NOVEMBER 2024

CHCF Explainer Brief

by Jill M. Yegian, PhD

Strengthening Independent Primary Care Practice in California

Understanding Small Practice Perspectives

Several related developments in the health care market are converging to highlight the importance of supporting small independent primary care practices: market consolidation, acceleration of value-based payment, and a shortage of primary care providers. Yet the experience and perspective of such practices are often not well understood. The objective of this brief is to increase understanding of small independent primary care practices in California among purchasers and policymakers, with the goal of identifying opportunities to strengthen and sustain them.

Independent primary care practices play an essential role in delivering health care in California, and a growing body of research shows solid cost and quality results for smaller and independent practices. Studies have found that small primary care practices have lower rates of preventable hospital admissions than larger practices;[1] small practices and independent physician-led accountable care organizations (ACOs) generated greater savings in the Medicare Shared Savings Program than larger practices and hospital-led ACOs;[2] physician-owned physician organizations had lower total expenditures per patient for commercial enrollees than hospital-owned physician organizations;[3] and rates of provider burnout were lower in small independent primary care practices.[4]

Even as evidence regarding the benefits of independent practice has accumulated, consolidation of health care providers has resulted in an increase in corporate ownership of physician practices and employment of physicians, and a corresponding decrease in the number of independent, physician-owned practices. In 2024, more than 77% of physicians and 58% of practices were employed by or owned by (respectively) hospitals, health systems, or other corporate entities — up by 25% for physicians and 50% for practices over the last five years (Table 1). Primary care practices are often targeted for corporate acquisition, given their role in managing the continuum of patient care (and hence the flow of patients and revenue), including specialist referrals, prescribing, and facility-based care.[5]

Provider consolidation generally increases health care costs without improving quality, equity, or access.[6] Advocates of vertical integration, including acquisition of physician practices by health systems, have promised improved clinical integration and coordination, resulting in better quality and outcomes; instead, care tends to shift to higher-intensity settings, accompanied by higher cost.[7] In addition, there is increasing concern about the profit motive driving corporate ownership of physician practices, including private equity, and the adverse effects on provider satisfaction.[8]

Table 1. Trends in National Employment of Physicians and Ownership of Practices, 2012–2024

Physicians and Practices	2012	2018	2019	2022	2024
Physicians					
Employed by hospitals/health systems	25.8%	44.0%	46.9%	52.1%	55.1%
Employed by corporate entities			15.3%	21.8%	22.5%
Subtotal			**62.2%**	**73.9%**	**77.6%**
Practices					
Owned by hospitals/health systems			24.3%	26.4%	28.4%
Owned by corporate entities			14.6%	27.2%	30.1%
Subtotal			**38.8%**	**53.6%**	**58.5%**

Source: *Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment, 2019-2023 (PDF)*, Physicians Advocacy Institute, April 2024.

Note: Figures may not sum due to rounding.

At the same time, there is growing interest in strengthening primary care through greater investment and payment that supports the delivery of advanced primary care. In May 2021, the National Academies of Sciences, Engineering, and Medicine (NASEM) released an influential report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. The NASEM report documented the value of primary care as the foundation of the health care system and highlighted concerns with the small — and declining — share of the health care dollar that is dedicated to primary care in the US. A central recommendation of the report is to "pay for primary care teams to care for people, not doctors to deliver services."[9] Toward that end, the report recommends that purchasers and payers adopt a hybrid payment model that combines capitation and fee-for-service — predictable prepayment for routine services coupled with additional payment for high-value services such as immunizations. The report also emphasizes the importance of multi-payer alignment to strengthen and simplify the signal received by primary care practices and to reduce the administrative burden associated with proliferating payment models; and it recommends that states use their authority to facilitate multi-payer collaboration on primary care payment.

Alongside payer and purchaser interest in adopting value-based payment for primary care, there is growing concern that small independent practices may be left out.[10] Small practices are not able to take on significant financial risk, and they lack the scale to spread the costs of essential resources and services for the provision of advanced primary care (e.g., population health management, integrated behavioral health). "Enablement" entities are emerging to support independent primary care practices with value-based payment, offering support ranging from financial to strategic and clinical; but these companies are often corporate- and private equity–owned, with interests that may diverge from those of independent providers.[11] If small independent practices are not able to participate fully in new payment models for primary care, the primary care market will increasingly be dominated by large health systems, health insurance companies, and other forms of corporate ownership such as private equity and venture capital. And patients served at small independent practices will lose — at best, they will not benefit from advanced primary care best practices; at worst, they may lose essential access if these practices close or reduce services or hours.

The ongoing and increasingly severe primary care workforce shortage elevates concerns and heightens the sense of urgency regarding the sustainability of independent practice.[12] The COVID-19 pandemic exacerbated existing challenges for independent practices, creating financial instability due to loss of revenue and accelerating the shift to employment;[13] financial support from the government for health care providers during the pandemic focused on hospitals and large health systems rather than independent practices.[14] In California, the share of patients without a usual source of care has increased over the last decade for both adults and children.[15] Despite significant investments in the health care workforce over the last five years, the supply of primary care providers continues to fall short of population needs in many areas of the state, particularly in rural regions.[16] Moreover, California's budget deficit resulted in a reduction of $926 million in planned investment in the health care workforce from the general fund and Mental Health Services Act Fund for FY 2024–25.[17] Without concerted effort to support independent practices, this important segment of the delivery system will continue to erode, exacerbating primary care workforce shortages and jeopardizing access to care.

Project Approach

Given California's vast scale and the degree of regional variation in market characteristics, this effort focused on two geographic areas: the Inland Empire (Riverside and San Bernardino Counties) in Southern California and Humboldt County in the rural north. A total of 15 independent primary care practices were interviewed (5 in Humboldt County and 10 in the Inland Empire). The Humboldt practices were identified by Humboldt Independent Practice Association (IPA); Inland Empire practices were identified by the Riverside County Medical Association and the San Bernardino County Medical Society. One-hour interviews were conducted by video or audio conference between March and May of 2024.

Topics covered in the interviews included the following:

- Experience running a practice and delivering care in the local area (either Humboldt or Inland Empire)
- Factors that have contributed to the practice's ability to remain independent, and challenges and opportunities encountered
- The practice's characteristics, including affiliations with IPAs and ACOs and payment arrangements with contracting payers
- Thoughts on the future of the practice
- Resources and supports that might help sustain a successful independent practice over time

In addition, interviews were conducted with seven health care leaders and subject matter experts to explore region-specific contexts, challenges and opportunities facing independent primary care practice statewide, existing resources available, and ideas about additional measures to strengthen and sustain independent practices.

Physicians interviewed for this project are not a representative sample of independent primary care practices in the state or in the two regions, so the findings are exploratory rather than definitive. Only two geographic areas were included in this project; market conditions and independent primary care practice characteristics and perspectives may be quite different in other areas of California.

Practices Interviewed

Table 2 summarizes the characteristics of the primary care practices interviewed. Practice size ranged from one physician and no advanced practice providers (APPs; e.g., nurse practitioners or physician assistants) to five physicians and 10 APPs. Seven of the practices were solo physicians; six had two to three physicians (including part-time ones); and the two largest had seven and five physicians, respectively. Most of the practices operated in only one location, though larger practices had multiple locations, and two of the solo practices operated in two locations each.

Most practices had been operating for years, sometimes decades; often, the current owner was recruited or joined a family member and gradually took over the practice. Four practices focused on pediatrics, while the others saw adults or a range of ages. Practice structure varied, with three main categories: sole ownership, with providers and other staff on payroll; partnership (i.e., joint ownership), with providers and other staff on payroll; and independently owned practices joined together to share common expenses.

Physicians were asked about the share of patients in the practice with Medicare, Medi-Cal, and commercial insurance coverage; these figures were not verified and should be regarded as rough estimates or ranges. Almost half of the practices do not accept Medi-Cal patients; those that do — including all the pediatric practices — tend to have a large share of Medi-Cal patients. All but one practice has at least one affiliation with an independent practice association (IPA), and several were also affiliated with an accountable care organization (ACO). Of the three practices with multiple IPA affiliations, one had three IPA affiliations, one had four, and the third did not specify how many it had. All the practices used an electronic medical record (EMR), and there was almost no overlap in the EMR used (not shown in the table).

Table 2. Characteristics of the 15 Primary Care Practices Interviewed, by Number of Physicians

Staffing and Locations			Insurance Coverage Sources by Patient (estimated)			Practice Started in Last 5 Years	Affiliations
# of Physicians	# of APPs	# of Sites	Medi-Cal	Medicare*	Commercial		
7	3	2	60%	20%–40%	20%–40%	No	Single IPA
5	10	5	85%–90%		10%–15%	No	Multiple IPAs
3	0	2	0	50%	50%	Yes	Single IPA
3 (1 PT)	4	1	0	40%–60%	40%–60%	No	Single IPA; ACO
2	2	1	80%		20%	No	Single IPA
2	1	1	50%–60%	30%	10%	No	Single IPA
2 (1 PT)	3 (PT)	1	80%		20%	No	Single IPA
2 (PT)	2 (PT)	1	No insurance accepted			Yes	None
1	2	2	<5%	65%	30%	Yes	Multiple IPAs
1	2 (PT)	2	30%	25%	40%–50%	No	Multiple IPAs; ACO
1	0	1	0	30%	70%	No	Single IPA
1	1	1	70%		30%	No	Single IPA
1	1 (PT)	1	0	15%–40%	40%–65%	No	Single IPA; ACO
1	0	1	0	65%	35%	No	Single IPA; ACO
1	0	1	0	50%	50%	No	Single IPA; ACO

Source: Author analysis of interviews.

Notes: *ACO* is accountable care organization. *APP* is advanced practice practitioner (e.g., nurse practitioner or physician assistant). *IPA* is independent practice association. *PT* is part-time.

* A blank in this column indicates a pediatric practice.

Common Themes Across the Two Regions

Based on the interviews, several common themes emerged, listed here and described in detail below.

1. Motivators for independent practice were autonomy, flexibility, and the ability to practice medicine in line with one's own values.
2. Practices feel squeezed between increasing costs and stagnant reimbursement — both of which are largely beyond their control.
3. Lack of stable, consistent commitment to primary care from state government erodes trust and constrains the ability of practices to plan and invest for the long term.
4. Practices have adopted multiple approaches to improve financial sustainability: managing costs, enhancing revenues, and creating a distinctive offering to patients.
5. Practices face a multitude of payment arrangements, payer coding and billing requirements, and performance measures; focusing on specific payer types can reduce complexity and enhance financial viability.
6. Fee-for-service payment presents challenges — both clinical and financial — to comprehensive primary care; capitation aligns with a population health management approach but must be adequate to meet patient needs.
7. Medi-Cal providers rely heavily on Medi-Cal plan incentive programs to make ends meet and have mixed experiences with these programs.
8. Plans for the next 5–10 years included growing the practice, maintaining the practice at its existing size, and retiring.

1. Motivators for independent practice were autonomy, flexibility, and the ability to practice medicine in line with one's own values.

Many of the physicians interviewed mentioned the ability to make their own decisions as a primary reason to choose independent practice. Several respondents noted that independent practice allowed them to balance work and family priorities. Many practice owners had worked in multiple other settings previously, including Federally Qualified Health Centers (FQHCs) and large health systems, and shared stories about organizational policies or practices that resulted in misalignment with the way they wanted to practice medicine. Several respondents noted that the standard approach of a large panel size and maximum 15-minute allocations for patient visits did not allow for optimal patient care or provider experience. Independent practice enabled them to see fewer patients each day, with more time for each visit — though that generally required accepting lower revenue. As one put it: "My goal isn't to get rich; it's to spend time with patients and provide unrushed, quality care." None of the respondents expressed interest or intent to sell their practice or shift toward an employment model, reflecting their strong motivation to remain independent.

2. Practices feel squeezed between increasing costs and stagnant reimbursement — both of which are largely beyond their control.

For many respondents, increasing costs were a big concern; specific mentions included inflation, labor costs, and the cost of inputs. California government mandates were viewed as a significant contributor to higher labor costs. California's $20 per hour minimum wage for fast-food workers and the state's $25 per hour minimum wage for health care workers were both mentioned frequently. Respondents note that even when the wage provisions are not directly applicable to the practice, the effect is the same: Competition

for a common labor pool requires that practices seeking to hire staff such as medical assistants must raise salaries because larger practices, hospitals, and even fast-food restaurants are offering those salaries. Several respondents noted the unintended consequences of government mandates like these minimum wage requirements disrupting small practices' ability to hire staff and survive.

Compounding the challenges associated with increasing costs is the inability to increase prices to cover those costs. Multiple respondents noted that they have no control over pricing, resulting in a threat to financial sustainability — and a sense of powerlessness. Payment rates are set by government entities, contracting health plans, and IPAs, with no opportunity for physicians to raise prices in response to increasing costs. One respondent pointed out that IPA contracts may last five years, with no adjustment for inflation. As one put it: "I'm a small fish in the sea. I take what I get." From another: "Our costs for things keep increasing, but we don't really have a way to change what we charge people. We just get what they give us."

3. Lack of stable, consistent commitment to primary care from state government erodes trust and constrains the ability of practices to plan and invest for the long term.

The California State budget shortfall that emerged in January 2024 was mentioned by several respondents, who specifically noted the shift in funding from health care purposes to the general fund to solve the state's budget problem. Proposition 56–funded directed payments to supplement Medi-Cal reimbursement for primary care services were mentioned as an important source of revenue that is now at risk.[18] The Targeted Rate Increase for Medi-Cal primary care providers was rolled out as a multiyear initiative, but full implementation will be delayed by California's budget challenges.[19] Another example: The final version of the California state budget for 2024–25 severely cuts back the Equity and Practice Transformation Payments Program, the Department of Health Care Services' $700 million initiative to support practice transformation for providers participating in Medi-Cal.[20] Of the 211 practices accepted into the first cohort, announced in January 2024, 51% were small independent practices. The program was intended to fund two cohorts of practice support; the final budget eliminated the second cohort completely and reduced funding for the first cohort only six months after the program was announced.

As one respondent put it: "Every time I turn around, reliable payment evaporates, and the governor throws us under the bus. We build the business based on expectations and understanding. Then in July everything changes."

4. Practices have adopted multiple approaches to improve financial sustainability: managing costs, enhancing revenues, and creating a distinctive offering to patients.

Practices mentioned an array of strategies to manage costs. Two practices mentioned hiring "virtual assistants" located in the Philippines. For around $8 per hour — less than one-third of the new market rate of $25 per hour mandated by the state for health care workers — these virtual assistants have received positive reviews from the physicians who hired them. The remote team member acts as a medical assistant and conducts many of the same services as the in-office medical assistants: taking calls from patients and following up as needed, calling patients to schedule appointments or deliver results, and conducting back-office tasks online.

"Patients love her — she is a great asset to the practice. Many didn't even know she was in [the] Philippines. Her English is really good; the connection is clear. She is a med student with a medical background. We trained her, oriented her to set our goals for our practice. She does callbacks to patients with lab results, schedules patients, answers calls, takes questions down and sends them to me, and I send a response back to her. If patients are emailing outside lab results, she will scan and link the info. She sends prescriptions that I write to the pharmacy, helps medical assistants with that; she can also do some prior-authorization work. They are in a hub — she works with the other medical assistants."

Respondents also mentioned an array of digital technologies such as greater use of telehealth, including high-definition cameras to support remote patient consultation, and adoption of text messaging to patients. Interestingly, advanced practice practitioners such as nurse practitioners and physician assistants were not identified as an approach to manage practice costs; one respondent noted that post-COVID-19, physician extenders want to be paid as much as physicians and demand convenient work schedules but still need clinical oversight, making the value equation unfavorable.

Another way to enhance financial sustainability is increasing practice revenue, and respondents mentioned several approaches.

- Some physicians added a "side gig," such as performing minor dermatology procedures, that brings in higher reimbursement than the evaluation and management services that primary care physicians typically provide.
- Some practices pursued a Rural Health Clinic designation to obtain a higher rate for Medi-Cal members; this process can be time-consuming and lengthy but may be worthwhile for qualifying practices with a high share of Medi-Cal patients.
- Multiple practices joined an accountable care organization aggregation platform to tap into shared savings revenue, most commonly for the Medicare Shared Savings Program. Most of the practices participating in ACOs identified Aledade as the platform, with Ilumed and California Clinical Partners also mentioned.
- Two practices adopted (or planned to adopt) a subscription fee program to supplement insurance reimbursements, allowing the physicians to see fewer patients for longer visits. A version of concierge care, this type of program supplements rather than replaces insurance coverage.[21] A choice of subscription levels may be offered, with higher fees tied to greater patient access to the physician and a quicker response time.

Finally, some respondents emphasized an effort to distinguish their practice and solidify their patient base. One practice invested substantial resources in developing a distinctive brand and a patient experience that stands out among competitors in pediatrics. Another practice created a niche in integrative functional medicine, which appeals to patients seeking a holistic approach to primary care that brings together homeopathic remedies with allopathic medicine.

5. Practices face a multitude of payment arrangements, payer coding and billing requirements, and performance measures; focusing on specific payer types can reduce complexity and enhance financial viability.

While clinical guidelines and appropriate care are (or should be) agnostic to insurance coverage source, the same is not true for reimbursement. Medi-Cal, Medicare fee-for-service, Medicare Advantage, and commercial coverage all feature distinct payment arrangements, billing and coding processes, and incentive structures, which requires practices to invest in learning the rules of the road and staffing appropriately to meet the requirements. That differentiation may contribute to a practice deciding to focus primarily on one or two coverage sources — in part to offset the resource cost associated with coverage-specific requirements and administrative burden.

Almost half of respondents did not accept Medi-Cal; those that did tended to have a large share of Medi-Cal patients (see Table 2). Pediatrician respondents noted that Medi-Cal members comprised a large majority (70%–90%) of their patients. Practices with a substantial share of Medi-Cal patients noted the importance — and the complexity and administrative burden — of the incentive programs offered by Medi-Cal plans (see below for additional details). Likewise, the Rural Health Clinic designation was pursued only by practices with a sufficient share of Medi-Cal patients to allow the higher rate to offset the resources required to obtain and maintain the designation.

One of the largest practices interviewed (seven physicians plus three APPs in two sites) estimated that 60% of its patients had Medi-Cal coverage and saw CalAIM (California Advancing and Innovating Medi-Cal) as a significant opportunity to meet the needs of complex patients. This practice created a Population Health Department, which sets up standing orders, bulk-orders screenings, and conducts outreach calls. Behavioral health integration is a major priority. The practice partners with food banks to identify individuals who need services provided through the Enhanced Care Management program and has launched a street medicine program to provide care to those without stable housing. The respondent clearly identified the CalAIM program — and, specifically, capitation payment that is sufficient to cover primary care and related social health needs — as key to their success: When capitation is adequate to meet patient needs, it "enables team-based care, reduces burnout, and allows focus on patients and quality."

Practices that did not accept Medi-Cal saw a mix of patients with Medicare (both Medicare Advantage and traditional Medicare) and commercial coverage. Among practices focusing on Medicare Advantage, organizing workflow around conducting Annual Health Assessments (to capture diagnoses used for risk adjustment) and meeting care transition requirements — and realizing associated incentives — were viewed as essential to financial viability. Among practices with a substantial share of Medicare fee-for-service patients, joining a Medicare Shared Savings Program (MSSP) ACO created an opportunity for shared savings.

Reimbursement requirements and financial incentives can make the difference between a practice operating at a loss or profit, but each one requires (1) substantial knowledge of the details; (2) choosing an intermediary organization if needed (e.g., an IPA for access to Medicare Advantage patients, or an ACO for access to MSSP); and (3) resources (staff and office infrastructure) to effectively administer. As one respondent put it: "In independent practice, you have to stay up on the business of practice because if you do not, you have a real tough time making ends meet. So I've had to learn this situation upside down and sideways so I don't work for nothing."

6. Fee-for-service payment presents challenges — both clinical and financial — to comprehensive primary care; capitation aligns with a population health management approach but must be adequate to meet patient needs.

Even among patients with commercial coverage, access to patients and payment arrangements diverge based on whether the individual is enrolled in a health maintenance organization (HMO) or a preferred provider organization (PPO). Payment for PPO members is made on a fee-for-service (FFS) basis and requires contracts with each health plan; payment for HMO members is generally capitated (per member per month based on age and sex of the patient) and requires contracts with one or more IPAs. Often, PPO members behave differently from HMO members, with implications for the practice. When PPO patients show up for a specific problem and are not interested in comprehensive primary care, FFS payment can present a clinical challenge to the holistic perspective of primary care providers and a financial risk for small practices working on small margins that can bill only for the specific service provided.

"The PPO patient population pays very differently — they come to you for a specific problem. Patients are also seeing other specialists; care is not very integrated.… The patient comes in for a rash, and our knee-jerk reaction is to talk about mammogram, HbA1c, screenings. They say, 'I see my gyn for that.' My staff tries to get those records so we know it's been handled, but it's hard when they are FFS; they are bouncing around, [and] we don't have the data. For HMO patients, we have all the data; it's more cohesive in terms of patient care. But I would not want to move away from PPO and toward HMO; HMO reimbursement is poor."

7. Medi-Cal providers rely heavily on Medi-Cal plan incentive programs to make ends meet and have mixed experiences with these programs.

Several respondents noted that Medi-Cal incentive programs are financially meaningful: "It's what keeps me in business; without that I would need to close my doors." Practices reported structuring workflow around the incentive programs: assigning staff to monitor measures, do outreach to patients, and schedule appointments to manage gaps in care. Some practices mentioned sharing earned incentives with staff. Several respondents thought the measures included in the incentive program represented good patient care and "make us better providers."

While acknowledging the importance of the incentive programs, some respondents raised concerns about the extent and fairness of required metrics. One noted that the "rat wheel of fee-for-service payment has been replaced by a rat wheel of metrics" — and that providers are worse off with pay-for-performance programs than with FFS because any incentive payments arrive long after services have been provided. Several mentioned the long list of required screenings and extensive documentation, which can be disruptive and burdensome for both providers and patients. The childhood immunization measure was particularly concerning: Multiple vaccines, including the flu shot, are required for that measure, and missing just one results in a zero score. Since vaccinations are heavily weighted in the incentive program, the provider takes a financial hit for patients (more often parents) that refuse a flu shot. One respondent highlighted the complexity of the program and noted that the practice had lost substantial revenue over multiple years, despite having performed well on the metrics, due to misunderstanding the coding requirements.

8. Plans for the next 5–10 years included growing the practice, maintaining the practice at its existing size, and retiring.

Some respondents plan to grow their practices; several mentioned plans to open additional offices, expand programs, hire additional providers, or enter into partnerships. One respondent shared their plans to establish a concierge model with an annual fee and small patient panel while continuing to run the existing practice. Others were satisfied with the status quo, or interested in growth but not optimistic about being able to recruit new providers to the practice. Still others expressed concern about their ability to remain in independent practice in California and were moving toward retirement; one respondent noted that the "goal for the last few years is to keep my head above water."

Region-Specific Findings

While many of the themes that emerged in the interviews with physicians were common across the two regions, others were region-specific.

In Humboldt County, few independent practices remain, and a severe primary care workforce shortage limits patient access to primary care.

The most recent Regional Market Study from the California Health Care Foundation (CHCF), published in 2020, included Humboldt and Del Norte Counties.[22] These rural north coast counties are poorer and less healthy than the state of California as a whole, with a median household income that is about one-third lower ($51,409 vs. $75,277) and an age-adjusted death rate about one-third higher (816 vs. 609 per 100,000 population). Compared with the state, a much larger percentage of the population is White (72.1% vs. 36.8%) and a much smaller percentage is Latino/x (13.2% vs. 39.3%). A smaller share of the population is covered by private insurance compared with statewide, and a larger share is covered by Medi-Cal and Medicare. Primary care physicians per 100,000 population, at 49.0, is below the California average of 59.7 and falls short of the Council on Graduate Medical Education (COGME)'s recommended supply of 60–80.[23]

The main providers of primary care services in Humboldt are Open Door Health Center, a large FQHC that has grown significantly in recent years, and Providence Medical Group, owned by Providence, a Catholic health system that delivers services across seven states. In an effort to maintain community access, Open Door has taken over several struggling independent practices that would otherwise have closed their doors. Not immune from regional workforce shortages, the FQHC posted this banner on its website in summer 2024: "Open Door is currently experiencing severely limited access for new

adult patients. Our Member Services Department is available to help community members navigate options for their care." Open Door, the main provider for Medi-Cal members in Humboldt and Del Norte, provides an estimated 90% of primary care services to Medi-Cal beneficiaries in these counties, and has reportedly had to stop accepting new non-Medi-Cal patients. Providence Medical Group in Eureka started with a focus on specialty care but has grown in the primary care space in recent years as independent practice has continued to erode. Several physicians interviewed noted that Providence restricts access to reproductive services, including vasectomies and contraception, and that such restrictions conflict with their values and ethics as primary care providers.

Humboldt IPA, the county's sole IPA, has evolved its role over time as independent practice has shifted toward employment; its network now includes not just independent physicians but also those affiliated with Open Door and Providence. While Humboldt IPA continues to contract with Anthem and Blue Shield, fewer patients flow through the HMO and PPO ACO contracts, and those contracts have not generated performance incentives or shared savings for the last several years — funds that Humboldt IPA would have passed on to participating physicians.

One respondent noted that it is almost impossible to run the kind of small independent primary care practice that was once the norm in the community, even for those deeply committed to the independent practice model: "If you're not an FQHC, you can't survive on the Medi-Cal reimbursement; if you're seeing commercial patients, you need to be able to bill a vast number of groups with divergent policies; if you're trying to survive on cash payment, our population isn't affluent enough."

Efforts to increase the supply of primary care physicians have not resolved the primary care workforce shortage.

A three-year family medicine residency program launched in 2019 by Providence St. Joseph Hospital and Open Door FQHC has ramped up to graduating six residents per year and is expanding to seven. Of the 11 graduates in the first two cohorts, four stayed in Humboldt; of the six 2024 graduates, at least three plan to stay. None of the new family medicine residents so far has chosen to pursue independent practice. Additional efforts are underway to address the primary care workforce shortage. A new partnership began in July 2024, with the Idaho College of Osteopathic Medicine providing clinical rotations for four medical students who will spend their third and fourth years in Humboldt. Providence Medical Group, St. Joseph Hospital, and Open Door are all helping with the rotations in hopes that medical students exposed to rural medicine and primary care in Humboldt will return there to practice. If the program goes well, it could continue and expand. Yet, given the severity of the primary care shortage, these efforts seem unlikely to address the need in the foreseeable future.

Primary care workforce shortage contributes to burnout.

The serious shortage of primary care providers and services in the community has resulted in enormous pressure on local practices in the face of unmet demand for access. In some cases, the access challenges are personal: Physician respondents shared stories of waiting months for an appointment for themselves or struggling to find a primary care provider for a family member. Some respondents expressed commitment to providing access to local residents but felt stretched. As one put it: "I just want to live life a bit more rather than work. I want to meet the needs of the community, but I can only do so much." For established independent primary care practices, finding additional providers to share the load or take over as retirement approaches can be challenging.

Humboldt County is not just small but geographically isolated and a long distance from an airport. One pediatric practice has been trying to attract an additional physician for two years, including spending money to advertise the position, with no success. Historically, a local hospital provided recruiting assistance, but that ended when the pediatric service was terminated. One physician noted that he had always planned to practice at least part-time until age 70 but may not last that long if he is unable to recruit a clinical partner to share the patient care load.

Is Rural Health Clinic designation a pathway to sustainability?

Given the rural location; shortage of primary care providers (all of Humboldt County is a Primary Care Health Professional Shortage Area, or HPSA[24]); and prevalence of Medi-Cal as a coverage source; designation as a Rural Health Clinic (RHC) — with reimbursement through the Prospective Payment System (PPS) to enable a higher payment rate for Medi-Cal members — would appear to be an appealing strategy to improve financial viability.[25] Yet several respondents described the RHC process as time-consuming and complex to understand for small practices. Reportedly, the Medi-Cal program's transition from fee-for-service payment to managed care a decade ago led to several practices becoming RHCs but ultimately failing due to misunderstanding the rate-setting and payment process and timeline. The California Department of Health Care Services (DHCS) reconciles payments made to RHCs 1.5 (or more) years after the initial capitation payments are made by Medi-Cal managed care plans to the practice, and requires return of any overpayments in full; practices without sufficient funds to repay those overpayments went under. In some cases, the RHCs' PPS rate was lower than the standard capitation rate paid by the Medi-Cal managed care plan; for these practices, the RHC rate locked in unsustainably low reimbursement and inevitably resulted in their owing DHCS after reconciliation. Since the current system has tight constraints on RHCs' ability to increase PPS rates, RHCs with low rates must see many patients to meet their costs, which contributes to provider burnout. RHCs continuing to operate in the area are those that have a sustainable rate and strategies to manage the delay in payment reconciliation and potential need to repay DHCS, such as putting funds aside in expectation of a future request for refund or calculating the amount due and sending DHCS payment in advance of reconciliation.

In Riverside and San Bernardino Counties, independent primary care practices carve a path in the face of market consolidation in the physician organization sector.

According to CHCF's Regional Market Study report on the Inland Empire, the population in the area is lower-income and less healthy than Californians as a whole, with a median household income of $65,512 vs. $75,277 statewide and higher rates of diabetes (18.2% vs. 15.9%) and obesity (30.6% vs. 27.3%) among adults.[26] In contrast with the rural north counties, a larger percentage of the population is Latino/x compared with the state overall (51.6% vs. 39.3%), and a smaller share is White (31.5% vs. 36.8%). A smaller share of the population is covered by private insurance compared with the state as a whole, and a larger share is covered by Medi-Cal. The supply of primary care physicians per 100,000 population, at 41.5, falls far below the California average of 59.7 and the recommended supply of 60–80. According to the CHCF report, in 2019 primary care physicians in Inland Empire were more likely to be independent compared with the state overall: 31% of physicians were in a practice owned by a hospital or health system compared with 43% for California.

Most practices were exclusive to one IPA, and practices gave mixed reviews of their affiliated IPAs.

All Inland Empire practices interviewed had a contract with at least one IPA, and some contracted with multiple IPAs. Benefits to the practice of exclusive affiliation with an IPA include (1) a higher capitation rate and bonus structure and (2) less complexity, given that IPAs have different processes (e.g., for referrals) and portals. However, as one respondent put it, "If they screw you for any reason, you're stuck," since the contract may be for five to seven years. Moreover, when a patient shows up with coverage through an IPA to which the practice does not belong, the practice must turn the patient away or persuade the patient to switch to an IPA with which the practice is affiliated. While some physicians viewed IPAs as required for access to patients but not valuable to the practice, others identified an array of useful services provided by IPAs — providing reports on patients with care gaps, reaching out to patients to schedule annual well checks, sending nurses to conduct annual patient visits at home, and providing health information technology support.

Half of the practices had a contract with an ACO, primarily for Medicare FFS.

Services mentioned as provided by ACOs include a monthly meeting to review updates in coding and risk-adjustment factors (important metrics for achieving Medicare ACO shared savings); communication via Slack, a messaging app for businesses that helps teams collaborate; and a portal that provides information on patients and a worklist for the practice (e.g., identifying patients recently discharged from a hospital stay who should receive a follow-up call, or patients missing screenings or services).

Consolidation of physician practices and IPAs in the area was a common concern.

Several respondents were with an IPA that had been purchased by another IPA (e.g., Optum acquired PrimeCare and Inland Faculty; Prospect acquired Vantage). Optum was mentioned multiple times as aggressively acquiring practices and other IPAs; several respondents noted that Optum-owned IPAs were preferentially directing patients to Optum physicians rather than to independent physicians. Concern was widespread about the long-term implications of continued consolidation. As one physician remarked: "I'm very upset that more hasn't been done — we're just left to be gobbled up by a big entity."

Local resources were viewed as valuable in supporting independent practice.

Several respondents mentioned using services offered by the Riverside County Medical Association (RCMA), such as practice audits to identify opportunities to improve in areas like patient flow, and weekly videos with information about the latest guidelines and legislative bills. Some noted that they or their staff members had benefited from the Population Health Fellowship offered by the Inland Empire Foundation for Medical Care (IEFMC), a sister organization of RCMA.[27] This one-year fellowship following the completion of medical residency training in Riverside and San Bernardino counties covers key population health topics and comes with supplemental financial support, including a sign-on bonus, a contribution toward the physician's salary, and funding support toward loan forgiveness. According to one respondent: "IEFMC was set up to maintain the practice of medicine for individual [independent] physicians. They have a population health management fellowship to attract family practitioners and internists to stay in the area. They will take a third-year resident and give them a first-year doc salary — they embed with a practice and get a five-year commitment. The program teaches them population health management so that they know about capitation rates and RAF [risk adjustment factor] scores when they come in the door."

Sustaining Independent Primary Care Practice

Respondents mentioned several areas in which resources and support could help sustain independent primary care practices. These themes align with the findings of recent national efforts focused on opportunities to support high-performing physician-owned practices, understanding the perspectives of small independent primary care practices serving socially vulnerable urban populations, and identifying challenges and potential solutions to greater primary care provider participation in value-based payment.[28]

1. Streamline clinical practice in the independent setting through reducing administrative burden by aligning processes and requirements across payers.

For independent practitioners, a range of administrative activities and reporting requirements compete with patient time. Examples include prior-authorization processes (including following up on denials of care), referrals to specialists, and reporting requirements for quality measurement and incentive programs — and often the processes and online portals to accomplish these tasks vary across contracts (payers, IPAs, and ACOs). Practices can hire staff to handle administrative tasks — and many do — but additional staff increases labor costs.

Promising programs and developments:

- The California Advanced Primary Care Initiative, led by the Purchaser Business Group on Health's California Quality Collaborative and the Integrated Healthcare Association, has convened payers to participate in an alignment effort focused on transparency, payment, investment, and practice transformation. Small independent primary care practices are the focus of the value-based Payment Model Demonstration Project, launching in fall 2024, which features multi-payer alignment on the measure set and reporting platform.
- Enormous progress has been made in recent years on alignment of measures, the proliferation of which can be resource-intensive and burdensome for providers. The Centers for Medicare & Medicaid Services (CMS) has been working on the "Universal Foundation" of quality measures to streamline across programs; within California, the California Quality Collaborative and Integrated Healthcare Association have worked with stakeholders to align on a measure set for advanced primary care.
- California's largest public purchasers — DHCS, Covered California, and CalPERS (California Public Employees' Retirement System) — have aligned on key contract provisions related to primary care, creating a consistent approach to primary care measurement, reporting, and investment across payers and payer types.[29]

2. Support business operations of independent practices.

Providers receive extensive education and training to provide medical care, and no preparation to run a small business. Many respondents expressed interest in resources that would support the practical needs of running an independent practice; these might be provided by medical societies or specialty associations, medical schools or residency programs, or government agencies. Specific ideas included the following:

- Create a "Playbook for Independent Practices" that describes how to launch and maintain an office.
- Provide guidance on the best products for independent practice — considering both affordability and functionality — to support needs including human resources, billing and payroll services, electronic medical record vendors, and population health management platforms.
- Create "Advocates for Independent Practices" that can provide expert support on topics including review of payer/IPA contracts and assistance working with Medi-Cal.

- Help independent practices recruit providers to join them, perhaps by providing access to a recruiting firm or financial support for placing ads and funding site visits.
- Provide access to a pool of temporary staff who can fill in for providers who want to take vacations or sick days, thereby reducing burnout.

Promising programs and developments:

- The California Medical Association offers practice management tools and one-on-one assistance to members, as well as a Physician Services Organization focused on practice transformation support.
- County medical associations throughout the state offer programs and networking opportunities. Some, such as the Inland Empire Foundation for Medical Care (IEFMC) Population Health Fellowship, offer funding as well as learning curricula. Another example: In 2022, the Los Angeles County Medical Association offered small grants and practice transformation technical assistance through its Medical Practice Makeover Initiative.

3. Make it easier and more financially feasible for physicians to start or join independent practices, and increase awareness of this option.

Graduating residents in primary care are less likely to consider independent practice as an option, and those that do may be discouraged by the lack of a clear financial and operational pathway and lack of models and mentors.

Promising programs and developments:

- The Population Health Fellowship offered by IEFMC combines a one-year curriculum in population health management for residents who have just completed their third year with financial support in the form of a sign-on bonus, salary contribution, and contribution toward loan forgiveness.
- Partnership HealthPlan of California (PHC) offers a Provider Recruitment Program, with substantial incentives available for providers starting to practice in the plan's 14-county service area, either because of graduating from residency programs or moving to the area. While FQHCs (not independent practices) provide the bulk of the plan's primary care services for Medi-Cal beneficiaries, the program could serve as a model for supporting providers starting out in independent practice.
- The CAFP Residency Network, formed by the California Academy of Family Physicians to support collaboration across more than 70 family medicine residency programs, is working to increase exposure to independent practice as an option for graduating residents. Some primary care residency programs are exploring rotations with independent practices.
- Aledade has created a 15-month program, Aledade FIRST, to support primary care residents with education about value-based care, financial support, and coordination of job placement in an Aledade partner practice or community health center.

4. Commit to long-term investment in primary care, including increasing primary care reimbursement, and explicitly include independent practices.

Long-term commitment to increasing primary care reimbursement rates and reducing the gap between primary and specialty care compensation is needed to improve sustainability for providers and address primary care workforce shortages and access issues. Small independent practices should be explicitly considered, and initiatives tailored to meet their needs.

Promising programs and developments:

- The Office of Health Care Affordability (OHCA) at the Department of Health Care Access and Information is charged with increasing primary care investment in the state and has proposed a statewide primary care investment benchmark of 15% of total medical expense (TME) for primary care by 2034.[30] While the prospect of substantially greater investment in primary care is promising, current provisions do not explicitly consider independent practices.

- Medi-Cal rates for primary care providers increased to 87.5% of Medicare rates, effective January 1, 2024.[31] This targeted rate increase, which applies to both fee-for-service (FFS) providers and those contracted with Medi-Cal managed care plans, represents significant progress in the effort to increase investment in primary care. However, due to California's budget challenges for FY 2024–25, these increases will lapse in 2025; rate increases are scheduled to be reinstated in 2026 at 95% of Medicare rates. Moreover, a November 2024 ballot initiative, Proposition 35, if passed, would replace the state budget provisions and require that Medi-Cal reimbursement rates for primary care services increase above those in effect on January 1, 2024. These provisions would apply to all primary care providers serving Medi-Cal, including independent practices.

- DHCS's $140 million Equity and Practice Transformation Payments Program represents a substantial investment in practice transformation, targeting primary care practices through directed payments based on successful completion of activities and milestones in population health management domains along with technical assistance.

- In FFS payment arrangements, billing codes that represent the full range of advanced primary care services increase reimbursement and support sustainability of independent practices. The proposed 2025 Medicare Fee Schedule identifies 13 services as part of Advanced Primary Care Management (e.g., 24/7 access, comprehensive care management, care transitions coordination) and allows a provider to bill one of three codes (depending on the number of chronic conditions the patient has) each month for $10–$110 as a supplement to other billed services.[32] The proposed changes are part of an evolution of billing codes to ensure adequate payment for managing complex patients, such as transitional care management codes and chronic care management codes.

- Blue Shield of California (BSC) launched Primary Care Reimagined, a hybrid payment model based on the NASEM approach, combining capitation, fee-for-service, and performance incentives and targeting independent practices with at least 100 BSC members. BSC reports that about 300 practices have been enrolled to date, and that participating primary care practices earn more revenue than they did before enrolling, with better quality of care and lower total cost of care.[33]

5. Consider independent primary care practices, including rural practices, in policy and purchasing decisions.

Policy initiatives and regulatory requirements are often developed without careful consideration of the implications for independent practices and can have unintentional adverse effects. By incorporating the perspective of independent practices up front, policymakers and purchasers can avoid such effects — and even strengthen the independent primary care practice sector.

Promising programs and developments:

- OHCA's statutory mandate includes establishing goals for the adoption of alternative payment models (APMs) and developing standards to encourage alignment across APM arrangements.[34] APM adoption goals have the potential to adversely impact independent practices if payers meet the adoption goal by contracting with large delivery systems with existing value-based payment capabilities rather than working with smaller practices to transition to APMs. Several OHCA standards, and their associated implementation guidance, highlight the importance of including small independent practices in APM contracting. For example, standard 5 is "Engage a wide range of providers by offering payment models that are fiscally feasible to entities with varying capabilities and appetites for risk, including small independent practices and historically under-resourced providers."[35]

Looking Forward

California is facing a serious primary care workforce shortage, reaching crisis levels in some regions of the state such as Humboldt County. Strengthening the independent primary care sector could prevent further erosion of practices, preserve access to care, and even — given the connection between provider consolidation and higher price — mitigate health care cost growth.[36] While the "right" balance of independent practice and physician employment is not clear, it lies somewhere between the decades-old model of FFS solo practice and the current status quo in which corporate ownership has skyrocketed and UnitedHealth Group alone employs 90,000 physicians — about 10% of all physicians in the US.[37]

Supporting independent practice in California will take resources and investment from many actors, including purchasers, payers, and policymakers, in each of the five areas outlined above. Many promising initiatives are already underway, some of which could be tailored to specifically address the needs of independent practices; and more can be done.

Purchasers can do the following:

- With continued focus on multi-payer alignment, use available levers — primarily contracts with payers — to prioritize strengthening independent practice as an important component of provider networks. For example, purchasers could require payers to participate in multi-payer alignment initiatives that standardize administrative processes and reduce administrative burden.
- Consider contributing to a pool of funding and/or technical assistance resources available to independent practices, perhaps focused on geographic areas in which members are experiencing severe primary care access issues.

- DHCS could explore opportunities to (1) streamline the process of obtaining and maintaining Rural Health Clinic designation for small practices, including simplifying and providing technical assistance for PPS rate-setting, payments, and reconciliations; and (2) create a process for small RHCs to more easily increase their PPS rates over time, so that they are reasonable and sustainable.

Payers and/or IPAs can do the following:

- Align and coordinate to reduce administrative burden for independent practices, focusing competition on areas of distinctive value and collaborating to standardize common processes and requirements.
- As suggested in OHCA's APM standard, offer "payment models that are fiscally feasible to entities with varying capabilities and appetites for risk" — which, for small primary care practices, may mean shared savings models with technical assistance support.[38]
- Develop regional resources for common practice-level needs such as a shared inventory of community resources to support patient referrals; technical assistance to support practices with implementation of new resources (e.g., changing practice workflow) is key to success.
- Explicitly include independent practices in efforts to adopt innovations and best practices, such as generative AI. Epic and Oracle Health have announced initiatives to incorporate AI into their EMR products, emphasizing the potential for improved provider experience and reduced burnout.[39] Yet relatively few independent practices have access to the most sophisticated EMRs; if innovations that reduce administrative burden are available only through high-cost EMRs, the digital divide between large health systems and independent providers will be exacerbated.

Policymakers can do the following:

- Consider developing a loan program for independent practices modeled after the state's 2023 Distressed Hospital Loan Program, which provided interest-free loans to nonprofit and public hospitals struggling financially or at risk of closure. The focus of this loan program was on independent facilities: Hospitals that were part of a health system with more than two separately licensed facilities were ineligible.[40]
- Consider a tax credit for independent practices along the lines of the one Indiana passed in 2023: Newly established practices operating for at least six months of the tax year are eligible to receive a tax credit of $20,000 for the anchor year and two subsequent years.[41]
- Consider targeted investment in practice transformation for independent practices, perhaps modeled after the CMS technical assistance program aimed at small and rural practices during the transition to the Quality Payment Program, or on the California Data Exchange Framework's Grants Program.
- Consider implications for independent practices when creating new policies that broadly affect the health care workforce.

Acknowledgments

This project was funded by the California Health Care Foundation; Kathryn Phillips, MPH, associate director, provided guidance and feedback throughout the project. Many thanks to independent physicians who participated in interviews, sharing their perspectives and insights. Leaders of the Humboldt IPA, Riverside County Medical Association, and San Bernardino County Medical Society graciously provided introductions to physician members. Diane Rittenhouse, MD, MPH, senior fellow at Mathematica, served as clinical consultant for the project. Project advisors were Jeff Norris, MD, Value-Based Payment Branch chief at the California Department of Health Care Services; Barbara Rubino, MD, associate chief medical officer at Covered California; and Lisa Albers, MD, director of Clinical Policy and Programs at CalPERS (California Public Employees' Retirement System). The members of the Primary Care Investment Coordinating Group of California provided helpful feedback on an early draft. Several experts and stakeholders shared their time and insights, including leaders from the California Academy of Family Physicians, the California Medical Association, Blue Shield of California, Partnership HealthPlan of California, and the Eureka Family Medicine Residency Program. The perspectives expressed in this paper are those of the author and do not necessarily reflect the views of those interviewed or advisors.

About the Author

Jill M. Yegian, PhD, is principal at Yegian Health Insights, which provides strategic planning, market and policy analysis, and program design and implementation support aimed at improving the health care system on behalf of patients, providers, and payers.

About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. Lawrence P. Casalino et al., "**Small Primary Care Physician Practices Have Low Rates of Preventable Hospital Admissions**," *Health Affairs (Millwood)* 33, no. 9 (Sept. 2014): 1680–88.
2. Jason B. Gibbons et al., "**Small Practice Participation and Performance in Medicare Accountable Care Organizations**," *American Journal of Managed Care* 28, no. 3 (Mar. 2022): 117–23; and Michael Cohen et al., ***Medicare Accountable Care Organizations: Past Performance and Future Directions*** (PDF), Congressional Budget Office, April 2024.
3. James C. Robinson and Kelly Miller, "**Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California**," *JAMA* 312, no. 16 (Oct. 22/29, 2014): 1663–69.
4. Batel Blechter et al., "**Correlates of Burnout in Small Independent Primary Care Practices in an Urban Setting**," *Journal of the American Board of Family Medicine* 31, no. 4 (July–Aug. 2018): 529–36.
5. Reed Abelson, "**Corporate Giants Buy Up Primary Care Practices at Rapid Pace**," *New York Times*, updated May 12, 2023.
6. Karyn Schwartz et al., "**What We Know About Provider Consolidation**," KFF, September 2, 2020.
7. Cheryl L. Damberg, ***Health Care Consolidation: The Changing Landscape of the U.S. Health Care System***, RAND Corporation, May 17, 2023.
8. Donald M. Berwick, "***Salve Lucrum:* The Existential Threat of Greed in US Health Care**," *JAMA* 329, no. 8 (Jan. 30, 2023): 629–30; David M. Cutler, "**Financial Games in Health Care—Doing Well Without Doing Good**," *JAMA Health Forum* 5, no. 5 (May 9, 2024): e241591; Erin C. Fuse Brown et al., "**The Rise of Health Care Consolidation and What to Do About It**," *Health Affairs Forefront*, September 9, 2024; Robert Pearl, "**Private Equity and the Monopolization of Medical Care**," *Forbes*, February 20, 2023; and Eyal Press, "**The Moral Crisis of America's Doctors**," *New York Times Magazine*, updated July 14, 2023.
9. Linda McCauley et al., eds., ***Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*** (Washington, DC: National Academies Press, 2021), 1.
10. Hayden Rooke-Ley, Zirui Song, and Jane M. Zhu, "**Value-Based Payment and Vanishing Small Independent Practices**," *JAMA* 332, no. 11 (Aug. 22, 2024): 871–72.
11. Kate de Lisle et al., ***Analyzing the Expanded Landscape of Value-Based Entities*** (PDF), Health Management Associates, February 2024.
12. Yalda Jabbarpour et al., ***The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now***, Milbank Memorial Fund, February 28, 2024.
13. ***COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020*** (PDF), Physicians Advocacy Institute, June 2021.
14. Donna R. Shelley et al., "**Independent Primary Care Practices Are Small Businesses, Too**," *Health Affairs Forefront*, May 21, 2020.
15. "**The Health of US Primary Care: 2024 Scorecard Data Dashboard**," Milbank Memorial Fund, accessed September 11, 2024. From the map, select "California"; from the top navigation bars, select "Access" and then "Percentage of adults [or children] without a usual source of health care."
16. Kristin Schumacher, ***How California Is Strengthening Its Health Workforce: An Explainer***, California Health Care Foundation, May 21, 2024; and ***Health Workforce Research Data Center Annual Report to the Legislature*** (PDF), California Department of Health Care Access and Information, January 2023, 12–13.
17. ***Agenda Item 4: HCAI Workforce Programs Update*** (PDF), California Department of Health Care Access and Information, September 16, 2024, 3.
18. "**Proposition 56 – Supplemental Payment for Physician Services**," California Department of Health Care Services, accessed September 11, 2024.
19. "**Medi-Cal Targeted Provider Rate Increases and Investments**," California Department of Health Care Services, accessed September 11, 2024.
20. "**Equity and Practice Transformation Payments Program**," California Department of Health Care Services, accessed September 11, 2024.
21. Dawnielle Robinson-Walker, "**What Is Concierge Medicine and Is It Worth the Price Tag?,**" Forbes Health, May 18, 2023.
22. Jill Yegian and Katrina Connolly, ***Humboldt and Del Norte Counties: Community Collaboration in the Face of Health Adversity***, California Health Care Foundation, October 30, 2020.
23. ***Council on Graduate Medical Education Eighth Report: Patient Care Physician Supply and Requirements: Testing COGME Recommendations*** (PDF), Health Resources and Services Administration (HRSA), revised November 1996.
24. ***California Regional Markets: Humboldt/Del Norte*** (PDF), California Health Care Foundation, October 2020.
25. "**Federally Qualified Health Centers and Rural Health Clinics**," California Department of Health Care Services, accessed September 30, 2024; see also ***Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*** (PDF), California Department of Health Care Services, updated March 2024.
26. Matthew Newman and James Paci, ***Inland Empire: Increasing Medi-Cal Coverage Spurs Safety-Net Growth***, California Health Care Foundation, December 8, 2020.
27. "**Population Health Fellowship**," Inland Empire Foundation for Medical Care, accessed September 11, 2024.

28. Diane Rittenhouse et al., ***Supporting and Promoting High-Performing Physician-Owned Private Practices: Voices from the Front Lines*** (PDF), American Medical Association, October 22, 2021; Diane R. Rittenhouse et al., "**Small Independent Primary Care Practices Serving Socially Vulnerable Urban Populations**," *Annals of Family Medicine* 22, no. 2 (Mar. 2024): 89–94; and Ann S. O'Malley et al., "**Why Primary Care Practitioners Aren't Joining Value-Based Payment Models: Reasons and Potential Solutions**," The Commonwealth Fund, July 17, 2024.

29. Jill Yegian, ***California Public Purchaser Contract Provisions on Primary Care: Multi-Payer Alignment Drives Investment*** (PDF), California Health Care Foundation, May 2023.

30. ***Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark*** (PDF), Department of Health Care Access and Information, April 2024.

31. "**Medi-Cal Targeted Provider Rate Increases and Investments**," California Department of Health Care Services, accessed September 28, 2024.

32. Christopher F. Koller, "**Proposed Medicare Fee Schedule Brings Important New Tools to Primary Care: Has CMS Nailed It?**," Milbank Memorial Fund, August 14, 2024.

33. "**Cost-Reducing Strategies**," California Department of Health Care Access and Information, accessed September 30, 2024.

34. "**Alternative Payment Model Standards and Adoption Goals**," California Department of Health Care Access and Information, accessed September 30, 2024.

35. "Alternative Payment Model Standards," HCAI.

36. Jodi L. Liu et al., ***Environmental Scan on Consolidation Trends and Impacts in Health Care Markets***, RAND Corporation, September 30, 2022.

37. Steph Weber, "**10% of US Physicians Work for or Under UnitedHealth. Is That a Problem?**," Medscape, December 14, 2023.

38. "Alternative Payment Model Standards," HCAI.

39. Heather Landi, "**Epic Touts New AI Applications to Streamline Charting and Bring Research Insights to the Point of Care**," *Fierce Healthcare*, August 21, 2024; and Mike Miliard, "**Oracle Cerner Adds Generative AI to Its EHR Platforms**," *Healthcare IT News*, September 19, 2023.

40. "**Distressed Hospital Loan Program**," California State Treasurer's Office, accessed September 30, 2024.

41. **HEA 1004** (Ind. 2023).