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Health Brief

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The Rise of Medicare Advantage Payviders

The term *payvider* has recently emerged to refer to financial integration between a health care payer and a provider organization. The increased focus on payviders coincides with substantial growth in the share of Medicare beneficiaries participating in Medicare Advantage (MA) plans, which could be accelerating the integration of MA payers and providers.

Partnerships between MA payers and providers could be grounded in "shared adherence to the Quadruple Aim," a framework for improving health system performance. However, the growth of payvider arrangements could also be a strategy to secure overpayment opportunities embedded in MA payment policy. Indeed, a recent survey of health system executives indicated 59 percent were planning to "own the premium dollar" through risk-based MA arrangements.

This brief combines information from published literature with diverse public data sources (including the Agency for Healthcare Research and Quality's Compendium of U.S. Health Systems) to describe emerging MA payvider patterns. We first summarize recent findings on MA payviders controlled by health systems. We then use new Compendium data sources to describe emerging patterns in MA plan affiliation with primary care providers, highlighting MA payvider trends and noteworthy initiatives by retail corporations. Finally, we use analyses from the Medicare Payment Advisory Commission and others to show how growing MA payvider control of primary care settings might reflect organizational strategies to use payvider arrangements to maximize MA payments.

Trends in MA participation and the growth of health systems as payviders

Before 2010, less than 25 percent of Medicare beneficiaries were enrolled in Medicare Advantage (MA) plans. At that time, the largest and most visible payviders were long-standing regional group model health maintenance organizations, such as Kaiser Permanente (KP). In addition, some regionally prominent integrated delivery systems such as Geisinger Health System and Intermountain Health had long-standing health plan affiliations, including with MA plans.

By 2024, 54 percent of Medicare beneficiaries were in MA plans nationally, with substantial local geographic variation in MA penetration. Thirty-seven percent of Medicare beneficiaries lived in a county where most Medicare beneficiaries (more than 60%) were enrolled in MA plans. Furthermore, UnitedHealth Group (United) and Humana accounted for almost half of MA enrollees in 2024 and covered at least 75 percent of MA enrollees in almost 30 percent of counties.

Understandably, these trends could affect the local market strategies of integrated delivery systems. Recent research suggests that systems' prices for provider services are higher when local health plans are

highly consolidated *and* health systems have a great deal of control over hospitals in the local market. Thus, the traditional inverse relationship between insurer concentration and prices (that is, greater concentration leads to lower prices) is attenuated in highly concentrated integrated delivery system markets.

In 2016, when national MA enrollment was up to 33 percent, the Agency for Healthcare Research and Quality's (AHRQ's) Compendium of U.S. Health Systems identified 74 vertically integrated health systems out of 626 total (12 percent) that owned or co-owned MA plans. An analysis of AHRQ Compendium data shows the number of people enrolled in MA plans owned by health systems rose from 2.6 million in 2016 to 4.4 million in 2023. However, the number of systems that owned MA plans in 2023 (81 of 639 systems, or 13 percent) had not risen much since 2016. Systems owning MA plans had over four times as many primary care physicians, had a high level of teaching intensity, and were almost twice as likely to include high disproportionate share hospitals (authors' analysis). Accordingly, these systems might have clinical and service missions more focused than other systems on meeting the diverse healthcare needs of their local populations.

Advocates for payer–provider integration note these relationships can reward more efficient care delivery, correcting the "challenging dynamics in many conventional mergers that force one party to yield control to another." A possible testament to this strategy is the long partnership between the not-for-profit Kaiser Foundation Health Plan and closely aligned (but independent) Kaiser Hospitals and Permanente medical groups. Indeed, the 2023 AHRQ Compendium shows the KP health system had MA plan enrollment of 1.89 million, nearly five times the enrollment of the next largest MA health system payvider, the Allegheny Health Network.

MA-oriented, senior-focused primary care practices

Recreating the KP MA payvider model in new markets can be costly and challenging. A simpler alternative could be the creation of MA-funded, senior-focused primary care practices. Advocates for this approach argue that "population-based payment in [MA] can foster innovation in care delivery by giving risk-bearing providers flexibility and strong incentives to enhance care and engage patients." Indeed, Swankoski et al. (2024) found that patients of senior-focused primary care practice organizations received 17 percent more primary care visits, with the largest increases among Black and dually eligible beneficiaries.

How might primary care practices achieve this "senior-focused" orientation? While existing independent primary care practice organizations could choose to contract with diverse local MA plans to shift focus to MA beneficiaries, another option is for MA plans to develop or acquire primary care practices. We used the AHRQ Compendium 2023 Outpatient Site Linkage File (OSLF) to identify the owners of the senior-focused primary care practice organizations identified by Swankoski et al. (2024), with a particular focus on owners that also own MA plans. We focused on the OSLF practice sites identified as medical groups (rather than health departments, outpatient surgical centers, or other types of outpatient facilities), with a specialty designation of primary care, general practice, family medicine, internal medicine, or geriatrics and at least one physician at the site. Table 1 shows nearly two-thirds (1,045) of the 1,618 physicians at these senior-focused practice organizations were at sites owned by companies that include MA plans.

Table 1. Ownership of senior-focused primary care practice organizations

Senior-focused primary care practice organizations	Number of sites	Number of physicians	Most common owners of sites (numbers of sites owned and physicians)
Oak Street Health	168	469	CVS Health (167 sites, 468 physicians)*
Conviva Care Centers	119	386	Humana (109 sites, 369 physicians);* Amicus Medical Centers (5 sites, 10 physicians)
Centerwell Senior Primary Care	80	217	Humana (78 sites, 208 physicians)*
Iora Health	20	55	Iora Health (16 sites, 44 physicians); One Medical/Amazon (4 sites, 11 physicians)
Chen Senior Medical Center	14	110	ChenMed (14 sites, 110 physicians)
Dedicated Senior Medical Center	65	340	ChenMed (56 sites, 312 physicians)
JenCare Senior Medical Center	8	41	ChenMed (8 sites, 41 physicians)
Total	**474**	**1,618**	

Sources: The senior-focused primary care practice organizations in the table are those identified in Swankoski et al. (2024). We identified ownership using the AHRQ Compendium of U.S. Health Systems, 2023 OSLF. The OneKey database, which is the source for the OSLF, focuses on practice sites, not practice organizations, so a physician could be counted multiple times if practicing at multiple locations with the same name.

Notes: CVS Health acquired Aetna in 2018. One Medical acquired Iora Health in 2021, and Amazon acquired One Medical in 2022. The 2023 OSLF does not list any sites using the name ChenMed Primary Care Centers, which is the name listed in Swankoski et al. (2024). The OSLF does include sites with the name Chen Senior Medical Center, and ChenMed is listed as the owner of 56 sites with the name Dedicated Senior Medical Center.

* Indicates ownership by a company that includes MA plans.

MA payvider ownership of primary care practice sites

We used the 2023 AHRQ Compendium OSLF to further explore patterns of primary care practice ownership by MA plan payviders. We focused on plans identified as owning primary care practices in a recent analysis of payer–primary care integration by Adler et al. (2025): United/Optum, Humana, Elevance, CVS Health, and Cigna. Table 2 shows the number of primary care sites owned by these plans, according to the OSLF. As in our previous analysis, we focused on OSLF medical groups.[1] In both the OSLF and Adler

[1] The 2023 OSLF counts of physicians in health plan–owned practices are lower than those in the analysis by Adler et al. (2025). That analysis used multiple data sources to identify practices acquired by MA plans, including insurer websites, corporate registration databases, and U.S. Securities and Exchange Commission filings. In contrast, the OSLF data are derived from IQVIA's OneKey database, which relies on a combination of regular surveys of practice sites and administrative data sources to identify owners and tight affiliations. These data likely miss some physicians compared with the exhaustive data sources analyzed by Adler et al. (2025). However, if we remove the restrictions we applied to practice site specialties when identifying primary care practice sites, we find physician counts similar to those reported by Adler et al. (2025) for practices owned by UnitedHealth Group/Optum, CVS Health, and Cigna but not by Humana or Elevance.

et al. (2025) analyses, United had the most physicians in primary care practice sites (almost 700 sites with nearly 2,700 physicians on site in the OSLF). In total, we identified almost 1,100 primary care practice sites owned by these five MA payviders in 2023.

Our analysis of the ownership of senior-focused primary care practice sites also revealed the prominent role of two retail companies: Walgreens and Amazon. We therefore expanded our analysis to describe their control of primary care practice sites (Table 3). At the end of 2023, both organizations had almost 900 physicians across more than 450 primary care practice sites.

Given the substantial geographic variation in penetration by MA plans, we also examined payvider and retail ownership of primary care sites by population enrollment in MA. As shown in Tables 2 and 3, most of these payvider and retail owners seem to be pursuing primary care practice site ownership in states with higher MA enrollment. For MA payviders, the percentage of physicians in states with the highest tertile of MA penetration varied from 8 percent (Cigna) to 93 percent (Elevance), with the largest MA payvider (United) having 72 percent of its physicians in states with the highest MA penetration. Amazon and Walgreens had 50 to 59 percent (respectively) of their physicians in states with the highest MA penetration.

Of the MA payviders, most (United, Humana, Elevance, and Cigna) had 3 percent or less of their primary care sites in any of the 17 states in the lowest tertile of MA penetration in 2023. Walgreens also had only 3 percent of its physicians in states with the lowest MA penetration.

CVS and Amazon, in contrast, had one-quarter or more of their physicians in the states with the lowest MA penetration. Notably, Amazon's primary care practice strategy is not tied to MA plan alignment. Likewise, recent reporting suggests CVS's acquisition strategy for Oak Street Health was not driven only by Aetna MA plan participation but also by integration of primary care and pharmacy revenue.

These different strategies for primary care acquisition might be contributing to differences across corporate entities in their primary care presence from state to state. Updated data will be needed to track how the geographic distribution of MA plan- and retailer-owned primary care practices evolves with changing national health policies. Among potentially relevant policies is the structure of Medicare payments to MA plans, which we discuss in the next section.

Table 2. MA plan–owned primary care practice sites

Insurers with MA plans that own primary care practice sites	Number of sites	Number of physicians	% of physicians at sites in lowest tertile of MA penetration by state	% of physicians at sites in highest tertile of MA penetration by state
United (including Optum)	699	2,674	3%	72%
Humana	191	584	2%	86%
CVS Health	167	468	25%	45%
Cigna	18	61	0%	8%
Elevance	16	41	0%	93%
Total	**1,091**	**3,828**		

Sources: The insurers with MA plans that own primary care practices are those identified in Adler et al. (2025). We identified ownership using the AHRQ Compendium of U.S. Health Systems, 2023 OSLF. The OneKey database, which is the source for the OSLF, focuses on practice sites, not practice organizations, so a physician could be counted multiple times if practicing at multiple locations with the same name.

Table 3. Retailer-owned primary care practice sites

Retailers without MA plans that own primary care practice sites	Number of sites	Number of physicians	% of physicians at sites in lowest tertile of MA penetration by state	% of physicians at sites in highest tertile of MA penetration by state
Amazon/One Medical	150	852	32%	50%
Walgreens	315	862	3%	59%
Total	**465**	**1,714**		

Sources: The retailers that own primary care practices are those identified in Adler et al. (2025). We identified ownership using the AHRQ Compendium of U.S. Health Systems, 2023 OSLF. The OneKey database, which is the source for the OSLF, focuses on practice sites, not practice organizations, so a physician could be counted multiple times if practicing at multiple locations with the same name.

Payer-led payviders and MA payment policy

MA plan-led provider integration has been accelerating, led by United, Humana, and CVS-Aetna. Their motivation for integrating might not seem clear given that, historically, the focus of health insurance companies has not been on deploying their managerial expertise to accomplish the difficult job of delivering high-value primary care. Rather, the reason might be that the companies' interest in being an MA payvider—and their anticipated financial success—depends on strategies that maximize MA payments.

Organizational control of clinician practices might contribute to financial success by facilitating clinician documentation of quality measures. However, a review of research on integrated delivery systems shows these systems might be better at improving guideline-oriented quality measures (dimensions relevant to the MA Quality Bonus Program) but no better at more difficult (but salient) areas of quality improvement. Indeed, recent research found that only legacy MA plan–physician practice collaborations such as KP were linked to meaningfully better performance on beneficiary experience measures.

Alternatively, the Medicare Payment Advisory Commission (MedPAC) notes that MA payviders might have substantial opportunities to increase Medicare payments through managing clinician coding and related

medical record documentation. In traditional Medicare, there is "little incentive for providers to record more diagnosis codes than necessary to justify providing a service." Instead, clinicians focus on reporting and documenting diagnoses proximately related to visits or procedures billed. As a result, various anomalies are common, such as inconsistent coding of chronic conditions (even for traditional Medicare fee-for-service beneficiaries who have serious conditions like kidney failure or paraplegia). Unlike traditional Medicare payments, MA premium payments are specific to each enrollee, based on a plan's payment rate and individual enrollee's diagnosis code–based risk score. Accordingly, MA plans "have a financial incentive to ensure that their providers record all possible diagnoses." MedPAC projects that in 2025, MA risk scores will be about 16 percent higher than scores for similar fee-for-service beneficiaries.

Other recent work also shows that individual MA plans vary substantially in the additional payments they receive from differential diagnosis coding (compared to traditional Medicare) and related chart reviews. For example, differential coding had an above-average predicted effect on the 2021 risk scores for United and Humana plans. In contrast, the collaboration between the Kaiser Foundation health plan and the KP health system produced below-average differential coding and risk scores.

Updated data sources and cross-database links will be needed to understand the degree to which other health systems and MA plan payviders vary in optimizing diagnosis codes. The data required include more current information on health system control over primary care practices and MA plans, practice ownership by MA plans, and practice and clinician linkages to Medicare claims and MA encounter data.

Conclusion

Advocates argue that payvider-type partnerships between providers and payers can reduce inefficiency caused by organizational conflicts and promote higher-value care. These advocates point to examples such as underserved MA beneficiaries receiving more primary care visits in MA-oriented senior-focused primary care practices. However, growing MA payvider investments in provider practices might instead reflect a strategy to maximize payments through visits that enhance documentation of diagnosis codes and quality metrics by primary care clinicians.

Using publicly available data files from the Compendium of U.S. Health Systems, we show the extent to which payviders control Medicare providers, especially in primary care. Updates to such data sources will be needed to help track the changing owners of primary care practices and MA plans and to link clinicians to MA encounter data. The resulting analyses could clarify the effects of health systems' and MA plans' evolving control of primary care and inform policies to ensure these growing MA-oriented payvider arrangements advance the value of health care for Medicare beneficiaries.

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