MASSACHUSETTS
HEALTH POLICY COMMISSION

PRELIMINARY REPORT:
Cost and Market Impact Review of Mass General Brigham and CVS MinuteClinic Primary Care (HPC-CMIR-2025-2)

APRIL 16, 2026

About the Health Policy Commission

The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency charged with monitoring health care cost trends and making policy recommendations to improve the affordability of health care for all residents of the Commonwealth.

Through data-driven analysis, actionable policy insights, public accountability, and innovative investments, the HPC seeks to improve health care delivery, lower costs, and reduce health disparities.

The HPC is committed to better health and better care — at a lower cost — for all residents of the Commonwealth.

For more information, visit https://masshpc.gov.

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Introduction

In 2012, policymakers, the health care industry, advocates, and the business community in Massachusetts collectively recognized that the challenge of unsustainable and unaffordable health care cost growth required bold action. Continuing the state's proud legacy of nation-leading health care reform, the Legislature enacted comprehensive health care reform (Chapter 224) that introduced a first-in-the-nation, statewide goal for moderating the growth in total health care spending. The law also established the Massachusetts Health Policy Commission (HPC) to monitor and guide this ambitious effort and to bring new public transparency and oversight to the entire health care system.

To promote these goals, one of the HPC's core responsibilities is to monitor and publicly report on the evolving structure and composition of the health care market. Health care market changes, including consolidations and alignments between health care organizations under new care delivery and payment models, can impact health care market functioning and the performance of the health care system in delivering high-quality, accessible, cost-effective care that puts patients first.

Through the filing of notices of material change by provider organizations, the HPC tracks the frequency, type, and nature of changes in the health care market.[1] The HPC may also conduct a more comprehensive review of particular transactions anticipated to have a significant impact on health care costs or market functioning. The result of such "cost and market impact reviews" (CMIRs) is a public report detailing the HPC's findings. In order to allow for public assessment of the findings, the transactions may not be finalized until the HPC issues its Final Report. The HPC reports may identify areas for further review or monitoring, enlist commitments from parties regarding certain concerns raised by the review, and be referred to other state and federal agencies for further action.

Massachusetts was the first state to establish such a process, which has now been replicated in states throughout the country.[2] The notice and review process enhances the transparency of significant changes to our health care system and can inform and complement enforcement and regulatory efforts of other agencies, such as the Attorney General's Office, the Department of Public Health, the Center for Health Information and Analysis, and the Division of Insurance, in overseeing our health care market on behalf of Massachusetts consumers.

This document is the Preliminary Report on the HPC's eleventh CMIR, examining the proposed contracting affiliation between Mass General Brigham (MGB) and CVS MinuteClinic Primary Care through which MinuteClinic nurse practitioners would become primary care providers affiliated with MGB. In connection with the affiliation, CVS plans to transition 37 MinuteClinic locations throughout Massachusetts currently providing "convenience care" to MinuteClinic Primary Care locations, providing longitudinal primary care and managing primary care patient panels. This transaction involves the largest health care organization operating in Massachusetts (MGB) and the second-largest health care organization in the United States (CVS). Based on criteria articulated in Chapter 224, recently updated by Chapter 343 of the Acts of 2024, and informed by the facts of the transaction, the HPC analyzed the likely impact of this transaction, relying on the best available data and information. The review considered the parties' stated goals for the

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[1] *See* Mass. Gen. Laws ch. 6D, § 13 (requiring health care providers to notify the HPC before making material changes to their operations or governance). *See also* Mass. Health Policy Comm'n, 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews (Jan. 2, 2015), *available at* https://masshpc.gov/sites/default/files/2023-04/958cmr7.00-noticesofmcnandcmir.pdf (last visited April 15, 2026).

[2] *See* National Academy for State Health Policy, *State Action on Health Market Oversight Chart*, (Dec. 13, 2024) https://nashp.org/state-tracker/state-action-on-health-market-oversight-chart/ (last visited April 9, 2026).

transaction and the information provided in support of how and when it would result in efficiencies and improvements to care delivery and access to high quality health care services.

The HPC conducts this review as the Commonwealth is grappling with serious concerns regarding both access to primary care services and the overall affordability of health care.

Adequate spending on and utilization of primary care is associated with better health outcomes, including lower mortality.[3,4] Unfortunately, 43% of Massachusetts residents reported having difficulty accessing care in 2025, due most frequently to the inability to get an appointment with a doctor's office or clinic as soon as needed.[5] Residents who are Black, Indigenous, and People of Color and those with increased socioeconomic barriers to care face greater challenges accessing primary care.[6] This lack of primary care access leads to unnecessary hospital utilization, as approximately two-fifths of ED visits in Massachusetts between 2016 and 2023 were for conditions that could have either been prevented with appropriate primary care or treated in a primary care setting.[7]

This primary care crisis in Massachusetts is driven by many factors. Primary care is undervalued relative to other medical services, Massachusetts has an aging primary care physician workforce and among the lowest shares of new physicians entering the field, and misaligned incentives and high administrative burden exacerbated by traditional fee-for-service (FFS) payment models contribute to primary care clinician burnout and workforce shortages.[8] Massachusetts is in need of more primary care providers and greater patient access to high-quality primary care, and the HPC welcomes creative solutions and new, innovative models that deliver the four pillars of effective, person-centered primary care: first-contact care, continuity of care, comprehensive care, and coordination of care.

Concurrently, Commonwealth residents and businesses also face increasing strain from rising health care premiums and out-of-pocket costs. In recent years, commercial health care spending, premiums, and out-of-pocket costs have exceeded income growth, especially for those with lower incomes. Health care spending grew 7.8% and commercial health insurance premiums for fully-insured members increased 6.0% on average from 2022 to 2023, while residents in the 40th income percentile only experienced average income growth of 3.7% in that period.[9] As of 2024, Massachusetts had the highest employer-based family health insurance premiums in the U.S., at $28,151.[10] If present trends continue, by 2030 an average family would see a reduction in take-home pay of more than $600 per month.[11]

Massachusetts must work to address access to high-quality, comprehensive, efficient primary care, without compromising the goals of health care affordability. This principle has been strongly endorsed by the state's Primary Care Access, Delivery, and Payment Task Force, which – in its recommendation to establish a primary care spending target that would, at a minimum, double the share of health care spending on primary care as a percentage of total health care spending in five years – also recommended that "any

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[3] HEALTH POLICY COMM'N, A DIRE DIAGNOSIS: THE DECLINING HEALTH OF PRIMARY CARE IN MASSACHUSETTS AND THE URGENT NEED FOR ACTION (Jan. 2025) [hereinafter DIRE DIAGNOSIS], *available at* https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and (last visited April 4, 2026).
[4] *See* Basu 2019, *infra* note 90.
[5] 2025 MHIS, *infra* note 87.
[6] *CHIA Primary Care Databook*, *infra* note 89.
[7] DIRE DIAGNOSIS, *supra* note 3.
[8] *Id.*
[9] HEALTH POLICY COMM'N, 2025 ANNUAL HEALTH CARE COST TRENDS REPORT AND POLICY RECOMMENDATIONS (Dec. 2025) at 8, 15, *available at* https://masshpc.gov/sites/default/files/2025%20CTR_1.pdf (last visited Apr. 5, 2026).
[10] *Id.* at 58.
[11] *Id.* at 5.

increase in primary care spending should not result in an increase in the growth of overall health care expenditure trends or to a net new increase in health insurance premiums and cost-sharing."[12]

The CMIR process allows the HPC to consider proposed transactions in light of these and other trends, the opportunities and challenges they may pose, and their impact on short- and long-term health care spending, quality, access to needed services, and equity. Through this process, the HPC encourages providers and payers alike to evaluate and take steps to minimize negative impacts and enhance positive outcomes of any given material change.

Following an opportunity for the parties to respond to these findings in the Preliminary Report and offer any commitments to address issues raised, the HPC will publish a Final Report.

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[12] PRIMARY CARE TASK FORCE DELIVERABLE #3, *infra* note 180 at 2.

Acronyms, Abbreviations, and Naming Conventions

ACO	Accountable Care Organization
ADI	Area Deprivation Index
APP	Advanced Practice Provider
AGO	Massachusetts Attorney General's Office
AMC	Academic Medical Center
APCD	All-Payer Claims Database
BIPOC	Black, Indigenous, and People of Color
BH	Behavioral Health
CHIA	Massachusetts Center for Health Information and Analysis
CMIR	Cost and Market Impact Review
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DPH	Massachusetts Department of Public Health
ED	Emergency Department
EHR	Electronic Health Record
FTC	Federal Trade Commission
GPSR	Gross Patient Service Revenue
HCC	Hierarchical Condition Categories
HMO	Health Maintenance Organization
HOPDs	Hospital Outpatient Departments
HPC	Health Policy Commission
HRSN	Health Related Social Needs
HSA	Health Status Adjusted
HSA TME	Health Status Adjusted Total Medical Expenses
LARC	Long-Acting Reversible Contraception
LPN	Licensed Practical Nurse
MA-RPO	Massachusetts Registration of Provider Organizations Program
MCN	Material Change Notice
NP	Nurse Practitioner
NPI	National Provider Identifier
NPSR	Net Patient Service Revenue
OUD	Opioid Use Disorder
PBM	Pharmacy Benefit Manager
PCAT	Primary Care Assessment Tool
PCMH	NCQA's Patient-Centered Medical Home
PCP	Primary Care Provider
POS	Point of Service
PSA	Primary Service Area
PQI	Prevention Quality Indicator
RN	Registered Nurse
TME	Total Medical Expenses

Parties and Related Organizations

CVS	CVS Health
MinuteClinic	CVS MinuteClinic
MCPC	MinuteClinic Primary Care
CVS MSO	CVS Management Support LLC
MGB	Massachusetts General Brigham
MGB ACO	Massachusetts General Brigham Accountable Care Organization
MGB MassHealth ACO	Massachusetts General Brigham MassHealth Accountable Care Organization

Payers

BCBS	Blue Cross Blue Shield of Massachusetts
MGBHP	Mass General Brigham Health Plan
HPHC	Harvard Pilgrim Health Plan

Other Providers

BILH	Beth Israel Lahey Health
BMC	Boston Medical Center
Tufts	Tufts Medicine Integrated Network
UMass	UMass Memorial Health Care, Inc.

Executive Summary

On June 6, 2025, Mass General Brigham (MGB) and CVS Health (CVS), through its subsidiary MinuteClinic Primary Care Massachusetts, (collectively "the parties") filed Notices of Material Change (MCNs) with the Health Policy Commission (HPC) regarding a proposed new contracting affiliation.[13] Under the proposed affiliation, CVS plans to transition its 37 Massachusetts MinuteClinic sites, which currently provide limited "convenience care" services, to become MinuteClinic Primary Care (MCPC) sites, offering a broader range of services in affiliation with the MGB contracting network.[14] MCPC's advanced practice providers (APPs), all nurse practitioners (NPs) in Massachusetts, would become MGB-affiliated primary care providers (PCPs), joining MGB's Accountable Care Organization (MGB ACO),[15] and becoming participating providers in MGB's value-based contracts with payers.

The parties state that approximately 80 existing MinuteClinic APPs could eventually manage primary care panels of 1,500 patients each, which could create capacity to serve up to 120,000 adult primary care patients across the state, although information shared with the HPC indicates that the parties expect MCPC to serve a smaller number of primary care patients in the first few years.[16] The parties state that the transaction would expand access to primary care for patients who do not currently have a PCP, including current MinuteClinic patients, those who are on an MGB PCP waitlist, and those who had an MGB PCP who separated due to retirement or changes in employment. The parties expect that this transition to the MCPC model would help alleviate the Commonwealth's primary care crisis, including by supporting MGB to increase access to primary care for its own patients,[17] given that approximately 15,000 patients in the MGB system have no PCP and have been waiting for months to see a provider in person.[18]

In connection with the transaction, CVS would apply to the Massachusetts Department of Public Health (DPH) for full clinic licensure for its MinuteClinic locations, which currently hold limited services clinic licenses,[19] to transition these sites to full clinics capable of providing primary care.[20] The parties state that parts of Worcester County, Bristol County, and western Massachusetts, in particular, are expected to benefit from increased capacity.[21] To date, the parties have not publicly announced the sites they would prioritize for transition.

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[13] MASS GENERAL BRIGHAM, INC, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMMISSION (JUNE 6, 2025), AS REQUIRED UNDER MASS GEN. LAWS CH. 6D § 13 (2012), *available at* https://masshpc.gov/sites/default/files/2025-06/20250606-MGB-CVS_MCN.pdf [hereinafter MGB MCN]; CVS HEALTH, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMMISSION (JUNE 6, 2025), AS REQUIRED UNDER MASS GEN. LAWS CH. 6D § 13 (2012), *available at* https://masshpc.gov/sites/default/files/2025-06/20250606-CVS-MGB_MCN.pdf [hereinafter CVS MCN].

[14] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13; *See* 105 CMR 140.020, *available at* https://www.mass.gov/doc/105-cmr-140-licensure-of-clinics/download.

[15] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.

[16] *Id.* Materials provided to the HPC indicate that CVS expects approximately 35% of MCPC's unique patients would be primary care patients by the third year after the transaction, if there is "moderate acceptance" of MCPC primary care by current MinuteClinic patients. The HPC estimates that this would result in MCPC serving approximately 42,000 primary care patients by the third year after the transaction.

[17] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.

[18] Jonathan Saltzman, *Why are so many primary care clinicians moving from Mass General Brigham to Beth Israel?*, BOSTON GLOBE, Nov. 24, 2025, *available at* https://www.bostonglobe.com/2025/11/24/business/mass-general-brigham-beth-israel-lahey/ (last visited April 15, 2026).

[19] Limited services clinics provide a limited scope of care including vaccinations, diagnosis and treatment for conditions like upper respiratory and sinus infections, and some wellness exams. *See* definition of "Limited Services," 105 CMR 140.020. MinuteClinic locations are the only licensed limited services clinics in the state.

[20] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.

[21] *Id.*

After a 30-day initial review, the HPC determined that the proposed transaction was likely to have a significant impact on costs and market functioning in Massachusetts and warranted further review. Following an opportunity for the parties to respond to the findings in this Preliminary Report, the HPC will issue a Final Report.

This report includes an outline of the analytic approach and the data utilized; a description of the parties to this CMIR and their goals and plans for undertaking the transaction; and the HPC's findings. Below is a summary of the findings presented in Section III:

1. **Cost and Market Profile.** MGB is the state's largest health care organization, comprising eleven Massachusetts hospitals, a large physician network, and the insurer Mass General Brigham Health Plan (MGBHP). MGB is the state's largest provider of primary care services, providing approximately 17% percent of primary care physician services statewide, and serving patients primarily in eastern Massachusetts. CVS is the second-largest health care organization in the United States, with more than 9,000 pharmacies and 900 MinuteClinic sites nationally, the insurer Aetna, and the pharmacy benefit manager (PBM) CVS Caremark. In Massachusetts, CVS operates 37 MinuteClinic locations, with a somewhat more broadly distributed patient population compared to MGB, including more of western Massachusetts. MGB generally has the highest prices in the Commonwealth for health care services, including adult primary care services. MinuteClinic's convenience care prices have historically been less than half of MGB's prices for the same services with the same provider type, and substantially lower than those of other comparable providers. MGB primary care patients have the highest spending among the largest Massachusetts provider organizations.

2. **Cost and Market Impact.** The transaction is likely to impact health care spending in key quantifiable ways:

   Spending for New Primary Care Patients: New primary care patients are expected to receive primary care services at MCPC at MGB's higher prices and are expected to be referred to higher-priced MGB specialists and hospitals. At the same time, patients who did not previously have a PCP would now have access to one, with changes to care that may reflect appropriate and improved management of health conditions. Based on analysis of spending trends of generally low-complexity primary care patients who are new to the MGB network, the HPC projects that these dynamics, combined, are likely to result in a commercial spending increase of approximately $27.7 million annually.

   Repricing of Convenience Care Services: The convenience care MCPC would continue to provide would be repriced at MGB prices, which are 129% higher, on average, than MinuteClinic's prices, likely increasing commercial spending by an additional $6.6 million annually.

   Diversion of Some Convenience Care Patients to Other Providers: As MCPC develops primary care panels and correspondingly decreases its convenience care capacity, some patients who would have otherwise sought convenience care at MinuteClinic locations are anticipated to be diverted to other providers, which are generally higher-priced, likely resulting in an additional commercial spending increase of approximately $5.9 million annually.

   These are conservative estimates of spending impacts in year three, based on the parties' projections of "moderate acceptance" of their model in that period, in which approximately 35% of all MCPC patients are primary care panel members. However, these annual spending impacts would increase if more primary care patients were to join the MCPC patient panel, and they would be significantly higher if MCPC sites were each to fill their primary care patient panels to the

maximum size. There are further cost and market impacts that the HPC is unable to quantify in its analysis, including the impact of additional bargaining leverage for MGB as a result of this expansion of MGB's primary care footprint. Expanding access to primary care could result in longer-term health care savings than incorporated in the HPC's spending estimates. The likelihood and scope of additional savings depends heavily on the success of the new MCPC model.

3. **Access and Quality Profile.** MGB and CVS are important providers of primary care and convenience care services, respectively, in Massachusetts. Both MGB and CVS serve higher proportions of commercial patients and lower proportions of Medicaid patients than the statewide average. MGB has historically performed comparably to or better than the statewide average on available quality metrics, and quality measures tracked by MinuteClinic appear to indicate generally strong performance, although comparator data are not available.

4. **Access and Quality Impact.** The transition of MinuteClinic sites to MCPC primary care locations has the potential to increase access to primary care for adult patients through a novel care delivery model in a retail setting that would meaningfully expand the services that MinuteClinic provides. However, the magnitude of this increase depends on the success of the model over time, which is difficult to predict based on current evidence, and on some key, yet-to-be-determined details of implementation. In particular, the potential for improved access to primary care for populations facing socioeconomic barriers may depend on how the parties prioritize the transition of sites in areas of greatest need. Further, focused effort to promote the use of the new primary care sites among MassHealth patients would likely be required to meaningfully increase access for MassHealth members.

   At the same time, the transition to MCPC may pose certain risks to access: shifting away from all-ages convenience care would eliminate access to convenience care for children and reduce access for adults. Further, it is unclear whether this new primary care model would be successful over the long term. To the extent it fails, access may be reduced relative to the status quo.

   Whether MCPC would provide comprehensive, high-quality primary care ultimately is uncertain. While the proposed care model includes key elements of comprehensive primary care, it also has notable limitations, and MCPC's ability to deliver high-quality care in coordination with MGB would depend heavily on how the model is implemented.

In summary, this transaction is likely to result in an increase to annual commercial health care spending of approximately $40.2 million by year three of the transaction, which includes spending increases for MCPC's new primary care patients and higher prices for both MCPC's continuing convenience care services and the convenience care services that would need to move to other providers. MinuteClinic's transition to primary care has the potential to increase access to adult primary care services, although CVS would need to prioritize support for sites in areas of higher need and target its outreach efforts thoughtfully to meaningfully improve access for populations facing socioeconomic barriers to care. The shift away from all-ages convenience care, however, would reduce access to those services, particularly for children. Finally, it is unclear whether MCPC would ultimately be able to provide comprehensive, high-quality primary care given that much would depend on how its plans are implemented.

Regular reporting of relevant cost, quality, and access metrics for the MCPC sites following the transaction would also provide the public with additional information about the impact and efficacy of the parties' proposed plans. If the transaction proceeds, the HPC expects to require ongoing reporting of certain metrics that are not otherwise publicly available in order to track the impact of the transaction over time, consistent with the HPC's authority to require ongoing reporting from parties for five years post-transaction.

The HPC welcomes any additional information the parties would like to provide in response to this report regarding measures it expects to track over time and those that could be provided to allow for ongoing evaluation of the impact of the parties' efforts on health care spending and on access to high-quality primary care.

The HPC invites the parties to provide any additional details in response to questions and concerns raised in this report in their written response, including any commitments. The parties should consider commitments regarding mitigation of spending impacts, as well as commitments to maximize the potential for improved access to high-quality care. Following the period for written response, the HPC will publish its Final Report, including any referrals or recommendations to other state agencies.

I. Analytic Approach and Data Sources

A. Analytic Approach

The Health Policy Commission (HPC) is tasked with examining impact in three interrelated areas in a cost and market impact review (CMIR):[22]

1. **Costs and Market Functioning.** The HPC may examine factors such as prices, total medical expenses, provider costs, and other measures of health care spending as well as market share, the provider's methods for attracting patient volume and health care professionals, and the provider's impact on competing options for care delivery.
2. **Access to and Equity of Care.** The HPC may also examine factors relating to the availability and accessibility of services provided and health equity, such as unmet need and the provider's role in serving at-risk, underserved, and government-payer patient populations.
3. **Quality and Care Delivery.** The HPC may examine factors related to the quality of services provided, including patient experience.

Additionally, the HPC may consider any other factors it deems to be in the public interest, including consumer concerns.[23]

Within this statutory and regulatory framework, the HPC determines those factors most relevant to a given transaction and then gathers detailed information relevant to those factors from the sources discussed below. The HPC examines recent data to establish the parties' ***baseline performance and current trends*** in each of these areas prior to the transaction. The HPC then combines the parties' baseline performance with known details of the transaction, as well as the parties' goals and plans, to project the ***impact of the transaction***. The analytic section of this report is divided into two parts, each addressing the parties' baseline performance and the likely impact of the transaction: Section III.A addresses costs and market functioning and Section III.B addresses access to and quality of care.

B. Data Sources

To conduct this review, the HPC relied on the documents and data the parties produced in response to information requests,[24] the parties' own description of the transaction as presented in their material change notices, and publicly available information published by the parties. The HPC also utilized information from the Massachusetts Registration of Provider Organizations program (MA-RPO)[25] and obtained data and documents from a number of other sources. These include other state agencies such as the Center for Health Information and Analysis (CHIA), from which the HPC received provider- and payer-

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[22] *See* MASS. GEN. LAWS ch. 6D, § 13(d) and 958 CMR 7.06.

[23] *Id*.

[24] The parties provided information to the HPC over the course of more than ten months, including responses to the HPC's initial information requests, to clarifying questions about initial submissions, and under their continuing obligation to produce information relevant to the HPC's information requests whenever it becomes available during the course of the HPC's review.

[25] MASS. GEN. LAWS ch. 6D, § 11 and ch. 12C, § 9 (requiring provider organizations to register annually with the HPC and CHIA and provide information on organizational structure and affiliations, and other requested information); *see also* 958 CMR 6.00 (2014) and 957 CMR § 11.00 (2017); *Registration of Provider Organizations*, MASS. HEALTH POLICY COMM'N, https://masshpc.gov/moat/rpo

level data,[26] and enrollment and claims-level data from the All-Payer Claims Database (APCD);[27] federal agencies such as the Centers for Medicare and Medicaid Services (CMS);[28] academic and research institutions, such as the University of Wisconsin School of Medicine and Public Health Neighborhood Atlas;[29] and other market participants. The HPC appreciates the cooperation of all entities that provided information in support of this review.

To conduct this review and analysis, HPC analysts, attorneys, economists, and care delivery experts worked alongside consultants with extensive experience evaluating providers and provider transactions and their impact on health care costs and the health care market, including economists, accountants, and clinician experts in health care quality and care delivery.

Where analyses rely on nonpublic information produced by the parties or other market participants, state law prohibits the HPC from disclosing such information without the consent of the producing entity, except in a preliminary or final CMIR report where "the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations."[30] Consistent with this requirement, this Preliminary Report contains only limited disclosures of such confidential information where the HPC has determined that the public interest in disclosure outweighs privacy, trade secret, and anti-competitive considerations.

For each analysis, the HPC utilized the most recent and reliable data available. Because data—whether publicly reported or privately held—are usually generated after some time has passed for data submission and cleaning, and on a variable schedule from entity to entity, the most recent and reliable data primarily reflect 2022 or 2023 data. The HPC has noted the applicable year for the underlying data throughout this report and, wherever possible, has examined multiple years of data to analyze trends and to report on the consistency of findings over time. For data and materials produced by the parties and other market participants, the HPC tested the accuracy and consistency of the data collected to the extent possible but also relied in large part on the producing party for the quality of the information provided.

Finally, most cost and market analyses focus on the anticipated impact in the commercially insured market. In the commercially insured market, prices for health care services – whether fee-for-service, global budgets, or other forms of alternative payments – are established through private negotiations between payers and providers. The terms of these payer-provider contracts vary widely with regard to both price and other material terms that impact health care costs and market functioning.

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[26] These data include relative price (RP) data, total medical expense (TME) data, and quality data. See *Relative Price and Provider Price Variation*, CTR. FOR HEALTH INFO. & ANALYSIS, https://www.chiamass.gov/relative-price-and-provider-price-variation/ (last visited April 8, 2026); *Total Health Care Expenditures, Total Medical Expenses and Alternative Payment Methods*, CTR. FOR HEALTH INFO. & ANALYSIS, https://www.chiamass.gov/thce-tme-apm (last visited April 8, 2026); *Clinical Quality and Patient Experience Measures*, CTR. FOR HEALTH INFO. & ANALYSIS, (2023), https://www.chiamass.gov/equity-in-quality-of-care-select-clinical-quality-and-patient-experience-measures#tableau-interactive (last visited April 6, 2026).
[27] *All-Payer Claims Database*, CTR. FOR HEALTH INFO. & ANALYSIS, http://www.chiamass.gov/ma-apcd/ (last visited April 8, 2026).
[28] *National Plan and Provider Enumeration System (NPPES),* U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES, *available at* https://nppes.cms.hhs.gov/login (downloaded July 2023).
[29] *2023 Area Deprivation Index v.4.0.1,* UNIV. WISCONSIN SCH. MED. PUB. HEALTH CTR. FOR HEALTH DISPARITIES RES., https://www.neighborhoodatlas.medicine.wisc.edu/ (downloaded Nov. 19, 2025).
[30] MASS. GEN. LAWS ch. 6D, § 13(c), *amended by* 2013 Mass. Acts 38, § 20; 958 CMR 7.09.

C. Methodologies

The analyses in this report build on well-established methodologies used in economic research, antitrust litigation, and prior HPC studies. Where possible the HPC made conservative assumptions in modeling potential impacts and presents quantitative findings only where they are well supported by available data and methodology. In most analyses the HPC modeled various sensitivities based on different underlying assumptions, resulting in ranges of potential impacts of the proposed transaction.

Additional details of the HPC's methodologies are provided throughout this report and in the Data Appendix.

II. Overview of the Parties and the Transaction

On June 6, 2025, Mass General Brigham (MGB) and CVS Health (CVS), through its subsidiary MinuteClinic Primary Care Massachusetts (collectively "the parties"), filed Notices of Material Change (MCNs) with the HPC regarding a proposed new contracting affiliation.[31] Under the proposed affiliation, CVS would transition its 37 Massachusetts MinuteClinic sites, which currently provide limited "convenience care" services, to become MinuteClinic Primary Care (MCPC), offering a broader range of services in affiliation with the MGB contracting network.[32] MCPC's advance practice providers (APPs), all nurse practitioners (NPs) in Massachusetts, would become MGB-affiliated primary care providers (PCPs), joining MGB's Accountable Care Organization (MGB ACO),[33] and becoming participating providers in MGB's value-based contracts with payers.

In connection with the transaction, CVS would apply to the Massachusetts Department of Public Health (DPH) for full clinic licensure for its MinuteClinic locations, which currently hold limited services clinic licenses,[34] to transition these sites from limited services clinics to full clinics capable of providing primary care.[35] The parties state that their proposed "scalable, APP-led model" would improve access to primary care by adding new primary care sites and expanding primary care access during evenings and weekends, supporting the growth of primary care "amid a shrinking physician pipeline."[36] The parties note that MCPC sites overlap with regions identified by the HPC as having primary care access challenges, including parts of Worcester County, Bristol County, and western Massachusetts.[37]

This section describes the parties and the proposed transaction.

A. Overview of the Parties

1. Mass General Brigham

Founded in 1994 by two academic medical centers (AMCs), Brigham and Women's Hospital (912 beds)[38] and Massachusetts General Hospital (1,065 beds),[39] MGB is the largest health care provider in Massachusetts and owns a health plan, MGB Health Plan (MGBHP).[40] MGB is financially robust overall.[41]

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[31] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.
[32] *Id.*; *See* 105 CMR 140.020.
[33] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.
[34] *See infra* Section II.A.2 for a discussion of limited services clinics.
[35] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.
[36] *Id.*
[37] *Id.*
[38] CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES: DATA THROUGH HOSPITAL FISCAL YEAR 2024, (Jan. 2026) at 4, *available at* https://www.chiamass.gov/assets/docs/r/hospital-profiles/2024/FY24-Massachusetts-Hospital-Profiles-Compendium.pdf (last visited April 5, 2026).
[39]*Id.* at 5.
[40] *About Us*, BRIGHAM AND WOMEN'S, *available at* https://give.brighamandwomens.org/about-us/ (Last visited March 10, 2025).
[41] MGB's HFY2025 performance reflects a continued recovery from pandemic-era operating losses, with a return to modest positive operating margins for a second consecutive year. CTR. FOR HEALTH INFO. & ANALYSIS, HOSPITAL AND HOSPITAL HEALTH SYSTEM ANNUAL PERFORMANCE (2026), *available at* https://www.chiamass.gov/hospital-and-hospital-health-system-annual-performance (last visited March 11, 2026). MGB's financial position is supported by a total margin of 9.5% compared to a statewide median of -6.6%, although its operating margin of 0.2% is comparable to the statewide median of 0.3%.MGB also maintained substantially stronger liquidity than the statewide median in HFY25, including 256 days cash on hand compared to an average of 24 days statewide and a current ratio of 3.1 compared to 1.2 statewide. CTR. FOR HEALTH INFO. & ANALYSIS, *Massachusetts Acute Hospital and Health System Financial Performance HFY 2024 Databook*, https://chiamass.gov/assets/Uploads/mass-hospital-financials/2024-annual-report/Acute-Hospital-Fina....

In addition to its two founding AMCs, MGB owns an extensive network of community and specialty hospitals. MGB's community hospitals in Massachusetts[42] include:

- Brigham and Women's Faulkner Hospital (Jamaica Plain): 171 beds[43]
- Cooley Dickinson Hospital (Northampton): 151 beds[44]
- Martha's Vineyard Hospital (Oak Bluffs): 31 beds[45]
- Nantucket Cottage Hospital (Nantucket): 18 beds[46]
- Newton-Wellesley Hospital (Newton): 339 beds[47]
- Salem Hospital (previously named North Shore Medical Center) (Salem): 403 beds[48]

MGB's specialty hospitals include Mass Eye and Ear, McLean Hospital, and Spaulding Rehabilitation.[49] MGB also owns 191 locations described as outpatient health care centers, 54 locations described as imaging centers, 43 blood draw labs, and 22 urgent care centers.[50]

MGB has established an HPC-certified ACO ("MGB ACO") that provides payer contracting services, population health management and quality improvement programs, and electronic record optimization to a large network of owned and affiliated providers.[51] MGB ACO holds commercial risk contracts, participates in the MassHealth ACO program as an Accountable Care Partnership ACO with MGBHP, and participates in the Medicare Shared Savings Program.[52]

MGB's network of employed and affiliated physicians in Massachusetts includes 7,776 physicians, representing 30% of all physicians in Massachusetts.[53] MGB's provider network also includes more than 3,500 APPs, including physician assistants, NPs, certified registered nurse anesthetists, psychiatric clinical nurse specialists, and certified nurse midwives.[54]

MGB is the state's largest provider of primary care, both within its primary care primary service area (PSA) and statewide; in 2024, MGB's statewide share of primary care physician visits was 17% while its share of primary care physician spending was 24%.[55] About 1,206 (15.5%) of MGB's 7,776 physicians are primary

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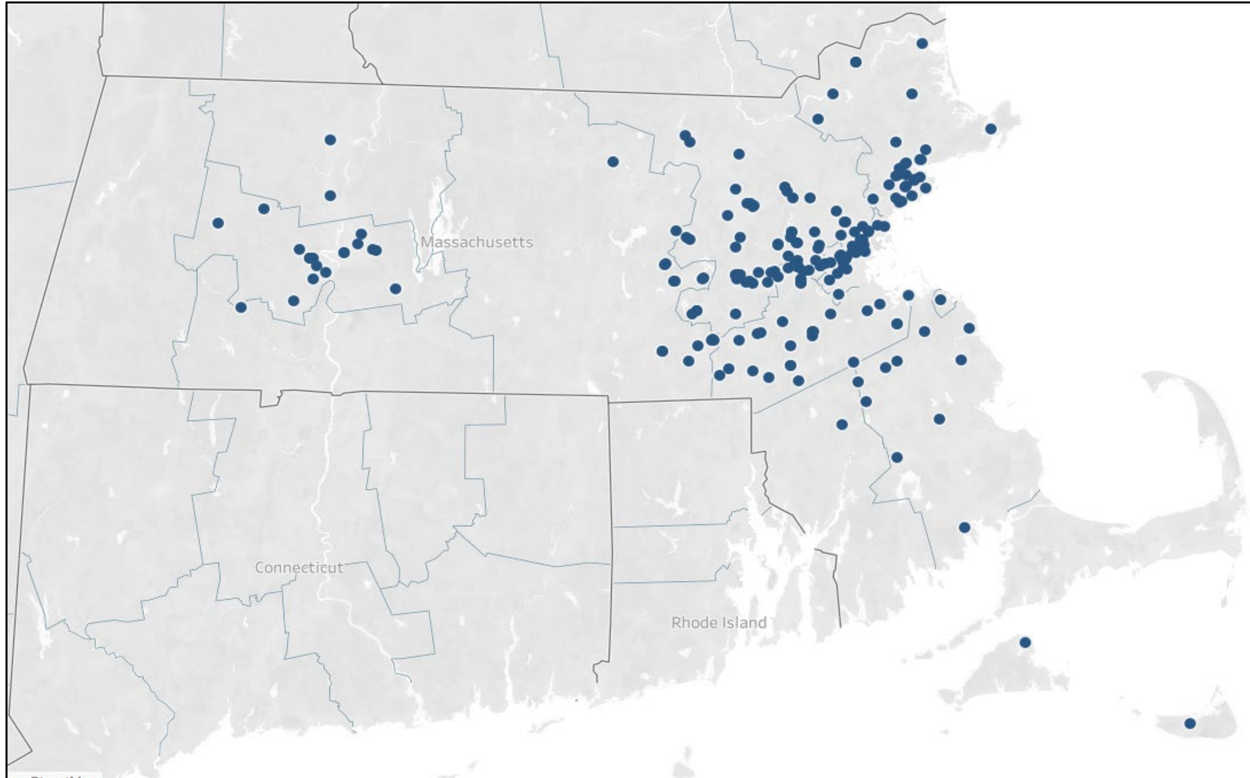
[42] MGB also owns Wentworth Douglass Hospital in New Hampshire.
[43] *Supra* note 38 at 9.
[44] *Id.* at 33.
[45] *Id.* at 19.
[46] *Id.* at 21.
[47] *Id.* at 22.
[48] *Id.* at 48.
[49] *Id.* at 6, 25.
[50] *Mass General Brigham's Locations*, MASS GENERAL BRIGHAM, https://www.massgeneralbrigham.org/en/patient-care/services-and-specialties/find-a-location (last visited April 5, 2026).
[51] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13. Current MGB ACO contracting affiliates include Affiliated Pediatric Practices, Charles River Medical Associates, Emerson Hospital/Emerson IPA, and Milford Regional Physician Group. MASSACHUSETTS REGISTRATION OF PROVIDER ORGANIZATIONS 2024 FILING: MASS GENERAL BRIGHAM (Feb. 26, 2025) [hereinafter MGB 2024 MA-RPO FILING].
[52] HEALTH POLICY COMM'N, ACCOUNTABLE CARE ORGANIZATIONS IN MASSACHUSETTS: PROFILES OF THE LEAP 2024-2025 CERTIFIED ACOS, *available at* https://masshpc.gov/sites/default/files/ACO%20profiles_accessibility.pdf (last visited April 9, 2026).
[53] MGB 2024 MA-RPO FILING, *supra* note 51.
[54] *Brigham and Women's Physician Assistants*, BRIGHAM AND WOMEN'S, https://www.brighamandwomens.org/medical-professionals/physician-assistant-services/pa-services-overview (Last visited March 26, 2026).
[55] Note that this analysis does not include services provided by primary care providers who are not physicians, and in particular that it does not include APP services, because the HPC does not currently have comprehensive affiliation data for the APPs of provider organizations other than MinuteClinic.

care physicians who work in MGB physician offices primarily located in the Boston area and the North and South Shore (see map below).[56] At these locations, patients can receive physical examinations, regular checkups, vaccinations, cancer screenings, treatment for conditions and illnesses such as COVID-19, the flu, allergies, etc., as well as assistance with managing chronic health conditions like diabetes or asthma.[57]

Figure II.A.1: MGB Primary Care Locations



Source: HPC analysis of 2024 MA-RPO data.

In spite of its statewide reach and large primary care network, a reported 15,000 patients in the MGB system have no PCP and have been waiting for months to see a provider in person.[58] At the same time that many patients are unable to access MGB primary care, existing MGB primary care physicians have recently expressed concerns with their work experience, including being "overwhelmed with patients" and having so much administrative work that it is difficult to keep a manageable work schedule, and are currently seeking to unionize as a mechanism to address these issues.[59] MGB has pledged to invest close to $400 million in primary care, including by hiring 90 new support staff and adding doctors.[60]

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[56] MGB 2024 MA-RPO FILING, *supra* note 51.
[57] *Primary Care*, MASS GENERAL BRIGHAM, https://www.massgeneralbrigham.org/en/patient-care/services-and-specialties/primary-care (Last visited March 10, 2026).
[58] Saltzman, *supra* note 18.
[59] Jonathan Saltzman & Bryan Hecht, *Mass General Brigham primary care doctors ask lawmakers for help with union fight*, BOSTON GLOBE, Feb. 10, 2026, *available at* https://www.bostonglobe.com/2026/02/10/business/mass-general-brigham-primary-care/ (last visited March 26, 2026).
[60] Saltzman, *supra* note 18.

2. CVS Health

CVS is the country's second largest health care company, after United Healthcare Group.[61] CVS's total revenue was $372.8 billion in 2024.[62] CVS owns a network of more than 9,000 pharmacies, the insurer Aetna, and the pharmacy benefit manager (PBM) CVS Caremark, as well as more than 900 MinuteClinic convenience care locations in select CVS Pharmacy and Target stores in 33 states and Washington, D.C.[63] In FY 2024, MinuteClinic locations in Massachusetts had total net patient service revenue (NPSR) of approximately $17.4 million.

In addition, CVS offers primary care in 12 states and Washington, D.C. CVS launched its national primary care strategy in 2024, when MinuteClinic began providing primary care services to Aetna members in certain areas of Texas, Georgia, South Florida, and North Carolina.[64] In the last year, it has expanded this effort to eight additional states and Washington, D.C.,[65] including through partnerships with large health systems such as Emory Healthcare Network in Georgia (beginning in February 2025),[66] Fairview Physician Associates Network in Minnesota (beginning in July 2025),[67] and Rush Health in Chicago (beginning in December 2025).[68] In addition, separately from the expansion of primary care in MinuteClinic settings, in 2023 CVS acquired Oak Street Health, a company that operates primary care centers for older adults in 27 states (Oak Street Health does not have any locations in Massachusetts).[69]

In Massachusetts, CVS has 37 MinuteClinic locations, or retail clinics, which are currently licensed as "limited services clinics," and CVS is the only provider so licensed in Massachusetts.[70] As limited services clinics, MinuteClinic cannot provide surgical, dental, physical rehabilitation, mental health, substance use

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[61] Molly Gamble, *Fortune 500's top 25 healthcare companies*, BECKER'S HOSPITAL REVIEW, (June 2, 2025), *available at* https://www.beckershospitalreview.com/rankings-and-ratings/fortune-500s-top-25-healthcare-companies/ (last visited April 8, 2026).

[62] *CVS Health Revenue 2012-2025*, MACROTRENDS, https://www.macrotrends.net/stocks/charts/CVS/cvs-health/revenue (Last visited March 26, 2026).

[63] *Neighborhood Pharmacy*, CVS HEALTH, https://www.cvshealth.com/services/pharmacy/neighborhood-pharmacy.html#:~:text=Transforming%20health%20through%20local%20care,more%20accessible%20for%20more%20people (last visited April 5, 2026); *CVS Health Completes Acquisition of Aetna, Marking the Start of Transforming the Consumer Health Experience*, CVS HEALTH (Nov. 28, 2018), *available at* https://investors.cvshealth.com/news/news-details/2018/CVS-Health-Completes-Acquisition-of-Aetna-Marking-the-Start-of-Transforming-the-Consumer-Health-Experience/default.aspx#:~:text=CVS%20Health%20(NYSE:%20CVS)%20completed%20its%20acquisition,$212%20per%20share%20or%20approximately%20$70%20billion** (last visited April 5, 2026); *Our History*, CVS HEALTH, https://www.cvshealth.com/about/our-strategy/company-history.html (last visited April 5, 2026); *Frequently Asked Questions*, CVS HEALTH, https://www.cvs.com/minuteclinic/info (last visited April 5, 2026).

[64] *CVS Health Expands Access to Primary Care Services at Select MinuteClinic Locations*, CVS HEALTH, (Nov. 12, 2024), *available at* https://www.cvshealth.com/news/community/cvs-health-expands-access-to-primary-care-services-at-select-minuteclinic-locations.html (last visited April 5, 2026).

[65] *How CVS is Working With Health Systems to Push Primary Care*, MODERN HEALTHCARE, (Sept. 5, 2025) *available at* https://www.modernhealthcare.com/providers/mh-cvs-minuteclinic-emory-rush-primary-care/ (last visited April 5, 2026).

[66] *Minute Clinic and Emory Healthcare Network Expand Primary Care Access to Georgians*, EMORY NEWS CTR. (Feb. 20, 2025), *available at* https://news.emory.edu/stories/2025/02/hs_cvs_minuteclinic_ehn_primary_care_collaboration_20-02-2025/story.html (last visited April 5, 2026).

[67] *Supra* note 65.

[68] *Rush Health Partners with MinuteClinic at CVS to Expand Access to Primary Care*, RUSH, *available at* https://www.rush.edu/news/rush-health-partners-minuteclinic-cvs-expand-access-primary-care (last visited April 5, 2026).

[69] *CVS Health completes acquisition of Oak Street Health*, CVS HEALTH, https://www.cvshealth.com/news/company-news/cvs-health-completes-acquisition-of-oak-street-health.html (last visited April 5, 2026).

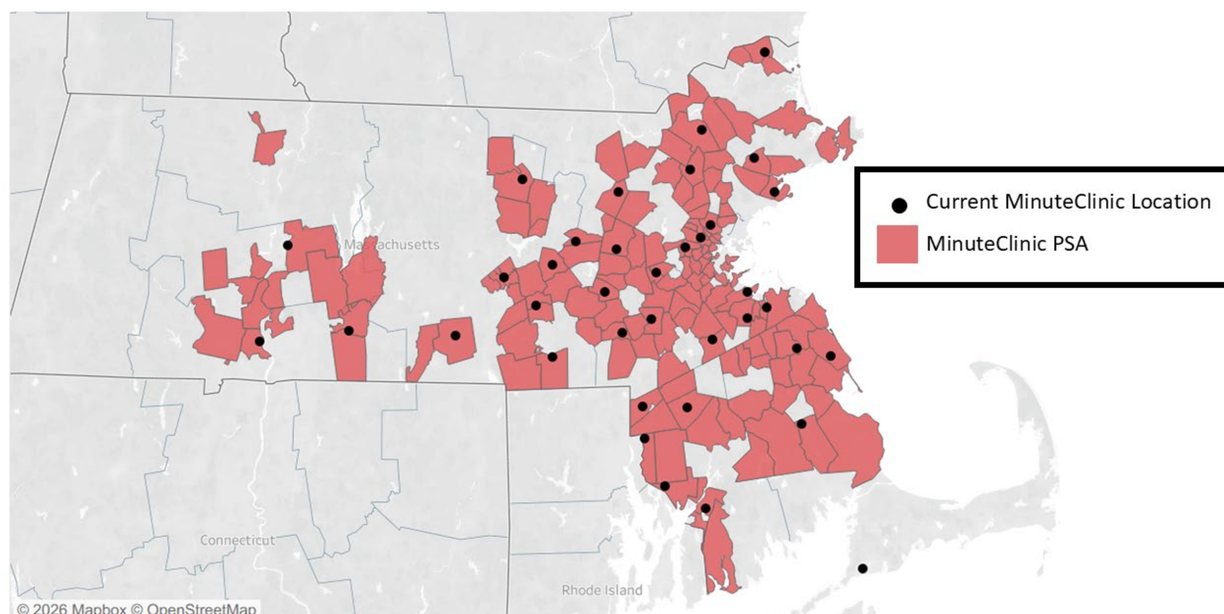
[70] *See* Massachusetts regulatory definition of "Limited Services," 105 CMR 140.020.

disorder, or birth center services.[71] CVS uses the term "convenience care" to describe these MinuteClinic services, which currently include:

- Diagnosis, treatment, and prescriptions for illnesses such as strep throat, bladder infections, pink eye, and infections of the ears, nose and throat;
- Vaccinations;
- Treatment for minor wounds, abrasions, joint sprains, and skin conditions such as poison ivy, ringworm, lice, and acne;
- Sports and camp physicals, health screenings, and TB testing; and
- Routine lab tests.[72]

As discussed in Section III.B.2, these services are considered to be components of primary care, but they do not comprise the full scope of primary care. Throughout this report, the HPC refers to these MinuteClinic services as "convenience care services" and describes them as "primary care adjacent." The 37 MinuteClinic locations in Massachusetts are co-located in CVS retail locations and staffed by approximately 80 APPs, all NPs.[73] As shown below, these sites are primarily in Eastern and Central MA.

Figure II.A.2 MinuteClinic Locations and Primary Service Area in Massachusetts[74]



Source: HPC analysis of 2023 APCD claims data and 2024 MA-RPO data.
Note: This map does not show Martha's Vineyard or Nantucket, which do not have any MinuteClinic sites.

CVS has created a new subsidiary, CVS MinuteClinic Primary Care Massachusetts, to operate primary care clinics in Massachusetts under full clinic licensure.

[71] *Id.*
[72] *Frequently Asked Questions*, CVS MINUTECLINIC, https://www.cvs.com/minuteclinic/info?icid=mchome-mcfaq-mcallfaq (last visited April 5, 2026).
[73] CVS MCN, *supra* note 13.
[74] The HPC calculated the MinuteClinic Primary Service Area (PSA) to be the smallest set of zip codes from which MinuteClinic draws 75% of its adult convenience care visits. For more information on MinuteClinic's PSA, see Section III.A.1.a.

B. The Proposed Transaction

In connection with the proposed contracting affiliation, CVS plans to apply to DPH for full clinic licensure of its 37 Massachusetts MinuteClinic sites, which currently provide limited convenience care, to allow them to become MCPC sites that offer longitudinal primary care.[75] In a novel approach in Massachusetts, CVS has said that MCPC sites would feature a "scalable, APP-led model" with extended evening and weekend hours[76] emphasizing a team-based approach to delivering patient-centered care. The new provision of longitudinal care, including chronic disease management, care coordination, and closed-loop referrals would expand the scope of services currently offered by MinuteClinic. CVS expects to implement this transition over time, beginning with five sites in the first year. CVS informed the HPC that it has not yet determined which sites would be included in this first group of sites to transition, and that it expects to fully transition all MinuteClinic sites in Massachusetts to MCPC sites within two to three years. CVS specified that the number of clinics that would transition each year would depend on the success of the model, the time it takes to obtain full clinic licensure, and available funding (e.g., for facility enhancements as needed). The parties stated that MCPC would provide care both to members of its primary care patient panels and to patients who are not members of its primary care panels ("non-empaneled patients"). Services provided to non-empaneled patients would largely be a continuation of MinuteClinic's current "convenience care" services, but they would be provided under an MCPC site's full clinic license post-transition.[77]

Under its existing "convenience care" model, MinuteClinic sites serve both pediatric and adult patients, but under the parties' proposed plans, MCPC would provide longitudinal primary care and continue to offer convenience care services to adults only. CVS does not plan for MCPC sites to provide either primary care or convenience care to patients under 18, although vaccinations would continue to be available at CVS Pharmacies for patients ages 5 and older.[78]

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[75] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13. Under Massachusetts Department of Public Health Regulations, a Clinic is defined as, "Any entity, however organized, whether conducted for profit or not for profit, is advertised, announced, established, or maintained for the purpose of providing ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In addition, clinic shall include any entity, however organized, whether conducted for profit or not for profit, advertised, announced, established, or maintained under a name includes the word clinic, "dispensary," or "institute," and suggests that ambulatory medical, surgical, dental, physical rehabilitation, or mental health services are rendered. With respect to any entity is not advertised, announced, established, or maintained under one of the names in the preceding sentence, Clinic shall not include a medical office building, or one or more practitioners engaged in a solo or group practice, whether conducted for profit or not for profit, and however organized, so long as such practice is wholly owned and controlled by one or more of the practitioners so associated, or, in the case of a not for profit organization, its only members are one or more of the practitioners so associated or a clinic established solely to provide service to employees or students of such corporation or institution. Notwithstanding the foregoing, Clinic shall include any entity certified or has applied for certification as an ambulatory surgery center by the Centers for Medicare and Medicaid Services for participation in the Medicare program. No matter how the clinic is named, clinic shall not include a clinic conducted by a hospital licensed under M.G.L. c. 111, § 51 or by the federal government, or the commonwealth. Clinic shall not include dental clinics operated by local schools and health departments for the sole purpose of providing education and dental hygiene services, including routine examinations, cleaning and topical fluoride applications. Clinic shall not include ad hoc health promotion and screening programs." 105 CMR 140.020.

[76] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.

[77] Throughout this report, the HPC uses the terminology "convenience care" to refer to both the current services provided by MinuteClinic under its current limited services clinic licensure and the similar "walk-in" services MCPC proposes to provide to non-empaneled patients after transition to full clinic licensure.

[78] Providers cannot hold licenses for both a limited services clinic and a full clinic at the same site. If a MinuteClinic site transitions to full clinic licensure as an MCPC site, it may no longer operate "convenience care" services under its limited services clinic license. Full clinic licensure requires certain physical plant and operational standards beyond those applicable to limited services clinics, and the MCPC sites would have to show capabilities to serve its proposed

Following the transaction, CVS expects to begin recruiting adult primary care patients, drawing primarily from former MinuteClinic patients who do not yet have a PCP. MGB plans to refer to MCPC individuals who contact its physician offices seeking PCPs when those offices cannot accommodate them, and individuals who had an MGB PCP who separated due to retirement or changes in employment. CVS expects that, while MCPC would serve patients with all complexity levels, many of these new primary care patients would be low-complexity and would not require a substantial amount of downstream specialist referrals, similar to MinuteClinic's current patient population. MinuteClinic sites currently serve a primarily commercial population, and while the parties plan for MCPC to participate in MassHealth, CVS expects that MCPC sites will have a high share of commercially insured patients, similar to its current payer mix as provided to the HPC (81% commercial, 14% Medicare, 6% MassHealth).

The parties state that approximately 80 existing MinuteClinic APPs could eventually manage primary care panels of 1,500 patients each, which could create a maximum capacity to serve up to 120,000 adults.[79] CVS informed the HPC that by the third year of the transaction, under an assumption of "moderate acceptance" of MCPC primary care by current MinuteClinic patients, it expects to serve approximately 35% of this maximum primary care patient panel, and that those primary care patients would be expected to constitute 45% of total MCPC visits. Thus, by the third year, if the parties are successful, MCPC clinics would provide primary care to approximately 42,000 adult patients, of whom approximately 34,000 would be commercial patients, while capacity to serve convenience care patients would decline overall by 45%, with no convenience care available to pediatric patients at MCPC sites.[80]

The HPC's analyses of cost, access, and quality impacts reflect the parties' plans and estimates of primary care and other volume at MCPC sites through the third year after the transaction. To the extent that MCPC primary care panels continue to grow after the third year, this would affect the HPC's projected impacts.

1. The parties have identified access and quality goals for the transaction.

The parties stated to the HPC that the primary goal of the transaction is to expand access to primary care for patients who do not currently have a PCP, including current MinuteClinic patients,[81] patients who are on an MGB PCP waitlist, and those who have an MGB PCP who separated due to retirement or changes in employment. The parties expect that this expansion would help alleviate the Commonwealth's primary care crisis in general and support MGB to increase access to primary care for its own patients in particular, especially by building an "APP-led model" that can support access to primary care "amid a shrinking physician pipeline."[82] The parties indicated to the HPC that they expect to further expand access to services by offering extended hours during evenings and weekends.[83]

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patient population, but the regulatory requirements do not vary based on the age of patients served. Once a site meets the requirements for full clinic licensure, it may provide any appropriate medical services within the scope of its license, including services commonly offered by limited services clinics. If a site chooses not to serve pediatric patients after transitioning to full clinic licensure, that may reflect an operational or business decision, e.g., to not acquire and maintain supplies and equipment for pediatric patients, rather than a restriction imposed by clinic licensure requirements. *See, e.g.,* full clinic requirements at 105 CMR 140.201-209 (Physical Plant), 105 CMR 140. 210-212 (Supplies and Equipment), 105 CMR 140.310-318 (related to staffing); and limited services clinic requirements at 105 CMR 140.205(D), 140.206, 140.304, and 140.1000-1002.

[79] MGB MCN, *supra* note 13; CVS MCN, *supra* note 13.

[80] This assumption regarding the number of MCPC commercial primary care patients is used throughout the HPC's modeling of spending impacts. If CVS were to fill MinuteClinic primary care panels to a greater extent, the spending impact would be greater than projected in this report.

[81] CVS estimates that approximately 80,000 current MinuteClinic patients do not have a primary care provider, though this estimate includes pediatric patients who would not be served by MCPC.

[82] MGB MCN, *supra* note 13; CVS MCN *supra* note 13.

[83] *Id.*

The parties identified in materials provided confidentially to the HPC several specific access and quality benefits they expect to result from patients receiving primary care at MCPC, including:

1. Extended primary care hours during evenings and weekend
2. Shorter wait times for primary care appointments
3. Lower rates of unnecessary emergency department (ED) and hospital utilization, including at MGB hospitals
4. Reductions in care gaps and improvements in chronic disease management
5. High-quality care provision through MCPC participation in MGB's quality and care delivery programs.[84]

2. CVS has identified and described several key aspects of its plans for MCPC operations.

While many details of implementation are yet to be finalized, CVS confidentially described to the HPC several important aspects of how MCPC would operate:

1. **CVS is proposing limited new staffing.** CVS expects to use the 80 existing MinuteClinic APPs to manage the new primary care panels. It has indicated that it has resources to hire one additional registered nurse (RN) or Licensed Practical Nurse (LPN) at each of the initial MCPC sites (i.e., the first five sites) to support its current APPs in managing primary care panels and that it plans to hire additional RNs and LPNs as needed as patient panels grow.
2. **MCPC APPs would undergo primary care training.** This training would focus on longitudinal care delivery, preventive health, and chronic disease management and would be delivered via a virtual learning curriculum of 22 continuing education credits tailored to the APP's role and experience.
3. **Administrative services would be managed centrally by the CVS Management Services Organization (MSO).** This includes services such as referral management and appointment scheduling.
4. **The transition of each MinuteClinic site would require development of new capabilities,** including chronic condition management, care coordination and closed-loop referrals, and 24/7 on-call clinician coverage.

3. The parties have clear plans related to MCPC participation in MGB contracts with payers.

The parties have stated that under the transaction, MCPC would join MGB ACO as a contracting affiliate and would be reimbursed at MGB ACO negotiated rates. In particular, the parties have confidentially informed the HPC that they expect that MCPC would be reimbursed at the MGB ACO rate for both primary care and for any convenience care services provided at MCPC locations for patients who are not MCPC primary care patients. Finally, MCPC would participate in the MGB ACO clinically integrated network and value-based payer contracts, which means that MCPC primary care patients would be attributed to MGB for certain total cost of care contracts.[85]

[84] *Id.*
[85] *Id.*

Figure II.B.1 Massachusetts Primary Care Landscape

As reflected in the HPC's 2025 report, "A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action," the Commonwealth is facing a crisis in primary care.[86] In 2025, 43% of Massachusetts residents reported having difficulty accessing care, most often because they could not get appointments soon enough. [87] In a recent survey of large metro areas, Boston was found to have the highest average physician appointment wait time, including a family practice appointment wait time of 69 days.[88] Black, Indigenous, and People of Color (BIPOC) residents and those with increased socioeconomic barriers to care face greater challenges accessing primary care.[89] These access challenges pose real risks to patient wellbeing. Adequate spending on and utilization of primary care is associated with better health and spending outcomes, including lower mortality, while lack of timely access to primary care is associated with higher utilization of emergency department and inpatient services, leading to worse health outcomes and higher spending. [90]

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[86] DIRE DIAGNOSIS, *supra* note 3.

[87] CTR. FOR HEALTH INFO. & ANALYSIS, FINDINGS FROM THE 2025 MASSACHUSETTS HEALTH INSURANCE SURVEY (Dec. 2025) at 46 [hereinafter 2025 MHIS], *available at* https://www.chiamass.gov/assets/docs/r/survey/MHIS-2025/2025-MHIS-Report.pdf. These difficulties persist despite most Massachusetts residents (90.4%) reporting having a primary care provider in 2025. *Id.* at 6. People in certain categories report higher rates of having a primary care provider: Non-elderly adults, aged 19-64, were less likely to have a PCP, compared to children and elderly adults, 86.2% compared to 96.5% and 97.3%, respectively. Hispanic and Asian residents were less like than White residents to have a PCP, (85.8% and 83.7%, respectively, compared to 92.4%), and those with lower family incomes were less likely to have a PCP (84.4% for less than 139% FPL to 85.1% for between 139% and 299% FPL, compared to 93.0% for at or above 500% FPL). *Id.* at 29.

[88] AMN HEALTHCARE AND MERRITT HAWKINS, 2025 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES AND MEDICARE AND MEDICAID ACCEPTANCE RATES (2025) *available at* https://online.flippingbook.com/view/83050962/2/ (last visited April 4, 2026).

[89] Hispanic and Black non-Hispanic residents (51.3% and 47.9%, respectively) reported their most recent ED visit was for a non-emergency condition, suggesting inequitable primary care access compared to White non-Hispanic residents, 26.5% of whom similarly reported non-emergency ED use. CTR. FOR HEALTH INFO. & ANALYSIS, *Primary Care in Massachusetts Databook* (Jan. 2023) [hereinafter *CHIA Primary Care Databook*], https://www.chiamass.gov/assets/docs/r/pubs/2023/MA-PC-Dashboard-Databook-2023-v2.xlsx (last visited Apr. 5, 2026). Patients with primary care access barriers including transportation, distance, or language are more likely to use the ED for non-emergent issues. Jennifer Villani & Karoline Mortensen, *Nonemergent Emergency Department Use Among Patients With a Usual Source of Care*, 6 J. AM. BD. FAM. MED. November 680 (2013), *available at* https://pubmed.ncbi.nlm.nih.gov/24204064/ (last visited April 4, 2026).

[90] *See, e.g.*, Sanjay Basu, et al., *Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015*, 179 JAMA INTERNAL MED. 506 (2019), *available at* https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393 (last visited April 4, 2026); Robert A. Lowe, et al., *Association between primary care practice characteristics and emergency department use in a Medicaid managed care organization*, 43 MED. CARE 792 (2005), *available at* https://pubmed.ncbi.nlm.nih.gov/16034293/ (last visited April 5, 2026); Anthony Jerant et al., *Extended office hours and health care expenditures: a national study*, 10 ANNALS FAM. MED. 388 (2012), *available at* https://pubmed.ncbi.nlm.nih.gov/22966101/ (last visited April 5, 2026) (finding extended hours, including evenings and weekends, are associated with lower total health care expenditures but do not have a statistically significant effect on mortality); Lawrence P. Casalino, et al., *Physician Altruism and Spending, Hospital Admissions, and Emergency Department Visits*, 5 JAMA HEALTH FORUM e243383 (2024), *available at* https://jamanetwork.com/journals/jama-health-forum/fullarticle/2824419 (last visited April 5, 2026) (finding that Medicaid patients of altruistic physicians – who were categorized as such using a game-based economic experiment – had 41% fewer potentially preventable emergency department visits, and 38% fewer preventable hospital admissions); Michael R. Daly et al., *Do Avoidable Hospitalization Rates among Older Adults Differ by Geographic Access to Primary Care Physicians?*, 53 HEALTH SERV. RES. 3245 (2018), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC6056577/ (finding "a statistically significant relationship between geographic accessibility and lower avoidable hospitalization rates") (last visited April 4, 2026).

This primary care crisis is driven in large part by limited primary care capacity. In 2021, only one in seven new physicians in Massachusetts entered primary care, the fourth-lowest share of all states;[91] likewise, the percentage of physicians choosing to practice primary care six to eight years after graduation declined from 22% in 2023 to 19.2% in 2024.[92] While Massachusetts has the highest total physicians per capita in the nation, PCPs represent a relatively small share of these physicians.[93] PCPs providing direct patient care represent the fifth lowest share of all physicians in Massachusetts compared to other states.[94] Similar challenges apply to APPs; the share of NPs working in office-based settings fell from 26% in 2018 to 21% in 2022.[95]

Two key factors disincentivize graduating care providers from entering primary care and drive practicing providers out of the field: The first is relatively lower salaries for PCPs,[96] which is a result of low reimbursement rates for primary care relative to specialty services. The second is the administrative burden associated with providing primary care, requiring as much or more clinician time as direct patient care. The administrative burden PCPs face includes a range of non-clinical tasks, such as electronic health record-related tasks and tasks associated with quality measurement, patient correspondence, and prior authorization.[97] To address these concerns without increasing overall health care spending, the HPC recommended action to: reduce sources of administrative burden and burnout for PCPs; strengthen the primary care pipeline by funding programs engaged in that work; and increase spending for primary care by increasing the overall rates paid for primary care, rebalancing payment toward primary care, and greater use of prospective, capitated payments. [98]

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[91] DIRE DIAGNOSIS, *supra* note 3 at 18.
[92] CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS PRIMARY CARE DASHBOARD (June 2025) at 4 *available at* https://www.chiamass.gov/assets/docs/r/pubs/2025/MA-PC-Dashboard-2025.pdf.
[93] DIRE DIAGNOSIS *supra* note 3 at 17. Primary care also represents a small and decreasing share of health care spending, with commercial spending on primary care declining from 8.4% in 2017 to 7.5% of total commercial spending in 2022. *Id*. at 13.
[94] *Id.* at 17.
[95] *Id.* at 38.
[96] *Id.* at 31-34.
[97] *Id.* at 35-36.
[98] *Id.* at 57.

III. Analysis of the Parties' Past Performance and Impacts of the Proposed Transaction

A. Cost and Market Functioning

The law governing CMIRs directs the HPC to examine different measures of the parties' respective cost and market position, including their size, prices, spending for attributed patients (e.g., health status adjusted total medical expenses), and market shares. The HPC examined the parties' performance on these measures, where available, over time and compared to other providers to establish a profile of the parties' baseline performance leading up to the proposed transaction. The HPC then combined the parties' performance to date with details of the transaction and the parties' goals and plans to project the likely impacts of the transaction on health care spending and market functioning. The HPC's findings are summarized below.

Cost and Market Profile:

- MGB is the state's largest provider organization with eleven hospitals in Massachusetts, a large physician network, and the insurer MGBHP. MGB is the state's largest provider of primary care services, providing approximately 17% percent of primary care physician services statewide, and serving patients primarily in eastern Massachusetts.
- CVS is the second largest health care organization in the country with over 9,000 pharmacies and over 900 MinuteClinic sites nationally, the insurer Aetna, and the PBM CVS Caremark.[99] In Massachusetts, CVS operates 37 MinuteClinic locations with a somewhat more broadly distributed patient population compared to MGB, including more of western Massachusetts.
- MGB generally has among the highest prices in the Commonwealth for health care services, including adult primary care services. MinuteClinic's convenience care prices have historically been less than half of MGB's prices for the same services with an APP, and substantially lower than other comparable providers.
- Spending of MGB-attributed primary care patients is higher than spending of patients attributed to other large Massachusetts provider organizations and spending of patients without a PCP. CVS expects to draw its new MCPC primary care patients primarily from those living in MinuteClinic's service area without a PCP, whose health care spending is lower than spending for patients attributed to the largest Massachusetts provider organizations.

Cost and Market Impact:

- The transaction is likely to impact health care spending in key quantifiable ways:
    - **Spending for New Primary Care Patients:** MCPC's new primary care patients are expected to receive primary care services at MGB's higher prices and to be referred to higher-priced MGB specialists and hospitals. At the same time, this new access to a PCP may lead to changes in care that may reflect appropriate and improved management of health conditions. Based on analysis of spending trends for new primary care patients to the MGB network, the HPC expects that these dynamics, combined, are likely to result in an annual commercial spending increase of approximately $27.7 million.

[99] *Supra* notes 61, 63.

- **Repricing of Convenience Care Services:** MCPC is expected to continue to provide a reduced volume of convenience care services at MGB's higher prices. Combining the expected changes to convenience care volume with the price differential between the two parties, commercial spending is likely to increase by an additional $6.6 million annually.
- **Diversion of Some Convenience Care Patients to Other Providers:** As MCPC develops its primary care panels and correspondingly decreases its convenience care capacity, some patients who would have otherwise sought convenience care at MinuteClinic locations are anticipated to be diverted to other providers, which are generally higher-priced, resulting in an additional likely increase in commercial spending of $5.9 million annually.

These are conservative estimates of spending impacts in year three, based on the parties' projections of "moderate acceptance" of their model in that period, resulting in approximately 35% of all MCPC patients being primary care by that point. However, these annual spending impacts would increase if more primary care patients were to join the MCPC patient panel, and they would be significantly higher if MCPC sites were to fill their primary care patient panels to the maximum stated size of 1,500 patients per APP. There are further cost and market impacts that the HPC is unable to quantify in its analysis, including the impact of additional bargaining leverage for MGB as a result of this expansion of MGB's primary care footprint.

The remainder of this section discusses these findings in greater depth.

1. Cost and Market Profile

a. MGB and CVS are both very large health care organizations and well-established providers across Massachusetts.

As discussed in Section II.A.1, MGB is the state's largest health care provider organization, with eleven Massachusetts hospitals, a large physician network, and the insurer MGBHP. CVS is the second largest health care organization in the country, with a large volume of pharmacy and MinuteClinic locations throughout the United States, the national insurance company Aetna, and the PBM CVS Caremark.

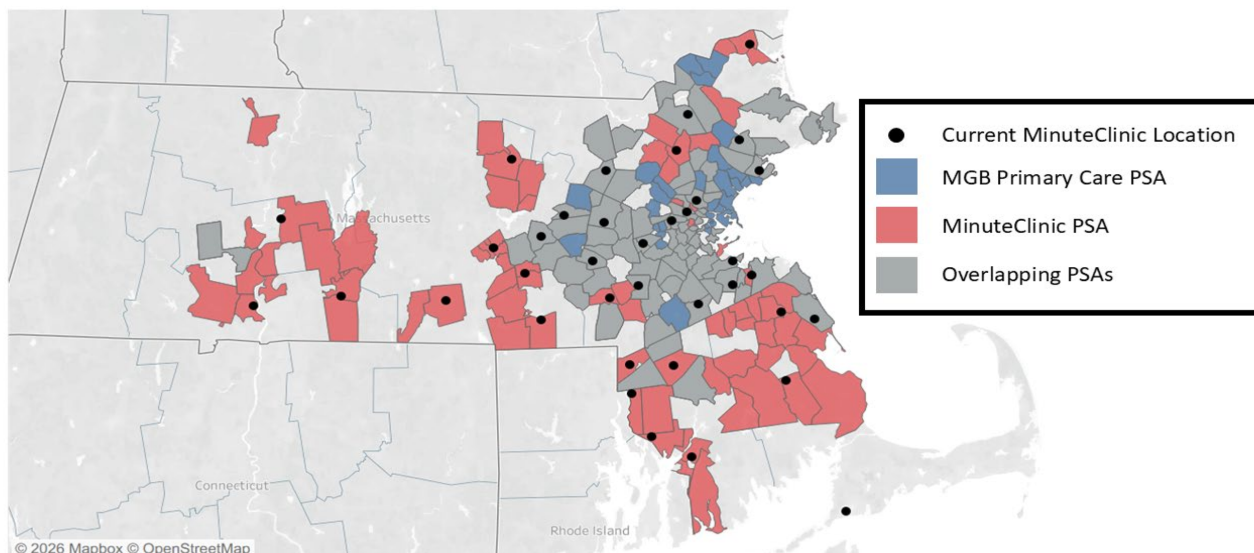
The HPC examined the parties' PSAs in Massachusetts to understand the geographies that would be most impacted by the transaction.[100] A PSA is defined as the smallest set of zip codes from which an entity draws 75% of its visits. Given that MinuteClinic would become a new adult primary care provider (MCPC) as a result of the transaction, the HPC identified two relevant PSAs: MinuteClinic's adult commercial PSA for its current "convenience care" services (hereinafter MinuteClinic's PSA) and MGB's adult commercial primary care physician PSA (hereinafter MGB's primary care PSA).[101]

[100] The CMIR statute directs the HPC to "examine factors relating to the provider or provider organization's business and its relative market position," including "the provider or provider organization's size and market share within its primary service areas" and "the provider or provider organization's impact on competing options for the delivery of health care services within its primary service areas." MASS. GEN. LAWS ch. 6D, § 13(i).

[101] MinuteClinic's PSA reflects the area where most of MinuteClinic's adult patients reside and is also the area where most of MCPC's patients would likely reside, given that CVS plans to recruit MCPC primary care panels' members from existing adult MinuteClinic patients. The HPC used adult commercial claims from the 2023 All-Payer Claims Database (APCD) to identify PSAs. Visits were identified as unique groupings of member, service date, and provider organization. See the Data Appendix for additional detail on how visits by provider organization were identified. Due to data limitations, the MGB primary care PSA uses only physician visits and does not include visits to APPs. For the purposes of this report, primary care services are defined as services delivered by providers with a primary care specialty who derive at least 60% of their revenue from primary care visits, and at least 5% of their revenue from preventive care visits specifically. Adult primary care visits comprise all primary care services delivered by a provider

As shown in Figure III.A.1, MGB's primary care PSA covers much of eastern Massachusetts, concentrated around Boston and the North and South Shore. MinuteClinic's PSA covers this area as well, but its patient population is somewhat more distributed across the state, covering more zip codes in central, western, and southeastern Massachusetts. MinuteClinic's PSA aligns with the locations of CVS's 37 MinuteClinic sites, which are concentrated around the Boston metro area but extend as far west as West Springfield and as far east as Falmouth.

Figure III.A.1: Commercial Adult Service Areas (2023)



Source: HPC analysis of 2023 APCD claims data and 2024 MA-RPO data.

The HPC examined adult primary care physician market shares statewide and within the parties' PSAs. Statewide market shares illustrate the parties' overall importance in Massachusetts, while shares in PSAs illustrate the parties' importance in those areas where most of their patients reside. MGB is the largest provider of adult primary care physician services in the parties' PSAs and statewide. Specifically, MGB has a 17% statewide market share of primary care visits with a physician. The second largest provider, Beth Israel Lahey Health (BILH), has a 13% market share.[102]

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who derives at least 70% of their revenue from patients 18 and over, and services delivered to patients 18 and over by a provider who derives between 30% and 70% of their revenue from patients 18 and over.

[102] Using 2023 claims data, the HPC defined market shares as each provider's share of adult primary care physician visits in the listed geography. Visits were identified as unique groupings of member, service date, and provider organization. See *supra* note 101 for more detail on how adult primary care claims were identified.

Figure III.A.2: Commercial Shares of Adult Primary Care Physician Visits (2023)

Provider Organization	MinuteClinic PSA	MGB PSA	Statewide
MGB	**19%**	**25%**	**17%**
BILH	16%	18%	13%
Optum (Atrius & Reliant)	10%	10%	8%
Tufts	6%	6%	6%
UMass	5%	2%	6%
Revere Medical[103]	4%	3%	5%
Baystate Health	2%	0%	3%
Signature Healthcare	1%	0%	1%
BMC Health	1%	1%	1%
Acton Medical	1%	1%	1%
Advanced Practice Providers from All Provider Organizations (Not yet attributable to individual Provider Organizations in MA-RPO)	*22%*	*23%*	*22%*
Other Physicians	*13%*	*10%*	*17%*

Source: HPC analysis of 2023 APCD claims data and 2024 RPO data.
Note: Shares are based on each provider organization's number of primary care physician visits in each PSA. A visit is defined as a unique combination of member, date, and provider organization using 2023 adult primary care claims data. See the Data Appendix for more details.

The market share table above focuses on physician primary care services and does not include primary care visits provided by APPs. Though MCPC is expected to be staffed by APPs, the HPC does not yet have comprehensive affiliation data for the APPs of other provider organizations, meaning that visits to APPs cannot yet be attributed to individual provider organizations, with their market shares updated accordingly to reflect such care.[104] Comprehensive APP data will be available for the first time through the MA-RPO program later in 2026. Based on visit projections provided by CVS, the HPC estimates that adding MCPC's projected primary care visit volume by year three to MGB's physician market share would increase MGB's market share by approximately 2 percentage points, statewide and within each party's PSA.

b. MGB generally has the highest provider prices in the Commonwealth, including for adult primary care services. MinuteClinic's convenience care prices are less than half those of MGB and substantially lower than those of other providers offering similar services.

As the HPC has reported previously, MGB's commercial prices are higher than those of nearly all other providers in Massachusetts.[105] In an analysis of 2023 hospital and physician group relative prices shown in the chart below, the HPC found that for the two largest commercial payers, constituting approximately

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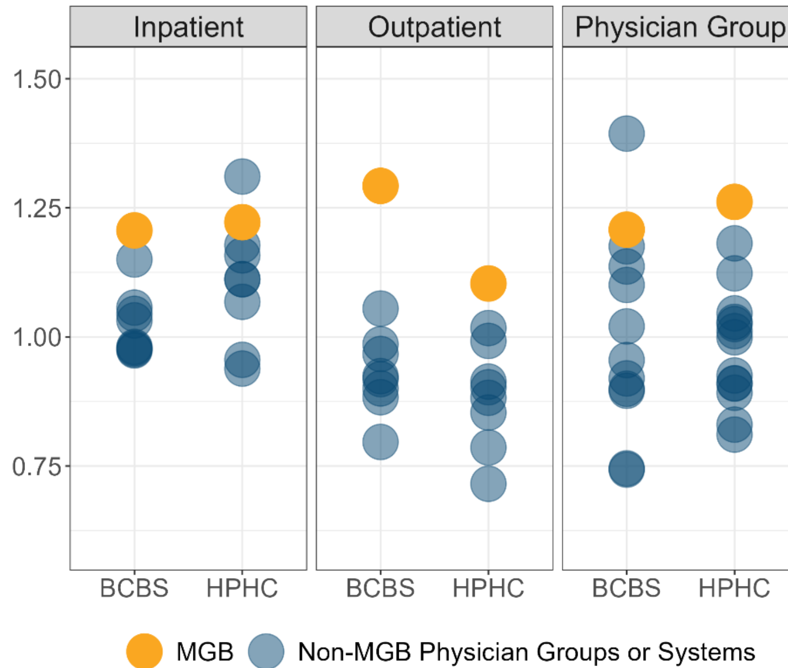
[103] Revere Medical is the successor to the Steward network.
[104] Other proprietary data sources do not include the information necessary to roll up to the organizational level at which the HPC would normally compute market shares.
[105] *See* MASS. HEALTH POLICY COMM'N, PUBLIC COMMENT: MASS GENERAL BRIGHAM INCORPORATED DETERMINATION OF NEED APPLICATIONS (Jan. 25, 2022) at 57 [hereinafter HPC COMMENT ON MGB DON] *available* at https://masshpc.gov/sites/default/files/20220125_PublicComment_MGB-DoN.pdf (last visited April 5, 2026). *See also* MASS. HEALTH POLICY COMM'N, BOARD MEETING PRESENTATION (Jan 25, 2022) *available at* https://masshpc.gov/sites/default/files/2023-04/20220125%20Board%20Meeting%20Presentation.pdf (last visited April 9, 2026).

64% of the commercial market in Massachusetts, MGB hospitals and physician groups are the most or second-most expensive in the Commonwealth.[106]

Figure III.A.3: Physician Group and System Average Hospital Relative Price (2023)



Source: HPC analysis of 2026 CHIA Relative Price Databook
Notes: Because relative price is calculated individually by payer, the price level associated with each payer's network average relative price (1.0) is not the same for different payers. Therefore, relative price should not be compared across payers.
Comparator physician groups include: Atrius Health, BILH (including BIDCO, Lahey Clinical Performance ACO, Lahey Physician Community Org, and MACIPA), Boston Medical Center Mgt Service, Lawrence General IPA, Reliant Medical Group, Signature Healthcare Medical Group, South Shore PHO, Southcoast Physician Group (/Network), Steward Network Services, Tufts Medicine Integrated Network (including Lowell General PHO and New England Quality Care Alliance (NEQCA)), and UMass Memorial Medical Group/UMass Memorial Medical Center-Based Practices.
Comparator systems include: BILH, BMC, Baystate, Steward, Tenet, Tufts, UMass, and a category for independent community hospitals.

Recognizing that MCPC is expected to bill payers at MGB rates under the proposed transaction, the HPC compared current MGB adult primary care prices for care delivered by APPs to MinuteClinic's current prices.[107] The HPC also compared MinuteClinic's current prices to prices for adult primary care delivered by APPs at other health systems with high primary care market shares. This analysis focused on the services billed most frequently by MinuteClinic across all Massachusetts locations for adult patients, summarized in

[106] Inpatient and outpatient system average relative prices exclude specialty hospitals. The HPC calculated system average relative prices using the methodology described in the HPC COMMENT ON MGB DON, *supra* note 105 at 57, n. 209.
[107] Because MinuteClinic is staffed exclusively by APPs, who generally receive a somewhat discounted rate relative to physicians, the HPC's prices for non-MinuteClinic physician rates are discounted (i.e., multiplied by 0.85) to approximate comparable APP prices across providers. The parties confirmed that MCPC expects not to use incident-to billing.

Figure III.A.4, as these are likely reflective of the services that MCPC would continue to provide post-transaction.

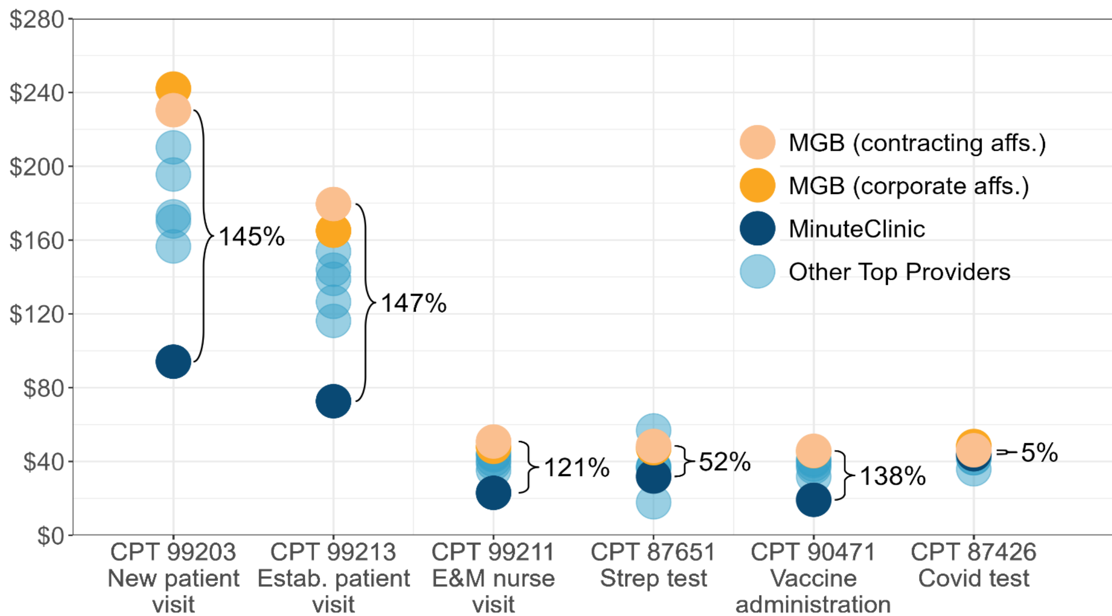
Figure III.A.4: Overview of Top 6 MinuteClinic Services by Volume (2023)

CPT Code	Description	Share of MinuteClinic's Volume
99203	New patient visit	11%
99213	Established patient visit	24%
87651	Strep test	11%
90471	Vaccine administration	10%
87426	Covid test	6%
99211	Nurse visit	6%
	Total	**67%**

Note: Volume shares are based on shares in the 2023 APCD commercial claims data.

The HPC also separately analyzed prices from MGB PCPs who are employed by MGB contracting affiliates (Charles River Medical Associates, Milford Regional Physician Group, and Emerson PHO) from those employed by the MGB system and its corporate affiliates to capture any price differences between them, recognizing that MCPC would become an MGB contracting affiliate post-transaction and thus may have prices that more closely reflect those of other MGB contracting affiliates.[108]

Figure III.A.5: Average APP Price for Top MinuteClinic Services by Provider (2023)



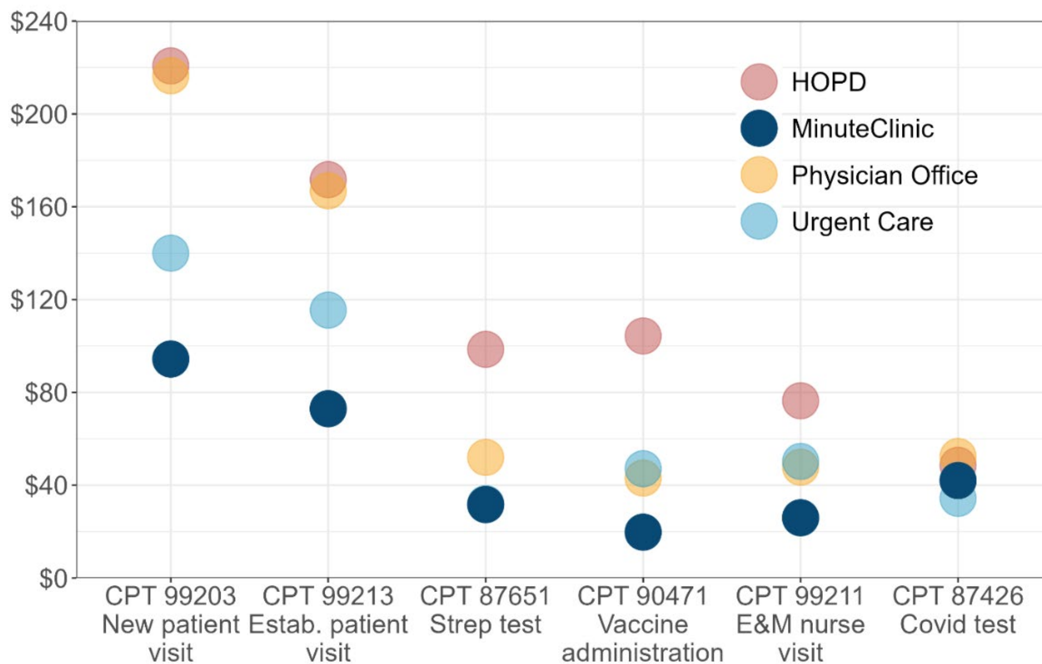
Source: HPC analysis of 2023 APCD claims data.
Note: The columns show MinuteClinic's top 6 CPT codes by volume. Prices are all-payer averages across the seven APCD payers, weighted by each payer's statewide share of adult primary care and MinuteClinic volume for the CPT code. Prices are calculated using claims for adult PCPs attributed to each provider organization. APP prices for non-MinuteClinic providers are calculated by multiplying physician prices by 0.85. Text labels show the percent difference between MGB contracting affiliates and MinuteClinic prices.

[108] Whereas fully owned corporate affiliates establish all contracts through MGB, MGB negotiates rates for contracting affiliates for a subset of payers, generally the largest payers, and contracting affiliates independently establish their own smaller payer contracts.

For five of the six services examined, MGB corporate and contracting affiliates have the top two highest adult primary care prices among PCPs; for three of the services, contracting affiliates are highest, and for the other two, corporate affiliates are highest. For strep tests, MGB affiliates have the second and third highest prices compared to other PCPs, behind only UMass. At the same time, MinuteClinic has the lowest price for four of the services examined. MGB APP prices are more than double MinuteClinic prices for patient visits, the most expensive of MinuteClinic's most common services.

If CVS fills its primary care patient panels in accordance with its expectations of "moderate acceptance," by year three, MCPC would have approximately half of MinuteClinic's current capacity remaining for convenience care services.[109] Recognizing that some patients who previously would have used MinuteClinic convenience care may seek care at alternative providers after the transaction, the HPC compares MinuteClinic's prices with the prices for comparable care at other providers that billed the procedure codes that align with MinuteClinic's highest volume convenience care services. Throughout this report, these providers are referred to as "comparator convenience care providers."[110]

Figure III.A.6: Average Price for Top MinuteClinic Services by Care Setting (2023)



Source: HPC analysis of 2023 APCD claims data.
Note: The columns show MinuteClinic's top 6 CPT codes by volume. Prices are all-payer averages across the seven APCD payers, weighted by each payer's statewide share of volume for the CPT code.

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[109] See *infra* note 124 for further detail on this dynamic.
[110] To identify providers offering similar services to those offered by MinuteClinic, the HPC first identified the highest volume services that comprised 80% of MinuteClinic's revenue in either 2023 or 2024. The CPT codes for 2023 were identified using the APCD, and the CPT codes for 2024 were provided by the parties. The analysis then excluded CPT codes for office visits, as these are billed for a wide range of care types in many settings that may not be relevant comparators for MinuteClinic. The trimmed list includes a variety of vaccines and tests for specific illnesses. Within MinuteClinic's PSA, encounters for these procedure codes with only 1 claim per member, date, and CPT code were identified. For each payer in the APCD data, the highest-volume providers located in Massachusetts that made up at least 80% of the volume of these procedure codes were then identified. These are considered the comparator convenience care providers throughout this report. These comparator providers include other MGB providers, e.g., MGB HOPDs. See the Data Appendix for more details.

As in the first price comparison, the HPC compared prices for MinuteClinic's most frequently billed services. These are the services that patients would likely seek at other sites as an alternative to MinuteClinic if MCPC has less capacity for convenience care patients post-transaction. Relative to the average price within each comparator provider type, MinuteClinic is a low-priced provider. Its prices are the lowest for five of its six highest volume services relative to the other listed provider types.[111] The average prices at physician offices are higher than MinuteClinic prices for all services examined, but the differences range from being 25% higher for Covid tests to being 129% higher for new patient visits. The average prices at urgent care centers range from 18% lower than MinuteClinic prices for Covid tests to 139% higher than MinuteClinic prices for vaccine administration.

c. MGB primary care patients generally have the highest spending among the largest Massachusetts provider organizations.

The HPC also evaluated MGB's performance in managing patient spending by examining annual spending for patients who have an MGB PCP. The HPC used both total medical expense (TME) data collected by CHIA for MGB's health maintenance organization (HMO) and point of service (POS) patients, as well as spending for patients attributable to MGB PCPs using the patient attribution methodology described in the Data Appendix. These measures of total patient spending reflect both utilization of services and price of hospitals and clinicians that patients use. The HPC examined unadjusted spending as well as health status adjusted (HSA) spending to account for underlying health differences that may affect spending levels for different provider organizations.

The analysis of TME data showed that spending for MGB's patients is generally higher than spending for patients of other provider organizations in the Commonwealth.[112] This is true for both unadjusted spending and HSA spending, which suggests that MGB's patients' higher spending does not simply reflect primary care patients with higher medical complexity.[113]

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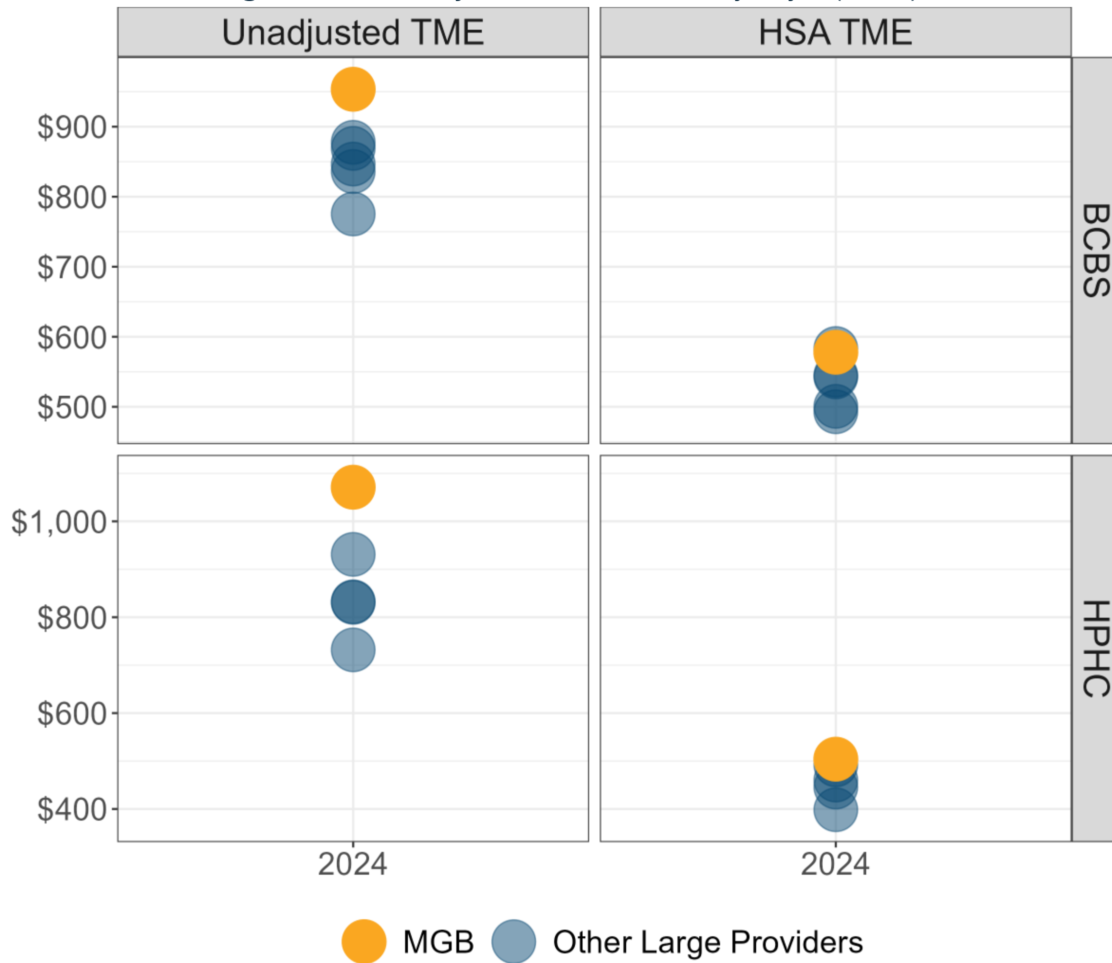
[111] Prices are weighted by the statewide average payer mix for each code. See the Data Appendix for more information on how recipient providers were categorized.

[112] The HPC was unable to compare MGB with MinuteClinic because MinuteClinic has not historically had a primary care panel and thus does not have TME data.

[113] These results are consistent with the HPC's past findings that AMC-anchored systems have the highest per-member spending relative to other organizations, mainly driven by higher spending for services delivered in hospital outpatient departments and, to a lesser extent, higher prices. MASS. HEALTH POLICY COMM'N, 2018 ANNUAL HEALTH CARE COST TRENDS REPORT (Feb. 2019), *available* at https://masshpc.gov/sites/default/files/2023-04/2018%20Cost%20Trends%20Report.pdf (last visited April 5, 2026).

Figure III.A.7: Unadjusted and HSA TME by Payer (2024)



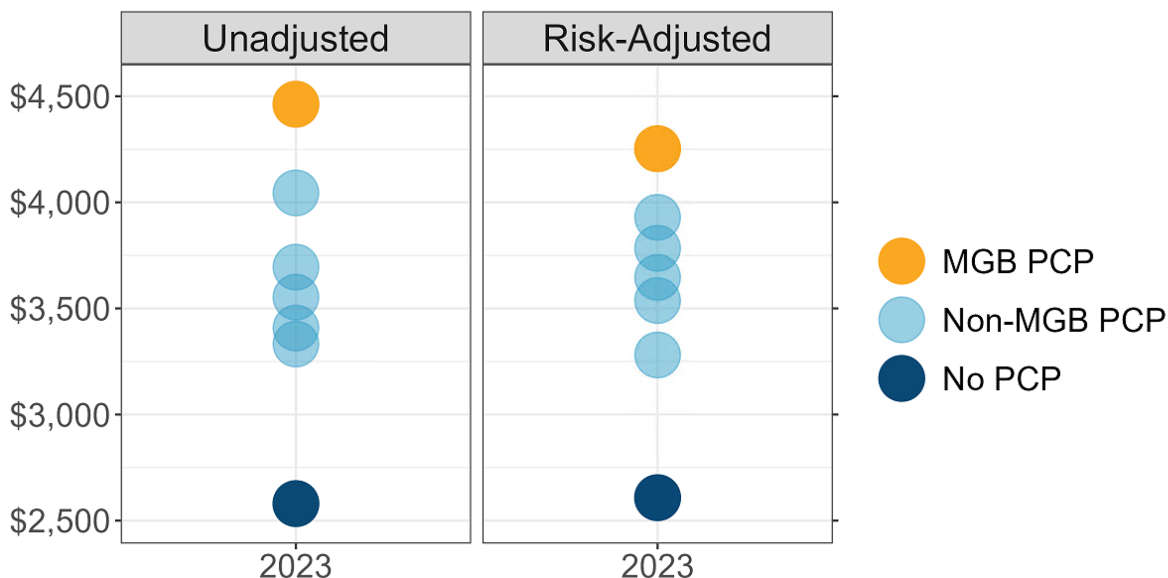
Source: HPC analysis of data from the CHIA Annual Report 2026.
Note: Data are filtered to PCP Type 1 and non-pediatric contracts. HSA TME cannot be compared across payers. "Other Top Providers" includes BILH, Baystate, Optum, Tufts, and UMass.

The HPC used claims data to examine spending for patients the parties expect MCPC's primary care patient panels to be drawn from: adults residing in MinuteClinic's PSA who do not currently have a PCP. Their spending is compared with spending of current adult MGB primary care physician patients residing in MinuteClinic's PSA as well as adult primary care physician patients of other provider organizations.

The HPC found that MGB patients had higher claims-based spending than patients of other provider organizations, on both an unadjusted and a health status adjusted basis. Unattributed patients had lower spending than either MGB patients or patients attributed to other provider organizations.[114]

[114] Given that MCPC plans to be a contracting affiliate of MGB, the HPC also examined spending separately for primary care patients of MGB contracting affiliates. The HPC found that it is very similar to, although slightly lower than, spending for all MGB primary care patients.

Figure III.A.8: Annual Claims-Based Medical Spending for Members in MinuteClinic's PSA (2023)



Source: HPC analysis of 2023 APCD.
Note: Members are attributed to provider organizations as detailed in the Data Appendix. Adult members with the top 5% of annual medical spending were dropped from the analysis. Exhibit includes only members living in the MinuteClinic PSA. Risk-adjusted medical spending includes adjustments for age, sex, HCC risk score, payer, product, and community-level variables related to socio-economic status.

2. Cost and Market Impact

As discussed in Section II.B., after the proposed transaction, MinuteClinic locations in Massachusetts are expected to be relicensed as full-service clinics and would be renamed MCPC. MCPC is expected to provide both longitudinal primary care and convenience care as capacity allows. MCPC is expected to join the MGB ACO as a contracting affiliate and participate in MGB ACO value-based payer contracts, and all MCPC primary care and convenience care services under these contracts are expected to be provided at MGB prices.

In addition to likely impacts that are difficult to quantify at this point, discussed further in Section III.A.2.d below, the HPC identified three primary quantifiable mechanisms through which the proposed transaction is likely to increase commercial health care spending:

- **Spending for New Primary Care Patients**: New MCPC primary care patients are expected to receive primary care services at MCPC at MGB's comparatively high prices. These patients may also be primarily referred to high-priced MGB specialists and hospitals. At the same time, patients who did not previously have a PCP would now have access to one, with changes to care that may reflect appropriate and improved management of health conditions.
- **Repricing of Convenience Care Services**: MCPC is expected to continue providing convenience care services post-transaction at MGB's higher prices.
- **Diversion of Some Convenience Care Patients to Other Providers**: Some patients who would have otherwise sought convenience care at MinuteClinic locations are anticipated to be diverted to other providers, at generally higher prices, as MCPC develops its primary care panels and correspondingly decreases its convenience care capacity.

The following sections walk through the HPC's methodology and spending impact estimates for each of these mechanisms.

a. For new MCPC primary care patients, annual commercial spending is likely to increase by approximately $27.7 million by year three.

As discussed above in Section II.B, the parties plan to recruit primary care patients from three main groups: individuals who have used MinuteClinic who do not already have a PCP, individuals who contact MGB physician offices seeking PCPs when those offices cannot accommodate them, and individuals who had an MGB PCP who separated due to retirement or changes in employment. Through these approaches, the parties state that they would primarily seek to recruit individuals who do not already have a PCP, rather than drawing patients away from other systems.

Primary care patients of different provider organizations have distinct spending patterns driven by, for example, different care management practices, referral patterns, and service prices, as discussed above in Section III.B.1.c.[115] As members of MCPC panels transition from primarily having no PCP to being patients of an MGB contracting affiliate, their annual health care spending may change in two primary ways.

One, members may have different utilization patterns, which would affect annual spending. For instance, members may not have had regular wellness visits prior to joining the panels. The wellness visits themselves may constitute new utilization, and patients may be newly referred to specialists. However, preventive care from their PCP may also help patients avoid other kinds of utilization, such as hospitalizations. Because MCPC would join certain MGB quality and care management programs post-transaction, MGB's internal care management practices and patterns could also affect utilization for members of MCPC panels.

Two, members may receive care that is priced differently after joining the panels, given that they would pay MGB prices for primary care and are more likely to receive specialist and hospital care from MGB providers at MGB prices as well. Because MGB prices are some of the state's highest, these price changes would likely increase members' annual spending. As described in Section III.B.1.c. above, MGB patients have the highest annual adjusted spending relative to the other provider organizations in the state as a result of the net effect of MGB-specific utilization and pricing patterns.

Based on information provided by the parties, it is expected that MCPC would draw its primary care panels from patients in MinuteClinic's PSA who do not currently have a PCP. The HPC's commercial spending impact methodology therefore seeks to estimate how spending patterns for these new MCPC primary care patients would change after transitioning from having no PCP to having an MGB PCP. To do this, the HPC used APCD claims data from 2019 to 2023 to identify adults in MinuteClinic's PSA who did not have a PCP but later obtained a PCP with an MGB contracting affiliate, as that is the most similar set of facts to the parties' proposal.

Longitudinal claims data analysis shows how spending evolves for specific individuals when they transition from no PCP to an MGB PCP. By comparing spending over time for the same individuals, the HPC can control for individual-specific health status and other patient factors that might drive spending differences. Further, looking at spending changes for the specific patient population that chose an MGB PCP may also account for other time-varying factors unique to patients that might affirmatively choose an MCPC PCP that might impact spending changes over time, such as individual knowledge of future health care needs.

Using claims data, the HPC calculated the average difference in annual medical spending for individuals with no PCP before and after they become a primary care patient of an MGB contracting affiliate, as

[115] *See also*, e.g., Samuel Moy, et al., *Variation in spending associated with primary care practices*, 27 AM. J. MANAGED CARE 297 (2021), *available at* https://pubmed.ncbi.nlm.nih.gov/34314119/ (last visited April 5, 2026).

measured using a multivariate regression model to control for key variables like patient risk.[116] Additional detail on the regression model methodology can be found in the Data Appendix.

On average, the analysis found that when controlling for these key variables, the annual claims-based spending of patients who previously had no PCP increased by $650 (from $1,867 to $2,517) in the year after they became patients of an MGB contracting affiliate PCP.[117] The analysis multiplied the per-patient spending increase by the number of MCPC commercial primary care panel members that CVS projects they would have by the third year (approximately 34,000), assuming "moderate acceptance" of the new primary care model, to estimate the total claims-based spending impact of MCPC sites filling their primary care panels to this level.[118] Based on this analysis, the HPC estimates that patients joining MCPC's primary care panels would likely increase commercial claims-based spending by approximately $22.1 million annually, if MCPC sites fill their primary care panels as expected.[119]

MGB also receives non-claims payments from payers, such as shared saving payments; bonus payments for achieving specific goals in certain domains such as quality, cost reduction, or equity; and population health and infrastructure payments to support specific care delivery goals.[120] According to CHIA TME data, annual non-claims payments for MGB members were approximately $165 higher than payments for members with no PCP. Thus, it is estimated that the expected number of patients joining MCPC's primary

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[116] The regression model controls for time and patient-specific fixed effects, so that the spending impact of having an MGB PCP can be estimated independent of changes in overall spending over time and differences in patient characteristics. The HPC averaged annual spending impacts per member post-switch over all available data years. On average, the HPC observed patient spending for approximately two years after a patient obtained a PCP. The HPC notes that patients who newly obtained a PCP with an MGB affiliate were lower-complexity on average, which is generally consistent with the overall population of members who were not attributed to a PCP.

[117] The HPC notes that the estimate of $650 annual spending per member is lower than the difference between the health-status-adjusted claims-based spending of MGB patients and patients with no PCP, described in SectionIII.B.1.c. This may suggest that the HPC's impact estimate is conservative.

[118] CVS projects that, by its third year, MCPC would serve 120,000 patients annually, of which 35% would be members of the primary care panels. Additionally, CVS projects that MCPC's payer mix would be similar to MinuteClinic's current payer mix, where 81% of patients are commercially insured. This means that, per CVS's longest-term projections provided to the HPC, MCPC would have approximately 42,000 primary care patients, of which approximately 34,000 would have commercial insurance.

[119] The HPC considered the sensitivity of these estimates to different assumptions. First, it confirmed that patients of MGB corporate affiliates experienced similar increases. Second, recognizing that MCPC care is expected to be provided by APPs, it used provisional data from RPO to look at patients who switched specifically to an MGB APP provider and found consistent spending impacts. Given that the APP data in RPO are not yet finalized, it decided not to rely on the APP analysis for its impacts. A few caveats and data limitations should be noted. First, it is possible that MCPC's patient panels could be partially filled by members currently attributed to other systems rather than members without PCPs. However, the estimated impacts would be the same if it is assumed that unattributed patients would backfill excess capacity at the systems that lose members to MCPC. Second, the spending impact excludes prescription drug spending, because a significant portion of members' plans have prescription drug benefits "carved out" to third parties for which the HPC does not have access to the claims data. The estimates therefore may understate the true transaction impact. Finally, while the spending impact is estimated using the per-member spending increase one year after obtaining an MGB PCP, it is assumed the higher spending persists as long as members remain part of the MGB panel. To the extent that either MGB-specific spending drivers (e.g., MGB relative utilization patterns or MGB relative prices) or individual utilization patterns evolve over time, the spending impacts may over or underestimate future annual spending impacts. Based on this analysis, it should be noted that MinuteClinic affiliating with any other provider organization in the state would likely lead to lower spending impacts. Estimated spending impacts ranged from approximately $280 to $530 annual spending per member for the top ten largest provider organizations in the state (excluding MGB), suggesting that a substantial portion of the spending impact from this transaction is driven by MGB's high prices.

[120] CTR. FOR HEALTH INFO. & ANALYSIS, DATA SPECIFICATION MANUAL: 957 CMR 2.00: PAYER REPORTING OF TOTAL MEDICAL EXPENSES AND ALTERNATIVE PAYMENT METHODS (June 24, 2025) at 32, *available at* https://www.chiamass.gov/assets/docs/p/tme-rp/2025/2025-TME-APM-Data-Specification-Manual-Final.pdf.

care panels by year three is likely to increase commercial spending by an additional $5.6 million annually through these non-claims payments.[121]

In total, combining increases in claims-based and non-claims-based payments, the HPC expects that commercial spending for MCPC's new primary care patients would likely increase by $27.7 million annually by year three if MCPC fills its panels to 35%, reflecting CVS's expectation of "moderate acceptance" of its new primary care model.[122]

b. For the convenience care services that MCPC would continue to provide, annual commercial spending would likely increase by an additional $6.6 million by year three due to MinuteClinic prices increasing to MGB rates.

Following the transaction, MCPC is expected to continue to provide convenience care services to patients who are not members of its primary care panels. Relative to MinuteClinic's current prices, however, MCPC's prices would likely be higher because MCPC would be reimbursed at MGB-negotiated rates for a number of large payers.

On average, the HPC found that MGB contracting affiliate APP prices are more than double the current prices for MinuteClinic's convenience care services (129% higher) for those payers, which represent approximately two-thirds of MinuteClinic's commercial revenue.[123] Combining this price differential with the parties' stated expectations of the size of their primary care panels by year three, the HPC estimates that this price increase for the convenience care portion of MCPC's services is likely to increase annual commercial spending by $6.6 million by year three post-transaction, or $105 per convenience care visit, if MCPC fills its primary care panels to 35% and any remaining patient volume is used for convenience care.[124]

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[121] Using CHIA's 2025 TME dataset, the HPC calculated the average difference in 2023 annual non-claims spending per member between unattributed and MGB commercial adult members for each payer, then averaged across all payers, weighting by each payer's share of total membership in MinuteClinic's PSA among adults with 12 months of continuous coverage in the 2023 APCD.

[122] *See supra* note 118.

[123] The HPC compared MinuteClinic prices per encounter and MGB contracting affiliate adult primary care prices per encounter for all MinuteClinic services in the 2023 APCD. See *supra* note 101 for the algorithm for identifying primary care claims. In the 2023 APCD, the sample of encounters was identified as member, date, and CPT code combinations with 1 claim and without an "incident to" billing modifier, dropping any combinations of payer, provider, and CPT code with fewer than 5 MinuteClinic encounters. The average price by provider, weighted by MinuteClinic's payer and service mix was then calculated. The HPC multiplied average physician prices by 85% to get APP prices.

[124] CVS projects that MCPC will serve 120,000 patients annually, with a similar payer mix as prior to the transaction. This means that approximately 81% of patients, or 97,200 individuals, would be commercial patients post-transaction. The parties also assume that 35% of unique patients served by MCPC would be part of MCPC's primary care panels and that these panel members would visit MCPC an average of 1.5 times per year. Thus, they expect 34,020 commercial patients would be members of the panels, and they would have 51,030 annual visits. The remaining 65% of patients would visit MCPC for convenience care once annually, so these 63,180 patients would have 63,180 visits. This means that non-empaneled primary care patients will account for 55% of annual visits. To obtain an estimated $6.6 million impact, the estimated 129% price increase by the 2024 MinuteClinic NPSR from payers covered by MGB risk contracts was multiplied by 55%, the share of annual visits the parties project will be accounted for by convenience care patients. The per-visit impact assumes no price increase for payers with whom MCPC expects to directly negotiate prices, which is a conservative assumption. CVS may also negotiate higher rates with the payers that it contracts with independently, which could somewhat increase the $6.6 million estimate.

c. As MCPC develops its primary care panels and correspondingly decreases its convenience care capacity, patients would seek care at other, generally higher-priced providers, likely increasing annual commercial spending by $5.9 million by year three.

Post-transaction, MCPC sites are expected to provide longitudinal primary care to adult patients on MCPC primary care panels and continue to offer convenience care services to adults who are not on MCPC primary care panels. Because MCPC expects that a portion of its capacity would be allocated to longitudinal primary care post-transaction, some patients who may have sought convenience care at MinuteClinic before the transaction would likely be diverted to other providers, such as urgent care centers and physician offices. To estimate the spending impact from this diversion, the HPC compared MinuteClinic prices with average prices at these comparator providers.

As mentioned above in Section III.A.1.a, the HPC identified a list of comparator convenience care providers that these convenience care patients would likely utilize as an alternative to MinuteClinic. These comparators were identified by looking at the providers in the MinuteClinic PSA that provide the largest shares of MinuteClinic's top convenience care services.[125] These providers were then categorized as either physician offices, urgent care centers, or hospital outpatient departments (HOPDs), with the remaining providers representing a mix of other settings. Based on a diversion model utilizing MinuteClinic's payer and service mix in the 2023 claims data, described in further detail in the Data Appendix, the HPC estimates that 67% of encounters are likely to divert to PCPs in physician offices, 18% of encounters are likely to divert to urgent care centers, 11% are likely to divert to HOPDs, and the remaining 4% are likely to divert to other settings. [126]

Finally, the HPC estimated the average price per encounter for MinuteClinic and the average price per encounter for each type of comparator convenience care provider weighted by MinuteClinic's payer and service mix and found that, on a weighted-average basis, comparator convenience care providers' prices were 94% higher than MinuteClinic's. Combining this price differential with the parties' stated expectations of the size of their primary care panels, the HPC estimates that commercial spending would increase by $114 per diverted visit when care previously provided by MinuteClinic shifts to other providers, or approximately $5.9 million annually by year three if MCPC achieves its patient panel goals in accordance with "moderate acceptance" of the model.[127]

In total, combining the impacts detailed above, this transaction is likely to increase annual commercial health care spending by approximately $40.2 million in year three if MCPC fills its patient panels to 35% by year three, consistent with CVS's "moderate acceptance" expectations, which includes spending increases for MCPC's new primary care patients and higher prices for both MCPC's continuing convenience care services and the convenience care services that would need to move to other providers. These estimates are conservative and could be substantially higher if MCPC sites were to each fill their primary care patient

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[125] See *supra* note 110 for a more detailed description of the HPC's methodology for identifying diversion recipients.

[126] The most common specialties for the physicians at physician offices, based on NPI taxonomies from CMS NPPES data, are internal medicine, pediatrics, and family medicine, accounting for 73% of all physician office NPIs. An encounter is defined as a member, date, and CPT code combination with 1 claim.

[127] Based on information provided by the parties, CVS expects that by year 3, 34,020 commercial patients would be MCPC panel members with 51,030 annual visits, accounting for 45% of total MCPC visit capacity. This means that 51,030 convenience care visits would be diverted to other providers. To obtain an estimated $5.9 million impact, the HPC multiplied the estimated 94% price increase by 45% of the 2024 MinuteClinic commercial NPSR. Because it could be argued that urgent care centers are a closer substitute to MinuteClinic due to their convenient locations, operating hours, and walk-in nature, the HPC conducted a sensitivity of the diversion analysis in which all convenience care visits were diverted to urgent care centers. This sensitivity found that urgent care center prices were on average 50% higher than MinuteClinic prices, resulting in an estimated spending impact of $3.1 million.

panels to the maximum size.[128] Figure III.A.9 summarizes the HPC's spending impact findings across all three mechanisms.

Figure III.A.9: Summary of Estimated Annual Commercial Spending Impact

Mechanisms	Anticipated Commercial Volume	Findings	Estimated Annual Impact
New MCPC primary care panels (reflects changes in pricing, utilization, treatment intensity, and care delivery patterns)	34,020 patients with 51,030 annual visits	Per-member annual increase of $650 for medical spending and $165 for non-claims spending	$27.7 million
Current convenience care remaining at MCPC	63,180 patients with 63,180 annual visits	129% price increase for contracts negotiated through MGB	$6.6 million
Current convenience care shifting to other providers	51,030 patients with 51,030 annual visits	94% spending increase due to higher prices at other providers	$5.9 million
Total MCPC Commercial Volume:	97,200 patients with 114,210 annual visits	**Total Projected Annual Spending Impact:**	$40.2 million

d. There are further cost and market impacts that the HPC is unable to quantify at this time, including the impact of MGB gaining bargaining leverage to negotiate higher rates in the future.

The estimated spending impact above is conservative for several reasons.

First, this estimate uses CVS's assumption of "moderate acceptance" of the MCPC primary care model by year three post-transaction, resulting in 35% of the primary care panels being filled by that time, with the remainder of MCPC services being convenience care. If MCPC is more successful in filling its patient panels, or those patient panels grow over time, these spending impacts would be higher. If the primary panels were filled entirely, the HPC estimates that the annual commercial claims-based spending impact would be approximately $76.2 million, with additional likely non-claims spending impacts.[129]

Second, the addition of MCPC to the MGB network is likely to result in some additional, incremental bargaining leverage for MGB, potentially enabling it to further increase commercial prices and health care spending, a concern also voiced by commercial payers.[130] However, such change in bargaining leverage is

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[128] The parties have argued that the transaction will provide access to primary care for up to 120,000 patients, if the MCPC APPs each had a full panel of 1,500 primary care patients. However, the estimates they provided to the HPC show that by year three, the latest year of data requested, the share of unique patients who are MCPC primary care patients would only be 35%. At some future point, if the MCPC APPs reached full primary care panels, then the annual commercial claims-based spending impact would likely be $63.2 million for the primary care panels and $13.0 million for the diversions of its current convenience care, for a total commercial claims-based spending impact of $76.2 million annually. There would also likely be an increase in commercial non-claims spending for the primary care panels. If those panels were full, the HPC estimates that non-claims spending would also likely increase by approximately $16.0 million annually. Even if MCPC is unsuccessful at building its patient panels and continues to provide only convenience care, the HPC estimates that commercial spending is likely to still increase by $12.0 million annually solely due to repricing those services at MGB rates.

[129] *See supra* note 128.

[130] Additional effects may include reduction of the feasibility of or savings for limited networks. Because the transaction would bring MCPC's continuing convenience care services into the MGB network, payers whose members

difficult to quantify at this point.[131] Furthermore, the new differentiation of MGB services – for instance, the addition of more convenient locations and hours to their service offerings – could itself increase future market leverage.[132] If MGB is able to negotiate higher prices following the transaction, this would increase not only the spending for individuals utilizing MCPC but also spending for other MGB patients.

Further, the HPC did not model any spending impact related to convenience care provided under the contracts that CVS would negotiate independently post-transaction. Post-transaction, CVS may be able to negotiate higher prices in part due to an increase in bargaining leverage resulting from its affiliation with MGB. CVS may also receive higher prices under new primary care contracts due to the additional resources involved in providing primary care compared to convenience care. Incorporating any such additional price increase into the HPC's model would likely increase the spending impact.[133]

e. Expanding access to primary care could result in longer-term health care savings. However, the likelihood and scope of additional savings here depends heavily on the success of the new MCPC model for primary care.

The parties say they expect savings associated with the transaction increasing the state's primary care capacity. For example, individuals who otherwise would not have had a PCP may see long-term health savings (i.e., savings after multiple years) due to factors such as better management of chronic health conditions, preventive care, and avoiding ED visits[134] after receiving access to a PCP.

The HPC acknowledges the potential for increased access to high-quality, comprehensive primary care to result in cost savings, as well as in improved health outcomes for patients. Some such savings are already

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have historically utilized MinuteClinic locations might find it more challenging to create limited network products that exclude MGB, if these products would also exclude MCPC's convenience care services.

[131] Two key factors limit the HPC's ability to accurately quantify the transaction's potential impact on bargaining leverage at this time: First, as described in Section III.A.1.a, the HPC does not yet have comprehensive affiliation data for the APPs of provider organizations other than MinuteClinic. Given that MCPC primary care would be provided exclusively by APPs, the inability to account for non-MCPC APPs in analyses of changes in market shares and concentration could potentially result in substantial inaccuracies. Second, while the HPC expects that any volume of primary care provided by MCPC would impact market shares and market concentration, the size of the impact would vary substantially based on the extent of MCPC's success in building up its primary care panels, which is currently uncertain.

[132] See, e.g., Nancy Beaulieu, et al., *Hospital capital Expenditures Associated with Prices and Hospital Expansion Or Withering, 2010-19*, 44 HEALTH AFFAIRS (2025), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01172 (last visited April 5, 2026).

[133] Another factor which makes the HPC's estimate conservative is that the HPC did not use office visit procedure codes to identify comparator convenience care providers, as these services are used too broadly to make them a useful input for model convenience care diversions. Because of this methodological choice, the HPC's model of convenience care diversions does not result in a significant number of patients diverting to EDs. To the extent that lack of convenience care at MinuteClinic sites increases ED utilization, particularly for pediatric patients, the spending impact would be higher.

[134] The parties also contend that the transaction could decrease statewide commercial spending through reduced emergency department (ED) boarding and reduced inpatient lengths of stay. The HPC defines ED boarding as staying at least 12 hours in a hospital ED before placement in an inpatient setting or discharge to home or to non-inpatient care. MASS. HEALTH POLICY COMM'N, EMERGENCY DEPARTMENT BOARDING IN THE COMMONWEALTH OF MASSACHUSETTS (March 2026) at 1 *available at* https://masshpc.gov/sites/default/files/ED-Boarding-Report.pdf. The HPC found that the state is unlikely to see spending reductions through these two mechanisms. The HPC's understanding is that reimbursement is not based on length of stay except in outlier cases, and only some payers incorporate ED boarding time into reimbursement. Thus, while any reductions in ED boarding and inpatient lengths of stay post-transaction would have other benefits for patients and providers, these reductions would be unlikely to generate substantial cost savings.

incorporated into the HPC's spending impact analyses. As described in Section III.A.2.a, the HPC examined claims-based spending for new primary care patients of MGB who did not previously have a PCP to identify total spending changes after joining MGB, which are likely attributable to a combination of price and utilization. Because the HPC's analysis used claims data from 2019 to 2023, the analysis incorporates the average annual savings per member from utilization changes that occur one to four years (two years on average) after obtaining a PCP, such as reductions in avoidable ED use. The HPC further examined how spending by care setting changed for these patients after joining MGB and observed a decrease in annual inpatient spending per member, which may reflect savings from appropriate care management. The decrease was modest and was accompanied by much larger increases in outpatient and professional care, resulting in the net impact in spending described in subsection (a) above.

There is a potential for longer-term savings beyond the period that the HPC was able to model if the MCPC model is successful in meaningfully improving access to high-quality primary care for adults in Massachusetts. As discussed in Figure II.B.1 and Section III.B.2, in addition to its benefits for patient health outcomes, access to high-quality primary care is associated with lower rates of hospitalization and reduced ED utilization. Studies have found that greater geographic accessibility of primary care and greater continuity of care with a specific primary care physician are associated with lower hospital use for older patients and Medicare beneficiaries.[135] Studies have also found that primary care practices with more evening hours, a lower ratio of patients per clinician-hour, and expanded interpreter services are all associated with lower rates of ED use.[136] As noted in the Introduction to this report and in Section III.B.2, approximately two-fifths of ED visits between 2016 and 2023 were for conditions that could have either been prevented with appropriate primary care or treated in a primary care setting,[137] and the HPC has found that if avoidable ED visit rates in the regions of the state with the highest avoidable ED use declined to the 75th percentile among regions, this would reduce health care spending by approximately $9.7 million.[138] There is thus evidence to support the additional claim that these utilization changes could reduce overall health care spending for an individual or a system, but the likelihood and scope of such savings is dependent on a number of factors.[139]

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[135] Daly, et al. (2018), *supra* note 90; Andrew Bazemore et al., *Higher Primary Care Physician Continuity Is Associated with Lower Costs and Hospitalizations*, 16 ANNALS FAM. MED. 492 (Nov. 2018), *available at* https://pubmed.ncbi.nlm.nih.gov/30420363/ (last accessed April 10, 2026).

[136] Lowe, et al. (2005), *supra* note 90; Villani & Mortensen (2013) *supra* note 89.

[137] 2025 MHIS, *supra* note 87; DIRE Diagnosis, *supra* note 3.

[138] HEALTH POLICY COMM'N, 2023 ANNUAL HEALTH CARE COST TRENDS REPORT AND POLICY RECOMMENDATIONS (Sept. 2025) at 46, *available at* 2023 Cost Trends Report.pdf (last visited Apr. 5, 2026).

[139] For instance, an observational study on patients attributed to PCPs in the Veterans Health Administration found that an additional in-person primary care visit was associated with annual per-member total cost reductions. Higher patient risk was associated with larger cost reductions. Multiple studies have also found that continuity of primary care – for instance, frequent, regular visits with the same PCP – is associated with lower healthcare costs. Again, there were greater savings for patients of higher complexity. Another study found that opening a pediatric walk-in clinic decreased low-acuity pediatric ED use for Medicaid patients, which generated savings to the Medicaid system. See, e.g., Jian Gao, et al., *The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration*, 23 J. Primary Care & Community Health (2022), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC9793026/ (last visited April 5, 2026); Dilara Sonmez, et al., *Primary Care Continuity, Frequency, and Regularity Associated with Medicare Savings*, 6 JAMA NETWORK OPEN e2329991 (2023), *available at* https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2808555 (last visited April 5, 2026); Andrew Bazemore, et al., *The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review*, 21 ANNALS FAM. MED. 274 (2023), *available at* https://www.annfammed.org/content/annalsfm/21/3/274.full.pdf (last visited April 5, 2026); Toren Davis et al., *Decreasing Low Acuity Pediatric Emergency Room Visits with Increased Clinic Access and Improved Parent Education*, 31 J. AM. BD. FAM. MED. 550 (2018), *available at* https://pubmed.ncbi.nlm.nih.gov/29986981/ (last visited April 4, 2026).

Specifically, research literature suggests that, while increasing PCP access can bring meaningful improvements in health care quality and health outcomes,[140] any resulting cost savings are highly dependent on factors like care continuity, patient complexity, and other contextual factors, such as whether a patient was also newly insured at the time they gained a PCP.[141] Studies have found greater savings in the context of high-quality, long-term longitudinal care with the same provider.[142] Thus the potential for additional savings here is highly dependent on whether this novel model proves successful, long-term, in increasing access to high-quality and comprehensive primary care, which, as discussed in the next section, remains uncertain. Additionally, greater savings have been found for higher-risk patients, such as patients with chronic conditions,[143] while members of MCPC's new primary care patient panels are expected to be lower-complexity on average,[144] suggesting that the potential long-term savings beyond what the HPC has modeled is likely to be modest.[145]

B. Access and Quality

To assess factors related to access and quality of care, the HPC examined the parties' current provision of primary care and adjacent services and their respective payer mixes; the parties' current quality performance and quality improvement strategies; the transaction's potential to increase access to primary care, especially for populations that face access barriers; the transaction's potential to decrease access to convenience care; factors likely to impact the model's long-term sustainability; the degree to which the proposed model constitutes comprehensive primary care; and the transaction's potential to support MCPC delivery of high-quality care. The HPC's findings are summarized below:

Access and Quality Profile:

- MGB and MinuteClinic are important access points for primary care and primary care adjacent convenience care services, respectively; both serve a high commercial payer population.
- MGB has historically performed comparably to or better than the statewide average on available quality metrics, and quality measures tracked by MinuteClinic appear to indicate generally strong performance.

Access and Quality Impact:

- The novel MCPC care delivery model has the potential to increase access to primary care for adult patients. The degree to which this potential is achieved depends on the success of the model over time and on some key details that have not yet been determined.

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[140] See discussion in Section III.B.

[141] See, e.g., Zirui Song, et al., *Will Increasing Primary Care Spending Alone Save Money?*, JAMA (2019), *available at* https://jamanetwork.com/journals/jama/fullarticle/2748667; Soeren Mattke, et al., *Evidence for the effect of disease management: is $1 billion a year a good investment?*, 13 AM. J. MANAGED CARE 670 (2007), *available at* https://pubmed.ncbi.nlm.nih.gov/18069910/ (last visited April 5, 2026); Kyle Edrington, et al., *Investing in Primary Care: Why it Matters for Californians with Medi-Cal Coverage*, California Health Care Foundation (2022), *available at* https://www.chcf.org/wp-content/uploads/2022/07/InvestingPrimaryCareMMC.pdf (last visited April 5, 2026).

[142] *See, e.g.,* Sonmez, et al. (2023), *supra* note 139; Bazemore, et al. (2023), *supra* note 139; Bazemore, et al. (2018), *supra* note 135.

[143] *See, e.g.,* Gao, et al. (2022), *supra* note 139; Mattke, et al. (2007), *supra* note 141; Edrington, et al. (2022), *supra* note 141.

[144] For more information, see Section II.B.

[145] In addition, the reduction in access to convenience care, particularly for children, could also lead to increased utilization of higher cost settings like EDs, the higher costs of which are also not fully reflected in the HPC's modeling. *See supra* note 133.

- MinuteClinic should consider prioritizing support for sites that have the most potential for improving access, including sites in Hampden, Plymouth, and Bristol counties.
- The MCPC payer mix is expected to remain primarily commercial following the transaction.
- Extended hours are proposed at MCPC sites, but not all MinuteClinic sites are currently open for the standard operating hours.
- The shift away from the all-ages convenience care only model would eliminate access to convenience care for children and may reduce access to such services for adults.
- It is unclear whether this new primary care model would be successful over the long term; to the extent it fails, access may be reduced relative to the status quo.
- Staff training and retention will be key to achieving a sustainable primary care model at MCPC in Massachusetts.
- The proposed care delivery model reflects some key features of comprehensive primary care but also has some notable limitations.
- While there is potential for MCPC to provide high-quality primary care in coordination with MGB, it is uncertain to what degree this potential would be realized.

1. Access and Quality Profile

a. MGB and MinuteClinic are important access points for primary care and primary care adjacent convenience care services, respectively; both serve a high commercial payer population.

As discussed in Section II.A.1, MGB is the Commonwealth's largest provider of primary care physician services in Massachusetts, with over 1,200 primary care physicians in their network, and accounting for 24% of the state's spending on primary care services. At MGB primary care offices, patients receive comprehensive primary care services including physical examinations, vaccinations, screenings, and treatment for illnesses and chronic conditions.

MinuteClinic currently offers convenience care for both adult and pediatric patients at its 37 Massachusetts locations staffed by approximately 80 APPs. Historically, MinuteClinic has been an important access point for a number of services that are generally considered to be part of primary care services, such as screenings, vaccines, infectious disease testing, and routine lab tests, but it has not provided longitudinal primary care in Massachusetts.

CVS provided the HPC with internal data on its current MinuteClinic patients. In 2024, MinuteClinic served 140,000 unique patients in Massachusetts with a total of 190,000 visits annually. Further, CVS reports that MinuteClinic sites in Massachusetts see over 20,000 pediatric visits per year, with up to 24% of annual patients at a given MinuteClinic site (and an average of 15% across all Massachusetts sites) being pediatric patients.

The HPC also reviewed information on both MGB's and MinuteClinic's payer mix. The parties provided internal data confidentially to the HPC showing that both MinuteClinic Massachusetts and MGB predominately serve commercially insured patients, with MGB's primary care patients being 67% commercially insured, and MinuteClinic's patients being 81% commercially insured. In comparison, statewide insurance enrollment is approximately 55% commercial.[146]

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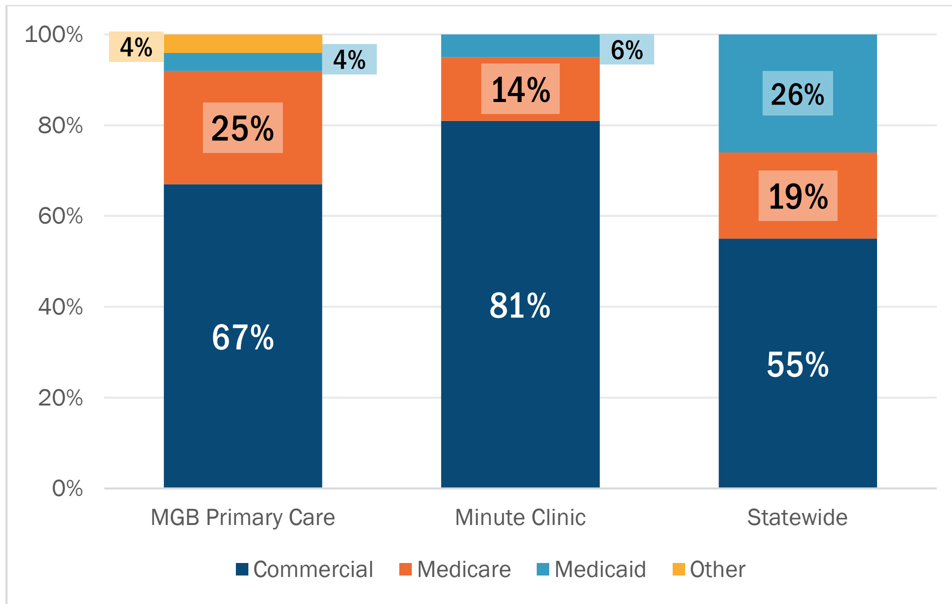
[146] CTR. FOR HEALTH INFO. & ANALYSIS, *Enrollment In Insurance Trends*, https://www.chiamass.gov/enrollment-in-health-insurance/ (last visited April 7, 2026).

Figure III.B.1: MGB Primary Care Payer Mix, MinuteClinic Payer Mix, and Statewide Payer Enrollment



b. MGB has historically performed comparably to or better than the statewide average on available quality metrics, and quality measures tracked by MinuteClinic appear to indicate generally strong performance.

To examine the parties' baseline performance in delivering high-quality patient care, the HPC reviewed their recent performance on quality metrics relevant to primary care and convenience care (for MGB and MinuteClinic, respectively), as well as information on systems the parties use to support high-quality care in these areas.

On HEDIS measures of primary care process quality, MGB performed in line with or higher than the statewide average rate on most measures, with higher performance on measures of adult diagnostic and preventive care, screening and prevention, and chronic care.[147] MGB also employs tools designed to support practices in delivering high-quality care and meeting quality benchmarks in payer contracts; materials provided to the HPC include descriptions of centralized administrative supports, data and analytic expertise, quality improvement programs, and patient satisfaction assessments.

While comparable market-wide data to fully understand and contextualize MinuteClinic's quality performance are not available, quality measures tracked by MinuteClinic, and provided to the HPC, appear to indicate generally strong performance.

[147] HPC analysis of *Clinical Quality and Patient Experience Measures*, CTR. FOR HEALTH INFO. & ANALYSIS, (2023), https://www.chiamass.gov/equity-in-quality-of-care-select-clinical-quality-and-patient-experience-measures#tableau-interactive (last visited April 6, 2026). MGB performed significantly higher than the statewide rate for three Adult Diagnostic and Preventive Care Colorectal Cancer Screening and two Women's Health Screening and Prevention measures. MGB performed comparably to statewide rates for three Chronic Condition Care (Cardiovascular and Diabetes Care) measures. MGB scored significantly lower than the statewide rate for three measures including Use of Imaging Studies for Low Back Pain, Chlamydia Screening in Women Ages 21 to 24, and Eye Exam for Patients with Diabetes.

Figure III.B.2: MinuteClinic Quality Performance (2023-2024)

Quality Metrics	2023 Performance	2024 Performance
Appropriate Treatment of Acute Bronchitis	90.73	92.50
Appropriate Follow up for Elevated BP	74.62	85.98
Appropriate Treatment of Pharyngitis	99.62	99.42
Appropriate Treatment of URI	98.80	99.27
Current Tobacco User and Cessation Counseling	80.09	85.83
Patient call back for ED referral	87.58	86.22

CVS provided the HPC descriptions of MinuteClinic's existing quality improvement framework, which includes Clinical Executive and Patient Safety committees providing governance and oversight, with executive sponsorship from a Chief Medical Officer and Chief Nurse Practitioner. The Clinical Executive Committee defines clinical services and standards based on national guidelines for evidence-based practices. The Patient Safety Committee monitors quality, patient safety, and experience through various reporting mechanisms including HEDIS metrics, audits, patient safety event reporting, and patient surveys.

CVS has maintained Ambulatory Health Care Accreditation from the Joint Commission since 2006, which requires providers to maintain performance standards, such as chronic disease management, contract management, and confidentiality of patient information, and encourages continuous improvement, and has NCQA certification for credentialling and privileging processes.[148]

2. Access and Quality Impact

a. The novel MCPC care delivery model has the potential to increase access to primary care for adult patients; the degree to which it meaningfully improves access depends on the success of the model over time and on some key details that have not yet been determined.

The transition of MinuteClinic sites to MCPC primary care locations has the potential to expand access to primary care for adults in the Commonwealth, and the HPC welcomes the parties' efforts to propose novel solutions to address the need for additional PCPs. The transaction's ultimate impact will depend on some key details that have yet to be determined, how the model is implemented over time, and how patients and providers respond—factors that are difficult to predict and are not well informed by existing evidence.

A transition from MinuteClinic sites to MCPC sites would entail an expansion of the services MinuteClinic currently offers adults, from episodic convenience care to longitudinal primary care – including chronic disease management, care coordination, and closed-loop referrals – which would be a meaningful increase in service offerings for adult primary care patients. The novel structure of this model, with APPs managing patient panels in all MCPC sites as well as offering ongoing convenience care to adult patients, may represent an opportunity to expand access to primary care even as the primary care physician workforce shrinks.[149]

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[148] *Why Choose* Us, CVS MINUTECLINIC, https://www.cvs.com/minuteclinic/why-choose-us/patient-quality (last visited April 6, 2026); *see also*, *Ambulatory Health Care Accreditation Program*, JOINT COMMISSION https://www.jointcommission.org/en-us/accreditation/ambulatory-health-care (last visited April 3, 2026).

[149] However, there are also challenges in the nurse practitioner primary care workforce; the share of NPs working in office-based settings fell from 26% in 2018 to 21% in 2022. DIRE DIAGNOSIS *supra* note 3 at 38.

One notable way in which the proposed MCPC model differs from other primary care practices in the Commonwealth is the potential for extended hours. The parties state that the MCPC sites would offer extended evening and weekend hours, which has the potential to improve access to primary care for future MCPC primary care patients. However, the potential scope of extended hours for primary care is not yet clear, particularly given that it appears that many MinuteClinic sites in Massachusetts currently offer reduced hours compared to MinuteClinic's standard hours of operation,[150] and that the current number of providers at each MinuteClinic location does not appear to correlate with the operating hours of the location.[151] In light of current hours and staffing for MinuteClinic sites, it is unclear to what extent MCPC primary care would be consistently available during extended hours. The access impact would depend on the extent to which services are available during extended hours.

Access to high-quality primary care has many key benefits that have been well-documented by the HPC and others, including increased life expectancy and lower mortality,[152] reduced chronic disease burden[153], fewer health disparities,[154] fewer hospitalizations,[155] and reduced ED utilization.

In Massachusetts, between 2016 and 2023, approximately two-fifths of ED visits were for conditions that could have either been prevented with appropriate primary care or treated in a primary care setting.[156] Geographic proximity of patients to care providers, expanded primary care office hours, and strong physician-patient relationships in primary care settings have also been found to reduce ED utilization. Some research has also found that NP primary care models, in particular, are associated with equivalent or better quality of care, and similar or lower ED visits and hospitalizations for patients with multiple chronic conditions, compared to models without NP involvement.[157]

Relatedly, the parties state that difficulty accessing primary care contributes to longer wait times, disjointed care, and an increased reliance on EDs. Their long-term goals include moving care delivery away from emergency and specialty settings and towards preventive and coordinated APP-led primary care. To the extent that the parties are successful in increasing access to primary care for adults, and to the extent that this care is characterized by features such as strong clinician-patient relationships, their patients could experience improved health outcomes and decreased ED utilization.

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[150] CVS stated that MinuteClinic standard hours of operation are Monday-Friday 8am-7pm, Saturday 9am-5:30pm, and Sunday 9am-4:30pm, but individual clinic hours vary. The HPC reviewed MinuteClinic sites' current operating hours in comparison to the standard hours of operation and found that less than half (16 out of 37, or 43%) of the Massachusetts MinuteClinic sites currently follow these standard operating hours. Some have reduced weekday or weekend hours, two are closed on weekends, and two are closed for at least one day during the week. *MinuteClinic Cities in Massachusetts*, CVS MINUTECLINIC, https://www.cvs.com/minuteclinic/clinic-locator/ma (last visited April 6, 2026).

[151] For example, materials provided to the HPC show that four locations with the standard operating hours identify only one provider staffing the location. It is unlikely that a single primary provider would be able to maintain this schedule in the long-term following a transition to a primary care model, even with support from other staff.

[152] Basu, et al. (2019), *supra* note 90.

[153] Rebecca Reynolds et al., *A Systematic Review of Chronic Disease Management Interventions in Primary Care*, 19 BMC FAM. PRAC. 11 (2018), *available at* https://doi.org/10.1186/s12875-017-0692-3 (last accessed April 10, 2026).

[154] Barbara Starfield et al., *Contribution of Primary Care to Health Systems and Health*, 83 MILBANK Q. 457 (Sept. 2005) [hereinafter Starfield 2005], *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC2690145/ (last accessed April 10, 2026).

[155] Bazemore et al. (2018), *supra* note 135.

[156] 2025 MHIS, *supra* note 87; DIRE Diagnosis, *supra* note 3.

[157] Amy McMenamin, et al., *A Systematic Review of Outcomes Related to Nurse Practitioner-Delivered Primary Care for Multiple Chronic Conditions*, 80 MED. CARE RES. REV. 563 (2023), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC10784406/ (last accessed April 9, 2026).

b. MinuteClinic should consider prioritizing support for sites in communities with the most potential for improving access.

Given that MCPC sites would be created by converting existing MinuteClinic sites, any expansion of access to primary care resulting from the transaction would be centered on the communities surrounding those sites. The parties' plan as described in materials provided to the HPC is to transition five sites in the first year and, depending on the success of MCPC, the ability to secure full clinic licenses, and available funding, to transition additional sites in the following years, with the full transition of all sites expected within two to three years. The parties' materials state that MinuteClinic's retail locations overlap with some high-need, high-Medicaid communities including Worcester, Springfield, Lawrence, Brockton, Fall River, and Lowell, although they did not indicate whether locations in these communities would be among the earlier or later sites to transition to the MCPC model.

The HPC analyzed metrics of primary care availability and need to assess which current MinuteClinic sites are located in communities with the greatest need for additional primary care services. The HPC identified some key differences that could guide the parties in their decisions regarding relative timing for transition, strategic and financial support, and targeted patient outreach across the 37 sites. The HPC assessed the sites utilizing six metrics: Area Deprivation Index (ADI),[158,159] which measures socioeconomic factors such as home value, poverty, and unemployment, to identify communities in the Commonwealth that may face greater socioeconomic barriers to accessing primary care; the federal Health Resources and Services Administration's Index of Medical Underservice Score,[160] which scores geographic locations on need; the share of commercially insured adults with no primary care use documented in claims data[161]; PCP counts per 100,000 Massachusetts residents[162]; the share of people with non-emergency ED use[163]; and the share of non-elderly adults covered by MassHealth[164] (For additional information on how the HPC used these metrics to assess the MinuteClinic sites, see Data Appendix Figure 3).

These data were used to identify communities that may face additional barriers to primary care. Considering all factors equally, the HPC identified current MinuteClinic locations in Hampden County (West Springfield and Palmer) and Plymouth County (Carver), both of which had composite primary care need scores of 17 out of 20 with 20 reflecting the greatest level of need, as having patient demographics most likely to benefit from expanded primary care access. Additional locations in Plymouth County (Marshfield) and Bristol County (Fall River), with composite scores of 15 out of 20, also rated highly in the HPC's analysis of need.

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[158] Amy J.H. Kind & William R. Buckingham, *Making Neighborhood-Disadvantage Metrics Accessible – The Neighborhood Atlas*, 378 N. ENGL. J. MED. 2456 (2018), *available at* https://www.nejm.org/doi/full/10.1056/NEJMp1802313 (last visited April 6, 2026).
[159] *2023 Area Deprivation Index v.4.0.1*, UNIV. WISCONSIN SCH. MED. PUBLIC HEALTH CTR. FOR HEALTH DISPARITIES RES., https://www.neighborhoodatlas.medicine.wisc.edu/ [hereinafter ADI v.4.0.1] (downloaded Nov. 19, 2025).
[160] HRSA DATA WAREHOUSE, Find MUA/P, https://data.hrsa.gov/topics/health-workforce/shortage-areas/mua-find [hereinafter HRSA Shortage Areas](last visited April 10, 2026)
[161] HPC analysis of 2023 APCD claims data
[162] HPC analysis of HRSA DATA WAREHOUSE, Area Health Resource File 2022-2023 Dataset, https://data.hrsa.gov/topics/health-workforce/nchwa/ahrf [hereinafter HRSA Area Health Resource] (last visited April 14, 2026).
[163] HPC analysis of CTR. FOR HEALTH INFO. & ANALYSIS, FINDINGS FROM THE 2023 MASSACHUSETTS HEALTH INSURANCE SURVEY (Dec. 2025) at 46 [hereinafter 2023 MHIS], *available at* https://www.chiamass.gov/assets/docs/r/survey/mhis-2023/2023-MHIS-Report.pdf.
[164] GEORGETOWN UNIV. CTR. FOR CHILDREN & FAMILIES, *Medicaid Coverage in Massachusetts Counties, 2023* (Feb. 6, 2025), https://ccf.georgetown.edu/2025/02/06/medicaid-coverage-in-massachusetts-counties-2023/ [hereinafter GEORGETOWN 2025](last visited April 10, 2026)

MinuteClinic should communicate their plans with the Commonwealth and consider prioritizing support for sites in these identified communities to the new MCPC model, including by providing sufficient infrastructure support to transform the physical space of each site, in order to have the greatest impact on primary care access for vulnerable populations.

c. The MCPC payer mix is expected to remain primarily commercial following the transaction.

The parties have stated to the HPC that the MCPC model is intended to improve and expand access to longitudinal primary care for all patients, regardless of payer, and that they are committed to a payer-agnostic approach to care delivery, providing equitable access for commercial, Medicare, and Medicaid members. MassHealth enrollees would be eligible to receive care at MCPC sites under fee-for-service arrangements until MCPC joins the MassHealth ACO.

In discussions with the HPC, while CVS representatives expressed commitments to continuing to serve Medicare and MassHealth patients, they also stated that they expect the payer mix of the MCPC clinics to resemble the current payer mix at its Massachusetts MinuteClinic sites, consistent with their experience in other markets. To the extent that MCPC clinics serve a mix of patients similar to MinuteClinic's current population, they would continue to serve primarily commercially insured patients, potentially limiting the impact of these sites on access for public-payer patients, even if MCPC locations in high-public payer regions are prioritized as suggested above. Thus, MCPC may need to make concerted efforts to advertise its services to MassHealth members in its service area in order to increase primary care access among this population.

d. The shift away from the all-ages convenience care only model would eliminate access to convenience care for children and may reduce access to such services for adults.

The conversion of MinuteClinic sites to the MCPC model may also be disruptive, particularly for pediatric patients. The parties have stated in information provided to the HPC that MCPC's initial practice scope for both primary care and convenience care services would be limited to adult patients, eliminating pediatric access to all current services, with the exception of vaccinations for patients aged five and older, which CVS has stated would remain available at CVS Pharmacy locations. Patients four and under cannot be served by pharmacist-administered vaccinations and would lose access to this service at MCPC sites.[165]

After the transition to primary care, MCPC states it would continue to serve some adult convenience care patients, but the availability of appointments for such patients is expected to decrease as the number of primary care patients increases. CVS projects that 45% of MCPC's visit capacity would be used for members of its primary care panels by year three, diverting an estimated 63,000 convenience care visits to other sites of care.[166] The potential impacts of this decreased access to convenience care are difficult to detail given the variety of acute and chronic care provided to convenience care patients. As described in Section III.A.2.c, HPC's diversion analyses suggest that patients unable to receive convenience care at a MinuteClinic are likely to divert primarily (67%) to physician office settings, with 18% of diverted patients likely seeking convenience care at urgent care centers, and 11% likely seeking care at a HOPD. Seeking care through these pathways has the potential to create further burdens on already strained system

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[165] MASS. GEN. LAWS ch. 94C, § 1; 105 CMR 700. However, as a limited services clinic MinuteClinic currently cannot serve children under 18 months of age, so the change in vaccine access would apply to those aged 18 months through age four. 105 CMR 140.1001.

[166] Access may also be reduced for patients in limited network products that include MinuteClinic but exclude MGB providers, as a result of the MCPC APPs joining the MGB network. See *supra* note 130 for a discussion of the potential market impacts of the addition of MinuteClinic's convenience care services to the MGB network.

resources, particularly for other primary care practices and for emergency departments; however, as discussed in Section III.A.2.e the parties contend that this transaction has the potential to reduce ED boarding, which may mitigate the increased burden on EDs from the loss of convenience care. These alternatives are typically higher cost, and if patients face greater cost-sharing burden, they may choose to delay or forgo care, worsening long-term health outcomes.

After-hours and convenience care services may be particularly important for the pediatric population, which made up 20,000 visits to MinuteClinic locations in 2024. As noted in Section II.A.2, MinuteClinic sites are the only licensed limited services clinics in the state, and the elimination of convenience care for children (without any new provision of primary care in its place) may have particular implications for children's access to timely care for low-complexity services. Many avoidable ED visits in this population are for upper respiratory infection, fever, and ear infections, all of which may be treated at convenience care sites, and research has found that availability of walk-in visits, such as those provided at MinuteClinic locations, can decrease the number of ED visits.[167] Receiving care at a MinuteClinic is likely to be faster for children than visiting an ED, because wait times at MinuteClinic sites average 22 minutes, compared to average ED wait times of 189 minutes.[168] Another benefit of timely and appropriate care for lower acuity pediatric patients is that such care decreases total health care spending.[169]

CVS has indicated that it would revisit the possibility of expanding convenience services to again include pediatric patients after the MCPC sites are established, potentially reversing this loss of access, but there is no specific plan or timeline for this reversal. The loss or disruption of convenience care for younger patients may result in higher rates of deferred care or unnecessary ED use for these patients, particularly infectious disease testing and treatment, and may have a negative effect on vaccine access for children under age 5.[170] As with adult patients, this has the potential to increase costs, delay care, and may worsen health outcomes for some portion of this pediatric population, and unlike adult populations, there would be no offsetting increase in access to primary care.

e. It is unclear whether this new primary care model would be successful over the long term; to the extent it fails, access may be reduced relative to the status quo.

As described above in Section II.A.2, CVS launched a national retail primary care strategy, similarly siting care in existing retail locations, and in some cases partnering with an AMC-anchored system like MGB. Due to the recent nature of the affiliations, the parties were not able to provide data, and the HPC was unable to identify independent information, on specific impacts on access or outcomes for primary care patients in those states or assess how the experiences in these states may apply to Massachusetts. There are also no national examples of long-term success for convenience care transitions to primary care, as other retail companies have struggled to establish a sustainable model for retail primary care.

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[167] Davis et al. (2018), *supra* note 139.

[168] Annie Jonas, *Massachusetts emergency room wait times rank among the longest in the U.S.* BOSTON.COM (Feb. 12, 2026), *available at* https://www.boston.com/news/local-news/2026/02/12/massachusetts-ranks-emergency-room-wait-times/ (last visited April 7, 2026); *How can I save time by choosing MinuteClinic?* CVS HEALTH, https://www.cvs.com/minuteclinic/why-choose-us/clinic-wait-time (last visited April 6, 2026).

[169] Patricia G. McBurney, et al., *Potential cost savings of decreased emergency department visits through increased continuity in a pediatric medical home*, 4 AMBUL. PEDIATR. 204 (2004), *available at* https://pubmed.ncbi.nlm.nih.gov/15153047/ (last visited April 6, 2026).

[170] CVS provided the HPC with internal data showing that, in 2024, approximately 25% of all MinuteClinic visits were for vaccinations; CVS expects that pediatric and other vaccinations will remain available at CVS pharmacies for patients over age 5, and disruptions to this care will be less significant. However, about 12% of these visits are for infectious disease testing (respiratory and strep), and the loss of these services has the potential to disrupt usual care for symptomatic pediatric patients.

Walgreens attempted to make this transition beginning in 2020, launching physician-led primary care practices under the "Village Medical at Walgreens" name.[171] In 2022, the brand announced launches for the Massachusetts market, starting with a location in Quincy.[172,173] By 2025, facing ongoing operating losses, Walgreens proceeded to close or sell its Village Medical locations, and reported difficulty filling patient panels as one factor contributing to the financial losses and subsequent closures; as of March 2026, none of the remaining Village Medical locations are sited in Massachusetts.[174, 175] Similarly, Walmart Health launched in 2019 and provided primary care, including behavioral care, alongside labs, X-rays, and dental care. [176] This also proved unsustainable, and the company closed all Walmart Health centers at the end of June 2024 citing thin margins, supply chain constraints, workforce shortages, and increases in the cost of care.[177]

Since the oldest of these affiliations began in 2024, it is not yet clear whether they will distinguish themselves from the failures of other similar models or the extent to which partnership and co-branding with MGB may contribute to success of the model in Massachusetts. If MCPC sites were to close, local communities would have lost both new primary care and existing convenience care, leaving them with fewer options for care than they have today. The parties have not specified whether transitioned sites would revert back to operate as MinuteClinic sites if they were deemed unsuccessful. If failed MCPC sites did not revert back to MinuteClinic sites that offered convenience care to all patients (including pediatric patients), access to care in affected communities would be reduced relative to the status quo.

f. Staff training and retention will be key to achieving a sustainable primary care model at MCPC in Massachusetts.

CVS would need to provide sufficient training, clinical support, and administrative assistance to the current MinuteClinic APPs in order to fully support them as they transition to managing primary care panels at MCPC sites. The parties' plans to build up the MCPC primary care patient panels over time may provide the APPs with a helpful ramp-up period to allow them to get accustomed to their new primary care responsibilities. However, during this ramp-up period, APPs would have to juggle both new primary care patients and continuing convenience care provision.

The parties stated in materials provided to the HPC that to support this transition, the MCPC APPs would undergo primary care training, focused on longitudinal care delivery, preventive health, and chronic disease management. The training would be delivered via a virtual learning curriculum of 22 continuing education credits tailored to the APP's role and experience. The parties stated that the curriculum is

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[171] Bruce Japsen, *Walgreens Edges Closer To Selling Stake In Clinic Operator VillageMD*, FORBES (Feb. 13, 2025), *available at* https://www.forbes.com/sites/brucejapsen/2025/02/13/walgreens-edges-closer-to-selling-stake-in-clinic-operator-villagemd/ (last visited April 6, 2026).

[172] Liu H. "Walgreens, VillageMD to open their first Mass. medical clinic in Quincy "Patriot Ledger. April 28, 2022. *Available at* https://www.villagemd.com/press-releases/walgreens-and-villagemd-expand-to-massachusetts-with-goal-of-opening-more-than-10-new-full-service-primary-care-practices-by-early-2023

[173] *Walgreens and VillageMD Expand to Massachusetts with Goal of Opening More Than 10 New Full-Service, Primary Care Practices by Early 2023*, VILLAGEMD (April 28, 2022), https://www.villagemd.com/press-releases/walgreens-and-villagemd-expand-to-massachusetts-with-goal-of-opening-more-than-10-new-full-service-primary-care-practices-by-early-2023 (last visited April 7, 2026).

[174] *Supra* note 171.

[175] *About VillageMD*, VILLAGEMD, https://www.villagemd.com/who-we-are (last visited April 7, 2026).

[176] Heather Landi, *Walmart Health's shutdown underscores major challenges for retail health 'disruptors'*, FIERCEHEALTHCARE (April 30, 2023), *available at* https://www.fiercehealthcare.com/providers/walmart-shuttering-all-51-health-centers-virtual-care (last visited April 7, 2026).

[177] Sai Balasubramanian, *The Shuttering Of Walmart Health Highlights The Challenges Of Consumer Healthcare*, FORBES, (May 31 2024), *available at* https://www.forbes.com/sites/saibala/2024/05/31/the-shuttering-of-walmart-health-highlights-the-challenges-of-consumer-healthcare/ (last visited April 7, 2026).

designed to prepare APPs to manage end-to-end care focusing on preventive care, including health maintenance visits, recommended screenings, and chronic conditions, in addition to training on electronic health record documentation and patient panel management. However, it is unclear from the information provided whether the proposed trainings would be sufficient to prepare MCPC APPs to provide a high standard of primary care. The parties also stated that collaborating physicians are available for consultation virtually or by phone and would provide weekly mentorship sessions and biweekly meetings to support primary care panel management. This structured mentor relationship is particularly important given that there would not be experienced primary care colleagues on-site at the MCPC locations to provide training, mentorship, and support.

Providing APPs with sufficient support for clinical tasks could also improve the sustainability of this care delivery model. CVS informed the HPC that, in addition to their current NPs, CVS has resources to be able to provide one RN or LPN at each initial site, that the care teams would have access to virtual or phone consultations by physicians, and that other RNs and LPNs would be added over time as needed based on patient volume and acuity. There is no universally recommended standard for team composition or number of support staff per primary care clinician. Several factors impact this, such as patient panel size, patient complexity, and the availability of non-clinical support staff; however, researchers have generally found that larger teams are better for both clinician well-being and patient outcomes.[178]

The transition from providing convenience care to primary care would also likely require additional administrative effort relative to the current demands placed on MinuteClinic APPs, which in many practices requires work outside of regular working hours.[179] CVS has some centralized resources that it states would support administrative responsibilities for MCPC practices, such as a care coordination team to support referrals for specialty, behavioral health, or ancillary care. This team also supports scheduling, prior authorization, results management, and follow-up for referrals. These centralized resources may help alleviate potentially burdensome areas for MCPC nurse practitioners.

Given the novelty of this proposed transition of APPs from providing convenience care to managing primary care panels, and the lack of data from comparable MCPC sites nationally, the HPC cannot evaluate the likelihood that the transition would be smooth for these clinicians, or that they would have sufficient

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[178] Christian D. Helfrich, et al., *The Association of Team-Specific Workload and Staffing with Odds of Burnout Among VA Primary Care Team Members*, 32 J. GEN. INTERNAL MED. 760 (2017), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC5481228/ (last visited April 7, 2026), (finding that primary care providers experienced higher levels of burnout when they were on teams that were not fully staffed, which was defined as 3 full-time staff for 1 full-time PCP). Sylvia J. Hysong, et al., *Impact of Primary Care Team Configuration on Access and Quality of Care* 40 J. GEN. INTERNAL MED. 4006 (2025), *available at* https://link.springer.com/article/10.1007/s11606-025-09456-z (last visited April 7, 2026), (finding that larger teams were associated with improved care coordination and performed better on quality measures, but were associated with longer patient wait times).

[179] These tasks include high-touch asynchronous messaging (such as responding to patient portal messages), navigating complex EHRs, quality measure reporting, assisting with prior authorization, and billing and coding documentation. MASS. MED. SOC., SUPPORTING MMS PHYSICIANS' WELL-BEING REPORT: RECOMMENDATIONS TO ADDRESS THE ON-GOING CRISIS, (March 2023), *available at* https://www.massmed.org/Publications/Supporting-MMS-Physicians--Well-being-Report---Recommendations-to-Address-the-Ongoing-Crisis/ (last visited April 7, 2026); Michael Stillman, *Death by Patient Portal*, JAMA (2023), *available at* https://pubmed.ncbi.nlm.nih.gov/37389857/ (last visited April 7, 2026); NAT'L. ACADEMIES OF SCIENCES, ENGINEERING, & MED., TAKING ACTION AGAINST CLINICIAN BURNOUT: A SYSTEMS APPROACH TO PROFESSIONAL WELL-BEING (2019), *available at* https://nam.edu/wp-content/uploads/2020/09/4.-NAM-Taking-Action-Against-Clinician-Burnout-systems-approach.pdf (last visited April 7, 2026); Edward Melnick, et al., *Perceived Electronic Health Record Usability as a Predictor of Task Load and Burnout Among US Physicians: Mediation Analysis*, 22 J. MED. INTERNET RES. e23382 (2020), *available at* https://pubmed.ncbi.nlm.nih.gov/33289493/ (last visited April 7, 2026); Harry S. Saag, et al., *Pajama Time: Working After Work in the Electronic Health Record*, 34 J. GEN. INTERNAL MED. 1695 (2019), *available at* https://pubmed.ncbi.nlm.nih.gov/31073856/ (last visited April 7, 2026).

support in juggling both primary care and convenience care provision during the ramp-up of their primary care panels. Given the parties' expectation that current APPs would form the primary workforce for MCPC clinics, any challenges in supporting and retaining staff could impact the success of the proposed care model.

g. The proposed care delivery model reflects some key features of comprehensive primary care but also has some notable limitations.

In response to the primary care access challenges in the Commonwealth described above in Figure II.B.1, the parties are proposing a novel model for providing primary care services in a retail setting that would meaningfully expand the services that MinuteClinic provides to enable MinuteClinic APPs to provide longitudinal primary care services. It is important for the Commonwealth to understand whether the proposed care delivery model would reflect the provision of comprehensive primary care.

At the same time, it is important for the Commonwealth to understand the extent to which the proposed care delivery model reflects standards for providing comprehensive primary care. Recognizing that there is no universal definition of or framework for evaluating primary care services,[180] the HPC considered several potential frameworks, ultimately focusing on MassHealth's Primary Care Sub-Capitation clinical tier criteria to inform the HPC's evaluation of the parties' proposed model.[181] The HPC used the MassHealth Primary

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[180] The Primary Care Task Force (PCTF) is charged with issuing a number of deliverables under Chapter 343 of the Acts of 2024, including recommendations to stabilize and improve primary care access, delivery, and payment, and defining primary care services, codes, and providers for measurement and tracking of primary care spending. The goal of Deliverable #1: Defining Primary Care Services, Codes, and Providers is to be able to measure primary care spending against a primary care spending target as recommended in Deliverable #3: Establish a Primary Care Spending Target. The HPC did not use the PCTF's definition of primary care services in this report given that the aim was to evaluate a proposed care delivery model. HEALTH POLICY COMM'N, PRIMARY CARE TASK FORCE DELIVERABLE #1: DEFINING PRIMARY CARE SERVICES, CODES, AND PROVIDERS (Sept. 15, 2025), *available at* https://masshpc.gov/sites/default/files/PCTF%20Deliverable%201%20-%20Defining%20Primary%20Care.pdf (last visited April 10, 2026); HEALTH POLICY COMM'N, PRIMARY CARE TASK FORCE DELIVERABLE #3: DEFINING ESTABLISH A PRIMARY CARE SPENDING TARGET (Dec. 15, 2025), *available at* https://masshpc.gov/sites/default/files/PCTFDeliverable3_Establish-a-Primary-Care-Spending-Target.pdf (last visited April 10, 2026).

[181] The HPC considered several framework options including the Primary Care Assessment Tool (PCAT) and NCQA's Patient-Centered Medical Home (PCMH) recognition program to inform this evaluation. The PCAT was developed by the Johns Hopkins Primary Care Policy Center to assess and assure the quality of primary care services delivery. The PCAT translates the broad concepts of primary care (Barbara Starfield's pillars: first-contact care, person-focused care over time, comprehensiveness, and coordination) into measurable characteristics. *Johns Hopkins Primary Care Policy Center, Primary Care Assessment Tools*, JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH, https://publichealth.jhu.edu/johns-hopkins-primary-care-policy-center/primary-care-assessment-tools (last visited April 10, 2026). The HPC determined that the PCAT was not appropriate for this purpose because the care delivery model was still a proposal and not yet operational. The NCQA PCMH program is an evaluation program based on six PCMH model concepts including team-based care and practice organization, knowing and managing your patients, patient-centered access and continuity, care management and support, care coordination and care transitions, and performance management and quality improvement. Given that many practices in Massachusetts do not hold this recognition, the HPC determined that applying the NCQA PCMH recognition criteria would impose an unfairly high standard on CVS in this evaluation. *Patient-Centered Medical Home (PCMH),* NCQA, https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/ (last visited April 10, 2026). The HPC also reviewed Barbara Starfield's 4 Pillars of Primary Care, the 10 Building Blocks of High Performing Primary Care, and the definition and features of primary care identified in NASEM's Implementing High-Quality Primary Care Report. Starfield 2005, *supra* note 154; Thomas Bodenheimer et al., *The 10 Building Blocks of High-Performing Primary Care*, 12 ANNALS FAM. MED. 166 (2014), https://doi.org/10.1370/afm.1616; NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, IMPLEMENTING HIGH-QUALITY PRIMARY CARE: REBUILDING THE FOUNDATION OF HEALTH CARE (2021), *available at* https://www.nationalacademies.org/projects/HMD-HCS-18-15/publication/25983 (last visited April 10, 2026). The HPC did not use these frameworks in this evaluation because they were largely

Care Sub-Capitation clinical tier criteria to inform the evaluation of the parties' proposed model, because these criteria are comprehensive, were developed recently, and are specific to Massachusetts, and because MCPC intends to participate in the MassHealth Primary Care Sub-Capitation Program as a Tier 1 practice, making these criteria especially relevant to MCPC. While the criteria were developed for MassHealth's primary care sub-capitation program, they provide a useful framework for assessing whether a provider's structure is designed to facilitate the provision of comprehensive primary care services in the Commonwealth.[182] In using MassHealth's framework to inform this evaluation, the HPC does not act on behalf of MassHealth and does not attest that MCPC would or would not meet the Primary Care Sub-Capitation Program clinical criteria.

MassHealth introduced the Primary Care Sub-Capitation Program in 2023 for providers participating in any of MassHealth's Accountable Care Organizations (ACOs) to support its goals of improving health outcomes and promoting health equity while managing health care costs.[183] Nearly 1,000 practices currently participate in the Primary Care Sub-Capitation Program; this represents more than 75% of all primary care practices that accept MassHealth.[184] Practices that participate in the Primary Care Sub-Capitation program must meet a set of minimum care delivery standards,[185] attesting that they meet the criteria for one of three clinical tiers. To achieve a Tier 2 or Tier 3 designation, a practice must also meet all the requirements of the lower tier(s). Data confidentially provided to the HPC show that out of 134 practice locations in MGB's MassHealth ACO, 73 (54%) are Tier 1, 37 (28%) are Tier 2, and 24 (18%) are Tier 3.

CVS shared information on its planned service offerings and structures. The table below summarizes the clinical criteria for Tier 1 and whether CVS expects the service to be available at MCPC. The HPC found that MCPC plans to deliver many of the required MassHealth Primary Care Sub-Capitation Tier 1 services. However, because MCPC would not provide certain services required under the MassHealth program, MCPC's care delivery scope would have notable limitations.

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theoretical and the HPC prioritized approaches that could be more easily applied to evaluate the information provided by the parties.

[182] The MassHealth Primary Care Sub-Capitation Program clinical tier criteria substantially overlap with criteria in other frameworks the HPC considered for evaluating primary care delivery, including the Johns Hopkins PCAT and the NCQA PCMH recognition program described above.

[183] *MassHealth Primary Care Sub-Capitation: Program Overview*, MASSHEALTH, https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview (last visited April 7, 2026).

[184] *Id.*

[185] Clinicians participating in MassHealth must also meet the requirements detailed in 130 CMR 433.000, *Physician services.* The Primary Care sub-capitation program standards are in addition to these requirements.

Figure III.B.4: MassHealth Primary Care Sub-Capitation Program Clinical Criteria and MCPC Care Delivery Plans

Requirement Category	Tier 1 Clinical Care Criteria	Service Planned for MCPC
Care Delivery Requirements	Traditional primary care	Yes
Care Delivery Requirements	Referral to specialty care	Yes
Care Delivery Requirements	Oral health screening and referral	No
Care Delivery Requirements	Behavioral health (BH) and substance use disorder screening	Partial
Care Delivery Requirements	BH referral with bi-directional communication, tracking, and monitoring	Yes
Care Delivery Requirements	BH medication management	Partial
Care Delivery Requirements	Health-Related Social Needs (HRSN) screening*†	Yes
Care Delivery Requirements	Care coordination*†	Yes
Care Delivery Requirements	Clinical Advice and Support Line*†	Yes
Care Delivery Requirements	Postpartum depression screening	Yes
Care Delivery Requirements	Use of Prescription Monitoring Program	No[186]
Care Delivery Requirements	Long-Acting Reversible Contraception (LARC)	Yes
Structure and Staffing Requirements	Same-day urgent care capacity	Yes
Structure and Staffing Requirements	Video telehealth capability	No
Structure and Staffing Requirements	No reduction in hours, relative to participation in the sub-capitation program	N/A
Structure and Staffing Requirements	Access to Translation and Interpreter Services	Yes

Source: *MassHealth Primary Care Sub-Capitation: Care Delivery Transformation*, MASSHEALTH, https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-care-delivery-transformation
Note: Criteria marked with a (*) can be provided by the Accountable Care Organization associated with a given practice; criteria marked with a (†) can be met virtually.

Initially, MCPC does not plan to offer oral health screening and referrals, would not use the Prescription Monitoring Program because it does not plan to prescribe controlled substances, and would not offer telehealth visits and the timeline for offering such services is not available. Of particular note is the expectation that MCPC would not prescribe controlled substances, which may limit access for many patients. For instance, MCPC would not be able to support patients who require opioids for pain management or patients receiving medications for treatment of opioid use disorders. MCPC also would not be able to effectively manage care for patients on pharmacologic treatment for various mental health conditions because many psychiatric medications are scheduled controlled substances. This gap creates uncertainty as to MCPC's ability to offer comprehensive primary care. Additionally, the lack of telehealth services would limit MCPC's ability to reduce certain access barriers for patients (e.g., difficulty attending an in-person visit due to lack of transportation, childcare, or other scheduling difficulties).

[186] CVS confidentially informed the HPC that medications would be prescribed for some behavioral health conditions, but they do not plan to prescribe controlled substances and therefore would not use the MA prescription monitoring program or hold a Massachusetts Controlled Substance Registration (MCSR). An MCSR is required in order to prescribe controlled substances in Schedules II through V, as listed in 21 CFR 1308.12-15. See 105 CMR 700 for more information.

Relatedly, MCPC has indicated it would provide behavioral health screening for depression, anxiety, and alcohol use disorder and will have a closed loop referral process to support bidirectional communication, tracking, and monitoring for behavioral health referrals. However, it has indicated that MCPC would not screen for or treat other substance use disorders, such as opioid use disorder.

h. While there is potential for MCPC to provide high-quality primary care in coordination with MGB, it is uncertain to what degree this potential would be realized.

CVS has described its planned approach to quality measurement and improvement at new MCPC sites. In materials provided confidentially to the HPC, CVS described its plan to use HEDIS primary care quality metrics and strategies to meet internal benchmarks to the 50th/75th and 90th HEDIS percentiles to track scores on the measures shown in Figure III.B.4.[187]

Figure III.B.5: MCPC Planned Quality Measures

2025 HEDIS Quality Metrics:
Avoidance of Antibiotics in Bronchitis
Tobacco Screening and Counseling
Blood Pressure Control (<140/90) in patients with hypertension
Hemoglobin A1c Control (<8%) for patients with diabetes mellitus
Depression Screening and Follow-up
Colorectal Cancer Screening
Kidney Health Evaluation for patients with diabetes mellitus
Cervical Cancer Screening
Asthma Medical Ratio
Adult Access to Preventive/Ambulatory Health Services
Immunizations: Influenza, TD, Tdap, Zoster, Pneumococcal

Materials provided by CVS also described its plans for additional quality tracking and improvement initiatives across several domains to support the transition to primary care, as shown in [Table IV.2]. Although these plans include elements that would tend to promote quality primary care, the preliminary and high-level nature of the descriptions make it impossible to determine to what extent the initiatives are aligned with best practice standards or would ultimately yield good quality primary care.

[187] Organizations can use internal benchmarking as a way to compare themselves against themselves. Benchmarking to percentiles can help organizations understand variation across HEDIS measures. Becky Kolinski, *Improving HEDIS Performance Through Benchmarking*, NCQA (May 6, 2025), *available at:* https://www.ncqa.org/blog/improving-hedis-performance-through-benchmarking/ (last visited April 7, 2026).

Figure III.B.5: MCPC Quality Tracking and Improvement Initiatives

- Credentialing and Privileging
  - Updates to include primary care standards
  - Training for MCPC providers on chronic disease management, HEDIS measures, HCC coding, and referrals
- Technology
  - Addition of Epic electronic health record primary care support, including documentation templates, care gap tracking, and decision support
  - Creation of dashboards for quality, management of patient panels, and patient registries
- Quality Assurance and Safety
  - Chart review process enhancement to assess longitudinal care and chronic disease management
  - Centralized nurse and care coordination team to support care referrals and follow-ups, as well as diagnostics
  - Provider competency reviews and coaching
- Policy and Compliance
  - Updated clinical, lab, and infection control policies to include primary care procedures
  - Mock surveys and reviews aligned with Joint Commission standards for medical centers
  - Readiness for 2026 Joint Commission Triennial Survey, including primary care site visits.

CVS stated to the HPC that in order to address compensation structures throughout the transition of MinuteClinic sites to primary care, MCPC APPs in Massachusetts would be incentivized to meet quality and efficiency targets through structured bonus programs that reward clinical excellence and operational performance. CVS would also conduct annual market analyses to ensure salaries are competitive.

As part of the affiliation, MGB described in materials provided to the HPC its plans to integrate MCPC into its system-wide quality oversight and population health management programs. It stated that MCPC's clinical and operational performance would be aligned with MGB's internal quality framework, which tracks practice performance against HEDIS, MIPS, STARS, and ACO measures.[188] MGB indicated to the HPC that it would embed MCPC sites into its clinically integrated network and govern them under MGB's existing quality, access, and equity standards. MCPC would be responsible for operations and outreach, while MGB would be responsible for oversight, metrics, and reporting.

In summary, MGB and MinuteClinic currently generally perform well on available relevant quality metrics and have systems in place to support care delivery. The parties have described plans for tracking and improving primary care quality during the transition to the MCPC primary care model, including providing training for APPs and integrating MCPC sites into MGB system-wide quality supports. However, the preliminary and in some cases high-level nature of the plans described by the parties limits the HPC's ability to assess to what extent they would result in high-quality primary care at the MCPC sites. The HPC expects to conduct ongoing monitoring and to require certain ongoing reporting by the parties if the transaction proceeds, consistent with its statutory authority to collect data for five years post-transaction, to assess such impact over time.

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[188] The Center for Medicare and Medicaid Services' Merit-based Incentive Payment System (MIPS) is a reporting option available to MIPS eligible clinicians for collecting and reporting data to MIPS. Performance is measured across 4 areas – quality, improvement activities, Promoting Interoperability, and cost. The Center for Medicare and Medicaid Services' Overall Hospital Quality Star Rating summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital.

IV. Conclusion

As described in Section III, the HPC found:

Cost and Market Impact. The transaction is likely to impact health care spending in key quantifiable ways:

> **Spending for New Primary Care Patients:** New primary care patients are expected to receive primary care services at MCPC at MGB's higher prices and are expected to be referred to higher-priced MGB specialists and hospitals. At the same time, patients who did not previously have a PCP would now have access to one, with changes to care that may reflect appropriate and improved management of health conditions. Based on analysis of spending trends of new, generally low complexity primary care patients to the MGB network, the HPC projects that these dynamics, combined, are likely to result in a commercial spending increase of approximately $27.7 million annually.
>
> **Repricing of Convenience Care Services:** The convenience care MCPC would continue to provide would be repriced at MGB prices, which are 129% higher, on average, than MinuteClinic's prices, likely increasing commercial spending by an additional $6.6 million annually.
>
> **Diversion of Some Convenience Care Patients to Other Providers:** As MCPC develops primary care panels and correspondingly decreases its convenience care capacity, some patients who would have otherwise sought convenience care at MinuteClinic locations are anticipated to be diverted to other providers, which are generally higher-priced, likely resulting in an additional commercial spending increase of approximately $5.9 million annually.

These are conservative estimates of spending impacts in year three, based on the parties' projections of "moderate acceptance" of their model in that period, in which approximately 35% of all MCPC patients are primary care panel members. However, these annual spending impacts would increase if more primary care patients were to join the MCPC patient panels, and they would be significantly higher if MCPC sites were each to fill their primary care patient panels to the maximum size. There are further cost and market impacts that the HPC is unable to quantify in its analysis, including the impact of additional bargaining leverage for MGB as a result of this expansion of MGB's primary care footprint. Expanding access to primary care could result in longer-term health care savings than incorporated in the HPC's spending estimates. The likelihood and scope of additional savings depends heavily on the success of the new MCPC model.

Access and Quality Impact. The transition of MinuteClinic sites to MCPC primary care locations has the potential to increase access to primary care for adult patients through a novel care delivery model in a retail setting that would meaningfully expand the services that MinuteClinic provides. However, the magnitude of this increase depends on the success of the model over time, which is difficult to predict based on current evidence, and on some key, yet-to-be-determined details of implementation. In particular, the potential for improved access to primary care for populations facing socioeconomic barriers may depend on how the parties prioritize the transition of sites in areas of greatest need. Further, focused effort to promote the use of the new primary care sites among MassHealth patients would likely be required to meaningfully increase access for MassHealth members.

At the same time, the transition to MCPC may pose certain risks to access: shifting away from all-ages convenience care would eliminate access to convenience care for children and reduce access for adults. Further, it is unclear whether this new primary care model would be successful over the long term. To the extent it fails, access may be reduced relative to the status quo.

Whether MCPC would provide comprehensive, high-quality primary care ultimately is uncertain. While the proposed care model includes key elements of comprehensive primary care, it also has notable limitations, and MCPC's ability to deliver high-quality care in coordination with MGB would depend heavily on how the model is implemented.

In summary, this transaction is likely to result an increase to annual commercial health care spending of approximately $40.2 million annually by year three of the transaction, which includes spending increases for MCPC's new primary care patients and higher prices for both MCPC's continuing convenience care services and the convenience care services that would need to move to other providers. MinuteClinic's transition to primary care sites has the potential to increase access to adult primary care services, although CVS would need to prioritize support for sites in areas of higher need and target its outreach efforts thoughtfully to meaningfully improve access for populations facing socioeconomic barriers to care. The shift away from all-ages convenience care, however, would reduce access to those services, particularly for children. Finally, it is unclear whether MCPC would ultimately be able to provide comprehensive, high-quality primary care given that much would depend on how its plans are implemented.

Regular reporting of relevant cost, quality, and access metrics for the MCPC sites following the transaction would also provide the public with additional information about the impact and efficacy of the parties' proposed plans. If the transaction proceeds, the HPC expects to require ongoing reporting of certain metrics that are not otherwise publicly available in order to track the impact of the transaction over time, consistent with the HPC's authority to require ongoing reporting from parties for five years post-transaction. The HPC welcomes any additional information the parties would like to provide in response to this report regarding measures it expects to track over time and those that could be provided to allow for ongoing evaluation of the impact of the parties' efforts on health care spending and on access to high-quality primary care.

The HPC invites the parties to provide any additional details in response to questions and concerns raised in this report in their written response, including any commitments. The parties should consider commitments regarding mitigation of spending impacts, as well as commitments to maximize the potential for improved access to high-quality care. Following the period for written response, the HPC will publish its Final Report, including any referrals or recommendations to other state agencies.

V. Data Appendix

A. APCD Data Processing

The claims data used in this report come from the CHIA APCD V2023, which includes data from 2019 to 2023. For the APCD analyses in this report, the HPC reported on patients with commercial insurance through seven payers: Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Plan, Health New England, Elevance Health, MGB Health Plan, and United Healthcare. The APCD data for these seven payers represent approximately 40% of the commercial market.[189] The APCD primarily includes claims for members enrolled in fully insured plans.

The HPC's analyses of price, market share, and primary service areas (i.e., all analyses except for those in Sections III.A.1.c and III.A.2.a) were filtered to 2023 claims with valid National Provider Identifiers (NPIs) and valid prices (i.e., excluding zero-pay claims, claims with negative allowed amounts, claims processed and paid as secondary with another carrier covering a portion of the reimbursement, capitated encounter records, and services paid under a global payment arrangement). Price comparisons across providers by encounter (defined as member, service date, and procedure code groups) were further filtered to encounters with one claim line.

1. Definition of Provider Systems

MinuteClinic claims were identified using NPIs provided by CVS. For other professional claims, the service provider NPI was mapped to a network using the HPC's MA-RPO program dataset. A Physician Roster includes all physicians on whose behalf the submitting entity establishes contracts, even if the submitting entity does not employ that physician. The HPC identified physicians specifically associated with MGB contracting affiliates by looking for non-employed physicians on the MGB Roster who were affiliated with local practice groups "Charles River," "Milford," or "Emerson PHO" in the MA-RPO data.

The HPC's price analyses (i.e., Sections III.A.1.b and III.A.2.b), map the service provider's NPI to a provider organization using the 2023 MA-RPO Physician Roster files.

The HPC's identification of PSAs and analyses of market shares (i.e., Section III.A.1.a) used the 2024 Physician Roster files to assign physicians to provider organizations. This is the most recently finalized version of the Roster and allows description of market conditions in a way that most closely reflects the current conditions. Entities submitted these Rosters to reflect physician affiliations as of 01/01/2024. To account for significant market transactions that have occurred since then, the HPC assigned physicians with a primary medical group of Milford Regional Physician Group on the MGB Roster to UMass Memorial Health Care. The HPC also assigned physicians with a primary local practice group of Healthcare South, PC on the Tufts Roster to MGB.

2. Identification of Comparator Convenience Care Providers

As part of the diversion analysis (i.e., Sections III.A.1.b and III.A.2.c), the HPC identified the service providers that most frequently provide MinuteClinic's top services, or the "comparator convenience care providers." To identify providers offering similar services to those offered by MinuteClinic, the HPC first identified the highest-volume services that comprised 80% of MinuteClinic's revenue in either 2023 or 2024. The CPT codes for 2023 were identified using the APCD, and the CPT codes for 2024 were provided

[189] The commercial market includes plans that are sold on the Massachusetts Health Connector, including subsidized ConnectorCare plans.

by the parties. The HPC then excluded CPT codes for office visits, as these are billed for a wide range of care types in many settings that may not be relevant comparators for MinuteClinic.

The following table shows the CPT codes used to identify MinuteClinic's comparator convenience care providers and estimate the spending impact of shifting convenience care volume in Sections III.A.1.b and III.A.2.c. These are the highest-volume codes that made up 80% of MinuteClinic's revenue in the indicated year. The rightmost column indicates which codes were specifically used to identify comparator convenience care providers, i.e., omitting office visits.

Data Appendix Figure 1: MinuteClinic High-Volume CPT Codes

CPT Code	Description	Top Code by Revenue: 2023	Top Code by Revenue: 2024	Used to Identify Comparator Convenience Care Providers
87426	COVID test	Yes	Yes	Yes
87502	Flu test		Yes	Yes
87651	Strep test	Yes	Yes	Yes
90471	Vaccine administration	Yes	Yes	Yes
90480	COVID vaccine administration		Yes	Yes
90750	Shingles vaccine	Yes	Yes	Yes
91320	COVID vaccine, 30 mcg		Yes	Yes
91322	COVID vaccine, 50 mcg	Yes	Yes	Yes
99203	New patient office visit, 30-44 minutes or low level of medical decision making	Yes	Yes	
99204	New patient office visit, 45-59 minutes or moderate level of medical decision making		Yes	
99211	Established patient office visit, minimal	Yes		
99212	Established patient office visit, 10-19 minutes	Yes		
99213	Established patient office visit, 20-29 minutes	Yes	Yes	

Within MinuteClinic's PSA, the HPC then identified encounters for these procedure codes with only one claim per member, date, and CPT code. For each payer in the APCD data, the HPC then identified the highest-volume providers located in Massachusetts that made up at least 80% of the volume of these procedure codes. These are considered the comparator convenience care providers for purposes of this analysis.

The HPC divided comparator convenience care providers into three categories: urgent care centers, physician offices, and HOPDs, with the remaining providers collapsed into an "Other" category in the table below. These categories allow the HPC to better discuss and characterize the market alternatives to MinuteClinic.

As described briefly in Section II, per Massachusetts regulation, MinuteClinic is a "limited services clinic," also known as a retail clinic. CVS uses the term "convenience care" to describe MinuteClinic's services.

Limited services clinics are typically staffed by APPs and located within large pharmacy chain stores. They provide a limited scope of care including vaccinations, diagnosis and treatment for conditions like upper respiratory and sinus infections, and some wellness exams. They cannot provide surgical, dental, physical rehabilitation, mental health, substance use disorder, or birth center services.

In contrast, urgent care centers provide diagnosis and treatment for a broader range of conditions, such as broken bones requiring x-rays and complex chronic conditions that are not life-threatening. They usually have physicians on staff and may be licensed as clinics or HOPDs.

The HPC identified urgent care NPIs through a manual review of entity names and sites of service from the claims data, and taxonomy codes from CMS NPPES data. For NPIs not categorized as urgent care centers, the HPC categorized them using the CMS Place of Service code set by identifying the most frequent site of service listed on claims provided by each recipient NPI. NPIs whose claims most frequently listed a site of service of 11 were categorized as physician offices. Next, NPIs whose claims most frequently listed a site of service of 22 were categorized as HOPDs. The remaining NPIs were categorized as "Other."

To calculate the provider distribution of diverted visits, the HPC multiplied the comparator convenience care providers' market shares within each payer-procedure code combination by the share of MinuteClinic's 2023 services accounted for by the payer and procedure code. The HPC then summed up the weighted market shares across all payer-procedure code combinations.

Data Appendix Figure 2: Provider Distribution of Diverted Visits

Provider Type	Number of NPIs	Share of Comparator Convenience Care Providers	Number of Diversion Visits	Share of Diversion Visits
Physician Office	3,618	89.0%	34,197	67.0%
Urgent Care Center	110	2.7%	9,330	18.3%
HOPD	96	2.4%	5,551	10.9%
Other	243	6.0%	1,952	3.8%

B. Patient Attribution Methodology

The process for attributing patients to a PCP in the APCD is based on a previously published methodology and slightly modified to align with the details of the transaction.[190]

1. Creating the Provider File

As in previous analyses, the HPC started by compiling a list of all Massachusetts individual provider NPIs, matching each NPI to a provider organization, and identifying which providers are PCPs. To create the overall provider file for 2023, the HPC combined data from the 2023 RPO and the 2023 IQVIA, Inc. Office Based and Hospital Based Providers (IQVIA) datasets.[191] The HPC used RPO data to match NPIs with

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[190] *See* MASS. HEALTH POLICY COMM'N, 2025 ANNUAL HEALTH CARE COST TRENDS REPORT TECHNICAL APPENDIX at 79-81 (Dec. 2025) [hereinafter 2025 CTR TECHNICAL APPENDIX], *available at* https://masshpc.gov/sites/default/files/2025CTR-CombinedAppendices.pdf

[191] *IQVIA OneKey Professionals Reference Database – 2023 Historical Data*, IQVIA GOVERNMENT SOLUTIONS INC., https://www.iqvia.com/locations/united-states/solutions/life-sciences/information-solutions/onekey-reference-data (last visited April 8, 2026).

provider organizations when possible and supplemented with IQVIA data for NPIs that did not appear in RPO. Within this list, the HPC identified PCPs using reported specialty information.

2. Attributing Patients to PCPs

The HPC attributed APCD patients to provider organizations through a two-step process. First, members were attributed through the APCD member eligibility file submitted by payers, which links patients to a PCP if they have an identifiable PCP in their record. Second, members were attributed to PCPs through well visits. Well visits were defined as claims with the following procedure codes: G0438, G0439, 99381-99387, 99391-99397, 99401- 99404, 99411-99412, 99420, 99429, 99432, and 99461. Well visits were also identified if they contained a procedure code modifier of 33. Several Affordable Care Act (ACA) preventative measures with zero cost sharing amounts were also operationalized as well visits.[192] Members were attributed to their most-frequented well-visit provider if that provider was listed in the PCP file described above in the year of claims being observed.

Unlike in previous work, any members who could not be attributed to a PCP using either of these two methods were considered unattributed. For this report, the HPC wanted to identify attributed patients as only those who appeared to have made an affirmative choice of PCP. Thus, the HPC did not attribute patients to a PCP based on more tenuous proxies for this choice, such as primary providers of sick visits or the most frequent prescriber for each patient in the pharmacy claims file.

Once members were attributed to a PCP, the PCP's provider organization was identified from the final provider file. Members were attributed to an MGB contracting affiliate if their assigned NPI was linked to MGB in RPO and was reported as a non-employed physician affiliated with local practice groups "Charles River," "Milford," or "Emerson PHO."

C. Primary Care Spending Impact

The following section describes the methodology for analyses in Section III.A.2.

To estimate the primary care spending impact, the HPC needed to identify "switches," or instances in which a member switched their primary care organization between two consecutive years. Using the APCD, the HPC created a panel dataset of annual spending per member from 2019 to 2023 by summing total medical spending for each member and year and attributed each member to a PCP and provider organization as described in the "Patient Attribution Methodology" section above. The next step was to filter to adult members with 12 months of continuous coverage in the APCD and drop the top 5% of members by spending in each year. The HPC further filtered to only members residing in MinuteClinic's PSA.

Using this panel dataset, the HPC identified a member "switch" as occurring when a member changed their attributed PCP and provider organization from the previous year. To ensure that the choice to switch was driven by the member, rather than their physician changing affiliations, a "switch" was only counted when members switched not just provider organizations but also PCPs. The HPC further dropped members who experienced multiple PCP switches or multiple provider organization changes from 2020 to 2023, then filtered to only unattributed members who gained a PCP, or members who had no switches.

A multivariate OLS regression model was used to estimate the average change in annual spending per member when previously unattributed members became attributed to each provider organization, controlling for provider organization, year, and member fixed effects. This allowed the HPC to consider the distinct effect of attribution to a specific system, controlling for characteristics unique to a given individual

[192] For a detailed list of preventive services used, see 2025 CTR TECHNICAL APPENDIX, *supra* note 190 at 80-81.

and year. In other words, a regression model was used to adjust for spending differences over time and in patient populations across providers by looking at how spending changed for a given member before and after they obtained a PCP.

D. Analysis of Locations with Barriers to Primary Care Access

To identify the MCPC locations with the most potential to improve primary care access for vulnerable populations, the HPC created a composite score based on six metrics of primary care availability and need:

- Primary care physicians per 100,000 MA residents[193]
- Share of non-elderly adults covered by MassHealth[194]
- Share of commercially insured adults with no primary care spending[195]
- Share of people with non-emergency ED use[196]
- ADI[197]
- HRSA Index of Medical Underservice Score[198]

The HPC's method compares each location to the other proposed locations by assigning a score from zero to four for each metric based on where the metric's value fell within the range of values. On a given metric, a score of zero indicates the lowest level of need while a score of four indicates the greatest level of need. The HPC then summed each location's score for every metric to determine the total composite score. The total scores are relative to each other; because the locations already exist, the HPC did not compare against other cities and towns within Massachusetts, so, for instance, it is possible there are other communities with greater primary care need than those identified in this analysis.

[193] HRSA Area Health Resource, *supra* note 162.
[194] Georgetown 2025, *supra* note 164.
[195] HPC analysis of 2023 APCD claims data.
[196] 2023 MHIS, *supra* note 163.
[197] ADI v.4.0.1, *supra* note 159.
[198] HRSA Shortage Areas, *supra* note 160. The lowest score (highest need) is 0; the highest score (lowest need) is 100. To qualify for Medically Underserved Area or Medically Underserved Population designation, the Index of Medical Underservice score must be less than or equal to 62.0. The score applies to the whole MUA or MUP, and not to individual portions of it.

Data Appendix Figure 3: Geographic Analysis of Barriers to Primary Care Access

Site Location [city / county]	Area Deprivation Index [zip code level]	Share of Non-Elderly Adults Covered by Medicaid [county based]	Percentage of adults with commercial insurance with no primary care use [HPC region level]	Share of people with non-emergency ED use [HPC region level]	PCPs per 100k MA Residents [county based]	Index of Medical Underservice Score [county based]	Composite Primary Care Need Score
Falmouth / Barnstable	3	18.4%	22%	39%	89.9	56	11
Fall River / Bristol	9	24.4%	20%	31%	50.5	58	15
Seekonk / Bristol	6	24.4%	21%	31%	50.5	58	14
North Attleboro / Bristol	6	24.4%	21%	31%	50.5	58	14
Norton / Bristol	6	24.4%	21%	31%	50.5	58	14
Swansea / Bristol	7	24.4%	20%	31%	50.5	58	14
Amesbury / Essex	6	23.6%	21%	31%	74.1	58	13
Danvers / Essex	5	23.6%	21%	31%	74.1	58	12
Andover / Essex	2	23.6%	23%	31%	74.1	58	11
Salem / Essex	6	23.6%	21%	31%	74.1	58	12
West Springfield / Hampden	9	28.5%	25%	28%	67.0	58	17
Palmer / Hampden	10	28.5%	25%	28%	67.0	58	17
Amherst / Hampshire	7	19.1%	25%	28%	128.7	62	8
Acton / Middlesex	3	15.8%	22%	31%	124.7	61	5
Sudbury / Middlesex	2	15.8%	22%	31%	124.7	61	4
Medford / Middlesex	3	15.8%	29%	21%	124.7	61	6
Watertown-Newtown / Middlesex	1	15.8%	29%	21%	124.7	61	5
Cambridge / Middlesex	2	15.8%	29%	21%	124.7	61	5
Hudson / Middlesex	7	15.8%	18%	31%	124.7	61	6
Wilmington / Middlesex	3	15.8%	22%	31%	124.7	61	5
Ashland / Middlesex	4	15.8%	18%	31%	124.7	61	4

Site Location [city / county]	Area Deprivation Index [zip code level]	Share of Non-Elderly Adults Covered by Medicaid [county based]	Percentage of adults with commercial insurance with no primary care use [HPC region level]	Share of people with non-emergency ED use [HPC region level]	PCPs per 100k MA Residents [county based]	Index of Medical Underservice Score [county based]	Composite Primary Care Need Score
Quincy / Norfolk	5	16.0%	22%	36%	119.8	57	9
Medfield / Norfolk	3	16.0%	18%	31%	119.8	57	5
Braintree / Norfolk	4	16.0%	22%	36%	119.8	57	9
Medway / Norfolk	3	16.0%	18%	31%	119.8	57	6
Stoughton / Norfolk	7	16.0%	23%	36%	119.8	57	10
Weymouth / Norfolk	7	16.0%	22%	36%	119.8	57	10
Wellesley / Norfolk	1	16.0%	29%	21%	119.8	57	6
Carver / Plymouth	9	19.5%	22%	36%	63.6	51	17
Hanover / Plymouth	2	19.5%	22%	36%	63.6	51	14
Marshfield / Plymouth	4	19.5%	22%	36%	63.6	51	15
Charlton / Worcester	7	22.4%	23%	28%	93.7	58	12
Worcester / Worcester	9	22.4%	23%	28%	93.7	58	12
Leominster / Worcester	8	22.4%	23%	28%	93.7	58	12
Northborough / Worcester	4	22.4%	23%	28%	93.7	58	10
Uxbridge / Worcester	6	22.4%	23%	28%	93.7	58	11
North Grafton / Worcester	7	22.4%	23%	28%	93.7	58	11

Acknowledgements

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Megan Wulff, Sasha Albert, Rebecca Balder, Adrienne Brown, Regina Dello Russo, Amy Katzen, Jessica Liu, Kristine Mackin, Dylan Moore, and Elizabeth Reidy prepared this report under the direction of Katherine Scarborough Mills, Senior Director of Policy for Market Oversight and Transparency, with significant contributions by Sasha Hayes-Rusnov, David Auerbach, and Lois Johnson. The report was designed by Ashley Johnston and Rebecca Willmer. The HPC wishes to acknowledge the analytic support provided by Bates White, LLC, and Health Management Associates, Inc. The HPC would also like to thank the provider organizations that provided information for this report for their courtesy and cooperation.