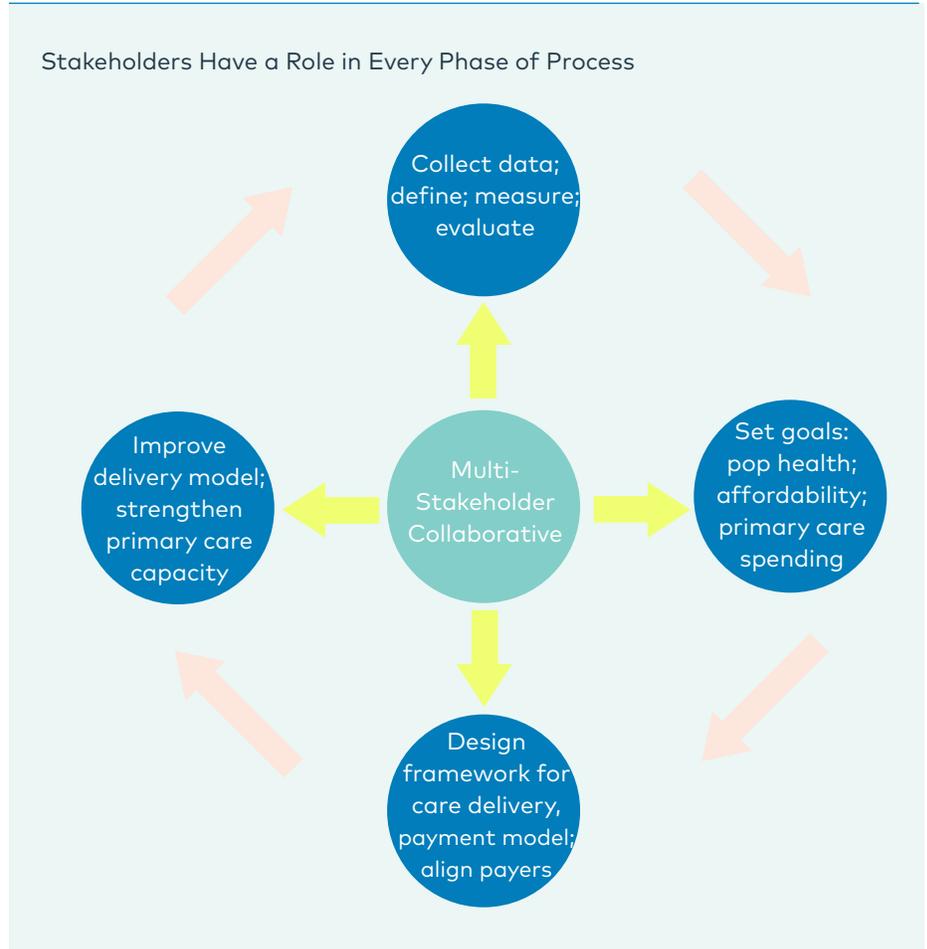
## INSIGHTS FROM FOCUSED INTERVIEWS WITH LEADERS AND STAKEHOLDERS IN EIGHT STATES

### 1. Process and scope

Interviews with state agency leaders who convene and participate in multi-stakeholder advisory groups revealed a deep appreciation for the feedback from and expertise of participants. Most of the multi-stakeholder groups follow state public meetings laws, with agendas, minutes, presentations, and reports posted publicly and public attendance at meetings permitted. Formal records of meetings, recommendations, and reports can be shared easily with elected leaders and other stakeholders. Few of the advisory groups take formal votes on policies or recommendations. Other approaches to demonstrate consensus and alignment, such as “signing on” to principles or commitments, are sometimes used.

Private sector stakeholders want to know that the advisory process is “real” and will lead to action. Stakeholders come to the process with different experiences and expertise; they may need conveners to organize presentations and discussions that “level set” and enable them to participate fully in the process. Independent facilitation was also noted as helpful to the group process.

A few of the multi-stakeholder groups had narrow, time-limited roles defined by the legislature to inform the definition of primary care for purposes of measuring primary care spending only. In at least one state, the presence of legislators and a strong chair (appointed by the governor) in the group helps to keep policymakers close to the strategy and process of measuring and investing in primary care. During the COVID-19 pandemic, some multi-stakeholder groups have advised the state on emergency rulemaking for policies such as telehealth. Despite the demands of the pandemic, at least six of the states (Delaware, Washington, Oregon, Connecticut, Pennsylvania, and Rhode Island) are in various stages of establishing healthcare-cost benchmarking initiatives with multi-stakeholder guidance. They will join Massachusetts in utilizing this transparency mechanism to sustain momentum for health-system reform.



STATE SNAPSHOT

**VERMONT**

The mission of the Green Mountain Care Board (GMCB) is to improve the health of Vermonters through a high-quality, accessible, and sustainable healthcare system. The GMCB is a unique state entity with regulatory oversight of hospital budgets, health insurance premium rates, certificate of need, accountable care organizations (ACOs), major healthcare datasets, and Vermont’s All-Payer Model.

In 2018, the GMCB used its authority granted in legislation to form technical advisory bodies to continue convening the Primary Care Advisory Group. The GMCB already had a multi-stakeholder advisory group in place. The Primary Care Advisory Group is made up solely of physicians, and its charter includes advising on a range of issues, including “hospital budget review, oversight of ACOs, payment and delivery system reform and evaluation, health information technology,

data collection and databases, healthcare workforce planning (including workforce wellness), and All-Payer Model reporting.”

In 2019, the Vermont legislature enacted Act 17 directing the Green Mountain Care Board and Vermont Department of Health Access to report to the legislature on the percentage of state healthcare spending dedicated to primary care. The law directs the two state entities to “consult with health insurers, hospitals, federally qualified health centers (FQHCs), accountable care organizations (ACOs), primary care providers, other health professionals, and interested stakeholders” to define and measure primary care spending in Vermont. The agencies delivered a detailed report on primary care spending to legislative leaders in January 2020. Vermont’s strategy to drive health-system transformation and primary care investment is

STATE SNAPSHOT

**VERMONT** (continued)

through the All-Payer ACO Model, an agreement between Vermont and the federal government that allows Medicare to join Vermont Medicaid and commercial insurers to pay for health care more differently. A major goal of the All-Payer Model is to improve the quality of health care, which includes increasing access to primary care. With regulatory oversight by the GMCB, Vermont’s sole ACO (OneCare Vermont) has a governing board made up of providers and consumers. OneCare’s budget and its care transformation activities are publicly reported and reviewed by GMCB annually, with opportunity for public stakeholder comment. The Vermont primary care spending report informs the GMCB as it evaluates the All-Payer Model and its success in increasing investment in primary care. Primary care stakeholders have multiple opportunities to engage and influence oversight and evaluation of the All-Payer Model implementation.

**2. Process Matters**

Below are some recommendations and lessons we heard in the interviews with stakeholders and state agency leaders:

- Participants should be chosen because they represent important stakeholders but should also demonstrate commitment to the strategy and the process.
- It may be necessary to engage multiple levels of organization leadership (CEO level for some advisory groups).
- Advisory groups should have clear deliverables they are informing, i.e., primary care spending reports, primary care delivery and payment models, regulatory framework, standards, metrics.
- Resources for facilitation and level-setting help all stakeholders participate fully in the process and help keep the group on track.
- More advanced and longstanding advisory groups function better with strong co-chairs who can drive the agenda, build consensus, facilitate work in between meetings, and serve as authoritative resources for state leaders.
- In contrast to state government staff, advisory group members can advocate outside the advisory group process with the legislature or executive branch leaders on topics or needs.

Key Challenges for Advisory Groups	Solutions include
Sustaining momentum for change	Engaging advisory groups to inform new procurement strategies for services from consultants, third-party administrators, etc.
Securing resource commitments	Engaging advisory groups to design, request Medicaid waivers to support transition costs in new payment and delivery models
Engaging more payers, purchasers, and providers over time	Launching a statewide healthcare cost benchmarking initiative to monitor “total cost of care” trends and engage business and community leaders and economists outside the healthcare industry
Integrating components of strategy into a coherent whole	Issuing regular public reports and newsletters; collaborating on communication and dissemination strategies
	Leveraging nonprofit resources (i.e., hospital community-benefit activities, healthcare or corporate foundations) to support activities

## STATE SNAPSHOT

## COLORADO

After trying to pass primary care investment legislation for a few years, Colorado primary care advocates revised their bill in 2019 to better align with legislators' and the governor's healthcare priorities, which are focused on affordability, transparency, and overall system improvement. (Gov. Jared Polis, D, established the Office of Saving People Money on Health Care.) They describe their legislation, HB 19-1233, as a "hybrid" of Rhode Island and Oregon's approaches to primary care investment. The new law enacted in 2019 creates a multi-stakeholder Primary Care Payment Reform Collaborative integrated into a comprehensive affordability mandate to the Department of Insurance.

The legislation tasks the Colorado Primary Care Payment Reform Collaborative with the following:

- Recommending a definition of primary care to the Insurance Commissioner
- Advising in the development of affordability standards and targets for commercial insurers for primary care investment
- Coordinating with the state all-payer claims database (APCD) to measure and report on primary care spending
- Report on insurer practices and methods of primary care payment that direct more resources to primary care innovation and improvement
- Identify barriers to adoption of alternative payment models (APMs) and make recommendations to address them

- Develop recommendations to increase the use of APMs and decrease role of fee-for-service
- Consider how to increase investment in advanced primary care without increasing costs to consumers or increasing the total cost of care
- Develop and share best practices and technical assistance

The 22-member collaborative includes representatives from other state agencies as well as private sector representatives of payers, providers, consumers, insurers, actuaries, and employers; it meets monthly and has met throughout the COVID-19 pandemic. The collaborative issued its first spending report with recommendations at the end of 2019 and is now writing its second annual report and recommendations as the Insurance Commissioner finalizes the first set of affordability standards in formal regulations with public comment. Colorado's collaborative has co-chairs—one a clinician representative and one a plan representative. Participants identified the co-chairs as effective in driving an agenda and serving as points of contact for state staff.

While the majority of the collaborative's members recommended that health insurers increase their investment in primary care by at least 1 percentage point per year for two years, the health insurer representatives on the collaborative expressed concerns with setting a target and issued a dissenting opinion. In contrast to advisory groups and collaboratives reviewed in other states, the Colorado collaborative established formal operating procedures that include voting on each of its recommendations to the Department of Insurance.

**"As we write recommendations for our second annual report, we are grappling with the balance of ensuring flexibility for practices and payers while also reaching a level of alignment that reduces administrative burden and promotes progress."**

Stephanie Gold, MD,  
Vice President, Colorado  
Association of Family  
Physicians and member  
of Colorado Primary Care  
Collaborative

## STATE SNAPSHOT

## WASHINGTON

Washington state makes use of multi-stakeholder groups and organizations and its purchasing power to inform and implement its primary care investment efforts. Led by the Washington Health Care Authority (HCA), the state is well into health-system transformation efforts. There are three current or recently engaged primary care-focused multi-stakeholder groups comprised of public and private sector experts, decision-makers, and implementers working to accelerate transformation. Some are time-limited and convened for specific activities, and some play ongoing, sustaining roles in transformation.

In 2011, the legislature created the Bree Collaborative (BC), housed at the nonprofit Foundation for Health Care Quality, "to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State." Workgroups review clinical evidence, disseminate strategies for adoption of best practices, and make recommendations to the WHA, which may incorporate them in its standards for Medicaid and public employees. Earlier in 2020, the Bree Collaborative created a workgroup to study and advise on the definition of primary care for the purposes of measuring primary care spend. The draft report is now out for public comment.

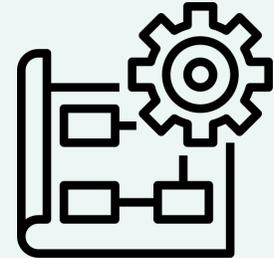
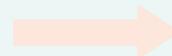
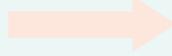
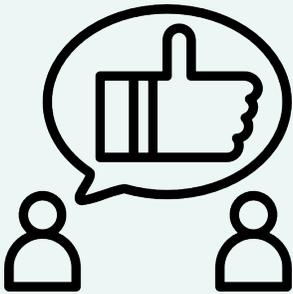
In late 2018, the HCA started convening all Washington payers to collaborate on multi-payer activities, including rural transformation and primary care payment models. A couple of months later, the "multi-payer collaborative" agreed to focus its collaborative work on building and implementing a multi-payer primary care model. Since then, HCA continues to convene the

multi-payer collaborative as well as large meetings with providers and primary care stakeholders to gather feedback on its plans for alignment around a comprehensive multi-payer primary care model for Medicaid and public and school employees as well as statewide. The HCA also established workgroups of payers and providers (the implementers) to guide model design and asked payers (the "multi-payer collaborative") in October 2020 to sign a memorandum of understanding committing to align around and implement key features of the model.

In 2019, the legislature provided an appropriation to the Office of Financial Management to issue a report on primary care spending and established a multi-stakeholder group of clinicians (including advanced nurse practitioners) to advise it on defining and measuring primary care. The report was issued in November 2019 and establishes statewide baselines for primary care spending percentages as well as estimates across different payers to guide ongoing transformation efforts. In addition, HCA has required all Medicaid MCOs and public and school employee plans to measure and report primary care spending for HCA lives starting January 2020.

In the interview, HCA leaders highlighted the important role resources from the federal State Innovation Model (SIM) grant played as they planned and launched an integrated transformation strategy almost 10 years ago as well as their successful effort to secure a Medicaid Delivery System Reform Incentive Payment Demonstration [add link/citation] to provide momentum to sustain SIM-supported transformation work. Lastly, they pointed to the new statewide Health Care Cost Transparency Board authorized by the legislature. The board will engage multiple stakeholders at a higher level of organization leadership than some of the other primary care-oriented stakeholder groups.

As Roles and Activities Change, Stakeholder Groups May Evolve



**ADVISE**

- State action to measure primary care spending
- Technical questions
- Feasibility issues

**ENGAGE & ALIGN**

- Multi-stakeholders
- Define framework
- Define standards, metrics
- Launch model(s)

**IMPLEMENT**

- Monitor progress
- Problem-solve
- Evolve models
- Stakeholders take more responsibility

Years 1-2: identify your baseline; set goals; Years 2-3: define, launch models; Years 4-6: implement, evaluate, revise; formalize stakeholder entity for sustaining momentum

Images: Flaticon.com

**RECOMMENDATIONS: PRIMARY CARE INVESTMENT AS THE FOUNDATION OF HEALTH-SYSTEM REFORM**

Interviews with state agency leaders and healthcare stakeholders revealed that health-system transformation is a multi-year, multi-phase process. It extends beyond the political calendar of four-year gubernatorial terms and requires a shared high-level strategy and commitment from the legislative and executive branches. It must be implemented in collaboration with payers, providers, clinicians, patients, community leaders, and business leaders.

By centering healthcare payment and delivery reforms around a strong foundation of primary

care, state leaders can engage a diverse group of stakeholders who have something to gain from the process. For the few, powerful stakeholders who may resist change, it was generally agreed that it is better to have them at the formal stakeholder table and committed to a transparent process. Understanding the interests and motivations of stakeholders is important; greater investment in primary care serves the interests of a broad range of stakeholders and appeals to both sides of the political spectrum. The Primary Care Collaborative’s Shared Principles of Primary Care can serve as a guide. For stakeholders who will have to adjust their business models to succeed under new payment and care-delivery models, the strategy should offer them a practical path and transition to a new business model.

Recommendations for Leaders and Stakeholders:  
Primary Care Investment and Transformation

STATES MEASURING PRIMARY CARE		STATES CONSIDERING MEASURING PRIMARY CARE	
State Leaders	Stakeholders	State Leaders	Stakeholders
Stay grounded in data and evaluation to guide, re-assess strategies	As organizations, commit to the long haul; devote right level of leadership to right stages and activities in the process	Take evidence-based, comprehensive approach to strengthen primary care; invest in data infrastructure; bring the public, key stakeholders into the conversation	Make case for primary care investment to solve state challenges <ul style="list-style-type: none"> <li>• Equity gaps</li> <li>• Rural gaps</li> <li>• Healthcare workforce gaps</li> <li>• Cost growth sustainability</li> </ul>
Adjust, re-commit to the strategy; consider if new authorities are needed to sustain or scale change	As leaders, use stakeholder process to educate and engage your constituency and members	Consider which authorities you have or may need to drive investment in new care delivery models, to oversee process	Advocate for your interests in context of solving state challenges, meeting other stakeholder needs and interests
Leverage multi-stakeholder organizations as they mature to maintain momentum, expand role(s)	Mobilize ongoing support for resources for data, analytics, and evaluation	Create formal multi-stakeholder group(s) to advise, build “buy in”, provide support to act	More diverse stakeholders engaged in primary care model design may lead to broader “buy in” for investment
Enlist business, education, community leaders in oversight, accountability processes	Communicate to legislature on progress, barriers	Embrace transparency in data, stakeholder process to build trust, accountability	Embrace open and transparent deliberative process; invite public participation

## ACKNOWLEDGMENTS



This brief was made possible with support from the Milbank Memorial Fund (MMF). The PCC is grateful to the MMF for its commitment to building the evidence base for primary care investment and related health-system reforms and to collaborating with states and stakeholders to implement and evaluate promising payment and care-delivery strategies.

The PCC appreciates the state leaders who took the time to speak with us about their state's primary care investment strategy and the role of stakeholder advisory groups in the process.

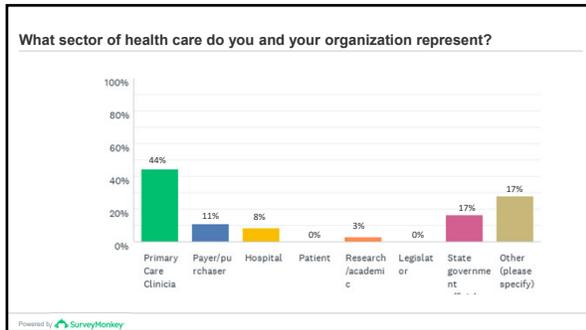
We also thank all of the respondents to the survey of participants in primary care stakeholder advisory groups. We hope this effort to collect their experiences and perspectives will be of value to stakeholders and to states in their efforts to increase primary care investment.

## LIST OF INTERVIEWEES

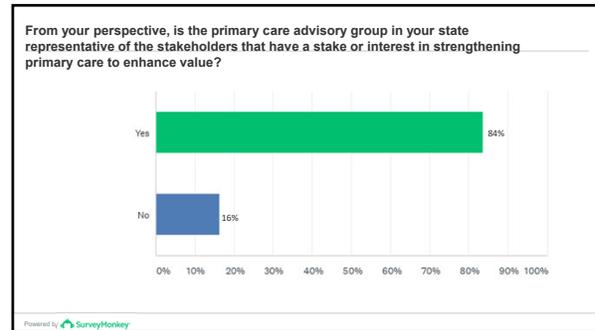
- Cory King, Director of Policy at Rhode Island Office of the Health Insurance Commissioner
- Christina McLaughlin, Health Policy Analyst, Green Mountain Care Board
- Susan Barrett, Executive Director, Green Mountain Care Board
- Michele Degree, Health Policy Advisor, Green Mountain Care Board
- Lisa Letourneau, MD, Senior Adviser for Delivery Systems Change, Maine Department of Health and Human Services
- Nancy Fan, MD, Chair, Delaware Health Care Commission
- Victoria Veltri, Director of Connecticut Office of Health Strategy
- Ryan Biehle, Executive Vice President and CEO, Colorado Academy of Family Physicians
- Stephanie Gold, MD, Vice President, Colorado Academy of Family Physicians
- Louise Kaplan, Associate Professor at Washington State University College of Nursing
- Tekisha Everette, Executive Director, Health Equity Solutions (Connecticut)
- Summer Boslaugh, Transformation Analyst, Oregon Health Authority
- Rachel Quinn, Special Assistant for Health Policy and Programs at Washington State Health Care Authority
- Judy Zerzan, MD, Chief Medical Officer at Washington State Health Care Authority
- Emily Transue, MD, Associate Medical Director for Clinical Quality and Care Transformation, Washington State Health Care Authority

## State Laws and Spending Reports

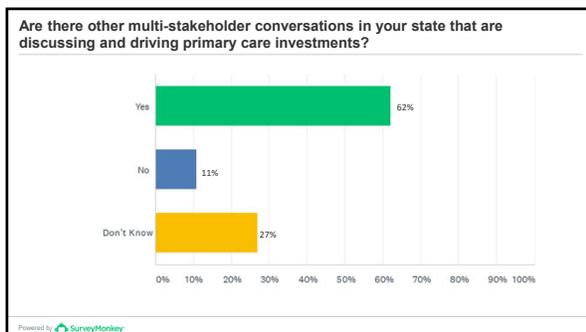
	Executive Orders	Legislation	Spending Reports	Collaborative reports
<b>Maine</b>	N/A	Legislation to measure primary care spending	Spending report	N/A
<b>Delaware</b>	N/A	Legislation to amend primary care collaborative	Preliminary cost benchmark (with primary care spending)	Primary care collaborative report
<b>Rhode Island</b>	N/A	Legislation to measure primary care spending	Rhode Island primary care spending report	Care Transformation Collaborative annual report
<b>Oregon</b>	N/A	Legislation to measure primary care spending	Primary care spending report	Primary Care Transformation Initiative
<b>Washington</b>	N/A	Legislation to measure primary care spending	Primary care spending report	Multi-payer Primary Care Transformation Model
<b>Colorado</b>	N/A	Legislation to measure primary care spending	Primary care spending report	Collaborative report (includes spending report)
<b>Connecticut</b>	Executive Order Cost Benchmark with Primary Care Target	N/A	Description of CT cost benchmark process, with primary care target	N/A
<b>Vermont</b>	N/A	Legislation to measure primary care	Primary care spending report	Charter of Primary Care Advisory Group
<b>West Virginia</b>	N/A	Legislation to measure primary care spending in Medicaid	N/A	N/A
<b>Pennsylvania</b>	Executive Order Cost Benchmark with Primary Care Target	Proposed: to establish Health Value Commission	N/A	N/A



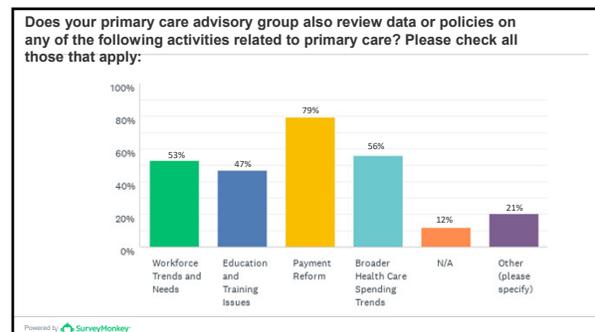
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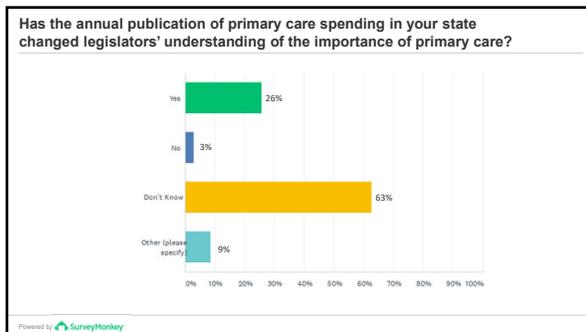
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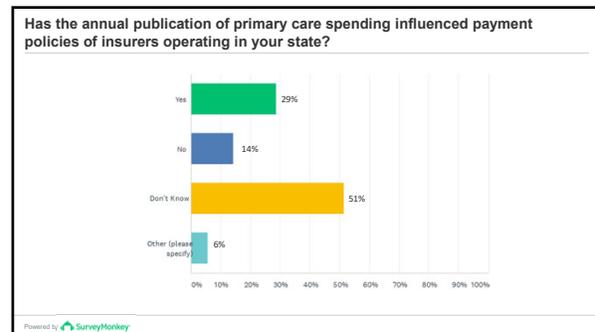
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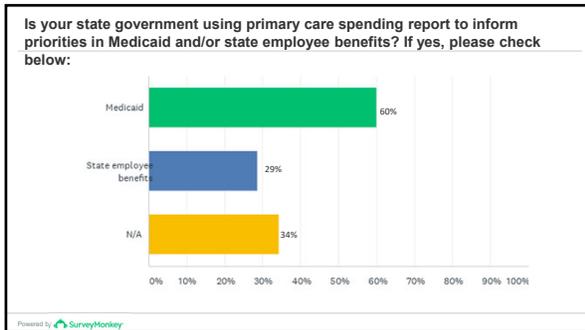
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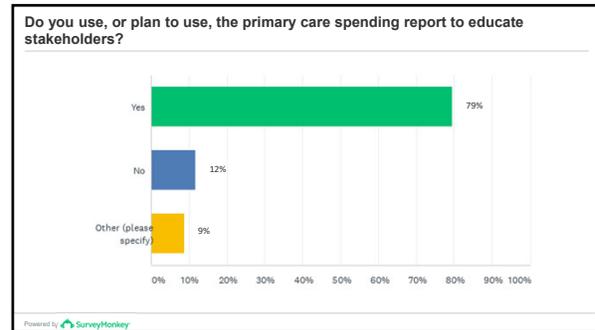
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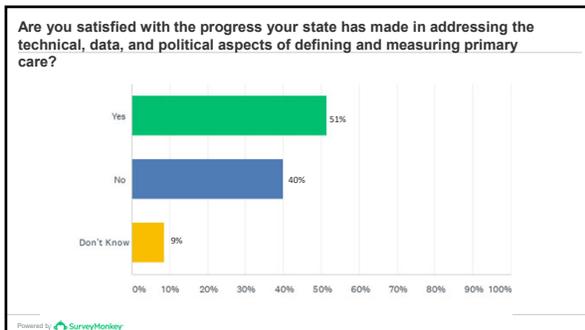
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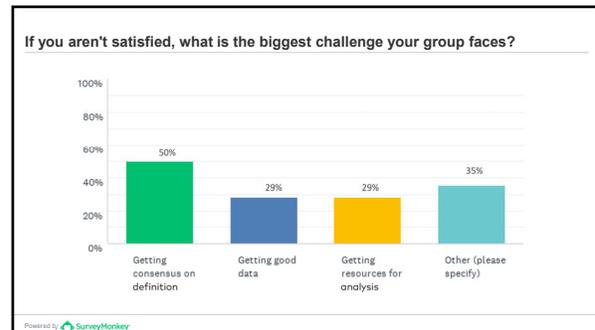
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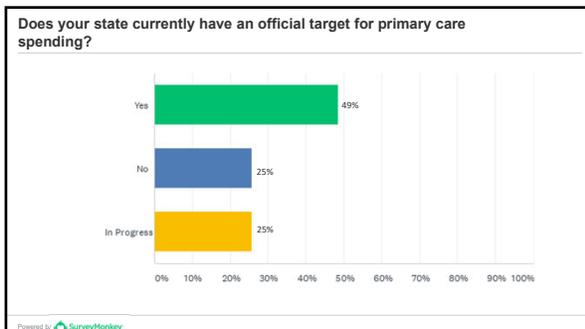
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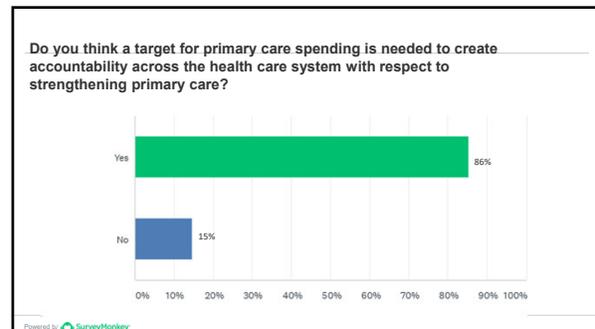
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