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COMMENTARY

Making Sense of New Approaches to Primary Care Delivery: A Typology of Innovations in Primary Care

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As concerns about the sustainability of the U.S. primary care system grow, an era of innovation is emerging in response to both the challenges and the opportunities in the field. Numerous new models of primary care financing and delivery are rapidly arising throughout the country, and some see this as a possible savior for primary care. But, in many ways, these changes could either fail to meet the hype around them, or in some cases even hasten the end of the independent primary care practices that once dominated the physician landscape. How do we evaluate these myriad developments and their implications from a policy, practice, and patient perspective? Given the lack of a systematic assessment of where these models differ and where they are the same, as well as their early results, here the authors develop a typology of new innovative primary care organizations — spanning comprehensive care providers, limited-service providers, and value-based care enablers — to provide a useful conceptual framework for classifying these emerging approaches along relevant dimensions and characteristics. The typology provides what might be considered modal types, but also recognizes the potential for substantial overlap among the different approaches, especially as innovative primary care organizations scale and diversify. The typology's goal is to define subgroups in which the constituent organizations have similar characteristics, and that this framework will allow for more meaningful comparison, evaluation, and discussion of the range of innovations occurring in the primary care sector today, both within archetypes and between them.

Many health care system stakeholders have voiced major concerns about the sustainability of the U.S. primary care system.[1,2] Even as primary care physicians (PCPs) and their teams are asked to assume ever greater responsibilities, payment rate increases have not kept pace with those in other specialties or with the increasing expenses required to run a modern primary care practice.[3] The PCP workforce is aging,[1] with many approaching retirement age, and the rate of medical school graduates entering primary care specialties is not high enough to meet the needs of an aging population.[4] For these and other reasons, recent data suggest that U.S. patients are accessing primary care less frequently, and the proportion of the population with an identified PCP is falling, particularly among younger and healthier populations.[5,6] Notably, only three-quarters of Medicare beneficiaries have a regular primary care physician, and the rate of primary care visits for those with a PCP has decreased over 20 years, while specialty visits have increased by 20%.[7] The median number of specialists that already-busy PCPs need to coordinate with just for their Medicare patients doubled over the past 2 decades to 95.[7]

Despite these trends, or potentially because of them, primary care delivery has become an area of intense focus and innovation as numerous models of primary care financing and delivery emerge throughout the country. Many see such new models as a potential savior for primary care, but it is notable that in many ways such models also might further challenge the viability of independent primary care practices that once dominated the physician landscape in the United States.[8] These new models take myriad sizes and shapes and have adopted a dizzying array of strategies, but to our knowledge there has been no systematic assessment of where these models differ and where they are the same, let alone how their outcomes differ.

To promote a common understanding among clinicians, researchers, administrators, policy makers, and other stakeholders in the health care system, in this paper, we develop a typology of new innovative primary care organizations in the United States to provide a useful conceptual framework for classifying these emerging models along the dimensions most relevant to policy makers and the broader health care system. This classification system also may add clarity and consistency to considerations of the merits and outcomes of each of these models, as well as their areas of potential application or extension, and will allow for comparison among like approaches. We, therefore, review and describe the landscape of emerging primary care models and analyze them from the perspective of their potential partners, patients, and regulators. We do not evaluate the outcomes or results of these models, nor judge their putative utility for various stakeholders across health care.

Conceptual Framework

There is a wide breadth of innovation in the primary care space that we capture in our typology (Figure 1).

FIGURE 1

A Typology of Innovations in Primary Care

This figure presents a classification system for primary care models, as well as care enablement mod
We offer a non-exhaustive list of representative firms and practices based on the authors' understanc
of the organizations' strategies at time of publication. Where no example is listed, the ellipses (...) indi
that none exists or is known to the authors.

Type of service	Scope of offering	Financial Model	Target Segments	Care Model Spectrum: Virtual-first / home-based	Care Model Spectrum: Traditional	Care Model Spectrum: Intensive	Innov Ty
Care Delivery	Comprehensive: segmenters	Capitation / risk contracts	High-need Medicare	...	...	Oak Street, ChenMed, Iora	Segm popul
			Medicaid / duals	...	...	Cityblock	
			Employer groups	Firefly, Amazon Care, NavigateNOW	Crossover	...	
	Comprehensive: fee-based	Enrollment + FFS	Employer groups and consumers	...	One Medical	...	Memb mo
			Consumers	...	Direct primary care, concierge care practices	...	
	Limited: urgent care	Enrollment + FFS	Employer groups and consumers	Teladoc, 98.6	CVS (MinuteClinic), PhysicianOne	...	Conv ca
	Limited: chronic care	Enrollment + risk	Employer groups	Livongo, Omada, Onduo	CVS Health Hub	...	Chronic fo
Care Enablement	Wraparound services	Capitation / risk contracts	Risk-bearing providers	Landmark, Accolade	...	...	Value care e
	Management partners	Fee + risk	Risk-bearing providers	Agilon, VillageMD, Aledade			
	Patient navigation	Enrollment + FFS	Employer groups	Grand Rounds, Quantum Health			

FFS = Fee for service

The organizations listed are representative of the type, not called out for any other special reason.

*Our typology provides what might be considered modal types, but also recognizes the potential for substantial overlap among the different approaches, especially as innovative primary care organizations scale and diversify.

Source: The authors' analysis

Importantly, though we begin with the holistic model of primary care characterized by the 4Cs of *first-contact care that is continuous, comprehensive, and coordinated*, the breadth of innovation in primary care extends beyond this relatively narrow conception of traditional primary care functions. We, therefore, include more focused innovations that either support the core primary care function or serve as targeted solutions for narrower aspects of care, population, and practice management. The goal of our typology is to define subgroups in which the constituent organizations have similar characteristics that allow for more meaningful discussion and comparison of the range of innovations occurring in the primary care sector today, both within

archetypes and between them. Below we describe the different types we identified that encompass the full spectrum of models currently being implemented.

We believe that innovative primary care delivery models in the United States can be distinguished by a number of characteristics. The first (under the Type of Service column in Figure 1) is whether they are*direct care providers* or provide*care enablement services* that can be practice-facing, like analytic and regulatory support, or patient-facing, like home-based care or navigation involving wraparound services including nonmedical elements such as social work or transportation that impact health and well-being.[9]

Second, (Scope of Offering column) for direct care delivery providers, it is important to distinguish organizations that provide *comprehensive* primary care services versus*focused* services for specific use cases. The former includes innovative organizations that provide enhanced services to specific population segments (Target Segments column), often under full-risk contracts as well as fee-based arrangements that supplement traditional fee-for-service (FFS) revenue to support provision of enhanced services (Financial Model column). Within*focused* providers (Scope of Offering column), there are those that provide*convenient* or*urgent care* services, usually for relatively minor or self-limited problems, and those that are focused on providing enhanced care for patients with specific*chronic medical conditions*. Across all types there is a spectrum of care delivery models ranging from*virtual-first* platforms to*intensive* models, though all these models often employ multiple methods to access care (Care Model column).

Challenges to Constructing a Typology

Though we believe it will be helpful to policy makers and others to have a useful, formal classification for these innovative models, a challenge to constructing one is that the various types we describe may overlap in some areas and are not necessarily fixed in time, role, or function. Thus, our typology provides what might be considered modal types, but also recognizes the potential for substantial overlap among the different approaches, especially as innovative primary care organizations scale and diversify. For example, risk-bearing contracts are becoming more common, particularly among those providing comprehensive primary care, but there also is potential for these types of contracts to be used across the entire spectrum that we consider. Similarly, focused delivery models are slowly expanding their scope of services and more traditional comprehensive primary care organizations are expanding their care models to incorporate virtual and asynchronous care, leading to some convergence in care models. Nonetheless, by focusing on the predominant strategies used by leading primary care organizations, our typology helps to distinguish organizations pursuing different strategies as well as distinct strategies adopted within a single organization.

Finally, our purpose is not to exhaustively identify and categorize all existing models and organizations that are either in development or already implemented. Instead, through review of the published and gray literature, reviews of company websites, press searches, discussions with select organizations, and focused interviews with leaders in the field, we identify representative organizations for each segment of our typology to provide concrete examples.

> *"By focusing on the predominant strategies used by leading primary care organizations, our typology helps to distinguish organizations pursuing different strategies as well as distinct strategies adopted within a single organization."*

Typology of Innovative Primary Care Models

Comprehensive Primary Care

We begin with innovative primary care models that seek to provide comprehensive primary care, usually to a defined population of patients enrolled or affiliated with the practice organization. A key aspect of these models is their financial model, which often involves some degree of prospective payment with risk-based contracting, but this is not a required component. The two major categories of comprehensive primary care models are what we term *segmented population models* (or*segmenters*) and*membership models*, which we elaborate on below.

Segmented Population Models

One group of primary care innovators that has received much attention offers comprehensive primary care services targeted to specific segments of the population. Though there is nothing in concept that limits these models to these specific population segments, we classify these models as *segmenters* because they generally have adopted features designed to meet the broad care needs and financial opportunities presented by some of the specific population segments that they target. In general, these organizations are designed around comprehensive primary care models using intensive primary care–based services that aim to deliver high-value care, typically in the context of a full-risk financial arrangement and prospective payment. These*segmenters* are targeting each of the three most common coverage segments within the U.S. health care system: commercial, Medicaid, and Medicare.[10]

Medicare-focused organizations such as (but not limited to) ChenMed, Iora (now part of One Medical), and Oak Street Health all target the elderly population enrolled in private Medicare Advantage (MA) health plans. Usually, these organizations partner with an insurance carrier in order to participate in MA, though some insurance carriers are also rolling out their own models (e.g., CenterWell by Humana, which is described as payer agnostic). Some entities also are expanding into the Medicare FFS population through accountable care organizations and direct contracting entities, which is transitioning to the ACO REACH (Realizing Equity, Access, and Community Health) model. These organizations are characterized by a focus on intensive primary care that include team-based care, enhanced access and support, and navigation and referral services. They frequently include important additional nonmedical services such as transportation to ensure that patients make it to their appointments. These organizations are supported by a robust and often novel technology infrastructure that undergirds their care model, but also provides enhanced capabilities for population health management regarding both quality and cost outcomes.

The financial model also is key to this segment. Medicare *segmenters* generally take on full risk under the MA program and stand to earn returns if they are able to provide high-value care within the confines of a capitated budget paid prospectively. Crucially, however, because MA payment rates currently are directly determined by diagnostic coding, these organizations also have invested heavily in tools and infrastructure to maximize the thoroughness of coding for their population to achieve the highest possible payment rates.

A prominent example of a *segmenter* serving the Medicaid population is Cityblock Health, which offers comprehensive care to the Medicaid population, as well as wraparound services in some markets that we distinguish elsewhere. Medicaid*segmenters* also have adopted a comprehensive approach similar to the Medicare*segmenters* above, but designed it to meet the specific needs of the Medicaid population, which generally is poor with a significant chronic disease burden.[11] Community health workers help serve as navigators for their population and offer a broad array of services in the home and virtually to meet their needs. Though Medicaid payment amounts are substantially lower than rates for Medicare, Medicaid*segmenters* also focus on capitated care for a defined population and coding is an important part of their strategy. Some are also starting to offer overlay services to help practices that serve significant populations of patients on Medicaid (as opposed to building new care delivery offerings de novo for Medicaid patients only).

Finally, a number of *segmenters* have emerged that target the often more affluent commercial population. Many of these commercial*segmenters*, such as Firefly Health, are virtual-first or offer an enhanced suite of virtual and asynchronous services in addition to traditional in-person care when needed. This combination of capabilities is designed to meet the needs of busy professionals and their employers who might prioritize convenience when obtaining care. These plans offer technology-enabled virtual solutions that also incorporate team-based care. Though some of these organizations take on full risk or even become health plans themselves, they also use cost savings and enhanced convenience for employees as selling points to self-insured employers and thus have the flexibility to use a variety of financial models. Some of these models have evolved from traditional, limited telemedicine companies now seeking to expand into comprehensive primary care, while others began by focusing solely on the comprehensive care strategy.

> *"To the extent that these models serve to bring more resources into primary care (both for team-based or intensive care delivery and to bolster PCP take-home pay), they also might serve to shore up a primary care system that is at risk of fiscal collapse from the Covid-19 pandemic."*

A final set of commercial *segmenters* is represented by innovative iterations of on-site employee health clinics. These clinics provide on-site convenient and/or comprehensive care that can be either virtual or in-person by entering into subscription-fee arrangements with employers (though not necessarily taking risk for the full cost of care).

Membership Models

In contrast to the *segmenters* described above that mainly receive (nearly) fully capitated payments with downside risk,*membership models* provide primary care physicians or teams with an additional, predictable, prospective revenue stream to supplement an underlying base of FFS payment. In return, they provide additional components of comprehensive care that are not necessarily reimbursable under current payment schemes, such as prolonged visits or access to 24-7 virtual or phone services. Even for models that do not continue to bill insurance, members generally retain insurance for services outside the scope of primary care including specialty, acute emergency department or hospital, and rehabilitative care, as well as diagnostics and lab procedures. Most*membership models* both charge enrollment fees and utilize FFS billing to existing insurers.

In *membership models* targeted toward employer groups, entities such as One Medical similarly charge a monthly or annual membership fee that finances enhanced primary care services. These enhancements might include upgraded clinic facilities, apps to enable 24-7 virtual care, improved access for acute issues, and enhanced opportunity for chronic condition self-management. Employers may provide membership as a benefit to their employees in addition to their standard health insurance in order to increase uptake of primary care services. Employers also may frame such memberships as a premium service to compete with other employers on benefits.

Consumer-oriented *membership models* fall into two categories. The first is targeted toward more affluent patients and involves membership fees that can range from relatively modest payments of several hundred dollars per year up to $25,000 per year (most commonly a few thousand dollars yearly) in return for access to a concierge physician who provides comprehensive care for a very small panel of patients, guarantees high levels of access 24-7 and unlimited lengthy visits, as well as care coordination and navigation with specialists. As noted above, One Medical has a similar team model that also is available to consumers, though the level of their membership fees is substantially lower than a typical concierge practice.

A second consumer-oriented model, known as *direct primary care*, involves primary care practices taking payment directly from consumers on a prospective monthly basis for comprehensive primary care services.[12] These primary care practices generally accept no insurance payments and can charge additional fees for providing services such as acute or preventive visits, but their fees tend to be much lower than those paid by traditional insurance. Patients generally still maintain wraparound insurance for non–primary care and lab/diagnostic services. The practices are able, therefore, to ensure a stream of predictable payment for their panel of patients and have relatively low overhead because most do not bill insurance. A second version of direct primary care is based more on an FFS model without prospective enrollment fees wherein the practice maintains its own fee schedule, which generally is much lower than typical insurance payments.

Focused Models

We next elaborate on focused, or limited, care models. In contrast to comprehensive primary care solutions, focused care models aim to provide one or more aspects of primary care in a siloed function that works alongside conventional primary care. Focused models generally target *urgent* or*convenient care* for relatively simple, urgent problems such as sore throats or sprains or specific chronic medical conditions like diabetes. In contrast to the comprehensive models noted above,

these models do not seek to provide 4C care that is first contact, comprehensive, coordinated, and continuous.

Convenient Care

Convenient care models focus on filling the gaps in access for patients who have urgent, often minor acute care needs. They fall into two main categories. First, brick-and-mortar offerings in traditional clinics (e.g., PhysicianOne) and nontraditional retail settings (e.g., CVS Minute Clinic) have become nearly ubiquitous around the country, and for many patients (especially younger, rural, and underinsured) are a main source of acute primary care. They are often staffed primarily by advanced practice providers, although some have physicians, and focus on acute, non–life threatening common ailments as well as common preventive care (e.g., vaccine administration) and selected simple procedures.

In the second category, virtual offerings connect Web-enabled patients to providers over virtual platforms to meet acute needs. Many traditional telemedicine firms (e.g., Teladoc) offer such services, as well as newer entrants like 98point6. These services can be covered by insurance or may be offered as a benefit by employers. In many instances, patients pay for these services out-of-pocket, though the prices generally are much lower than for accessing traditional brick-and-mortar primary care.

> *"If instead of resulting in more resources for primary care, these additional funds are siphoned off to investors or others who seek to profit from these care models, then these desired effects might not materialize."*

Chronic Disease Focused

A number of innovators have emerged that seek to offer care for a limited set of chronic medical conditions. Brick-and-mortar focused models include the recently launched CVS HealthHUBs, which are clinics designed to provide screening and monitoring services for important chronic medical conditions such as diabetes and hypertension, on top of a suite of existing preventive and urgent care services, including in collaboration with CVS Minute Clinics. These programs can range from complete management of such conditions to adjunctive screening and monitoring. This place-based *chronic disease–focused model* offers technology-enabled algorithmic care, usually from advanced practice providers working under the supervision of physicians. Part of the appeal is that these locations are convenient and do not require time-intensive or costly appointments. The reimbursement model for these options is still evolving but may vary from FFS to monthly capitated payments and risk-based payments linked to disease outcomes rather than total costs of care.

A second set of emerging virtual *chronic disease–focused models* focus on intensive management of chronic conditions, with an early emphasis from companies such as Onduo, Omada, and Livongo on offering intensive telehealth and online care and counseling services for conditions such as diabetes and hypertension. These organizations work with employers and health plans to offer

these enhanced services, usually on a subscription basis with upside potential related to either cost savings or achieving quality or outcome targets. Importantly, these programs serve as augmented complements to — rather than replacements for — primary care.

Care Enablement Models

As commercial and government payers increasingly demand greater value from their provider partners, a group of organizations has emerged to provide services that support more traditional primary care practices to enhance their capabilities in managing populations under risk-based contracts. These organizations do not offer most primary care services directly themselves, but rather enter into vendor relationships with physician practices and health plans to provide a range of back-end administrative services (e.g., care management analytics), front-end administrative services (e.g., care navigation) and, in some cases, limited supplemental clinical services such as home-based care or discharge planning.

Many *enablers* — especially those with more limited control over care delivery — rely solely on subscription pricing while others share risk on total cost of care with their customers. As payer demand for risk-based payments outpaces providers' and benefit managers' willingness to accept them, enablers also are moving up the value chain to directly own risk-based payer contracts and then convene downstream networks of physician practices willing to share in some of the risk.

Value-Based Care Enablers

One type of *value-based care enabler*, including such companies as Landmark, offer wraparound services that supplement traditional primary care offerings with specific patient care capabilities such as in-home care, remote monitoring, and telephonic support targeted to maximize the value of risk-based contracts. By bundling advanced analytics with some focused direct care delivery in a single offering,*wraparound enablers* are not totally reliant on their clinician partners to deliver value and can operate more independently within a health plan or ACO, though typically they partner with existing primary care teams. They may, therefore, be more willing to take on risk and to partner with a broader range of organizations.

The signature capability of wraparound *enablers* is routing toward, or providing, a lower-cost alternative to emergency and urgent care, typically through home visits and better benefits or specialty decisions.*Enablers* use these home visits to reduce the use of higher-cost sites of care, and also as a platform to deliver other high-value services or nudge patients toward them. An important additional area is risk coding, which combines advanced analytics to identify under-coded patients with actual care delivery to document diagnoses. They also may combine analytics and delivery to offer care management (prediction of high-risk patients plus interventions to manage them), address social determinants of health (prediction of vulnerability plus case work to address it), manage transitions of care (identification of patient admission plus post-discharge planning), and close quality metric gaps. Wraparound*enablers* may enable practices and smaller health plans to provide similar services as national carriers that can build or buy their own supplemental care capabilities by virtue of their scale.

> *"Private equity and other organizations that are purchasing primary care practices at a rapid pace may, at one level, be trying to build strong long-term organizations to manage and profit from risk contracts. They also might be quickly preparing to sell these practices to vertically integrating organizations looking for market share or predictable management of health care costs over time."*

A second type of value-based care enabler, including such entities as Agilon and Aledade, function as management partners. *Management partner enablers* offer many of the same analytics capabilities as*wraparound enablers*, but generally are not involved in the direct provision of care. This division of responsibilities allows providers to retain control over patient care delivery but can pose operational, technological, and contractual challenges to maximizing the value of risk-based contracts.

To deliver similar value as their wraparound competitors, management partners may adopt some strategies characteristic of enterprise software vendors like Epic or Salesforce: an upfront investment in software implementation and integration, a focus on provider experience and workflow optimization, and ongoing advisory support. They may also handle additional back-end functions such as negotiating with payers or meeting Centers for Medicare & Medicaid Services (CMS) requirements under the Medicare Shared Savings Program. These services often are offered on a subscription basis, though these organizations also can share risk with provider organizations. Some of these new management partners are backed by private equity, venture capital, or growth equity organizations, who are investing in primary care at an increasingly rapid pace.[13]

A final type, *patient navigation enablers* like Grand Rounds and Accolade, offer patient-facing services like wraparound providers but eschew direct patient care like management partners. These players, usually contracting with self-insured employers, take on a limited set of traditional front-end health plan capabilities like care navigation, second opinions, expert advice, coordination for high-risk members, and patient advocacy in billing disputes.*Patient navigation enablers* may allow employers using a direct-to-employer contracting approach or a third-party administrator with limited patient-facing capabilities to offer comparable experiences to their employees as employers with traditional health plan partners.

Implications for Patients, Payers, and Policy Makers

The emergence of innovations in primary care has important implications for the U.S. health care system. Importantly, to the extent that such models enhance the delivery of 4C primary care for some or most patients, these innovations could strengthen the primary care system, enhance patient experience, and, potentially, result in lower total spending as seen in other health systems with more robust primary care infrastructure. They could also become an important route for attracting new professionals into primary care roles, and retaining existing cadres of primary care providers, many of whom are beleaguered and burned out by existing models.

A key challenge to primary care that these new models may address is that the provider workforce is aging or leaving and fewer medical students are choosing careers in primary care.[4] Thus, to the extent that team-based models of care — which expand the care team to include additional team members such as advanced practice providers, nurses, nutritionists, behavioralists, or community health workers — can leverage the ability of PCPs to care for larger numbers of patients and provide attractive new models of practice and compensation, these models also might help with workforce challenges. Similarly, relatively low payment for primary care relative to most specialties is a major challenge for attracting new physicians and other providers to the profession. To the extent that these models serve to bring more resources into primary care (both for team-based or intensive care delivery and to bolster PCP take-home pay), they also might serve to shore up a primary care system that is at risk of fiscal collapse from the Covid-19 pandemic.[14]

However, if instead of resulting in more resources for primary care, these additional funds are siphoned off to investors or others who seek to profit from these care models, then these desired effects might not materialize. Thus, policy makers and payers must closely monitor the extent to which additional resources directed toward primary care are supporting additional or new partner organizations with an as-yet-unproven benefit, which could end up diverting much needed resources from traditional primary care. Alternatively, new entrants backed by private equity or venture capital into the primary care market can potentially provide important additional resources to fund extended functionality and sustainability of primary care teams. What will be very important to understand from the marketplace is what the exit strategy for these funders might look like, and whether they align with the long-term viability of team-based, population-oriented primary care.

Regarding both types of comprehensive models, there remains a dearth of evidence about their true effectiveness. In the case of *membership models* such as concierge medicine, patients and their employers are making their own choices and the very success of these models confirms that they offer a service that is valued by patients who can afford them. However, there is little evidence of benefit regarding the impact on total spending and quality of care. Moreover, though entering a membership model practice is a strategy by which primary care physicians can regain control over their practice lives while also substantially boosting their pay, from a policy point of view these models effectively decrease the supply of primary care physicians (because of limited panels) and are inherently inequitable as they are largely available only to those who can afford to pay. In many ways, these models can be seen as a symptom of what currently ails the primary care system, not as a scalable, viable solution. There is little evidence that these membership models integrate often or well with existing value-based policy initiatives like accountable care organizations or state/federal primary care demonstration models.

The *segmented population models* are clearly showing initial financial success and have attracted substantial interest from investors. Whether these initial results have been driven by their improved care model, more intensive coding (resulting in higher payment), patient cherry-picking, or some combination remains an open question, and rigorous evaluation will be required before policy makers can understand the full impact of these models. In particular, any increased investment such organizations make into coding should be considered an unintended consequence of current policy. Much as these concerns have been raised for MA plans in general,[15] risk adjustment systems

in this context may not be working in the way they were intended. Whether and how well these segmented offerings integrate, and feed, into future Center for Medicare & Medicaid Innovation (CMMI) and state models is also unclear.

> *"Previous planning has been hampered by an often-oversimplified view of practice arrangements — making distinctions mainly around practice size and ownership arrangements — and imagining a monolithic view of a 'standard' doctor-driven model of office-based care fueled by visits-volume over population health needs."*

The potential impact of focused care providers (*urgent care* and *convenient care models*) may raise more concerns as well as opportunities. To the extent that these organizations siphon away care from traditional primary care, they may undermine the ability of primary care practices to deliver 4C care with sufficient predictable revenue streams (and staff) to stay open. Urgent care is one of the primary functions of primary care and an important part of providing whole-person comprehensive care. Conversely, others have argued that carving out treatment of relatively simple one-off urgent conditions such as sore throats or urinary tract infections may provide more timely care while not importantly impacting the other functions, or may even augment the ability of general practices to focus on more longitudinal, complex diagnostic and therapeutic management of patient needs.

Alternatively, we may see traditional primary care do a better job at offering such services in ways that are convenient to patients (e.g., through their own provision of telehealth services or asynchronous modalities). Similarly, chronic disease–focused services might serve to replace primary care management of specific conditions or enhance their management by allowing for better incorporation of data from outside the care setting. How this segment of the market will evolve remains an open question, as does the extent to which the proliferation of these models will undermine the relationship between primary care physicians and their patients.

Patients are voting with their feet, often unhappy with the current state of primary care provision in the United States. For particular functions like timely access, they are willing to pay extra for convenient and efficient delivery options that meet their needs, harkening the potential growth of these models. This is true particularly for virtual-first offerings for tech-enabled segments whose expectations for easy, quick problem resolution grows relentlessly. Moreover, other patient segments who have high care needs may continue to opt for high-touch, comprehensive models offered by these new entrants. Whether overlaid options for chronic disease management can integrate effectively with existing practice infrastructure to serve patient needs effectively remains to be seen. And the range of employer-based wraparound services are likely to be taken up heterogeneously as are most employer offerings in the United States.

Other policy implications of these different models are quite variable and hard to predict as well. Most likely, though, all signals point to the continued growth of these models given existential

pressures on traditional primary care, widespread interest and venture funding behind these new models, the policy push toward value-based care, and shifting consumer demand.

Segmented population entrants in the MA and Medicaid markets may find durability through CMS-led federal or state level programs and demonstrations that shift risk and change payment in service of value-based care and alternative payment model (APM) model growth. The alignment between these business and policy models is far from certain, though, as many*segment models* depend on coding investments within MA to generate the margins from which they can share savings. This coding-driven margin potential may not be a permanent feature of the payment landscape for these entrants, leaving open the possibility that their business model may be at risk over the long term. Private equity and other organizations that are purchasing primary care practices at a rapid pace[13] may, at one level, be trying to build strong long-term organizations to manage and profit from risk contracts. They also might be quickly preparing to sell these practices to vertically integrating organizations looking for market share or predictable management of health care costs over time.

Convenient care offerings will likely continue to grow given access challenges for patients in current primary care offerings as well as modern consumer demand expectations, despite the fact that they most likely add to total cost as opposed to substituting lower-cost care.[16] Their growth may continue, given the limited primary care workforce, so it will be important to see if large corporate entrants like pharmacies and retailers will expand these offerings toward more comprehensive services needed by the population. In many low primary care–density areas, retail and urgent care offerings are already playing a large role in the provision of routine primary care, so expanded comprehensive and integrated care offerings may be quite welcome.

Finally, it is clear that policy makers and workforce planners will need to continue to incorporate an understanding of these new types of market entrants into future payment, delivery, and training models. Previous planning has been hampered by an often-oversimplified view of practice arrangements — making distinctions mainly around practice size and ownership arrangements — and imagining a monolithic view of a "standard" doctor-driven model of office-based care fueled by visits-volume over population health needs. This rapidly changing view of primary care provision, such as that highlighted by an important National Academies of Sciences, Engineering, and Medicine report on the future of primary care,[17] must be taken into account by key stakeholders as they plan for ways to make key primary care functions and services more equitably and effectively available to all people. Moreover, the extent to which investor-owned organizations are proliferating within certain of these segments might suggest that some of these organizations are arising to take advantage of regulations or other payment system quirks that create opportunities for investors to realize substantial returns without fundamentally improving care or outcomes. Further alignment of recently articulated federal policy goals around increasing the number of beneficiaries in a care relationship with accountability for both costs and quality of care supporting care innovation, advancing equity, and enhancing affordability will require a more granular and nuanced view of primary care innovation inclusive of the array of types discussed in this paper.

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