operations, evaluation, and meaningful community engagement. Health systems, particularly in an era of shrinking margins, may balk at infrastructure investments for an anchor strategy. Although the Affordable Care Act mandated completion of CHNAs and Community Health Improvement Plans (CHIPs), hospitals were not provided additional resources to invest in innovative public health initiatives. We believe that just as the Health Information Technology for Economic and Clinical Health (HITECH) Act provided financial incentives for adoption of electronic health records, federal legislation is needed that offsets the costs of adoption of meaningful anchor strategies.

An audio interview with Dr. Ansell is available at NEJM.org

Other critical questions center on how best to monitor outcomes. At Rush, and for many other HAN members, CHNAs and CHIPs provide a roadmap for evaluating the success of the anchor strategy. HAN has developed a dashboard of health and socioeconomic metrics that form the basis of ongoing performance measurement. Similarly, WSU monitors progress using a public-facing dashboard that tracks outcomes across four domains: health and health care, economic vitality, educational attainment, and neighborhood built environment. Metrics include local hiring and career pathways, purchasing, investing, public health, and community wealth building. But anchor strategies may take years to measurably improve population health, particularly after the declines in life expectancy seen during the Covid-19 pandemic. Methods such as social-return-on-investment analyses have shown promise for capturing the broader social, environmental, and economic benefits of anchor investments.[5] Federal and philanthropic grant funding is necessary to support evaluations of existing anchor initiatives to distinguish which ones have the highest social return on investment.

Despite these challenges, an anchor strategy can be an effective health care institution approach to address place-based, racial, economic, and other structural inequities that drive population health and wealth.[4]

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Corporate Investors in Primary Care — Profits, Progress, and Pitfalls

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On July 21, 2022, Amazon announced plans to acquire One Medical — a primary care practice with nearly 200 locations serving more than 700,000 patients — for $3.9 billion. The deal, if approved, would represent Amazon's largest payment for a health care company to date. On September 5, 2022, CVS Health confirmed its acquisition of Signify Health, which offers in-home and traditional primary care, for around $8 billion.

These deals reflect a broader trend in the United States toward corporate investment in primary care, driven by an increasing focus on "total-cost value-based care" — a model in which health care providers are paid to manage the total cost of care for their patients and the size of each patient's capitated budget may be increased on the basis of the patient's health risks and the provider's performance on quality metrics. Though potentially beneficial for certain well-insured patients, the trend of corporate investment in primary care could threaten equitable access to care, raise health care costs, and reduce physicians' clinical autonomy. Physicians, patients, and policymakers should understand what's

driving these investments, their potential benefits and risks, and possible policy levers for mitigating those risks.

An overarching revenue strategy underlies investors' appetite for primary care. As Medicare and commercial payers move toward total-cost value-based payments, such as capitation, and away from fee-for-service reimbursement, primary care practices may hold the key to increased profitability of health care under value-based payment systems.[1] Primary care practices can generate substantial profits by growing their population of patients covered by Medicare Advantage (and other lucrative payers), maximizing the "budget" for each patient's care using risk adjustment and quality bonuses, minimizing their health expenditures with utilization management, and referring patients to other product and service offerings, such as pharmacy. Primary care providers are health care's front door not just for patients, but also for investors who see those patients as a revenue stream. Primary care practices offer corporate investors access to these patients and their data, both for risk-coding advantages and as potential customers for other lines of service.

Corporate interest in primary care practices is not new — the introduction of managed care and capitated payments in the 1980s and 1990s spurred a boom (then bust) of physician practice management companies. But the pace of recent investment is noteworthy. Between 2010 and 2021, the total capital raised for private investment in primary care in the United States increased by a factor of more than 1000 — from $15 million to $16 billion.[2]

Corporate-owned primary care practices (CPCPs) can be grouped into three categories: retail-owned (e.g., Amazon, CVS, Walmart), insurance-owned (e.g., UnitedHealth Optum, Humana), and investor-backed (e.g., Agilon Health, Oak Street Health). Many CPCPs fit into more than one category; for example, Oak Street's initial investors included Humana and private equity companies, and since going public, it has established a partnership with Walmart. The organizational structures of CPCPs vary with the market segment or payment model they are targeting (e.g., Medicare Advantage, Medicare or commercial accountable care organizations [ACOs], or direct contracting under the new ACO Realizing Equity, Access, and Community Health [REACH] model), but they all benefit from increasing the risk-adjusted payments they receive by engaging in more intensive and strategic risk coding, and they have market incentives to do so. CPCPs may also have resources that facilitate intensive coding practices — including proprietary coding software, robust beneficiary data, and additional administrative staff — that are less available to independent primary care physicians.

Perhaps the biggest draw for investors is the growing Medicare Advantage market, which accounts for nearly half of Medicare spending. The program's risk-adjusted payments attract corporate investors to primary care practices serving Medicare Advantage patients, since such practices can aggressively code beneficiaries' diagnoses to draw higher payments.[3] Indeed, between 2006 and 2011, risk scores for Medicare Advantage beneficiaries were 6 to 16% higher — translating into approximately $650 more per beneficiary — than they would have been under traditional fee-for-service Medicare.[4]

Although One Medical is known for concierge-style practices for well-insured workers, it recently entered the Medicare Advantage market by acquiring senior-focused Iora Health, which made it an attractive investment target. Because Medicare Advantage contracts give CPCPs control of the entire capitated payment for each patient, about half of One Medical's 2021 net revenue came from its Medicare Advantage members, who made up only 5% of its patient population.[5]

CVS's acquisition of Signify Health also creates a strategic inroad into the Medicare Advantage market. CVS owns Aetna, one of the largest Medicare Advantage coverage providers. Signify's data analytics and care management technology for home health visits and health risk assessments could allow CVS to code more strategically and aggressively to boost reimbursement for the care of Aetna's Medicare Advantage beneficiaries. Similarly, Humana has partnered with private-equity firm Welsh, Carson, Anderson, and Stowe to purchase primary care clinics for its Medicare Advantage plans, a form of vertical integration between payer and provider that's associated with increased coding intensity — and profit.[3,4]

For patients and physicians, the proliferation of CPCPs could have certain benefits for primary care delivery. Patients, especially those enrolled in commercial insurance, Medicare Advantage, or a Medicare ACO, may have greater and more convenient access to newer models of primary care delivery than they would with a hospital-based or independent primary care service. For physicians, partnering with a CPCP provides access to capital for investing in information technology and supplemental services that could improve patient

care. Working for a CPCP could relieve physicians of the administrative burden of managing a practice, reduce the size of their patient panels, compensate them well, and provide better work–life amenities, such as flexible scheduling or reduced work hours.

The risks posed by corporate investors' land grab for primary care, however, should not be discounted. For patients, issues related to equity and access abound. Since most CPCPs focus primarily on lucrative Medicare Advantage and commercially insured beneficiaries, younger Medicaid or uninsured patients may be left behind. Underserved, low-income patients could have less access to essential primary care services if more physicians choose to work for CPCPs, which offer greater pay and benefits, rather than for safety-net or rural facilities. Furthermore, CPCPs' success depends on growth and consolidation, and massive integrated primary care networks can exert market power to raise prices and limit access. CPCPs may also pose privacy threats to patients if they cannot adequately silo protected health information from other segments of their business.

Clinicians face risks of burnout and moral distress if the CPCP pressures them to intensify coding to maximize risk scores and boost quality bonuses while reducing staffing levels and clinical autonomy. CPCPs may also use strict noncompete and nondisclosure agreements that limit physicians' ability to leave or speak out about these practices.

We believe that policymakers and regulators need to consider these risks for patients, practitioners, and health care costs and apply their available oversight tools vigorously.[3] Federal and state enforcers could expand antitrust scrutiny to these transactions to identify threats to competition. The Federal Trade Commission is reviewing the Amazon and CVS deals but could also evaluate smaller, incremental acquisitions of physician practices and transactions spanning multiple geographic and product markets. The Centers for Medicare and Medicaid Services could limit opportunities for gaming the risk-coding system that determines Medicare Advantage payments, to prevent excess public dollars from being spent on coding efforts rather than improvements in care. Federal and state fraud and abuse enforcers could increase their scrutiny of referral and coding practices used by CPCPs, whose duties to maximize profits for shareholders and investors may conflict with what's best for patient care. And states could strengthen their doctrines regarding the corporate practice of medicine and limit use of noncompete and nondisclosure agreements so as to preserve physicians' authority over clinical practices and administrative decisions affecting patient care.

Primary care has evolved from family doctors visiting patients by horse and buggy, to professional physician groups, to integration into larger health systems. Now, corporate investors are moving aggressively into this field, drawn by financial opportunities created by the shift to value-based care, with major ramifications for the decades ahead. It is critical that neither the historical creed of medicine nor patients' trust in primary care physicians be sacrificed along the way.

Disclosure forms provided by the authors are available at NEJM.org.

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A Rural Idyll

John A. Connolly, Ph.D.

Michael stepped out the door, feeling the dark morning air on his cheeks. He walked a few steps down the path made from old slabs. Forty years of his morning routine were worn into the limestone, and each morning he would look down and see the rivulet of time running into the