



primary care  
collaborative

February 13, 2023

Meena Seshamani  
Director, Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Woodlawn, MD 21244

**Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications  
CMS-4201-P**

Dear Deputy Administrator Seshamani:

On behalf of the Primary Care Collaborative (PCC), we appreciate the opportunity to offer comment on this proposed rule.

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 67 organizational [Executive Members](#) ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and “upstream” drivers for a better patient experience and better health outcomes (See the [Shared Principles of Primary Care](#)).

Primary care is the one component of the health care system where increased supply is consistently associated with improved population health, lower costs and more equitable outcomes, as highlighted in the 2021 National Academies of Science, Engineering and Medicine report, *Implementing High-Quality Primary Care*. Unfortunately, the U.S. devotes just 5%-7% of health care spending to primary care.<sup>1</sup> This underinvestment persists despite the growth in prevalence and related costs of preventable and manageable chronic diseases, exacting a disproportionate burden on marginalized communities.

Medicare Advantage is positioned to drive better health outcomes because it can align incentives across health plans, clinicians and providers, and beneficiaries. Medicare Advantage plans have flexibilities not available in traditional Medicare, along with certain accountabilities. PCC greatly appreciates CMS' work in this proposed rule to improve health equity, assure access to behavioral health and primary care, and further streamline prior authorization processes. The PCC will focus our comments on a subset of the proposals that we think have the most influence over the ability of beneficiaries

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<sup>1</sup> Kempfski A, Greiner A. Primary Care Spending: High Stakes, Low Investment. Primary Care Collaborative (PCC). December 2020. [https://www.pcpcc.org/sites/default/files/resources/PCC\\_Primary\\_Care\\_Spending\\_2020.pdf](https://www.pcpcc.org/sites/default/files/resources/PCC_Primary_Care_Spending_2020.pdf)

across all types of communities enrolled in MA plans to receive high-quality primary care.

## **Overall Comments**

In 2022, the PCC submitted detailed [comments](#) in response to the CMS RFI on Medicare Advantage (CMS-4203-NC).<sup>2</sup> In those comments, we called on CMS to measure the proportion of spending for primary care relative to overall spending. **We reiterate our request that CMS begin collecting data from MAOs on primary care spending (in both fee-for-service and alternative payment models) and the amount and share of total Part C spending in alternative payment models, using the definitions from the Health Care Learning and Action Network.** This is a critically important first step toward ensuring the needed resources flow through to primary care practices and the beneficiaries they serve. Particularly for those communities grappling health disparities, these resources are urgently needed.

MedPAC recently [estimated](#) that 49% of eligible Medicare beneficiaries were enrolled in Medicare Advantage (MA) in 2022.<sup>3</sup> In 2023, almost all beneficiaries have access to a MA plan, and almost all beneficiaries have access to a \$0 premium MD plan with Part D. The average number of plan choices beneficiaries have has doubled from 20 in 2018 to 41 in 2023, yet the 7 largest MA organizations cover 84% of MA enrollees, according to the Kaiser Family Foundation.<sup>4,5</sup> Given the diversity of MA plans, we acknowledge that technical or operational challenges in the short term may warrant phasing in new requirements for MA plan sponsor organizations.

As enrollment in Medicare Advantage has grown, there has been substantial investment in primary care practice models specializing in serving MA enrollees. Primary care entrepreneurs find the MA program attractive due to innovative and flexible payment arrangements that are less constrained by the fee-based reimbursement prevalent in traditional Medicare and other payers. We cited peer-reviewed literature in our 2022 comment letter suggesting MA enrollees are more likely than beneficiaries in traditional Medicare to have a usual source of primary care, receive preventive services, and have fewer avoidable hospitalizations and readmissions. However, despite many public announcements from MA plans about value-based payment arrangements supporting medical group-MA collaborations, CMS does not collect and release data that would support greater stakeholder understanding of and evaluation of these arrangements. Many of them appear to support robust primary care services and teams that are difficult to finance and not incentivized in traditional Medicare. **Enhanced reporting and**

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<sup>2</sup> McNeely L. Re: Request for Information on Medicare (CMS-4203-NC). Primary Care Collaborative (PCC). August 2022.

[https://www.pcc.org/sites/default/files/news\\_files/MA\\_RFIResponse\\_FINAL.pdf](https://www.pcc.org/sites/default/files/news_files/MA_RFIResponse_FINAL.pdf)

<sup>3</sup> Serna L, Johnson A. The Medicare Advantage Program: Status Report. MedPAC. January 2023. <https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf>

<sup>4</sup> Serna L, Johnson A. The Medicare Advantage Program: Status Report. MedPAC. January 2023. <https://www.medpac.gov/wp-content/uploads/2023/01/MedPAC-MA-status-report-Jan-2023.pdf>

<sup>5</sup> Freed M, et al. Medicare Advantage in 2022: Enrollment Update and Key Trends. Kaiser Family Foundation. August 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

**transparency in how primary care is paid is needed to provide further insight into the prevalence and efficacy of such arrangements.**

These growing MA-focused primary care practice models are diverse, with MA plan sponsors taking ownership stakes in some primary care entities, partnering closely through contractual relationships, and even acquiring practices and employing primary care clinicians directly. Congress and CMS have significant influence over how and where this investment is deployed and sustained to improve care quality, beneficiary experience, and health outcomes across all communities by how they structure the terms of participation, competition, and oversight for Medicare Advantage Organizations (MAOs). The PCC urges CMS to use its authority to foster competition around high quality, transparency, beneficiary experience and outcomes, closing health disparities and promoting health equity, and meaningful beneficiary choice of plans to meet their needs – while simultaneously using its authority to strengthen primary care as a key foundation to realizing these goals.

## **Comments on CMS’ Specific Proposals**

### **Medicare Advantage Part C and Part D Quality Rating System**

#### CMS Proposal:

CMS proposes the addition of a health equity index (HEI) reward for 2027 to incentivize Part C & D plans to improve care for enrollees with social risk factors (SRF); to remove the current reward factor; reduce weight of patient experience, complaints and access measures to further align efforts with other CMS quality programs and “better balance” the contribution of different types of measures in the Star Ratings (SR); CMS also proposes changes to other quality measures and how the Star Ratings are constructed and calculated.

#### PCC Comments

##### Design of the Health Equity Index

The “star rating” quality bonus program (SR) in Medicare Advantage generates at least \$10 billion annually for MA plans, according to the Kaiser Family Foundation.<sup>6</sup> **The PCC applauds CMS for proposing a Health Equity Index (HEI) to incentivize MA and Part D plans to improve care for their enrollees with social risk factors.** As CMS moves forward with this proposal, it should also ensure that plans’ enrollment of patients with high social risk is not disincentivized.

As we highlighted in our 2022 [comments](#) in response to the CMS Medicare Advantage RFI (CMS-4203-NC), Medicare Advantage can facilitate primary care investment and innovation by aligning incentives, rewarding quality outcomes, and supporting beneficiary choice.<sup>7</sup> We concur with the goal of rewarding “high relative performance among enrollees with the SRFs included in the HEI compared to other contracts to

<sup>6</sup> Biniek J, et al. Spending on Medicare Advantage Quality Bonus Program Payment Reached \$10 Billion in 2022. Kaiser Family Foundation. August 2022. <https://www.kff.org/medicare/issue-brief/spending-on-medicare-advantage-quality-bonus-program-payment-reached-10-billion-in-2022/>

<sup>7</sup> McNeely L. Re: Request for Information on Medicare (CMS-4203-NC). Primary Care Collaborative (PCC). August 2022. [https://www.pcc.org/sites/default/files/news\\_files/MA\\_RFIResponse\\_FINAL.pdf](https://www.pcc.org/sites/default/files/news_files/MA_RFIResponse_FINAL.pdf)

incentivize high performance for enrollees with the SRFs included in the HEI.” The proposed HEI would summarize MA contract performance in relation to enrollees with certain SRFs across multiple existing Star Ratings measures into a single score using data from the most recent two measurement years.

**We applaud CMS for recently releasing stratified results for Star Ratings measures to support MA plans in their efforts to address disparities for enrollees with social risk factors.** The recently released data can support improvement efforts in advance of the proposed 2027 HEI implementation date. If made available to researchers, such data can also help deepen understandings around the factors influencing disparities, how to define beneficiaries with social risk factors, and actions that may ameliorate the impact SRF have on health outcomes and care experience. The PCC agrees that the role of social risk factors and how to account for them in health care payments, programs, and care models must be carefully studied and tested if CMS is to maximize improvements in health equity through greater investment, innovation, and community and beneficiary engagement.

For now, however, we appreciate the Agency’s description of their review of evidence related to incorporating a composite measure of social risk factors (in addition to quality measures) within the HEI and the MA Star Ratings. **Given the information available, at this time, the PCC supports the proposed subpopulations that would be included in the HEI, receipt of the Low-Income Subsidy or being Dually Eligible for Medicare and Medicaid (LIS/DE) or being enrolled in Medicare because of a disability.** Dual-eligible beneficiaries, for example, are more likely to have multiple chronic conditions--including mental illness-- than Medicare-only beneficiaries, and more likely to be frail and have limitations that affect their ability to carry out activities of daily living. Over 4 million LIS/DE beneficiaries were enrolled in Dual-Eligible Medicare Advantage Special Needs Plans (SNPs) in 2022, and almost 2 million dually-eligible beneficiaries were enrolled in non-SNP MA plans in 2020.<sup>8</sup> The proposed HEI should accurately capture the relative plan performance of care for these beneficiaries across both types of MA plans.

**We support the goal of minimizing administrative burden and the initial decision to use existing measures and measure weights already included in Star Ratings.** The CMS Office of Minority Health published research suggesting that there are a group of clinical measures where LIS/DE beneficiaries were more likely to experience disparities than non-LIS/DE beneficiaries.<sup>9</sup> Disparities in some of these measures arguably have a higher impact on patient safety and outcomes than others and may warrant greater emphasis in a HEI over time. The HEI as proposed should be difficult to “game” because it will be calculated by CMS and will use an independent source of data to identify LIS/DE and disabled Medicare beneficiaries.

#### Structure of the reward

In general, the PCC expects that more investment in robust primary care models will be made in underserved communities with high numbers of beneficiaries experiencing social risk factors if the HEI is structured to reward investment in these communities. A

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<sup>8</sup> Freed M, et al. Medicare Advantage in 2022: Enrollment Update and Key Trends. Kaiser Family Foundation. August 2022. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

<sup>9</sup> Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy. Centers for Medicare and Medicaid Services (CMS). September 2021. <https://www.cms.gov/files/document/2021-delis-national-disparities-stratified-report.pdf>

tiered structure, as proposed, has strengths and some shortcomings. A tiered structure that rewards high performance among contracts serving a higher-than-industry-median share of LIS/DE and disabled beneficiaries will incentivize plans to dedicate more resources in communities with *high shares* of these disadvantaged beneficiaries. However, the tiered structure as proposed does not reward those contracts that may serve *large absolute numbers* of LIS/DE and disabled beneficiaries, perform well relative to industry averages, but fail to meet the industry median threshold share of such beneficiaries enrolled under their contract. CMS should consider modifying the reward structure to allow such contracts to be eligible for a reward. We also encourage CMS to work with all stakeholders to adopt a Health Equity Index that rewards both performance improvement and high performance relative to industry averages.

### **Strengthening Translation and Accessible Format Requirements for MA, Part D, D-SNP Enrollee Marketing and Communications Materials**

#### CMS Proposal

CMS proposes that MA, D-SNP, Cost, and Part D sponsors must provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5% of individuals in the plan benefit package service area or accessible from using auxiliary aids and services, extend the requirement to individualized plans of care for SNPs; also requiring that FI-SNPs, HIDE SNPs, and AIPs as defined at 422.561 translate required materials into any language required by the Medicare translation standard at 422.2267 plus any additional languages required by Medicaid translation standard as specified in contracts.

#### PCC Comments

**The PCC supports the proposal to strengthen translation and accessible format requirements for all MA plan types.**

### **Health Equity in Medicare Advantage**

#### CMS Proposal

CMS proposes to further clarify the broad application of policy to provide services in a culturally competent manner and amend the list of populations to include people: 1) w/LEP or reading skills 2) of ethnic, cultural, racial, or religious minorities; 3) w/disabilities 4) who identify as LGBTQ or were born intersex 6) who live in rural areas, others w/high deprivation and 7) otherwise adversely affected by persistent poverty or inequality; CMS proposes to codify best practices for provider directories; require MAOs to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits; use MA QI programs as “optimal vehicle to develop and implement strategies and policies designed to reduce disparities in health and health care, and advance equity in health and health care” especially for underserved populations. CMS proposals that MAOs incorporate one or more activities into their overall QI program that reduce disparities.

#### PCC Comment:

**The PCC supports the broad definition of equity CMS is applying to the policies and data driven approaches necessary to identify health disparities across groups of beneficiaries. We recommend that MA plan sponsors develop targeted best practices for digital health education in partnership with community leaders from diverse communities.** We agree that quality improvement programs are an “optimal vehicle to develop and implement

strategies and policies designed to reduce disparities in health and health care, and advance equity in health and health care.” It is important that economic incentives in MA reward reductions in health disparities and align the interests of MA plans and the delivery system, particularly primary care. The Star Ratings bonuses provide economic incentives. Public recognition and display of Star Rating and the measures that comprise the ratings can reinforce the importance of closing disparities in care and outcomes.

### **Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools**

#### CMS Proposal

Prior authorization (PA) for coordinated care plans may only be used to confirm the presence of diagnoses or the medical criteria and/or ensure that an item or service is medically necessary based on standards specified in this rule. Second, CMS proposes that any approval granted through PA be valid for duration of an approved course of treatment, and plans provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to new MA plan. Third, CMS proposes that MA plans must comply with national coverage determinations (NCDs) local coverage determinations (LCDs), and general coverage and benefit conditions included in traditional Medicare (TM) statutes and regulations as interpreted by CMS. Further, CMS proposes that MA plans cannot deny coverage of a Medicare covered item or service based on internal, proprietary, or external clinical criteria not found in TM coverage policies. When there is no applicable coverage criteria in the TM statute, regulation, NCD, or LCD, MAOs may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers. Finally, to ensure PA is used appropriately, we propose to require all MA plans to establish a UM Committee to review all UM policies and ensure consistency with TM.

#### PCC Comment

Although prior authorization can be used selectively as a tool to avoid delivery of inappropriate or low-value care, prior authorization requests from providers or practices (on behalf of patients) to health plans impose costs on clinicians in the form of time taken from direct care, potential delays in care that may result in suboptimal care, and added out-of-pocket costs for patients. While many MA plans and primary care practices are working closely together to improve care, care outcomes, and the care experience, costly points of friction remain. Prior authorization is one such point of friction.

Nonetheless, CMS proposals to bring more consistency in coverage decisions between MA plans and traditional Medicare coverage decisions are reasonable, requiring MAOs to rely on relevant and up-to-date clinical expertise in utilization management, and providing greater transparency to prescribers, orders, and patients are also reasonable. MA plan sponsors will still be able to require prior authorization and other utilization management policies. CMS encourages MA plan sponsors to “gold card” by limiting PA requirements for contracted providers and primary care practices that have a track record of compliance with plan policies and procedures. **PCC agrees that such “gold card” programs may have potential to “facilitate more efficient and timely delivery of health care services to enrollees.”** However, such programs must be thoughtfully designed and implemented. CMS should ensure gold card programs include primary care clinicians who provide a broad scope of services and are designed to limit

administrative burden associated with compliance. Additionally, to ensure whole-person care is available to beneficiaries and support the goal of mental health parity, CMS should ensure the mental and behavioral health clinicians have a full and fair opportunity to participate in gold card programs.

### Continuity of Care

CMS proposes to protect enrollees new to a MA plan who are in an active course of treatment from prior authorization for that treatment for a period of at least 90 days, even if the treatment is provided by out-of-network organizations. **The PCC recognizes the special vulnerability of beneficiaries undergoing a specific course of treatment at the time of plan switch. PA should not be required for beneficiaries in this situation.**

### Role and Composition of UM Committee

A Utilization Management committee within a MAO is an important internal entity for promoting adoption of evidence-based rationales for orders that require prior authorization, and CMS expects it to operate like a Pharmacy & Therapeutics committee. After establishing or modifying an existing UM committee to comply with the proposed composition, all existing and new prior authorization requirements must be reviewed by the UM committee beginning on or after January 1, 2024, and then at least annually after that. **The PCC supports these review requirements because evidence is continually updated and the rationale for the original PA requirement may be superseded by new evidence.**

The PCC recommends that MA plan sponsors look to clinical leaders drawn from primary care professional organizations, ACOs and other high-performing integrated groups and networks to serve on UM committees. Sponsors should consider addressing PA policies in value-based contract terms to improve alignment and minimize waste and administrative burden. Evidence-based practice protocols developed or endorsed at the specialty, practice and ACO or other group level can assure MA plan sponsors that policies are already in place and likely to be followed because they have been developed by clinicians with the appropriate expertise and in consultation with peers.

## **Behavioral Health in Medicare Advantage**

### CMS Proposal

In the 2023 proposed rule, CMS solicited comments regarding challenges in building MA behavioral health networks and opportunities for improving access to services. To strengthen network adequacy requirements and reaffirm MAOs responsibilities to provide BH services, CMS proposes to 1) add Clinical Psychologists, LCSWs, and Prescribers of Medication for Opioid Use Disorder (MOUD) as specialty types that will be evaluated as part of the network adequacy reviews under 422.116, and make these new specialty types eligible for the 10% point telehealth credit as allowed under 422.116(d)(5) 2); amend general access to services standards at 422.112 to include explicitly BH services; 3) codify, from existing guidance on reasonable wait times that apply to both PC and BH services; 4) clarify that some BH services may qualify as emergency services and must not be subject to PA; and 5) extend current requirements for MAOs to establish programs to coordinate covered services with community and social services to BH services programs to close equity gaps in treatment between primary health and behavioral health.

Network Adequacy: Addition of Clinical Psychologists, LCSWs and MOUDs

The PCC recognizes the shortage of behavioral health professionals and challenges in building behavioral health networks. **We support the addition of qualified specialty types to behavioral health networks, including Clinical Psychologists and Licensed Social Workers.** In addition, Clinical Pharmacists are increasingly being deployed as part of robust primary care and behavioral health teams. **PCC should consider addition of Clinical Pharmacists as well.**

We ask that CMS clarify whether and how the removal of the x-waiver requirement by Section 1262 of the CAA of 2022 affects its proposal to similarly recognize prescribers of opioid use disorder medications.

We again note that MA plans are not limited to the rates established in the Physician Fee Schedule for behavioral health professionals and should consider alternative payment contracts that support behavioral health integration in the primary care setting, in order to enhance access and care coordination.

The PCC believes the introduction of the Health Equity Index, which would stratify quality measures for LIS/DE beneficiaries and those enrolled in Medicare based on a disability, will incentivize MA plans to develop complex care models and relationships with practices that regularly treat beneficiaries with ‘dual diagnoses’ of physical and behavioral conditions. Special Needs Plans are especially well-positioned to address the complex needs of the beneficiary groups included in the HEI.

Network adequacy wait times standards

PCC is encouraged that CMS is considering steps to assure access to both primary care and behavioral health services in Medicare. Establishing and enforcing network adequacy standards is difficult, and quantifiable and measurable standards are preferred. Time and distance, aggregate ratios of clinicians to enrollees, and appointment wait time standards are all used in different programs and markets, and each has its own limitations. Namely, they are point-in-time measures only, and they do not capture in-network practices and clinicians no longer accepting new patients, for example.

One important way health plans can incentivize shorter wait times is to enter alternative payment model (APM) or value-based arrangements with primary care and behavioral health practices. Primary care practices participating in APMs can receive the added support, resources and the financial incentive needed to provide after-hours access, telephone and telehealth appointments, and advanced population health outreach. They are better able to deploy the multi-disciplinary teams that minimize the need for separate specialty and lab visits for beneficiaries with chronic conditions. These capabilities can be found among innovative advanced primary care, ACO, and ACO-like entities participating in MA today. With a strong population health focus, these organizations often provide shorter appointment wait times, enhance access and promote care coordination but they are largely unrecognized in traditional network adequacy quantitative standards. (A small credit for telehealth capabilities does exist). While the PCC does not object to proposed wait time standards applied to both primary care and behavioral health network providers, **we request that CMS articulate how the proposed wait time standards incentivize plans to contract with, invest in, and support such care models. We recommend that CMS conduct a monitoring strategy, including a role for CAHPS access measures, to evaluate the impact of the proposed wait time standards on**



**primary care and behavioral health wait times and the composition of MA networks.**

**Expanding Eligibility for Low-Income Subsidies (LIS) Under Part D of Medicare Program**

CMS Proposal

Section 11404 of Inflation Reduction Act mandate an expansion of eligibility for full LIS to individuals with incomes up to 150% FPL beginning on or after 1/1/24. In addition, the change will provide the full LIS subsidy for those who currently qualify for partial LIS subsidy.

PCC Comment

PCC is pleased to see CMS moving forward to implement Section 11404's expansion of eligibility for the full LIS. This important provision of the rule will address the cost barriers that can prevent patients from following the optimal course of treatment recommended by their primary care team.

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PCC looks forward to working with the CMS team to strengthen primary care in Medicare Advantage and across CMS' programs. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at [lmcneely@thepcc.org](mailto:lmcneely@thepcc.org).

Sincerely,



Ann Greiner  
President & CEO  
Primary Care Collaborative

## **PCC Executive Members**

Below is a list of the Primary Care Collaborative's executive members that pay dues to the organization and support its mission. Membership does not indicate explicit endorsement of this letter.

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AARP

Accreditation Association for Ambulatory Health Care, Inc.

Allways Health Partners

Alzheimer's Association

America's Agenda

American Academy of Child & Adolescent Psychiatry

American Academy of Family Physicians

American Academy of Pediatrics

American Academy of Physician Associates (AAPA)

American Association of Nurse Practitioners

American Board of Family Medicine Foundation (ABFM Foundation)

American Board of Internal Medicine Foundation (ABIM Foundation)

American College of Clinical Pharmacy

American College of Lifestyle Medicine

American College of Osteopathic Family Physicians

American College of Osteopathic Internists

American College of Physicians

American Psychiatric Association Foundation

American Psychological Association

Amerihealth Caritas

Array Behavioral Care

Ascension Medical Group

Black Women's Health Imperative (BWHI)

Blue Cross Blue Shield Association

Blue Cross Blue Shield of Michigan

Brigham and Women's Hospital Primary Care Center of Excellence

CareFirst, BlueCross BlueShield

Catalyst Health Network

Community Care of North Carolina

Converging Health

CVS Health

Elation Health

Elevance Health (Formerly Anthem)

Families USA

GTMRx Institute

Harvard Medical School Center for Primary Care

HealthTeamWorks

IBM

Innovaccer

Institute for Patient- and Family-Centered Care

Johns Hopkins Community Physicians, Inc.

Johnson & Johnson

Mathematica Policy Research

MedNetOne Health Solutions

Mental Health America



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Merck  
MGH Stoeckle Center for Primary Care Innovation  
Morehouse School of Medicine - National Center for Primary Care  
National Alliance of Healthcare Purchaser Coalitions  
National Association of ACOs  
National Committee for Quality Assurance (NCQA)  
National Interprofessional Initiative on Oral Health (NIIOH)  
National PACE Association  
National Partnership for Women & Families  
National Rural Health Association  
Oak Street Health  
PCC Pediatric EHR Solutions  
Pediatric Innovation Center  
Penn Center for Community Health Workers  
Primary Care Development Corporation (PCDC)  
Purchaser Business Group on Health (formerly Pacific Business Group on Health)  
Society of General Internal Medicine  
Society of Teachers of Family Medicine  
St. Louis Area Business Health Coalition  
Takeda Pharmaceuticals  
UPMC Health Plan  
Upstream USA  
URAC  
VillageMD