MASSACHUSETTS
HEALTH POLICY COMMISSION

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

JUNE 11, 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.

Table of Contents

Introduction

In 2012, policymakers, the health care industry, 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 Final 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 transaction, information provided in support of how and when it would result in efficiencies and

---

[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 June 10, 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 June 10, 2026).

improvements to care delivery and access to high quality health care services, the parties' response to the HPC's Preliminary Report, and subsequent commitments made by the parties.[3]

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.[4,5] 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.[6] Residents who are Black, Indigenous, and People of Color and those with increased socioeconomic barriers to care face greater challenges accessing primary care.[7] 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.[8]

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.[9] 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.[10] As of 2024, Massachusetts had the highest employer-based family health insurance premiums in the U.S., at $28,151.[11] If present trends continue, by 2030 an average family would see a reduction in take-home pay of more than $600 per month.[12]

Massachusetts must work to improve 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

---

[3] The parties' Joint Response is appended to this report as Exhibit A, subsequent commitments by the parties are appended as Exhibit B, and the HPC's Analysis of the Joint Response and Party Commitments is appended as Exhibit C.
[4] 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 June 10, 2026).
[5] *See* Basu 2019, *infra* note 93.
[6] 2025 MHIS, *infra* note 90.
[7] *CHIA Primary Care Databook*, *infra* note 92.
[8] DIRE DIAGNOSIS, *supra* note 4.
[9] *Id.*
[10] 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 June 10, 2026).
[11] *Id.* at 58.
[12] *Id.* at 5.

primary care as a percentage of total health care spending in five years – also recommended that "any 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."[13]

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.

We now issue this Final Report to contribute important and evidence-based information to the public dialogue as providers, payers, government, consumers, and other stakeholders strive to develop a more affordable, accessible, and equitable health care system.

[13] PRIMARY CARE TASKFORCE, Deliverable #3, *infra* note 197, 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.[14] 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.[15] 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),[16] and becoming participating providers in MGB's value-based contracts with payers.

The parties expect to ramp up primary care capacity at MCPC sites over a number of years and estimate that the approximately 80 existing MinuteClinic APPs could eventually manage primary care panels of 1,500 patients each, serving up to 120,000 adult primary care patients across the state.[17] The parties aim to 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. If successful, 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,[18] 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.[19]

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,[20] to transition these sites to full clinics capable of providing primary care.[21] The parties state that parts of Worcester County, Bristol County, and western Massachusetts, in particular, are expected to benefit from increased capacity.[22] To date, the parties have not publicly announced the specific sites they would prioritize for transition.

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. On April 16, 2026, the HPC issued a Preliminary Report presenting the analysis and key findings from its

---

[14] 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].

[15] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14; *See* 105 CMR 140.020, *available at* https://www.mass.gov/doc/105-cmr-140-licensure-of-clinics/download (last visited June 10, 2026).

[16] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.

[17] *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.

[18] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.

[19] Jonathan Saltzman, *Why are so many primary care clinicians moving from Mass General Brigham to Beth Israel?*, BOSTON GLOBE, November 24, 2025, *available at* https://www.bostonglobe.com/2025/11/24/business/mass-general-brigham-beth-israel-lahey/ (last visited June 10, 2026).

[20] 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.

[21] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.

[22] *Id.*

review.[23] The parties provided a written response to these findings on May 15, 2026 (Joint Response) and subsequently offered commitments on June 5, 2026.[24] The HPC now issues this Final Report, including the Joint Response (attached as Exhibit A), commitments made by the parties (attached as Exhibit B), and the HPC Analysis of Parties' Joint Response (attached as Exhibit C).

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 annual spending among the largest Massachusetts provider organizations, even after accounting for differences in patient medical complexity.

2. **Cost and Market Impact.** The transaction is likely to impact health care spending in key quantifiable ways once the MCPC sites are operational and the new MGB rates are in effect:

   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

[23] MASS. HEALTH POLICY COMM'N., PRELIMINARY REPORT: COST AND MARKET IMPACT REVIEW OF MASS GENERAL BRIGHAM AND CVS MINUTECLINIC PRIMARY CARE (HPC-CMIR-2025-2) (April 16, 2026) [hereinafter PRELIMINARY REPORT], *available at* https://masshpc.gov/sites/default/files/MGB-CVS-Report-Combined-Prelim_acc.pdf (last visited June 10, 2026).
[24] Response by Mass General Brigham and MinuteClinic Primary Care Massachusetts to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care HPC-CMIR-2025-2 (May 15, 2026), [hereinafter Joint Response], attached as Exhibit A; Commitments by Mass General Brigham and MinuteClinic Primary Care Massachusetts in Response to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care HPC-CMIR-2025-2 (June 5, 2026) [hereinafter Party Commitments], attached as Exhibit B.

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 $5.5 million annually.

These are conservative estimates of spending impacts once the MCPC sites are operational and the new MGB rates are in effect, based on the parties' projections of "moderate acceptance" of their model by year three of implementation, in which approximately 35% of all MCPC patients are primary care panel members. 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 because of this expansion of MGB's primary care footprint. Expanding access to primary care could result in longer-term health care savings than those incorporated in the HPC's spending estimates. The likelihood and scope of additional savings depend heavily on the successful implementation of the new MCPC model.

The parties acknowledge that a substantial portion of the likely spending impacts are due to MGB's uniquely high rates and commit to exploring ways to mitigate these impacts. The HPC looks forward to working with the parties to identify such mitigation opportunities and to monitoring the impact of the transaction on prices and spending.

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 connect up to 120,000 Massachusetts residents to a primary care provider through a novel care delivery model in a retail setting that would meaningfully expand the services that MinuteClinic provides. The magnitude of this increase in access 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. The parties' commitment to provide targeted outreach to MassHealth patients increases the likelihood that MassHealth members may have meaningfully increased access to primary care services. CVS did not initially plan for MCPC to offer pediatric convenience care at MCPC sites but has now committed to maintain this important access point. The parties should prioritize meaningful action on their commitments to realize the potential for improved access to primary care.

   Key areas of uncertainty remain regarding whether or when MCPC would provide comprehensive, high-quality primary care that would be sustainable long-term. 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. The HPC will be requiring ongoing reporting from the parties to monitor the implementation of the model over time to assess these impacts.

In summary, this transaction has the potential to increase primary care access for a substantial number of Massachusetts residents. MinuteClinic's transition to primary care has the potential to increase access to primary care services for up to 120,000 adult patients over time, with an expectation of serving approximately 42,000 primary care patients by year three. The magnitude of the increase in primary care access depends on the success of the model over time and on some key yet-to-be-determined details of implementation, such as how the parties prioritize the transition of sites in areas of greatest need and how the parties plan to ensure the provision of comprehensive primary care services.

The proposal is also likely to result in an increase to annual commercial health care spending of approximately $39.9 million once the MCPC sites are operational and the new MGB rates are in effect, assuming moderate acceptance of the model by year three. This projection includes spending increases for MCPC's new primary care patients – some of which may reflect appropriate and improved management of health conditions – as well as higher prices for both MCPC's continuing convenience care services and the convenience care services that would need to move to other providers. Spending impacts would be significantly higher if MCPC sites were each to fill their primary care patient panels to the maximum size at the new MGB rates.

The HPC welcomes the parties' new commitments to address identified concerns regarding spending and equitable access for primary care, including the commitments to maintain pediatric convenience care and to provide targeted outreach to MassHealth patients. If the parties prioritize meaningful, measurable action on the commitments offered as part of the HPC's review, concerns about affordability and equitable access highlighted in the Preliminary Report may be mitigated.

Regular reporting of relevant cost, quality, and access metrics for the MCPC sites following the transaction will 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.

These metrics include, but are not limited to: the number of MCPC APPs and other clinicians who join MGB contracts and receive MGB contracted rates over time; information about MCPC primary care and convenience care prices and price increases for commercial payers; the list of sites that receive full clinic licensure each year; primary care panel size at each MCPC site; annual volume of primary care visits, specialty referrals for primary care patients, and convenience care visits at each MCPC site; open hours by MCPC site; the payer mix of primary care and convenience care patients served at MCPC sites; which MCPC sites permit qualified APPs to prescribe controlled substances; and MCPC performance on primary care quality metrics. The HPC will also require reporting on MCPC's progress and timeline for joining the MGB MassHealth ACO, including whether MCPC has added video telehealth capability, oral health screening, full behavioral health screening, and/or full behavioral health medication management.

Based on these findings, the HPC submits this report to DPH and MassHealth for consideration in connection with clinic licensure and other regulatory determinations. The HPC also submits this CMIR Final Report to the Office of the Attorney General for consideration in the context of its statutory authority under Mass. Gen. Laws ch. 12, § 11N(a), to monitor the Massachusetts health care market.

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):[25]

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.[26]

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,[27] 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)[28] 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-

[25] *See* MASS. GEN. LAWS ch. 6D, § 13(d) and 958 CMR 7.06.
[26] *Id*.
[27] 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.
[28] 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 (last visited June 10, 2026).

level data,[29] and enrollment and claims-level data from the All-Payer Claims Database (APCD);[30] federal agencies such as the Centers for Medicare and Medicaid Services (CMS);[31] academic and research institutions, such as the University of Wisconsin School of Medicine and Public Health Neighborhood Atlas;[32] 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."[33] 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.

---

[29] 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 June 10, 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 June 10, 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 June 10, 2026).

[30] *All-Payer Claims Database*, CTR. FOR HEALTH INFO. & ANALYSIS, http://www.chiamass.gov/ma-apcd/ (last visited June 10, 2026).

[31] *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).

[32] *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/ (downloaded Nov. 19, 2025).

[33] MASS. GEN. LAWS ch. 6D, § 13(c); 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, in the Data Appendix, and in Exhibit C: HPC Analysis of Parties' Joint Response.

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.[34] 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.[35] 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),[36] 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,[37] to transition these sites from limited services clinics to full clinics capable of providing primary care.[38] 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."[39] 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.[40]

This section describes the parties and the proposed transaction.

[34] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.
[35] *Id.*; *See* 105 CMR 140.020.
[36] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.
[37] *See infra,* Section II.A.2 for a discussion of limited services clinics.
[38] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.
[39] *Id.*
[40] *Id.*

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)[41] and Massachusetts General Hospital (1,065 beds),[42] MGB is the largest health care provider in Massachusetts and owns a health plan, MGB Health Plan (MGBHP).[43] MGB is financially robust overall.[44]

In addition to its two founding AMCs, MGB owns an extensive network of community and specialty hospitals. MGB's community hospitals in Massachusetts[45] include:

- Brigham and Women's Faulkner Hospital (Jamaica Plain): 171 beds[46]
- Cooley Dickinson Hospital (Northampton): 151 beds[47]
- Martha's Vineyard Hospital (Oak Bluffs): 31 beds[48]
- Nantucket Cottage Hospital (Nantucket): 18 beds[49]
- Newton-Wellesley Hospital (Newton): 339 beds[50]
- Salem Hospital (previously named North Shore Medical Center) (Salem): 403 beds[51]

MGB's specialty hospitals include Mass Eye and Ear, McLean Hospital, and Spaulding Rehabilitation.[52] 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.[53]

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.[54] MGB ACO holds commercial risk contracts, participates

---

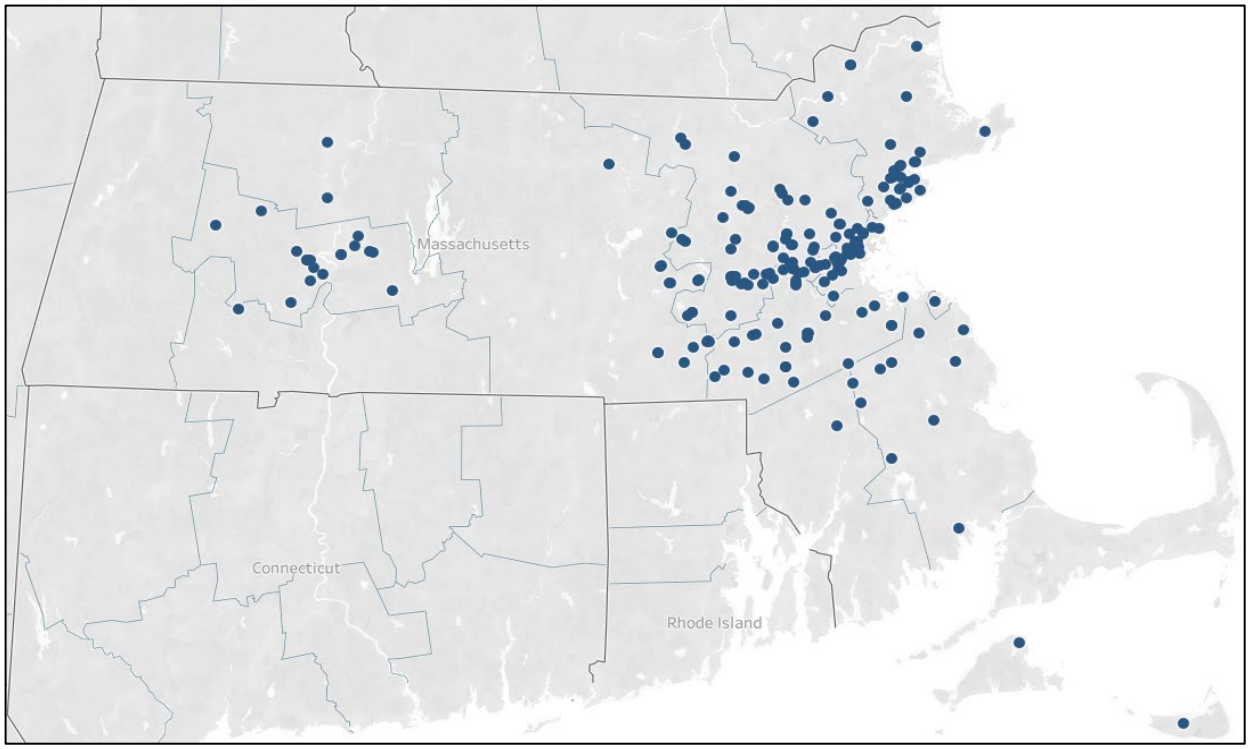
[41] CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES: DATA THROUGH HOSPITAL FISCAL YEAR 2024, (Jan. 2026) at 4, *available at* https://www.chiamass.gov/assets/docs/r/hospital-profiles/2024/FY24-Massachusetts-Hospital-Profiles-Compendium.pdf (last visited June 10, 2026).
[42] *Id.* at 5.
[43] *About Us*, BRIGHAM AND WOMEN'S, https://give.brighamandwomens.org/about-us/ (last visited June 10, 2025).
[44] 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 June 10, 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…. (last visited June 10, 2026).
[45] MGB also owns Wentworth Douglass Hospital in New Hampshire.
[46] *Supra* note 41, at 9.
[47] *Id.* at 33.
[48] *Id.* at 19.
[49] *Id.* at 21.
[50] *Id.* at 22.
[51] *Id.* at 48.
[52] *Id.* at 6, 25.
[53] *Mass General Brigham's Locations*, MASS GENERAL BRIGHAM, https://www.massgeneralbrigham.org/en/patient-care/services-and-specialties/find-a-location (last visited June 10, 2026).
[54] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14. 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].

in the MassHealth ACO program as an Accountable Care Partnership ACO with MGBHP, and participates in the Medicare Shared Savings Program.[55]

MGB's network of employed and affiliated physicians in Massachusetts includes 7,776 physicians, representing 30% of all physicians in Massachusetts.[56] 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.[57]

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%.[58] Approximately 1,206 (15.5%) of MGB's 7,776 physicians are primary care physicians who work in MGB physician offices primarily located in the Boston area and the North and South Shore (see map below).[59] 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.[60]

Figure II.A.1: MGB Primary Care Locations



Source: HPC analysis of 2024 MA-RPO data.

[55] 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 June 10, 2026).
[56] MGB 2024 MA-RPO FILING, *supra* note 54.
[57] *Brigham and Women's Physician Assistants*, BRIGHAM AND WOMEN'S, https://www.brighamandwomens.org/medical-professionals/physician-assistant-services/pa-services-overview (Last visited June 10, 2026).
[58] 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.
[59] MGB 2024 MA-RPO FILING, *supra* note 54.
[60] *Primary Care*, MASS GENERAL BRIGHAM, https://www.massgeneralbrigham.org/en/patient-care/services-and-specialties/primary-care (Last visited June 10, 2026).

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.[61] 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.[62] MGB has pledged to invest close to $400 million in primary care, including by hiring 90 new support staff and adding doctors.[63]

2. CVS Health

CVS is the country's second largest health care company, after United Healthcare Group.[64] CVS's total revenue was $372.8 billion in 2024.[65] 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.[66] 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.[67] In the last year, it has expanded this effort to eight additional states and Washington, D.C.,[68] including through partnerships with large health systems such as Emory Healthcare Network in Georgia (beginning in February 2025),[69] Fairview Physician Associates Network in Minnesota (beginning in July 2025),[70] and Rush Health in Chicago (beginning in

---

[61] *Supra* note 19.
[62] 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 June 10, 2026).
[63] *Supra* note 19.
[64] 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 June 10, 2026).
[65] *CVS Health Revenue 2012-2025*, MACROTRENDS, https://www.macrotrends.net/stocks/charts/CVS/cvs-health/revenue (Last visited June 10, 2026).
[66] *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 June 10, 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 June 10, 2026); *Our History*, CVS HEALTH, https://www.cvshealth.com/about/our-strategy/company-history.html (last visited June 10, 2026); *Frequently Asked Questions*, CVS HEALTH, https://www.cvs.com/minuteclinic/info (last visited June 10, 2026).
[67] *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 June 10, 2026).
[68] *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 June 10, 2026).
[69] *MinuteClinic 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 June 10, 2026).
[70] *Supra* note 68.

December 2025).[71] 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).[72]

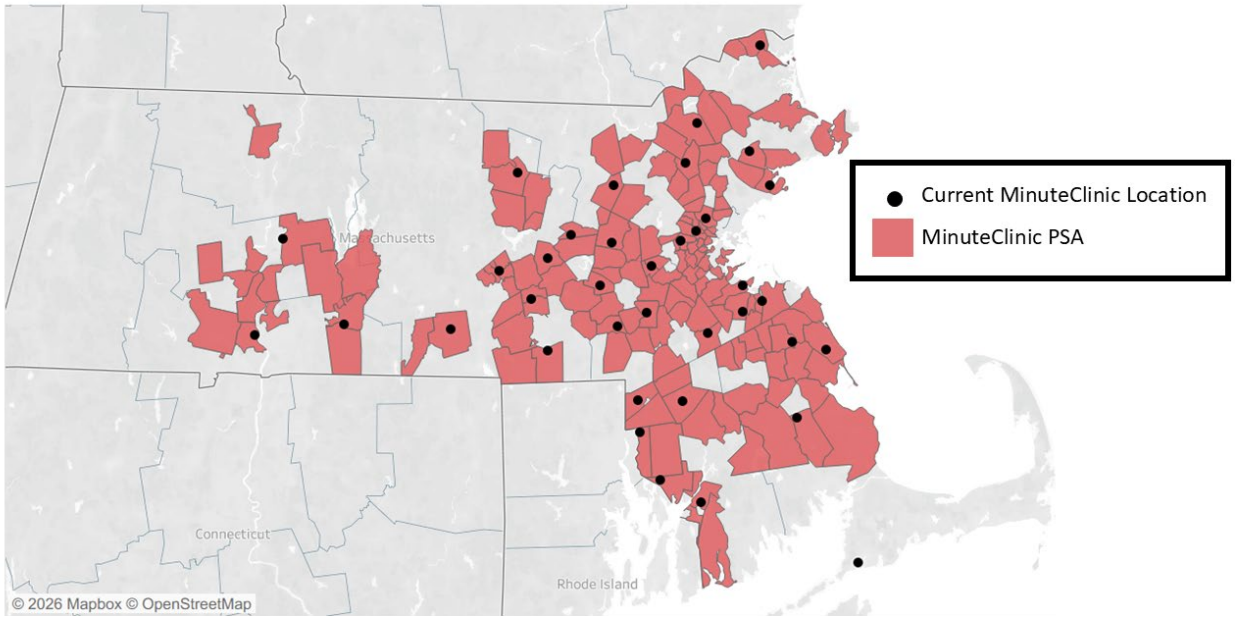
In Massachusetts, CVS has 37 MinuteClinic locations, or retail clinics, which are currently licensed as "limited services clinics," and CVS is the only provider so licensed in Massachusetts.[73] As limited services clinics, MinuteClinic cannot provide surgical, dental, physical rehabilitation, mental health, substance use disorder, or birth center services.[74] 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.[75]

As discussed in Section III.B.2, many of 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.[76] As shown below, these sites are primarily in Eastern and Central MA.

[71] *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 June 10, 2026).
[72] *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 June 10, 2026).
[73] *See* Massachusetts regulatory definition of "Limited Services," 105 CMR 140.020.
[74] *Id*.
[75] *Frequently Asked Questions*, CVS MINUTECLINIC, https://www.cvs.com/minuteclinic/info?icid=mchome-mcfaq-mcallfaq (last visited June 10, 2026).
[76] CVS MCN, *supra* note 14.

Figure II.A.2 MinuteClinic Locations and Primary Service Area in Massachusetts[77]



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.

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.[78] 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[79] emphasizing a team-based approach to delivering patient-centered care. The new provision of

[77] 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.

[78] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14. 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.

[79] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.

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.[80]

Under its existing "convenience care" model, MinuteClinic sites serve both pediatric and adult patients. CVS does not plan for MCPC to offer pediatric primary care and initially expected to end provision of pediatric convenience care at MCPC sites. The parties subsequently committed to "maintain convenience care and continue to serve children" absent regulatory prohibitions.[81]

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.[82] 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

[80] 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.
[81] Joint Response, *supra* note 24, at 7. According to DPH, convenience care services can be provided under full clinic licensure for pediatric as well as adult patients. 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 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. *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.
[82] MGB MCN, *supra* note 14; CVS MCN, *supra* note 14.

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.[83]

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,[84] 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."[85] The parties indicated to the HPC that they expect to further expand access to services by offering extended hours during evenings and weekends.[86]

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.[87]

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

[83] 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.
[84] CVS estimates that approximately 80,000 current MinuteClinic patients do not have a primary care provider, although this estimate includes pediatric patients who would not be served by MCPC.
[85] MGB MCN, *supra* note 14; CVS MCN *supra* note 14.
[86] *Id.*
[87] *Id.*

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.[88]

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.[89] In 2025, 43% of Massachusetts residents reported having difficulty accessing care, most often because they could not get appointments soon enough. [90] 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.[91] Black, Indigenous, and People of Color (BIPOC) residents and those with increased socioeconomic barriers to care face greater challenges accessing primary care.[92] These access challenges pose real risks to patient wellbeing. Adequate spending on and

[88] *Id.*
[89] DIRE DIAGNOSIS, *supra* note 4.
[90] 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 (last visited June 10, 2026). 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.
[91] 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 June 10, 2026).
[92] 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 June 10, 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*

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. [93]

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;[94] 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.[95] While Massachusetts has the highest total physicians per capita in the nation, PCPs represent a relatively small share of these physicians.[96] PCPs providing direct patient care represent the fifth lowest share of all physicians in Massachusetts compared to other states.[97] Similar challenges apply to APPs; the share of NPs working in office-based settings fell from 26% in 2018 to 21% in 2022.[98]

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,[99] 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.[100] 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

---

Use Among Patients With a Usual Source of Care, 6 J. AM. BOARD FAM. MED. November 680 (2013), *available at* https://pubmed.ncbi.nlm.nih.gov/24204064/ (last visited June 10, 2026).

[93] *See, e.g.*, Sanjay Basu, et al., *Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015*, 179 JAMA INTERN. MED. 506 (2019), *available at* https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2724393 (last visited June 10, 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 June 10, 2026); Anthony Jerant et al., *Extended office hours and health care expenditures: a national study*, 10 ANN FAM. MED. 388 (2012), *available at* https://pubmed.ncbi.nlm.nih.gov/22966101/ (last visited June 10, 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 June 10, 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 June 10, 2026).

[94] DIRE DIAGNOSIS, *supra* note 4, at 18.

[95] 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 (last visited June 10, 2026).

[96] DIRE DIAGNOSIS *supra* note 4, 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.

[97] *Id.* at 17.

[98] *Id.* at 38.

[99] *Id.* at 31-34.

[100] *Id.* at 35-36.

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. [101]

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.[102] 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, even after accounting for differences in patient medical complexity. 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 once the MCPC sites are operational and the new MGB rates are in effect:
    - **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

[101] *Id.* at 57.
[102] *Supra* notes 64 and 66.

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 $5.5 million annually.

These are conservative estimates of spending impacts once the MCPC sites are operational and the new MGB rates are in effect, based on the parties' projections of "moderate acceptance" of their model by year three of implementation, in which approximately 35% of all MCPC patients are primary care panel members. 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 because of this expansion of MGB's primary care footprint. Expanding access to primary care could result in longer-term health care savings than those incorporated in the HPC's spending estimates. The likelihood and scope of additional savings depend heavily on the successful implementation of the new MCPC model.

The parties acknowledge that a substantial portion of the likely spending impacts are due to MGB's uniquely high rates and commit to exploring ways to mitigate these impacts. The HPC looks forward to working with the parties to identify such mitigation opportunities and to monitoring the impact of the transaction on prices and spending.

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.

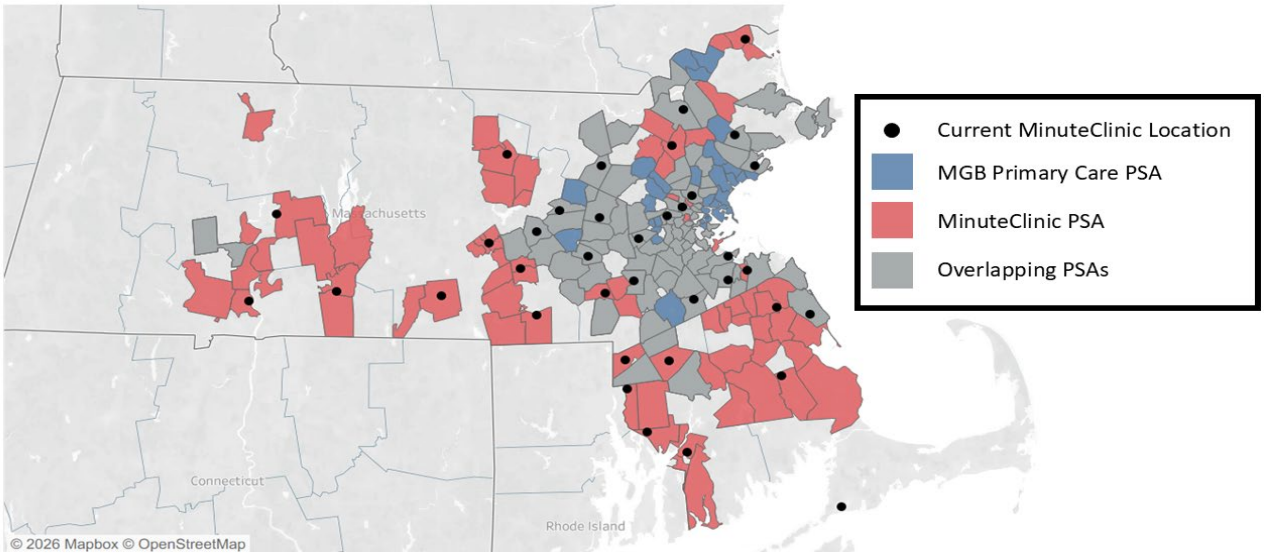
The HPC examined the parties' PSAs in Massachusetts to understand the geographies that would be most impacted by the transaction.[103] A PSA is defined as the smallest set of zip codes from which an entity

[103] 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

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).[104]

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

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).

[104] 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 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.

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.[105]

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[106]	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. Although 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.[107] 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.

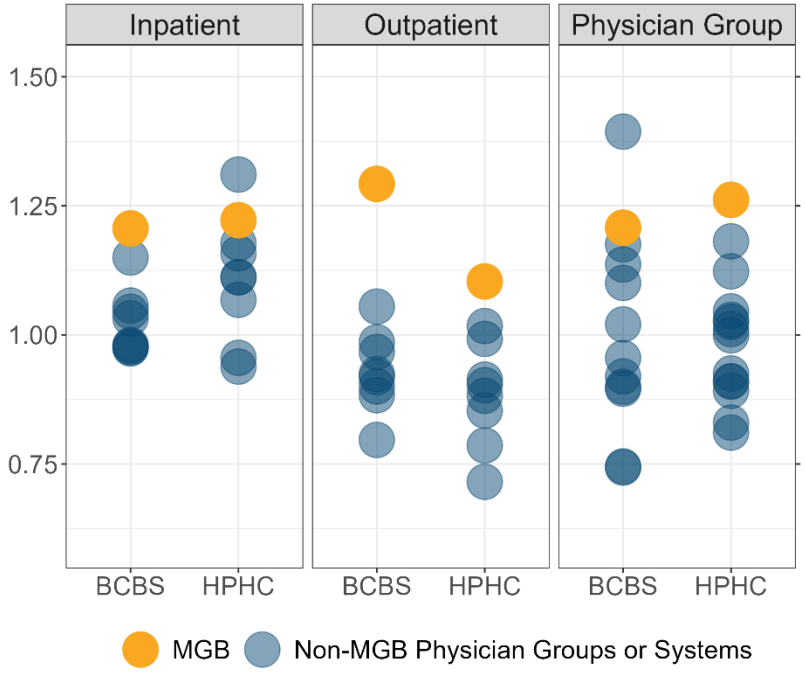
b. MGB generally has the highest provider prices in the Commonwealth, including for adult primary care services. MinuteClinic's convenience care prices are less than half those of MGB and substantially lower than those of other providers offering similar services.

As the HPC has reported previously, MGB's commercial prices are higher than those of nearly all other providers in Massachusetts.[108] In an analysis of 2023 hospital and physician group relative prices shown

[105] 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 113 for more detail on how adult primary care claims were identified.
[106] Revere Medical is the successor to the Steward network.
[107] 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.
[108] *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 June 10, 2026). *See also* MASS. HEALTH POLICY COMM'N, BOARD MEETING PRESENTATION (Jan 25, 2022) *available at*

in the chart below, the HPC found that for the two largest commercial payers, constituting approximately 64% of the commercial market in Massachusetts, MGB hospitals and physician groups are the most or second-most expensive in the Commonwealth.[109]

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 contracted rates under the proposed transaction, the HPC compared current MGB adult primary care prices for care delivered by APPs to MinuteClinic's current prices.[110] 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

https://masshpc.gov/sites/default/files/2023-04/20220125%20Board%20Meeting%20Presentation.pdf (last visited June 10, 2026).

[109] 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 108, at 57, n. 209.

[110] 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.

the services billed most frequently by MinuteClinic across all Massachusetts locations for adult patients, summarized in Figure III.A.4, as these are likely reflective of the services that MCPC would continue to provide post-transaction.

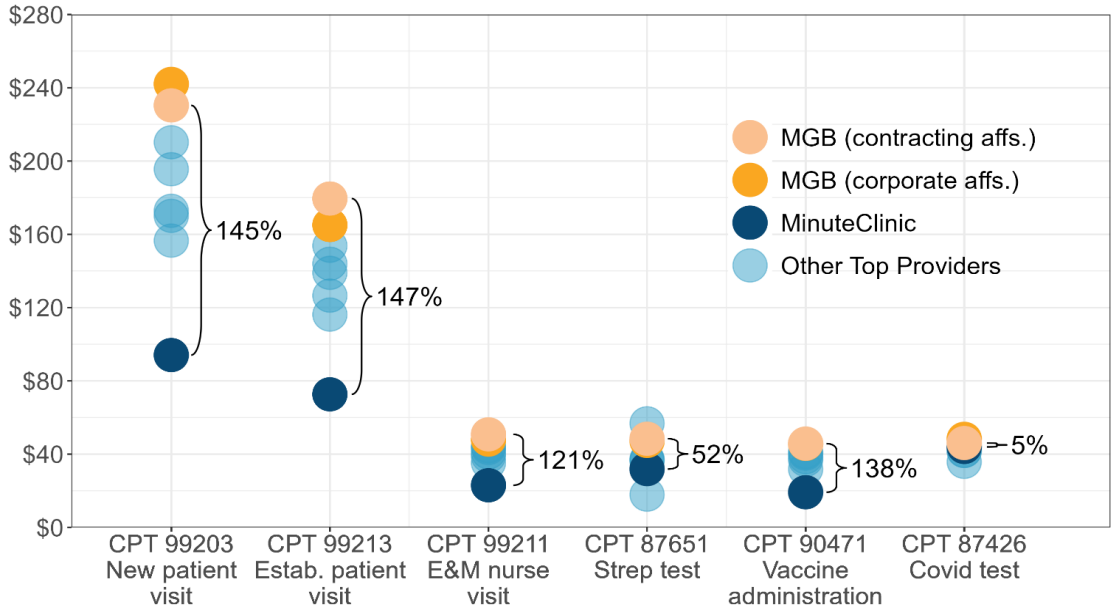
Figure III.A.4: Overview of Top 6 MinuteClinic Services by Volume (2023)

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 analyzed prices for MGB PCPs who are employed by MGB contracting affiliates (Charles River Medical Associates, Milford Regional Physician Group, and Emerson PHO) separately 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.[111]

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-

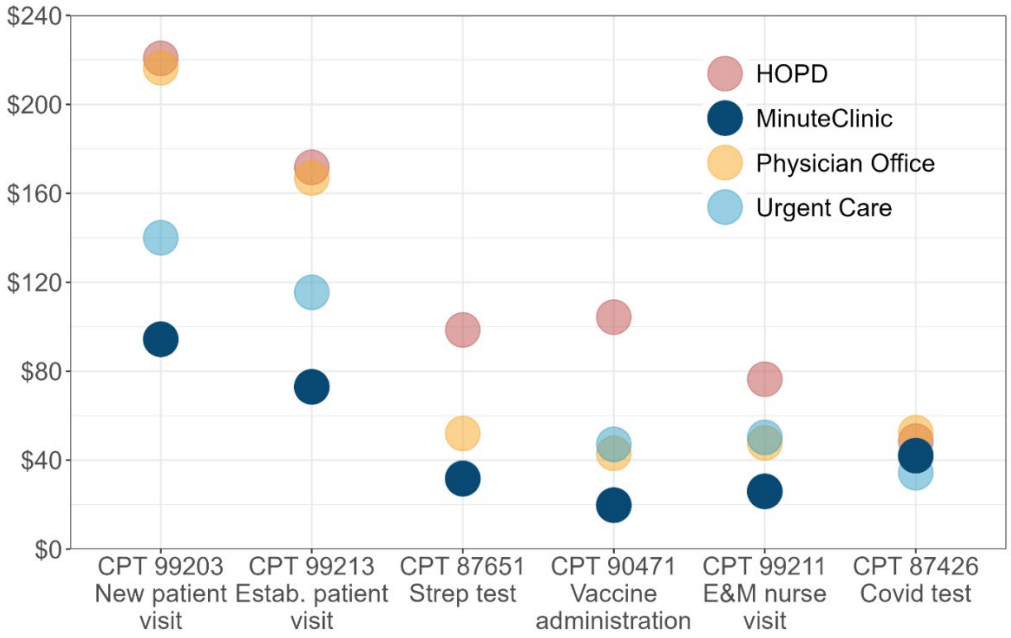
[111] Whereas fully owned corporate affiliates establish all contracts through MGB, MGB negotiates rates for contracting affiliates for a subset of payers, generally the largest payers, and contracting affiliates independently establish their own smaller payer contracts.

MinuteClinic providers are calculated by multiplying physician prices by 0.85. Text labels show the percent difference between MGB contracting affiliates and MinuteClinic prices.

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 common services.

If CVS were to fill its primary care patient panels in accordance with its expectations of "moderate acceptance" of the model by year three, MCPC would have approximately half of MinuteClinic's current capacity remaining for convenience care services.[112] 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."[113]

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



Source: HPC analysis of 2023 APCD claims data.

[112] See *infra* note 146 for further detail on this dynamic.
[113] 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.

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.

Here too, 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 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.[114] 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.[115] 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.[116]

[114] 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.
[115] 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.
[116] 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 June 10, 2026).

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

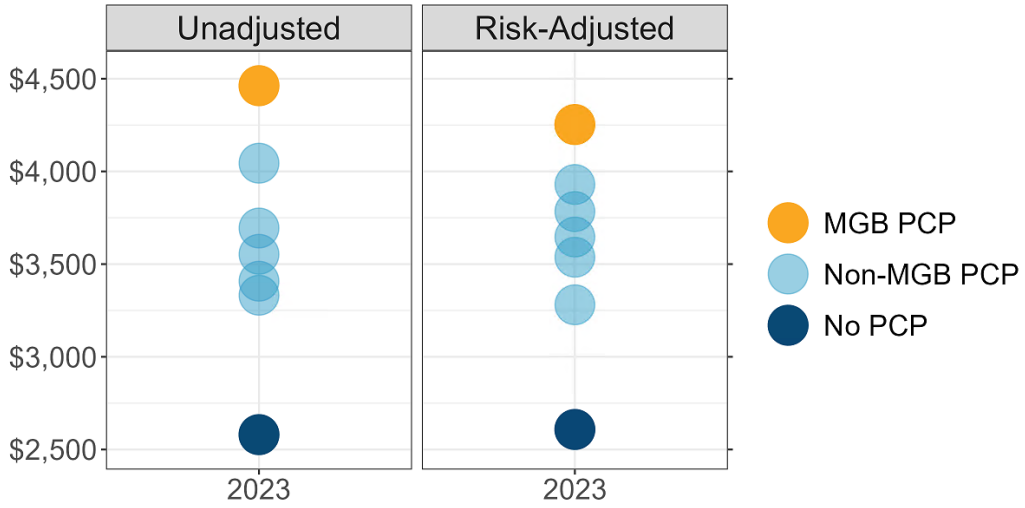
Source: HPC analysis of data from the CHIA Annual Report 2026.
Note: Data are filtered to PCP Type 1 and non-pediatric contracts. HSA TME cannot be compared across payers. "Other Top Providers" includes BILH, Baystate, Optum, Tufts, and UMass.

The HPC used claims data to examine spending for the patient population from whom the parties expect MCPC's primary care patient panels to be drawn: 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.[117]

[117] 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. Figure includes only members living in the MinuteClinic PSA. Risk-adjusted medical spending includes adjustments for age, sex, HCC risk score,[118] 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

[118] Risk scores were generated from the U.S. Department of Health and Human Services Hierarchical Condition Categories (HHS-HCC) Risk Adjustment Model Software ("Do It Yourself (DIY)" Software Version 0723) with modifications. The HPC modified the model by applying a coding intensity adjustment that removed eight diagnosis groups from consideration in patient risk scores. These groups were selected based on peer-reviewed research that identified ten diagnosis groups that were most differentially coded in Medicare Advantage compared to traditional Medicare. See Richard Kronick et al., *Are Fewer Diagnoses Better? Assessing a Proposal to Improve the Medicare Advantage Payment System*, 44 HEALTH AFFAIRS 66 (2025), *available at* https://pubmed.ncbi.nlm.nih.gov/39761456/ (last visited June 10, 2026).

providers, at generally higher prices, as MCPC develops its primary care panels and correspondingly decreases its convenience care capacity.

The impacts of these three mechanisms are additive, not overlapping.[119] The following sections walk through the HPC's methodology and spending impact estimates for each of these mechanisms.

d. 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.[120] 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.

First, members may have different utilization patterns, which would affect annual spending. Members may receive regular wellness visits, screening and diagnostic testing. and specialist referrals that constitute new utilization. Some of this new utilization would likely occur regardless of the provider organization with which the patient's PCP is affiliated, while some would reflect MGB-specific utilization patterns. For example, because MCPC would join certain MGB quality and care management programs post-transaction, MGB's internal care management practices and patterns could affect utilization for members of MCPC panels. Some changes in utilization may reflect appropriate and improved management of health conditions; to the extent that such changes reduce spending for, e.g., hospital stays, the HPC estimate incorporates those savings, as discussed in more detail in Section III.A.2.e.

Second, members may receive care that is priced differently after joining the panels. Members would pay MGB prices for primary care and be 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, resulting from the combined 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

[119] See Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section G for further discussion.
[120] *See also*, e.g., Samuel Moy, et al., *Variation in spending associated with primary care practices*, 27 AM J MANAG CARE 297 (2021), *available at* https://pubmed.ncbi.nlm.nih.gov/34314119/ (last visited June 10, 2026).

but later obtained a PCP with an MGB contracting affiliate.[121] The HPC used these data because they reflect the most similar available set of facts to the parties' proposal.[122]

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, spending changes for the patient population that chose an MGB PCP may also account for other time-varying factors, such as individual knowledge of future health care needs, that might impact spending changes over time and may also be unique to the patients who might affirmatively choose an MCPC PCP.[123]

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 measured using a multivariate regression model to control for key variables like patient risk.[124] 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.[125] 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.[126] 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.[127]

---

[121] The HPC's methodology allows patients to be attributed to physicians and APPs as PCPs. Patients who are considered to have no PCP were not attributed to a PCP of any kind, regardless of provider type.

[122] *See* Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section C, for further discussion of the HPC's analysis confirming that the sample population represents a group of low-acuity patients similar to those likely to join MCPC panels.

[123] *See* Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section A for descriptions of the sensitivity analyses performed to confirm that the HPC's spending impact estimate is not inflated by the spending of patients in the HPC's sample that chose a PCP due to a health need that would have increased their spending regardless of PCP attribution.

[124] 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.

[125] 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 Section III.B.1.c. This may suggest that the HPC's impact estimate is conservative. The HPC also conducted a sensitivity using the patient attribution methodology from the HPC's Cost Trends Report and found minimal change to the total spending impact. See Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section E for more details.

[126] 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.

[127] 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

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.[128] 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 care panels by year three is likely to increase commercial spending by an additional $5.6 million annually through these non-claims payments.[129]

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 once the MCPC sites are operational and the new MGB rates are in effect, if MCPC filled its panels to 35%, reflecting CVS's expectation of "moderate acceptance" of its new primary care model by year three.[130] This estimate accounts for all projected changes in price, utilization, service mix, and provider mix associated with patients newly acquiring an MGB-affiliated PCP. The spending changes due to these factors would not occur absent this transaction.[131] Additionally, the HPC appreciates the parties' commitment to exploring ways to mitigate the spending impact of MCPC APPs joining MGB contracts.[132] The parties' clarification that the migration to MGB contracted rates would occur over two years,[133] on its own, is not anticipated to change the overall spending impact of the transaction.

---

provider and found consistent spending impacts. Given that the APP data in RPO are not yet finalized, the HPC decided not to rely on the APP analysis for its impacts. Third, the HPC conducted a sensitivity analysis excluding the years most affected by COVID and found no decrease to the estimated spending impact. It also conducted sensitivities using different outlier cutoffs and found minimal change to the overall spending impact. See Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section C and Section D for further details on these sensitivity analyses. 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, if instead of MGB, MinuteClinic affiliated with any other provider organization in the state, the likely spending impact would be lower. The lower impact from an affiliation with any other provider organization would result from other providers' respective (lower) prices and utilization patterns. Estimated spending impacts ranged from approximately $280 to $530 annual spending per member for the top eight 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 and particular utilization patterns.

[128] 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 (last visited June 10, 2026).

[129] 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.

[130] *See supra* note 126.

[131] *See* Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section B for further discussion of how the spending impact includes both utilization and price-driven components, which are interrelated and cannot easily be disaggregated.

[132] Party Commitments, *supra* note 24.

[133] *Id.*

a. 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 , 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.[134] Combining this price differential with the parties' stated expectations of the size of their primary care panels based on "moderate acceptance" of the model 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, or $105 per convenience care visit, once MCPC transitions to MGB rates, fills its primary care panels to 35%, and uses any remaining patient volume for convenience care.[135] Again, the parties' clarification that the migration to MGB contracted rates would occur over two years, on its own, is not anticipated to change the overall spending impact of the transaction.

b. 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 $5.5 million.

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 patients 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 absent the transaction would likely be diverted to other providers, such as urgent care centers and physician offices, while other patients would likely no longer need such convenience care after they become primary care patients of MCPC and receive similar services through primary care visits.[136] To

---

[134] 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 113 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.

[135] 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.

[136] As described in the HPC Analysis of Parties' Joint Response (Exhibit C), the HPC updated this analysis since the Preliminary Report. The total volume diverted was reduced from 51,030 visits to 48,240 visits to reflect the parties' claim in the Joint Response that, for MinuteClinic patients who join MCPC primary care panels, at least 40% of the

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.[137] 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.[138] 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. [139]

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 $5.5 million annually by year three if MCPC achieves its patient panel goals in accordance with "moderate acceptance" of the model.[140]

---

previously provided convenience care services would now be available through primary care visits at MCPC and would not need to be diverted to other providers.

[137] See *supra* note 113 above for a more detailed description of the HPC's methodology for identifying diversion recipients. The HPC omitted office visit codes from the list of procedure codes used to identify the convenience care comparator providers and conducted a sensitivity confirming that including office visit codes would have slightly increased the resulting spending impact. See Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section F for more details.

[138] Diversions to community health centers are captured under the "physician office" category.

[139] 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.

[140] 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 up to 51,030 convenience care visits could be diverted to other providers, but it is likely that a portion of the patients who join the MCPC primary care panels would be able to fulfill some of their convenience care needs through their new PCP. Specifically, the parties estimate that 40% of MinuteClinic convenience care services could "map directly onto primary care," and thus this convenience care demand would not need to be diverted for patients who join MCPC primary care panels. The HPC used the APCD to estimate the average number of MinuteClinic convenience care visits per year for unattributed adults in the MinuteClinic PSA who used MinuteClinic at least once from 2019 to 2023. This group visited MinuteClinic an average of 0.41 times annually. Assuming that 50% of the MCPC primary care panels are filled with these patients who get 40% of their convenience care demand met by their PCP, and the remainder are patients who have not historically used MinuteClinic for convenience care, the number of diverted convenience care visits is calculated as approximately 48,240, which accounts for 42% of total MCPC visit capacity. To obtain an estimated $5.5 million impact, the HPC multiplied the estimated 94% price increase by 42% 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. The HPC conducted additional sensitivity analyses responsive to concerns and assertions raised in the Joint Response, as described in Exhibit C: HPC Analysis of Parties' Joint Response, Methodological Appendix, Section F, and found these sensitivities had minimal impact on the spending increases modeled in this section.

In total, combining the impacts detailed above, this transaction is likely to increase annual commercial health care spending by approximately $39.9 million once the MCPC sites are operational and the new MGB rates are in effect, and if MCPC fills its patient panels to 35%, consistent with CVS's "moderate acceptance" expectations by year three. This estimate 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 – reaching $91.5 million annually – if MCPC sites were to each fill their primary care patient panels to the maximum size.[141] 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	48,240 patients with 48,240 annual visits	94% spending increase due to higher prices at other providers	$5.5 million
Total MCPC Commercial Volume:	97,200 patients with 114,210 annual visits	**Total Projected Annual Spending Impact:**	$39.9 million

c. 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.

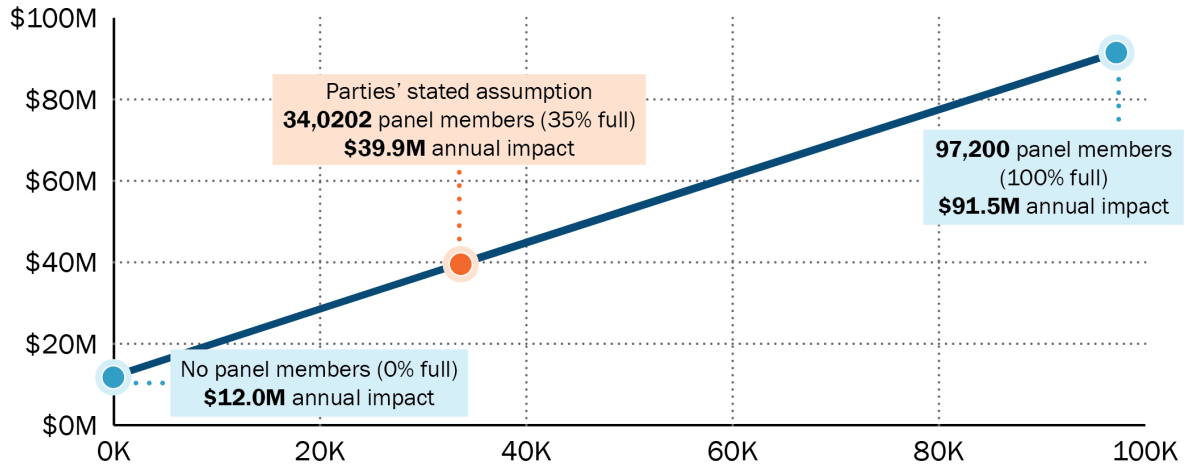
The estimated spending impact above is conservative for several reasons.

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 spending impact would be approximately $91.5 million.[142]

[141] 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 $79.2 million for the primary care panels and $11.2 million for the diversions of its current convenience care, for a total commercial spending impact of $91.5 million annually. There would also likely be an increase in commercial non-claims spending for the primary care panels. 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.

[142] *See supra* note 141.

Figure III.A.10: Total Annual Commercial Spending Impact by Number of Commercial Primary Care Panel Members



Note: These figures are conservative as they do not incorporate further price increases due to enhanced bargaining leverage as MGB's market share increases and MCPC begins offering new services.

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.[143] Such change in bargaining leverage is difficult to quantify at this point.[144] 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.[145] 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

[143] 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 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.

[144] 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.

[145] 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 June 10, 2026).

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.[146]

d. Expanding access to primary care could result in longer-term health care savings. The likelihood and scope of additional savings here depend 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[147] 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 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.[148] 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

---

[146] Another factor that makes the HPC's estimate conservative is that the HPC did not use office visit procedure codes to identify comparator convenience care providers, because 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 who may have fewer urgent care options than adults, the spending impact would be higher.

[147] 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 (last visited June 10, 2026). 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.

[148] Daly, et al. (2018), *supra* note 93; 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 visited June 10, 2026).

associated with lower rates of ED use.[149] 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,[150] 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.[151] 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.[152]

Specifically, research literature suggests that, while increasing PCP access can bring meaningful improvements in health care quality and health outcomes,[153] 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.[154] Studies have found greater savings in the context of high-quality, long-term longitudinal care with the same provider.[155] 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.[156]

The MCPC model and patient population are not expected to reflect most factors associated with success in these studies. The parties emphasize that the MCPC population is expected to be less medically complex

---

[149] Lowe, et al. (2005), *supra* note 93; Villani & Mortensen (2013) *supra* note 92.
[150] 2025 MHIS, *supra* note 90; DIRE Diagnosis, *supra* note 4.
[151] 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 June 10, 2026).
[152] 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 June 10, 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 June 10, 2026); Andrew Bazemore, et al., *The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review*, 21 ANN. FAM. MED. 274 (2023), *available at* https://www.annfammed.org/content/annalsfm/21/3/274.full.pdf (last visited June 10, 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 June 10, 2026).
[153] See discussion in Section III.B.
[154] 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 (last visited June 10, 2026); Soeren Mattke, et al., *Evidence for the effect of disease management: is $1 billion a year a good investment?*, 13 AM. J. MANAG. CARE 670 (2007), *available at* https://pubmed.ncbi.nlm.nih.gov/18069910/ (last visited June 10, 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 June 10, 2026).
[155] *See, e.g.,* Sonmez, et al.(2023), *supra* note 152; ; Bazemore, et al. (2023), *supra* note 152; Bazemore, et al. (2018), *supra* note 148.
[156] *See, e.g.,* Gao, et al. (2022), *supra* note 152; Mattke, et al. (2007), *supra* note 154; Edrington, et al. (2022), *supra* note 154.

and primarily commercial, in contrast to studied populations.[157,158] It is not yet clear whether patients will receive long-term continuity of care from specific clinicians, given outstanding questions on APP staff retention and the overall sustainability of MCPC's model.[159] While proposed extended evening and weekend hours would be beneficial, the scope of the extended hours remains unclear.[160] Because the proposed model does not align with the critical factors identified in the literature and there is substantial uncertainty regarding the MCPC model, the HPC cannot use those studies to estimate cost savings for the MinuteClinic transition to primary care.[161]

***

In summary, this transaction is likely to result in an increase to annual commercial health care spending of approximately $39.9 million once the MCPC sites are operational and the new MGB rates are in effect. This includes spending increases for MCPC's new primary care patients – some of which may reflect appropriate and improved management of health conditions, potential savings from which are accounted for in the HPC's estimate in the short-term – as well as 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 do not include potential additional costs due to increased negotiating leverage. While there is some potential for longer-term savings associated with new access to primary care, such savings depend on factors that are not yet determined and cannot be easily quantified.

To provide the public with additional information about the impact and efficacy of the parties' proposed plans and to support monitoring of factors affecting these cost estimates, the HPC will require ongoing reporting of several key metrics.[162]

These metrics will include, but are not limited to:

- The number of MCPC APPs and other clinicians who have joined MGB contracts;
- Primary care panel size for each MCPC site;
- Annual volume of primary care and convenience care visits for each MCPC site; and
- MCPC prices and price increases for all commercial payers, for both primary care and convenience care services.

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

[157] For more information, see Section II.B.
[158] In addition, the reduction in access to convenience care 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 146.
[159] For more information, see Section III.B.2.e.
[160] For more information, see Section III.B.2.a.
[161] The HPC references the 2023 Cost Trends Report to offer a sense of the potential scope of savings that reduced avoidable ED use could generate, if it were to occur. *Supra* note 151. The Joint Response inaccurately states that this report "quantified the benefits of this transaction at $9.7 million." Joint Response, *supra* note 24, at 15. The 2023 Cost Trends Report did not evaluate a transaction first proposed in 2025, and it also did not seek to describe the mechanisms by which the ED reduction could be achieved. There is no evidence of the potential scope of ED reduction for this specific transaction, and thus it is not possible to estimate any associated savings.
[162] *See* 958 CMR 7.15 for information regarding the HPC's authority to require submission of data and information necessary for the HPC to assess post-transaction impacts.

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, with an estimated 42,000 primary care patients expected to be served by MCPC, but the capacity to serve up to 120,000. The degree to which this potential increased access is achieved depends on the success of the model over time and on some key details that have not yet been determined.
- 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, although the parties' commitment to conduct targeted outreach to MassHealth members increases the likelihood that access will be enhanced for public payer patients.
- Extended hours are proposed at MCPC sites, but not all MinuteClinic sites are currently open for the standard operating hours.
- While the shift away from convenience care would reduce access to those services, the parties' commitment to maintain access to pediatric convenience care mitigates concerns about this population.
- 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.

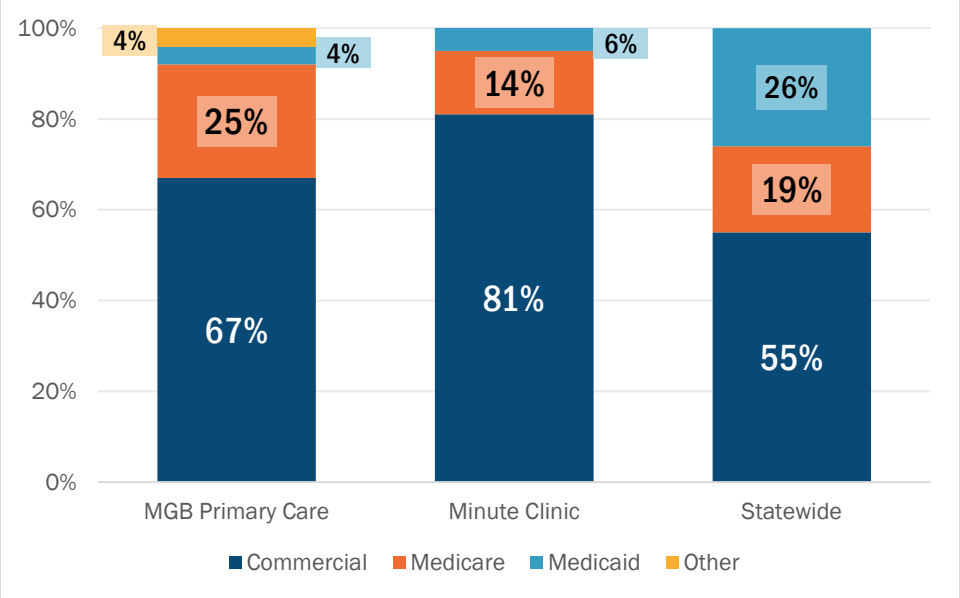
As discussed in Section II.A.1, MGB is the Commonwealth's largest provider of primary care physician services in Massachusetts, with over 1,200 primary care physicians in their network, and accounting for 24% of the state's spending on primary care services. At MGB primary care offices, patients receive 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.[163]

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

[163] CTR. FOR HEALTH INFO. & ANALYSIS, *Enrollment In Insurance Trends*, https://www.chiamass.gov/enrollment-in-health-insurance/ (last visited June 10, 2026).

preventive care, screening and prevention, and chronic care.[164] 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 is not available, quality measures tracked by MinuteClinic, and provided to the HPC, appear to indicate generally strong performance.

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.[165]

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, with an anticipated 42,000 adults newly connected to

[164] 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 June 10, 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.

[165] *Why Choose* Us, CVS MINUTECLINIC, https://www.cvs.com/minuteclinic/why-choose-us/patient-quality (last visited June 10, 2026); *see also*, *Ambulatory Health Care Accreditation Program*, JOINT COMMISSION https://www.jointcommission.org/en-us/accreditation/ambulatory-health-care (last visited June 10, 2026).

primary care services through MCPC if the parties achieve their anticipated 35% patient panel size by year three, and up to 120,000 adults if MCPC fills its primary care panels entirely. The HPC welcomes the parties' efforts to propose novel solutions to address the need for additional PCPs. The full impact of the parties' plans on primary care access in Massachusetts 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, but which the HPC expects to monitor subsequent to the transaction through ongoing reporting by the parties.

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.[166]

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. 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,[167] and that the current number of providers at each MinuteClinic location does not appear to correlate with the operating hours of the location.[168] 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, and any potential for associated cost savings, 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,[169] reduced chronic disease burden,[170] fewer health disparities,[171] fewer hospitalizations,[172] and reduced ED utilization.

---

[166] 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 4, at 38.
[167] 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 June 10, 2026).
[168] 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.
[169] Basu, et al. (2019), *supra* note 93.
[170] 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 visited June 10, 2026).
[171] 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 visited June 10, 2026).
[172] Bazemore et al. (2018), *supra* note 148

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.[173] 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.[174]

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. Cost savings from such changes in the first few years are already incorporated into the HPC's calculations of the spending impact of the transaction. As discussed in Section III.A.2.e, the magnitude of these changes over the longer term, and any potential cost savings associated with them, cannot be estimated with available information.

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), [175,176] 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, [177] which scores geographic locations on need; the

[173] 2025 MHIS, *supra* note 90; DIRE Diagnosis, *supra* note 4.
[174] 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 visited June 10, 2026).
[175] 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).
[176] *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).
[177] 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)

share of commercially insured adults with no primary care use documented in claims data;[178] PCP counts per 100,000 Massachusetts residents;[179] the share of people with non-emergency ED use;[180] and the share of non-elderly adults covered by MassHealth[181] (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. By contrast, seven MinuteClinic locations (of which six are located in Middlesex County) had scores under six.

The parties have committed to "prioritizing the evaluation of MinuteClinic locations in Massachusetts identified by the HPC as having the greatest unmet need for primary care for conversion to full clinic licensure, subject to a site-specific assessment of the feasibility to meet Department of Public Health (DPH) clinic licensure standards."[182] As discussed in Exhibit C, the HPC appreciates the parties' commitment to prioritizing evaluation of the sites identified as higher need, and the HPC and other agencies will monitor the parties' investments and progress in providing access in high-need communities.

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. The parties' subsequent commitment to "developing and implementing an outreach plan specifically for MassHealth patients and other underserved populations, and to otherwise work to expand MinuteClinic's proportion of MassHealth and other government payer populations"[183] has the potential to increase the share of MCPC patients covered by MassHealth. The parties should prioritize meaningful action on these commitments to realize their access goals.

---

[178] HPC analysis of 2023 APCD claims data
[179] 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).
[180] 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.
[181] 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).
[182] Party Commitments, *supra* note 24.
[183] *Id.*

c. While the shift away from convenience care would reduce access to those services, the parties' commitment to maintaining access to pediatric convenience care mitigates concerns about this population.

In the Preliminary Report, the HPC described the parties' plans to limit MCPC's practice to adult patients, for both primary care and convenience care, which would have eliminated pediatric access to all current services, with the exception of vaccinations for patients aged five and older, which CVS had stated would remain available at CVS Pharmacy locations.[184]

The parties indicated in the Joint Response and subsequent commitments that absent regulatory barriers, MCPC would continue to offer convenience care services to non-empaneled pediatric patients. As discussed further in Exhibit C, Section III.B, DPH has confirmed to the HPC that there is no such regulatory barrier. Accordingly, the HPC expects that convenience care services will be maintained for pediatric patients and appreciates CVS's commitment to maintaining these important services.[185]

After the transition to primary care, MCPC has stated that it would continue to serve some adult convenience care patients, but that the availability of appointments for such patients is expected to decrease as the number of primary care patients increases. With MCPC's welcome commitment to continue pediatric convenience care, the same reduction in appointment availability would necessarily apply to pediatric patients, although to a lesser extent than if pediatric care were eliminated. 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.[186] 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 PCP 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 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.

As discussed at length above, the Commonwealth needs additional primary care capacity, and the HPC appreciates that the proposed model represents an important opportunity to expand access to primary care. At the same time, the parties do not plan to recruit new providers to the Commonwealth to serve as

---

[184] Patients four and under cannot be served by pharmacist-administered vaccinations and would lose access to this service at MCPC sites if pediatric convenience care ended. 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.

[185] Elimination of convenience care for children, which represented approximately 20,000 visits to MinuteClinic locations in 2024, would likely have had implications for pediatric access to timely care for low-complexity services, such as fevers, upper respiratory infections, and ear infections. Research has found that availability of walk-in visits can decrease the number of ED visits and timely and appropriate care for lower acuity pediatric patients can result in lower healthcare spending. Davis et al. (2018), *supra* note 152; 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 June 10, 2026). Any loss or disruption of convenience care for the pediatric population would have risked higher rates of deferred care, an increase in avoidable ED utilization, and negatively impact vaccine access.

[186] 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 143 for a discussion of the potential market impacts of the addition of MinuteClinic's convenience care services to the MGB network.

the MCPC PCPs; the new primary care capacity would be achieved by shifting APP time away from convenience care.

d. 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.

Walgreens attempted to make this transition beginning in 2020, launching physician-led primary care practices under the "Village Medical at Walgreens" name.[187] In 2022, the brand announced launches for the Massachusetts market, starting with a location in Quincy.[188,189] 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.[190, 191] Similarly, Walmart Health launched in 2019 and provided primary care, including behavioral care, alongside labs, X-rays, and dental care. [192] 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.[193]

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. The parties have stated that the existence of MinuteClinic's existing patient population and its strong brand, combined with the affiliation with MGB, distinguish the model from other retail-based primary care efforts, and the HPC agrees that these factors may indeed be supportive. CVS offers no data or evidence from its primary care practices in other states or other financial modeling to support its contention that MCPC will succeed in Massachusetts, so the HPC's assessment that there is some risk of closure remains unchanged.

---

[187] 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 June 10, 2026).
[188] 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 (last visited June 10, 2026).
[189] *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 June 10, 2026).
[190] *Supra* note 187.
[191] *About VillageMD*, VILLAGEMD, https://www.villagemd.com/who-we-are (last visited June 10, 2026).
[192] 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 June 10, 2026).
[193] 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 June 10, 2026).

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.

e. 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. 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 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. 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.[194]

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

[194] 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. INTERN. MED. 760 (2017), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC5481228/ (last visited June 10, 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. JEN. INTERN. MED. 4006 (2025), *available at* https://link.springer.com/article/10.1007/s11606-025-09456-z (last visited June 10, 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).

requires work outside of regular working hours.[195] 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 support in juggling both primary care and convenience care provision during the ramp-up of their primary care panels.[196] 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.

f. 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 or when the proposed care delivery model would reflect the provision of comprehensive primary care.

Recognizing that there is no universal definition of or framework for evaluating primary care services,[197] the HPC considered several potential frameworks, ultimately focusing on MassHealth's Primary Care Sub-

---

[195] 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 June 10, 2026); Michael Stillman, *Death by Patient Portal*, JAMA (2023), *available at* https://pubmed.ncbi.nlm.nih.gov/37389857/ (last visited June 10, 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 June 10, 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 June 10, 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 June 10, 2026).

[196] The Joint Response does not offer new information on MCPC plans to support APPs or evidence on APP retention in other states. The HPC therefore remains unable to fully evaluate the model's ability to support and retain staff.

[197] 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 June 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 June 10, 2026).

Capitation Program clinical tier criteria to inform the HPC's evaluation of the parties' proposed model.[198] The HPC used the MassHealth Primary Care Sub-Capitation Program 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; that is, the HPC's use of this framework is not intended to evaluate whether MCPC will be able to participate in the Primary Care Sub-Capitation Program, but rather to generally assess the degree to which the proposed model reflects comprehensive primary care for all patients.[199] Further, 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 as a requirement for providers participating in any of MassHealth's Accountable Care Organizations (ACO) to support its goals of improving health outcomes and promoting health equity while managing health care costs.[200] 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.[201] Practices that participate in the Primary Care Sub-Capitation program must meet a set of minimum care delivery standards,[202] 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

---

[198] 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 June 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 June 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 171; 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 June 10, 2026). The HPC did not use these frameworks in this evaluation because they were largely theoretical and the HPC prioritized approaches that could be more easily applied to evaluate the information provided by the parties.

[199] 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.

[200] *MassHealth Primary Care Sub-Capitation: Program Overview*, MASSHEALTH, https://www.mass.gov/info-details/masshealth-primary-care-sub-capitation-program-overview (last visited June 10, 2026).

[201] *Id.*

[202] 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.

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. Because MCPC would not provide certain services required under the MassHealth program, MCPC's care delivery scope would have notable limitations.

Figure III.B.3: 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[203]
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 and would offer limited behavioral health screening and treatment. 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. MCPC has indicated

[203] 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 federal Drug Enforcement Administration (DEA) Controlled Substance Registration. DEA registration is required in order to prescribe controlled substances in Schedules II through V, as listed in 21 CFR 1308.12-15. See 21 CFR 1300 for more information.

that it would not screen for other substance use disorders, such as opioid use disorder, and accordingly would not fully meet the care delivery requirements for behavioral health and substance use disorder screening. The Joint Response indicates a general intention to add all other Tier 1 requirements, such as oral health screening and behavioral health screening, but does not offer a specific timeline for doing so, instead tying these additions to the timeline on which MCPC would join MGB's MassHealth ACO and participate in the Primary Care Sub-Capitation Program, which in turn depend on MCPC developing a sufficient MassHealth primary care panel. This timeline is uncertain and may depend on the success of the parties' MassHealth member outreach efforts.

MCPC also does not plan to offer video telehealth visits, and the parties did not specifically address this gap or identify any plans or timeline for adding this service in the Joint Response. 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).

MCPC also would not use the Prescription Monitoring Program, because it does not plan to prescribe controlled substances. The parties emphasize in the Joint Response that the decision not to prescribe controlled substances is a design choice, made based on an assessment of anticipated patient needs and the costs associated with controlled substance registration. This design choice would likely limit access for many patients as well as precluding MCPC from fully meeting Tier 1 criteria for behavioral health medication management and participation in the Prescription Monitoring Program. Without controlled substance prescribing, 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, including ADHD and anxiety and panic disorders, because many psychiatric medications are scheduled controlled substances. If not permitted to prescribe controlled substances, MCPC clinicians would also not be able to prescribe certain drugs to treat sleeping disorders, cough, diarrhea, and many other conditions commonly treated in a primary care setting.

The parties have stated that for patients requiring treatment for conditions that require controlled substance management, "MCPC providers will identify the need, initiate the appropriate referral, and manage the handoff through the centralized care coordination."[204] This is a standard practice for patients requiring specialty care referrals that are outside the scope of primary care, but it is not a substitute for providing comprehensive primary care for conditions such as the examples above, which fall within the usual scope of primary care, or for behavioral health conditions that can be managed under comprehensive primary care. To the extent that MCPC patients have or develop these conditions, this approach could result in potentially avoidable treatment delays and care fragmentation.

Further, this approach is likely to discourage patients who already need care for these conditions from choosing MCPC in the first place, with potential equity implications. In addition to impacting access and equity, this dynamic weakens the value of the parties' commitment, in Exhibit B, to ongoing evaluation of the need for these services among MCPC patients.[205] If patients who need controlled substance prescribing are unlikely to join MCPC due to the lack of this service, it is consequently unlikely that the parties' evaluation of MCPC patient needs will lead to a change in the MCPC model. The HPC continues to encourage the parties to develop a clear timeline for prescribing of controlled substances at all MCPC sites, given that this remains a concerning service limitation that may be a barrier for certain patients to benefit from this model.

[204] Joint Response, *supra* note 24, at 6.
[205] Party Commitments, *supra* note 24.

g. 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, and ongoing reporting is needed to monitor progress.

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.[206]

Figure III.B.4: 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.

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, Hierarchical Condition Categories (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

[206] 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 June 10, 2026).

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.

- 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.[207] MGB indicated to the HPC that it

[207] 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

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. The preliminary 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, but the HPC will be requiring reporting by the parties to allow for ongoing monitoring of the quality of care.

***

In summary, the transition of MinuteClinic sites to MCPC primary care locations has the potential to connect up to 120,000 Massachusetts residents to a primary care provider through a novel care delivery model, although the magnitude of this increase depends on certain yet-to-be-determined implementation details as well as the success of the model over time. 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. The parties' commitment to provide targeted outreach to MassHealth patients increases the likelihood of increased access for MassHealth members. The parties should prioritize meaningful action on these commitments to realize the potential for improved access to primary care. While the shift away from convenience care would reduce access to those services, the parties' commitment to maintain pediatric convenience care mitigates concerns about loss of access to these services. The proposed care model includes key elements of comprehensive primary care, with notable limitations, and MCPC's ability to deliver high-quality care in coordination with MGB would depend heavily on how the model is implemented.

The HPC will require ongoing reporting from the parties to monitor the implementation of the model over time and to assess these impacts.

These metrics will include, but are not limited to:

- Payer mix for both primary care and convenience care services at MCPC sites;
- Primary care panel size, annual volume of primary care visits, specialty referrals, and convenience care visits, and open hours by MCPC site;
- Whether each MCPC site permits qualified APPs to prescribe controlled substances;
- Reporting on MCPC's progress and timeline for joining the MGB MassHealth ACO, including whether the following capabilities have been added:
  - Video telehealth;
  - Oral health screening;
  - Full behavioral health screening;
  - Full behavioral health medication management; and
- MCPC performance on primary care quality metrics, including care coordination.

---

4 areas – quality, improvement activities, Promoting Interoperability, and cost. *Quality Payment Program: About MIPS*, U.S. CENTERS FOR MEDICARE & MEDICAID Services, https://qpp.cms.gov/get-started/what-is-mips/about-mips (last visited June 10, 2026). 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. *Overall Hospital Quality Star Rating*, U.S. CENTERS FOR MEDICARE & MEDICAID Services, https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/ (last visited June 10, 2026).

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 once the MCPC sites are operational and the new MGB rates are in effect:

> **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 $5.5 million annually.

These are conservative estimates of spending impacts once the MCPC sites are operational and the new MGB rates are in effect, based on the parties' projections of "moderate acceptance" of their model by year three of implementation, in which approximately 35% of all MCPC patients are primary care panel members. 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 because of this expansion of MGB's primary care footprint. Expanding access to primary care could result in longer-term health care savings than those incorporated in the HPC's spending estimates. The likelihood and scope of additional savings depend heavily on the successful implementation of the new MCPC model.

The parties acknowledge that a substantial portion of the likely spending impacts are due to MGB's uniquely high rates and commit to exploring ways to mitigate these impacts. The HPC looks forward to working with the parties to identify such mitigation opportunities and to monitoring the impact of the transaction on prices and spending.

Access and Quality Impact. The transition of MinuteClinic sites to MCPC primary care locations has the potential to connect up to 120,000 Massachusetts residents to a primary care provider through a novel care delivery model in a retail setting that would meaningfully expand the services that MinuteClinic provides. The magnitude of this increase in access 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. The parties' commitment to provide targeted outreach to MassHealth patients increases the likelihood that MassHealth members may have meaningfully increased access to primary care services.

CVS did not initially plan for MCPC to offer pediatric convenience care at MCPC sites but has now committed to maintain this important access point. The parties should prioritize meaningful action on their commitments to realize the potential for improved access to primary care.

Key areas of uncertainty remain regarding whether or when MCPC would provide comprehensive, high-quality primary care that would be sustainable long-term. 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. The HPC will be requiring ongoing reporting from the parties to monitor the implementation of the model over time to assess these impacts.

In summary, this transaction has the potential to increase primary care access for a substantial number of Massachusetts residents. MinuteClinic's transition to primary care has the potential to increase access to primary care services for up to 120,000 adult patients over time, with an expectation of serving approximately 42,000 primary care patients by year three. The magnitude of the increase in primary care access depends on the success of the model over time and on some key yet-to-be-determined details of implementation, such as how the parties prioritize the transition of sites in areas of greatest need and how the parties plan to ensure the provision of comprehensive primary care services.

The proposal is also likely to result in an increase to annual commercial health care spending of approximately $39.9 million once the MCPC sites are operational and the new MGB rates are in effect, assuming moderate acceptance of the model by year three. This projection includes spending increases for MCPC's new primary care patients – some of which may reflect appropriate and improved management of health conditions – as well as higher prices for both MCPC's continuing convenience care services and the convenience care services that would need to move to other providers. Spending impacts would be significantly higher if MCPC sites were each to fill their primary care patient panels to the maximum size at the new MGB rates.

The HPC welcomes the parties' new commitments to address identified concerns regarding spending and equitable access for primary care, including the commitment to maintain pediatric convenience care and to provide targeted outreach to MassHealth patients. If the parties prioritize meaningful, measurable action on the commitments offered as part of the HPC's review, concerns about affordability and equitable access highlighted in the Preliminary Report may be mitigated.

Regular reporting of relevant cost, quality, and access metrics for the MCPC sites following the transaction will 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.

These metrics include, but are not limited to: the number of MCPC APPs and other clinicians who join MGB contracts and receive MGB contracted rates over time; information about MCPC primary care and convenience care prices and price increases for commercial payers; the list of sites that receive full clinic licensure each year; primary care panel size at each MCPC site; annual volume of primary care visits, specialty referrals for primary care patients, and convenience care visits at each MCPC site; open hours by MCPC site; the payer mix of primary care and convenience care patients served at MCPC sites; which MCPC sites permit qualified APPs to prescribe controlled substances; and MCPC performance on primary care quality metrics, including care coordination. The HPC will also require reporting on MCPC's progress and timeline for joining the MGB MassHealth ACO, including whether MCPC has added video telehealth

capability, oral health screening, full behavioral health screening, and/or full behavioral health medication management.

Based on these findings, the HPC submits this report to DPH and MassHealth for consideration in connection with clinic licensure and other regulatory determinations. The HPC also submits this CMIR Final Report to the Office of the Attorney General for consideration in the context of its statutory authority under Mass. Gen. Laws ch. 12, § 11N(a), to monitor the Massachusetts health care market.

Data Appendix

C. 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.[208] 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 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.

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

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	
99214	Established patient office visit, 30-39 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%

D. 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.[209]

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.[210] The HPC used RPO data to match NPIs with 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.

---

[209] *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

[210] *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 June 10, 2026).

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.[211] 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. Additionally, previous work considered a person to have no PCP if the PCP identified for that person could not be properly attributed to a provider organization. This included all individuals attributed to APPs, as RPO has historically included affiliation information only for physicians. However, for this report, the HPC considered these people as having a PCP in the "Other" category, rather than having no PCP.

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."

E. 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

[211] For a detailed list of preventive services used, see 2025 CTR TECHNICAL APPENDIX, *supra* note 209, at 80-81.

distinct effect of attribution to a specific system, controlling for characteristics unique to a given individual 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.

F. 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[212]
- Share of non-elderly adults covered by MassHealth[213]
- Share of commercially insured adults with no primary care spending[214]
- Share of people with non-emergency ED use[215]
- ADI[216]
- HRSA Index of Medical Underservice Score[217]

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.

[212] HRSA Area Health Resource, *supra* note 179.
[213] Georgetown 2025, *supra* note 181.
[214] HPC analysis of 2023 APCD claims data.
[215] 2023 MHIS, *supra* note 180.
[216] ADI v.4.0.1, *supra* note 176.
[217] HRSA Shortage Areas, *supra* note 177. 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

Commissioners

Deborah Devaux
Chair

Martin Cohen
Vice Chair

Michael Caljouw
Commissioner of the Division of Insurance

Sandra Cotterell

Umesh Kurpad

Chris Leibman

Dr. Kiame Mahaniah
Secretary of Health and Human Services

Dr. Keith Marzilli Ericson

Dr. Alecia McGregor

Steve Walsh

James Willmuth

Executive Leadership

David Seltz
Executive Director

Coleen Elstermeyer
Deputy Executive Director

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.

MASSACHUSETTS
HEALTH POLICY COMMISSION

EXHIBIT A:

Response by Mass General Brigham and MinuteClinic Primary Care Massachusetts to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care
HPC-CMIR-2025-2
(May 15, 2026)

Response to HPC Preliminary Report

Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care

HPC-CMIR-2025-2

Statistical, Methodological, and Analytical Concerns Regarding the $40.2M Projected Spending Impact

May 15, 2026

Executive Summary

MinuteClinic Primary Care Massachusetts and Mass General Brigham respectfully submit this response to the Preliminary Report issued by the Massachusetts Health Policy Commission ("HPC") on April 16, 2026, regarding the proposed contracting affiliation between MinuteClinic Primary Care Massachusetts ("MCPC") and Mass General Brigham ("MGB").

MinuteClinic offers adult primary care today in 16 states, nearly 600 clinics, and collaborates with five Clinically Integrated Networks to bring in-network primary care to patients. This represents an evolution in MinuteClinic's model that is built on twenty years of serving the communities we serve. MCPC continues to believe a collaboration between Mass General Brigham and MinuteClinic would meaningfully benefit Massachusetts patients. This collaboration would expand access to primary care, a finding validated by the Commission's interim assessment, using the available capabilities of two trusted health care delivery organizations in the state.

The primary care access deficit in both Massachusetts and the U.S. is severe and well-documented. From patient wait times that can stretch into months to workforce pipeline challenges resulting in reductions in the numbers of PCPs available and payment models that systematically under-reimburse, the need to shore up the provision of primary care in the Commonwealth is clear. A strong and consistent body of evidence demonstrates that expanding access to primary care reduces total health care costs for patients over time, which should be considered fully when evaluating the potential collaboration. This context is particularly important in Massachusetts, where multiple official reports have highlighted that lengthy wait times for primary care appointments and overutilization of emergency departments suggest that improved access could help redirect care to more appropriate, lower-cost settings.

The Preliminary Report appears to overstate the potential impact this affiliation will have on health care spending in the Commonwealth. Review of the HPC's findings identified the following areas of concern with the approach to assessing cost spend:

1. The largest cost estimate is driven by patients who previously had no primary care provider and finally establish one; the analysis treats this as new and ongoing cost rather than overdue care those patients either should have received earlier or need to receive now.
2. The cost projections rely on assumptions about patient behavior that do not reflect how patients seek care, including assumed displacement of convenience care to more expensive settings and primary care office visits, rather than to urgent care, virtual care, or no visit at all.

In addition to the cost estimates, MinuteClinic and Mass General Brigham would like to further contextualize some of the non-cost related topics, including prescribing controlled substances and access to pediatric acute care services.

The sections below address each issue in more detail and conclude with a list of changes requested for the HPC's final report. We appreciate the opportunity to answer the questions raised by Commissioners and provide further input for this assessment.

I. The HPC's Own Research Establishes the Urgent Need for This Transaction

A. The Evidence Base on Primary Care Is Clear

Primary care is the front line for driving early detection and intervention, controlling chronic disease, reducing preventable admissions, and connecting patients to needed care. The research on its impact is consistent and substantial. States with more primary care physicians per capita have lower mortality rates; fewer hospitalizations and emergency department visits; better detection of cancer, diabetes, and hypertension at treatable stages; and lower total health care spending.[1] In one widely cited analysis, each additional primary care physician per 10,000 residents was associated with a reduction of approximately 52 deaths per 100,000 population annually.[2]

With a primary care provider, conditions like hypertension and diabetes are identified and managed early, abnormal results are addressed promptly, and referrals occur through coordinated pathways rather than fragmented self-navigation. This upstream management prevents avoidable emergency visits and hospitalizations. Preventive coordinated primary care is among the lowest cost interventions in the system, while the acute and specialty care it averts is among the most expensive.

These findings form the empirical foundation of the HPC's own policy agenda. The *Dire Diagnosis* report;[3] the Primary Care Access, Delivery, and Payment Task Force recommendations; and the Commission's call to double primary care's share of health spending within five years all rest on this evidence base. Any evaluation of this transaction that does not account for these documented benefits of expanded primary care access is analytically incomplete.

---

[1]Barbara Starfield et al., Contribution of Primary Care to Health Systems and Health, 83 Milbank Q. 457 (Sept. 2005), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC2690145/.

[2]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.

[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.

B. Massachusetts Faces a Structural Primary Care Crisis

In January 2025, the HPC published *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*. Its findings establish the context against which this transaction must be evaluated. Massachusetts is one of the wealthiest states in the country with the highest total physician-to-population ratio in the nation. And yet it faces among the worst primary care access of any state. That contradiction is not a paradox. It reflects a structural failure in how primary care is valued, compensated, and delivered.

The access deficit is severe and well-documented. A 2025 survey of physician appointment wait times found that Boston had the longest average wait for a new primary care appointment of any major metropolitan area in the country, at 69 days for a family practice appointment.[4] Forty-three percent of Massachusetts residents reported difficulty accessing medical care in 2025, with the most frequently cited reason being inability to obtain a timely appointment.[5] Approximately 15,000 patients in the MGB system alone have no attributed primary care provider and have been waiting months for an in-person appointment.[6]

The workforce pipeline driving this access deficit is structural and worsening. In 2021, only one in seven new physicians in Massachusetts entered primary care, the fourth-lowest share of all states.[7] The proportion of physicians choosing primary care six to eight years after graduation declined from 22% in 2023 to 19.2% in 2024.[8] Nearly half of Massachusetts physicians in office-based primary care settings are 55 or older, with only 8% under 35.[9] A significant wave of retirements is approaching without a sufficient pipeline behind it. The share of nurse practitioners working in office-based settings fell from 26% in 2018 to 21% in 2022, compressing even the APP-based safety valve.[10] Commercial spending on primary care declined from 8.4% of total commercial spending in 2017 to 7.5% in 2022, growing at half the rate of all other medical services.[11]

The structural causes of this crisis are interconnected. Primary care is systematically under-reimbursed relative to procedural specialties: A 20-minute visit that catches early-stage hypertension and prevents a future stroke is reimbursed at a fraction of the interventional care required after the stroke occurs. Administrative burden falls disproportionately on primary care,

---

[4]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/.

[5]Ctr. for Health Info. & Analysis, Findings from the 2025 Massachusetts Health Insurance Survey (Dec. 2025) [hereinafter 2025 MHIS], available at https://www.chiamass.gov/assets/docs/r/survey/MHIS-2025/2025-MHIS-Report.pdf.

[6]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/.

[7]Dire Diagnosis, supra note 3, at 18.

[8]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.

[9]Dire Diagnosis, supra note 3, at 9.

[10]Dire Diagnosis, supra note 3, at 38.

[11]Dire Diagnosis, supra note 3, at 13.

with studies finding that clinicians spend one to two hours on documentation and administrative tasks for every hour of direct patient care.[12] These factors drive both entry-level diversion from the field and mid-career exits.

The consequences are distributed unequally. Hispanic and Black non-Hispanic residents in Massachusetts used the emergency department for non-emergency conditions at rates of 39.9% and 52.4% respectively, compared to 30.4% for White non-Hispanic residents.[13] The HPC's own survey data indicate that primary care access barriers are the primary driver of this disparity. Approximately 40% of emergency department visits in Massachusetts between 2016 and 2023 were for conditions that could have been prevented with timely primary care or treated in a primary care setting.[14] The geographic distribution of the deficit is also pronounced: Central and western Massachusetts, Bristol County, Hampden County, and Plymouth County have substantially fewer PCPs per capita and higher rates of unattributed patients than the Boston metropolitan area.

C. The MCPC Model Is a Direct Response to the HPC's Own Recommendations

The *Dire Diagnosis* report called for three principal reforms: reducing administrative burden on primary care clinicians, strengthening the primary care provider pipeline with explicit emphasis on advanced practice providers, and increasing investment in primary care capacity. The MCPC model is designed to advance all three.

MinuteClinic's centralized management services organization absorbs the scheduling, prior authorization, referral management, and results follow-up functions that the HPC identified as root causes of clinician burnout and workforce exit. The APP-led model leverages precisely the workforce category the HPC highlighted as essential to primary care's future given the declining physician pipeline. The conversion of 37 existing convenience care retail locations to longitudinal primary care represents a material expansion of capacity in the communities the HPC's own geographic analysis identified as having the greatest unmet need.

A cost analysis that characterizes this transaction primarily as a spending problem, without equivalent rigor in quantifying its benefits to patients, providers, and the broader health care system, is not consistent with the Commission's own stated priorities or with the evidence base they have assembled.

---

[12]Dire Diagnosis, supra note 3, at 35–36. See also Nat'l Academies of Sciences, Engineering, & Med., Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being (2019); Mass. Med. Soc., Supporting MMS Physicians' Well-Being Report (March 2023).

[13]Ctr. for Health Info. & Analysis, Primary Care in Massachusetts Databook (Jan. 2023) [hereinafter CHIA Primary Care Databook], available at https://www.chiamass.gov/assets/docs/r/pubs/2023/MA-PC-Dashboard-Databook-2023-v2.xlsx.

[14]2025 MHIS, supra note 5; Dire Diagnosis, supra note 3.

II. Clarifications on the HPC's Access and Quality Characterizations

The Preliminary Report raises two specific access and quality concerns that MCPC wishes to address directly: the decision not to prescribe controlled substances, and the near-term discontinuation of pediatric convenience care at transitioning sites. Each is characterized in the Preliminary Report in a way that warrants clarification.

A. The Decision Not to Prescribe Controlled Substances Is a Design Choice

The Preliminary Report characterizes MCPC's decision not to prescribe controlled substances as a scope limitation that creates uncertainty about MCPC's ability to offer comprehensive primary care.[15] MCPC respectfully disagrees with this characterization. The decision is a considered design choice, grounded in the population MCPC will serve and the phased development of the practice model.

MCPC is built as a longitudinal primary care model for adults who currently have no primary care provider. The majority of conditions those patients present with, including hypertension, diabetes, hyperlipidemia, depression, preventive care needs, and care coordination, do not involve controlled substance prescribing. The model is built to support that population and those conditions at launch; having our providers maintain DEA licensure and building the infrastructure to compliantly prescribe these substances introduces administrative complexities and costs at this stage. Once live, our practice will monitor its ability to effectively care for patients and continually evaluate the need to expand scope to prescribe controlled substances.

For patients who have conditions that require controlled substance management, MCPC providers will identify the need, initiate the appropriate referral, and manage the handoff through the centralized care coordination. The patient will be free to choose the specialty provider of their choice (whether at MGB or any other location in the Commonwealth). Closed-loop referral management is a core function of the MCPC model. This approach is consistent with how the broader primary care system manages conditions that fall outside a given practice's scope. The ability to recognize a clinical need and connect the patient to the appropriate resource is itself a central primary care function, and MCPC is well-positioned to perform it.

MinuteClinic and MGB respectfully request that the Final Report reflect this distinction: The decision not to prescribe controlled substances is a scope definition suited to MCPC's intended patient population that supports our current operations, not a gap in the model's design, which MinuteClinic will continue to evaluate and expand services as the practice matures.

[15]Preliminary Report at 54.

B. The Near-Term Discontinuation of Pediatric Convenience Care Reflects Massachusetts's Unique Regulatory Structure

The Preliminary Report identifies the loss of pediatric convenience care as a risk to access[16] and notes that MCPC's decision to limit services to adults reflects an operational or business decision.[17] To the contrary, this reflects MinuteClinic's understanding of Massachusetts' regulations. In fact, MinuteClinic has retained access to pediatric convenience care in every other state where the practice has expanded into primary care.

Based on MinuteClinic's understanding of Massachusetts regulations, the state does not permit a provider to hold both a limited services clinic license and a full clinic license at the same site simultaneously.[18] As we convert sites to primary care, the limited services license and current scope of services, including pediatric convenience care, cannot be retained.

MinuteClinic will work with the Massachusetts Department of Health to confirm our understanding of state regulations and discuss options to preserve our acute care and primary care practices in the Commonwealth.

MinuteClinic and MGB request that the Final Report recognize the Massachusetts-specific regulatory constraint that is the primary driver of the near-term pediatric impact, rather than characterizing the outcome solely as a MinuteClinic business or operational preference. If permitted by the Commonwealth, MinuteClinic will maintain convenience care and continue to serve children.

C. Timeline to Participate as a Medicaid Tier 1 Provider

MinuteClinic Primary Care intends to offer Medicaid patients access to primary care at launch. Timing of our participation in the MassHealth Primary Care Sub-Capitation Program will depend on two key factors:

1. The ability to establish an attributed patient population with baseline performance data.

2. Regulatory timelines for enrollment in MGB's MassHealth ACO program. We anticipate requiring at least one year of full operational status as a primary care practice in Massachusetts before joining the MassHealth ACO.

Based on the state's defined clinical requirements, MinuteClinic Primary Care expects to participate as a Tier 1 practice. As the practice establishes its Medicaid population, it will assess the timeline to expand its service offerings to meet all Tier 1 requirements, including oral health screens and expanded behavioral health screenings. MinuteClinic is committed to working with

[16]Preliminary Report at 48–49

[17]Preliminary Report at 20, fn. 78.

[18]Preliminary Report at 20, fn. 78 ("Providers cannot hold licenses for both a limited services clinic and a full clinic at the same site")..

MGB and state partners to phase in these capabilities over time as patient volume and operational readiness support sustainable delivery.

D. Long-Term Sustainability of The Model, Particularly With Respect to Staffing, Training, and the Historical Performance of the Retail Clinic Model

The MCPC primary care practice model is grounded in a proven care delivery framework, a scalable workforce strategy, and over 15 years of performance in convenient, community-based settings. As part of a national strategy, MinuteClinic has expanded adult primary care to nearly 600 clinics to date. By leveraging existing clinical infrastructure and physical locations, we are transitioning to a primary care offering without geographic expansion, enabling strategic growth and increasing primary care access for the Commonwealth. To protect against over-extending our financial and operational resources, MinuteClinic is phasing clinic conversion over a multi-year period.

MinuteClinic currently serves approximately 200,000 patients annually across the Commonwealth, providing a strong and trusted foundation on which to build primary care relationships. This existing patient volume and brand recognition significantly reduces the risks typically associated with launching new primary care practices. This coupled with an MGB affiliation will support our practice in converting from a fee-for-service construct to value-based, incenting high-quality, cost-effective care.

From a staffing and training perspective, our model intentionally builds on an established, APP-led workforce. This approach offers an innovative and sustainable alternative to a traditional physician-only primary care model and helps address the growing shortage of primary care physicians. Our APPs are supported by standardized clinical protocols, robust training, board-certified collaborating physicians, and integrated care pathways, allowing them to practice at the top of their license while maintaining high quality and consistency of care.

Finally, consumer demand supports the long-term viability of this model with 65% of patients surveyed in CVS stores reacting positively to having access to primary care at MinuteClinic, reinforcing that patients value accessible, convenient, and trusted sites of care.

E. Site Selection and Phased Rollout, Especially as Tied to Areas of Unmet Need (*Springfield, Palmer, Carver, Marshfield, and Fall River)*

DPH licensure and level of investment will decide the pace at which expansion can progress. There will be a phased roll-out based on the capital budget. At this stage, funding supports approximately 5 clinics in year 1 with the number of added clinics in subsequent years based on success of the model, speed at which licensure is secured, and available funding. Current projections have a full transition to primary care within 2-3 years.

While phase 1 clinics have not been identified yet, criteria for clinic selection include:

- Current Patient Volume
- Capital Investment needed to meet state licensure requirements
- Geographic distribution with emphasis on underserved communities
- Clinic proximity to provide adequate access to pediatric populations (pending further clarification from DPH)

F. Market Consideration: MGB Market Concentration and Leverage with Expanded Footprint Via MinuteClinic Primary Care

The clinic footprint expands beyond the MGB service area. While we are excited to partner with MGB to increase high-quality primary care in the Commonwealth, our referrals to specialty care are managed by our Referral Coordinator team. They collaborate with both the patient and the payer to identify an in-network provider within the patient's preferred geographic area. All referrals honor and maintain the patient's preferences.

III. HPC Financial Impact Analysis

The Preliminary Report presents a number of statistical and methodological approaches that, taken together, cause the $40.2 million headline estimate to overstate the transaction's likely cost impact by a substantial margin. These are not minor technical issues; they affect the study design, the cohort definition, the counterfactual, and the cost-benefit framework.

Two overarching concerns drive our response:

- The primary care spending estimate ($27.7M) contains a fundamental statistical error: The study design cannot establish causal identification because the treatment variable (gaining a PCP) is endogenously driven by health status changes that member fixed effects cannot absorb. Additional problems with the study's methods further exaggerate the findings, including relying on a time period that both reflects the sharp disruptions during the COVID-19 pandemic and the rebound in utilization post-pandemic.
- The diversion ($5.9M) component rests on assumptions about substitution behavior that are inconsistent with clinical practice and with the HPC's own data.

With the above corrections incorporated into the HPC's methodology, estimated cost impact of this affiliation drops from $40.2M to ~ $13.8M - $22.3M.

HPC Mechanism	HPC Estimate	Concern with Methodology	Adjusted Range
Repricing convenience care	$6.6M	Generally aligned with repricing assumptions	$6.6M (no adjustment)
Spending for new primary care patients	$27.7M	Reverse causation; front-loaded window; wrong counterfactual; attribution methodology change	$4.1M to $12.6M (using HPC's own fn. 119 data)
Diversion to other providers	$5.9M	Office visit codes excluded from comparator pool; capacity constraints ignored	$3.1M (HPC sensitivity)
Total Impact	**$40.2M**	**Cumulative overstatement; double counting across components**	~$13.8M-$22.3M

A. The $27.7M Primary Care Spending Estimate: One Fundamental Error and Additional Supporting Concerns

The primary care spending estimate accounts for over two-thirds of the headline figure. The HPC derives it as follows: 34,020 projected MCPC commercial primary care patients, multiplied by a $650 per-member-per-year (PMPY) net claims spending increase[19] and $165 PMPY in non-claims payments.[20] The $650 figure comes from a regression analysis comparing members in the MinuteClinic primary service area who had no PCP and either remained unattributed or became attributed to an MGB contracting affiliate between 2019 and 2023.

MCPC's concerns with this estimate fall into two categories. Section III.A describes a fundamental statistical error in the study design that cannot be resolved through adjustments at the margin. Sections III.B and III.C describe additional methodological concerns that compound the overstatement.

A Fundamental Statistical Error: The Study Design Cannot Isolate the Effect It Claims to Measure

The HPC's identification strategy has a selection bias problem that member fixed effects are structurally incapable of solving. The report relies on within-person before/after comparisons, claiming that member fixed effects control for health status. This is true for *time-invariant* health status. It is not true for *time-varying* health status, which is precisely the confounder at issue here.

[19]HPC Preliminary Report, HPC-CMIR-2025-2 (Apr. 16, 2026) [hereinafter Preliminary Report] at 36.
[20]Preliminary Report at 37.

The core problem is that the supposedly independent variable, gaining a PCP, is not independent. It is endogenously timed: People go from not having a PCP to having a PCP because of a new diagnosis, a medical scare, anticipation of future health needs, or worsening of an existing condition. These are exactly the circumstances that also cause spending to rise. Member fixed effects absorb stable characteristics like age and general health baseline. They do not absorb the specific event that caused an individual to seek a PCP at time T rather than time T-1.

To put it plainly: If people acquired a PCP randomly, the methodology would work. But PCP acquisition is not random. It is health-driven. A pre/post design that does not account for health-driven selection will always conflate two distinct effects:

- The MGB-specific effect of prices, referral patterns, and care management that the HPC wants to measure.
- A reverse causation effect: spending driven by the health circumstances that prompted the patient to seek a PCP in the first place.

A matched event study with a difference-in-differences analysis, using an event window around the year of attribution, a properly matched control group of members who did not gain a PCP (rather than within-person fixed effects alone), and an explicit test for parallel pre-trends between the treatment and control samples before the attribution event would be the standard practice for causal inference from observational data. The HPC has the APCD data required to implement it.

Given the model used, the $650 PMPY estimate cannot be interpreted as the causal effect of MCPC affiliation on spending. It is an association that includes an unknown but potentially substantial reverse-causation component. To illustrate: If reverse causation accounts for 30% of the $650 figure, the $27.7M impact decreases by approximately $8M. The true share is unknown, which is the point.

Additional Methodological Concerns

Each of the following concerns independently overstates the $27.7M estimate. In combination with the fundamental identification failure described in Section III.A, they further reduce confidence in the $650 PMPY figure.

Good Spending Is Conflated with Price-Driven Spending

The $650 PMPY estimate does not distinguish between appropriate, evidence-based utilization that occurs when a previously unattributed patient gains access to primary care, such as wellness visits, screenings, and chronic disease management, and price-driven spending resulting from care being delivered at MGB's comparatively higher rates. These reflect very

different policy outcomes. The first is spending the HPC's own *Dire Diagnosis* report and Primary Care Task Force have called urgently necessary. The second is the incremental cost attributable to MGB pricing.

The HPC's own data make this decomposition tractable. Footnote 119 of the Preliminary Report discloses that the spending impact for members switching to the ten largest non-MGB provider organizations ranges from $280 to $530 PMPY.[21] The midpoint of that range, approximately $405 PMPY, represents the utilization-driven component that would occur with any PCP attribution. The MGB-specific premium (presumably made up of both MGB-specific price and MGB-specific utilization) is therefore approximately $245 PMPY, or 38% of the $650 figure. To the extent that any of the $245 PMPY is MGB-specific utilization, that may also be due to differential pre-period risk levels between patients who choose MGB-affiliated PCPs and patients who choose otherwise affiliated PCPs, so the $245 PMPY may be overstated as well.

Adjusted Range Using HPC's Own Footnote 119 Data

MGB-specific incremental impact: $650 minus $280 to $530 = $120 to $370 PMPY. Applied to 34,020 members:

- Adjusted range: $4.1M to $12.6M, a 37% to 85% reduction from $27.7M.
- Approximately 62% of the $27.7M headline, roughly $17M, reflects utilization the Commission's own policy agenda calls for. A framework that counts this as a cost to minimize is in direct tension with the HPC's stated goal of doubling primary care's share of health spending within five years.

MCPC Patients Are Lower-Complexity Than the Regression Population

The regression uses members who actively chose to obtain a PCP at an MGB contracting affiliate. MCPC will recruit its panels through existing channels. This recruitment methodology differs structurally from health-motivated PCP selection. The HPC acknowledges that MCPC's expected patients will be lower complexity but applies the $650 PMPY figure uniformly without stratification by risk score or comorbidity burden.[22] The HPC has HCC risk scores and chronic

[21]Preliminary Report at 36, fn. 119. Note: Footnote 117 of the Preliminary Report addresses a separate point, stating that the $650 estimate may be conservative relative to the HSA TME comparison. The $280 to $530 PMPY range for non-MGB provider organizations appears in footnote 119.

[22]Preliminary Report at 21 (acknowledging that MCPC's new primary care patients are expected to be lower-complexity and would not require a substantial amount of downstream specialist referrals); id. at 36, fn. 116 (noting 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").

condition flags in the APCD. A stratified sensitivity analysis is straightforward and has not been presented.

Additionally, the HPC narrowed its attribution methodology for this report relative to prior analyses. The 2025 Cost Trends Report Technical Appendix (pages 79 to 81) used sick-visit providers and pharmacy prescribers as additional attribution proxies. For this report, the HPC states that any member not attributed through the two primary methods "were considered unattributed" (page 62).[23] This mechanically expands the no-PCP pool. If 10% to 20% of members classified as unattributed under this report's narrower definition would have been attributed under the standard methodology, the $27.7M estimate decreases by approximately $2.2M to $4.4M. The HPC should explain this change and present a sensitivity using the prior approach.

A related issue: Figure III.A.2 shows that 22% of Massachusetts primary care visits are delivered by APPs not attributable to any named organization in the MA-RPO data. This is the single largest category in the market share table. Members receiving ongoing primary care from these providers are classified as having no PCP, which biases the control group and inflates the estimated spending change.

The Observation Window Encompasses COVID Disruption and Is Front-Loaded

The 2019 to 2023 observation window spans the acute COVID-19 disruption and the post-pandemic utilization rebound. With approximately two years of post-attribution data on average (footnote 116),[24] the $650 figure is heavily influenced by Year 1 spending, which is structurally elevated due to catch-up utilization for patients who had deferred care. If Year 2 and beyond spending is materially lower, the persistent-annual framing overstates steady-state cost. For illustration, if Year 1 spending runs roughly 20% above Year 2 due to deferred-care catch-up, anchoring the projection on the blended average rather than the Year 2+ run-rate could overstate the steady-state effect by a meaningful margin. The HPC has not presented results excluding 2020 and 2021, nor event-time estimates that would reveal whether the coefficient declines over time.

B. The $5.9M Diversion Estimate Contains Multiple Overstating Assumptions

The HPC estimates $5.9M in additional spending from convenience care patients who will seek care elsewhere as MCPC capacity shifts to primary care.[25] The estimate assumes that 45% of

[23]Preliminary Report, Data Appendix at 62–63.
[24]Preliminary Report at 36, fn. 116.
[25]Preliminary Report at 38–39.

existing MinuteClinic visits are displaced and that displaced patients divert to other providers at a 94% weighted-average price premium. Both assumptions appear to be overstated.

The Comparator Pool Was Built by Excluding Lower-Cost Alternatives

To identify where diverted patients would seek care, the HPC matched on MinuteClinic billing codes, but excluded all office-visit CPT codes from the matching exercise on the grounds that they are too broadly used.[26] Office-visit codes account for 41% of MinuteClinic volume. These codes, had they been included, would have matched primarily to physician office visits, which are lower cost than urgent care centers and hospital outpatient departments. Excluding them before building the comparator pool results in a pool that skews toward higher-cost alternatives.

The HPC's own sensitivity analysis at footnote 127 is revealing: Limiting diversion entirely to urgent care reduces the estimated impact from $5.9M to $3.1M.[27] That nearly 50% reduction from a single assumption change illustrates how sensitive the estimate is to comparator selection.

Not All Displaced Volume Requires External Diversion

At least 40% of current MinuteClinic visits are non-vaccine, non-viral-testing services that map directly onto primary care. For MCPC panel members, these visits will be served within the MCPC model itself, not diverted to another provider. The HPC's calculation treats the entire 45% of displaced volume as requiring external substitution. As a result, this double-counts volume that reclassifies within the site.

Capacity Constraints Prevent Full Substitution

The diversion model assumes all displaced patients will find alternative care. This is in tension with the HPC's own findings throughout the Preliminary Report: Boston has the longest new-patient appointment wait times among major U.S. metro areas, 43% of Massachusetts residents report difficulty accessing timely care, and 15,000 patients on MGB's waitlist alone cannot obtain a PCP. The primary care system the HPC describes as severely capacity-constrained cannot simultaneously absorb 67% of MinuteClinic's displaced volume. In practice, low-acuity care will be substituted with home testing (widely available for COVID-19, influenza, and strep) or virtual care. None of these pathways carry the price premium applied in the HPC's model.

C. The Three Components Double-Count Overlapping Patient Populations

The HPC's model treats the 34,020 primary care panel members and 63,180 convenience care patients as mutually exclusive populations. They are not. Convenience care patients transition

[26]Preliminary Report at 59–60 (Data Appendix, Appendix A).
[27]Preliminary Report at 38, fn. 127.

into primary care panels (approximately 8,400 per year in the HPC's model), meaning a portion of these individuals will be counted in both groups over the projection period.

Additionally, the HPC assumes that 67% of the 51,030 diverted convenience care visits flow to physician offices. To the extent those patients establish ongoing PCP relationships as a result, the pool of members available to generate the $27.7M primary care component decreases correspondingly. The potential offsetting effect is up to $5.6M. Even a conservative estimate of the overlap implies approximately $660K of overstatement on the $6.6M repricing component. The HPC should reconcile the patient populations across all three components and eliminate double counting before presenting a total figure.

D. Quantifiable Benefits the HPC Framework Does Not Address

[28] The HPC's own 2023 Cost Trends Report quantified the benefit of this proposed transaction at $9.7M.[29] The HPC further notes that approximately two-fifths of ED visits are for conditions preventable or treatable with timely primary care access.[30] The mechanism for achieving this reduction is exactly what MCPC provides: 34,000 adults who currently lack a PCP gaining access to one.

Other Quantifiable Benefits Are Not Addressed

The analytical asymmetry extends beyond the ED savings figure. The HPC does not assign dollar values to:

- Providing primary care access to up to 42,000 adults who currently have none, including patients on MGB's waitlist.
- Chronic disease management for patients whose conditions are currently unmonitored, reducing downstream hospitalization.
- Reduction in racial and ethnic disparities in primary care access, given the HPC's documented finding that Hispanic and Black residents use the ED for non-emergency conditions at nearly double the rate of white residents.
- Extended evening and weekend hours that address the appointment access barriers the HPC identified as the leading driver of difficulty accessing care.

The *Dire Diagnosis* report cites research that states with more primary care physicians have lower mortality, fewer ED visits and hospitalizations, and lower total health care costs. These are empirically grounded findings from the HPC's literature review. A Final Report that projects

[28]Preliminary Report at 41, fn. 138.
[29]Health Policy Comm'n, 2023 Annual Health Care Cost Trends Report and Policy Recommendations (Sept. 2025) at 46.
[30]Dire Diagnosis, supra note 3, at 28.

$40.2M in spending increases without netting against these documented benefits presents an incomplete and potentially misleading picture of the transaction's estimated net impact.

IV. The Report Does Not Provide Sufficient Information for Independent Verification

With the $40.2M estimate being an important factor in the outcome of this transaction, it's important to highlight MinuteClinic and MGB cannot independently verify or challenge the estimate because the following information is absent from the Preliminary Report:

Model specification: The full regression equation is not disclosed. The report references OLS with fixed effects but does not specify:

- Which fixed effects are included beyond member and year.
- Whether random effects or a hierarchical model structure was considered.
- Whether the dependent variable (total commercial spending) is log-transformed, adjusted to reduce outliers, or modeled in levels.
- Which time-varying covariates are included (risk scores, comorbidity indices, chronic condition flags).
- Whether there is an interaction between attribution timing and spending, or the clustering level for standard errors.

Model outputs and diagnostics: No standard errors, confidence intervals, p-values, model fit statistics, or residual diagnostics are reported for any of the three component estimates or the $40.2M total. There is no comparison across alternative model specifications. The Commission presents a point estimate of $650 PMPY without reporting whether it is statistically distinguishable from $400 or $900.

Sample construction: The report does not disclose 1) how many members were in the initial sample prior to exclusions, 2) how many were removed under each filter (i.e., top 5% of spenders excluded, multiple switchers removed), or 3) the distribution of post-attribution observation lengths (how many members have one or multiple years of follow-up data).[31]

The top 5% spending exclusion threshold is not reported. No sensitivity analysis tests how the $650 estimate changes under alternative exclusion thresholds of 1%, 3%, or 10%.

[31]Preliminary Report at 62.

Counterfactual and sensitivity range: Only one upward sensitivity is disclosed: the $76.2M estimate under full panel fill.[32] No downward sensitivity is presented. The $280 to $530 PMPY range is disclosed in footnote 119 but is not applied as an alternative counterfactual in the body of the analysis.[33] We respectfully request The Commission present a complete range of scenarios, including those in which the transaction's net impact is neutral or beneficial.

Replication: We believe a determination that informs the partnership of two health care organizations should include reproducibility. Based on the information disclosed in the Preliminary Report, an independent analyst could not reproduce any of the three component estimates. There is no code, pseudocode, or algorithmic description provided. Nor is a data dictionary for the APCD variables used included.

Requests for the Final Report

MinuteClinic and MGB respectfully request that the Health Policy Commission's Final Report acknowledge the limitations in their methodology and assumptions underlying the Preliminary estimates that bias the projected cost impact upward. In particular, the Final Report should:

1. **Clarify the limits of causal inference** in the analysis, recognizing that the design cannot fully separate the effects of PCP attachment from the underlying health needs that lead patients to seek primary care, and that this may overstate attributed spending increases. Where feasible, the Final Report should also describe alternative designs - such as event-study or instrumental-variable approaches - that could better isolate the causal effect of attachment from selection.
2. **Acknowledge that observed spending growth reflects expected and clinically appropriate utilization**, as previously unattached patients access preventive, diagnostic, and chronic care services, rather than increases driven by price or ownership effects.
3. **Recognize that the primary care spending estimate represents an upper-bound application**, given the assumption that patients would otherwise obtain care at providers with materially lower spending differentials than those applied in the analysis.
4. **Note that uniform spending assumptions were applied across patient populations with differing acuity**, despite evidence that the anticipated MCPC patient population is lower acuity on average, which may inflate aggregate projections.
5. **Describe the potential influence of the COVID-era observation window**, including the likelihood that post-pandemic catch-up care disproportionately affects the measured spending estimates.

[32]Preliminary Report at 39, fn. 128.
[33]Preliminary Report at 36, fn. 119.

6. **Acknowledge the uncertainty inherent in repricing and diversion assumptions**, particularly with respect to future service mix, substitution behavior, and capacity constraints.
7. **Recognize the potential for overlapping effects across analytical components**, increasing the risk that utilization is reflected in more than one spending mechanism.
8. **Characterize the controlled substance prescribing decision more precisely** in the Final Report as a considered scope definition suited to MCPC's intended patient population, noting that referral with closed-loop follow-up is the appropriate mechanism for patients requiring controlled substance management.
9. **Recognize the Massachusetts-specific regulatory constraint on pediatric care** and acknowledge MinuteClinic's plan to serve this population if feasible in the Final Report. The Final Report should reflect that this constraint will be explored in coordination with the Department of Public Health.
10. **Commit to independent verification of the cost-impact estimates** - including peer review or third-party replication of the analytic methodology and inputs - before the Final Report is used to inform regulatory or licensing decisions.

MinuteClinic and MGB believe that acknowledging these limitations will provide additional context for interpretation of the Preliminary Findings and better inform policymakers and the public regarding the magnitude, uncertainty, and likely direction of the projected impacts.

Conclusion

The Commonwealth is confronting a deepening primary care shortage, driven by workforce constraints, practice consolidation, and the continued retreat of many traditional providers from primary care altogether. In that context, there are few proposals that aim to scale access in a meaningful way, particularly in communities where patients already struggle to secure timely appointments. As Governor Healey noted in her 2025 State of the Commonwealth address, the goal should be to "build a whole army of primary care providers… so that when you call for an appointment, you'll get one. You'll get the affordable care you need, where and when you need it."[34] MinuteClinic's expansion into primary care represents one such responsible and pragmatic step toward that goal, leveraging a convenient and familiar site of care to meet patients where they are. While this approach may not satisfy every view of what primary care expansion ought to entail, continued inaction risks exacerbating access challenges that the existing delivery system has thus far been unable to solve.

[34] http://www.mass.gov/doc/healey-state-of-the-commonwealth-address-2025-as-prepared/download (page 7)

MinuteClinic and Mass General Brigham are committed to expanding access to high-quality, affordable primary care in Massachusetts. Both organizations welcome rigorous analytical review and will continue to work with the Commission to align on the methodology to assess cost impact, work to preserve affordability, and address additional quality concerns for the final report.

Respectfully submitted,

MinuteClinic Primary Care Massachusetts
One CVS Drive, Woonsocket, RI 02895

Mass General Brigham
399 Revolution Dr., Somerville, MA 02145

May 15, 2026

EXHIBIT B:

Commitments by Mass General Brigham and MinuteClinic Primary Care Massachusetts in Response to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care

HPC-CMIR-2025-2

(June 5, 2026)

Exhibit B: Commitments by Mass General Brigham and MinuteClinic Primary Care Massachusetts in Response to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care HPC-CMIR-2025-2 (June 5, 2026)

1. MinuteClinic Primary Care ("MCPC") commits to working with DPH to address any regulatory considerations as needed to maintain access to pediatric convenience care services at all MinuteClinic locations, including after their transition to MCPC locations.
2. MCPC commits to ongoing monitoring and evaluation of patient need for controlled substance prescribing within its primary care population. MCPC will track and assess referral patterns for patients with conditions that may require controlled substance management and will provide annual reporting to the HPC on such referrals. Consistent with its patient-centered care model, MCPC further commits to developing and implementing controlled substance prescribing capabilities in a measured and clinically appropriate manner should a demonstrable and sustained patient need be identified.
3. MCPC commits to prioritizing the evaluation of MinuteClinic locations in Massachusetts identified by the HPC as having the greatest unmet need for primary care for conversion to full clinic licensure, subject to a site-specific assessment of the feasibility to meet Department of Public Health (DPH) clinic licensure standards.
4. MCPC commits to developing and implementing an outreach plan specifically for MassHealth patients and other underserved populations, and to otherwise work to expand MinuteClinic's proportion of MassHealth and other government payer populations.
5. MassGeneral Brigham ("MGB") and MCPC commit to exploring ways to mitigate the spending impact of MCPC APPs joining MGB contracts, such as by phasing in the migration of MCPC APPs to the MGB contracted rate schedule over two years, prioritizing in a manner consistent with the transition of MCPC sites to the MCPC Primary Care model.

EXHIBIT C:
HPC Analysis of the Parties' Joint Response to the Preliminary Report and Party Commitments

Exhibit C: HPC Analysis of Parties' Joint Response to Preliminary Report

This document analyzes and addresses the principal topics raised in the May 15, 2026 response of Mass General Brigham and MinuteClinic Primary Care (Joint Response)[1] to the HPC's Preliminary CMIR Report (Preliminary Report)[2] as well as the parties' commitments in connection with the transaction, provided to the HPC on June 5, 2026 (Party Commitments).[3]

The HPC invited the parties to provide additional details regarding significant outstanding questions and concerns raised in the Preliminary Report and at the April 16, 2026 meeting of the HPC Board.[4] The parties were also invited to offer commitments regarding mitigation of identified spending impacts, as well as commitments to maximize the potential for improved access to high-quality care. At that Board meeting, commissioners suggested that spending impacts could be mitigated, for example, by delaying MCPC's receipt of higher MGB rates until the successful establishment of its primary care model.

Commissioners also specifically asked the parties to provide clarification regarding:

- The rationale behind the decision to eliminate pediatric convenience care;
- If and when MCPC would prescribe certain controlled substances, such as for behavioral health, and any plans over time to incorporate more behavioral health and substance use treatment; and
- How MCPC would expand access to primary care for MassHealth members, given MinuteClinic's current low MassHealth payer mix.

The parties address some of these topics in the Joint Response. The parties also make additional commitments to mitigate identified concerns regarding spending and equitable access to primary care, particularly for underserved populations, and to address limitations in the model's provision of comprehensive primary care (as documented in the Party Commitments, see Exhibit B). The HPC appreciates the parties' willingness to work with the Commonwealth by offering commitments to help maximize the benefits of the transaction and minimize some of the concerning impacts. Because the parties propose a novel model for providing primary care in the state, it will also be important for the Commonwealth to monitor the implementation of this new model and its impacts on health care costs, quality, and equitable access. To that end, the HPC is requiring certain ongoing reporting from the parties, as described in greater detail in the Final Report.

The remainder of this document addresses specific elements of the Joint Response in more detail and identifies updates to the Final Report. The HPC concurrently issues the Final Report containing

---

[1] Exh. A: Response by Mass General Brigham and MinuteClinic Primary Care Massachusetts to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care HPC-CMIR-2025-2 (May 15, 2026) [hereinafter Joint Response].

[2] MASS. HEALTH POLICY COMM'N, PRELIMINARY REPORT: COST AND MARKET IMPACT REVIEW OF MASS GENERAL BRIGHAM AND CVS MINUTECLINIC PRIMARY CARE (HPC-CMIR-2025-2), (April 16, 2026) [hereinafter PRELIMINARY REPORT], *available at* https://masshpc.gov/sites/default/files/MGB-CVS-Report-Combined-Prelim_acc.pdf (last visited June 3, 2026).

[3] Exh. B: Commitments by Mass General Brigham and MinuteClinic Primary Care Massachusetts in Response to HPC Preliminary Report Cost and Market Impact Review of Mass General Brigham and MinuteClinic Primary Care HPC-CMIR-2025-2 (June 5, 2026) [hereinafter Party Commitments].

[4] *See* HPC Board Meeting Materials, April 16, 2026. Available at https://masshpc.gov/meetings/board-meeting/april-16-2026.

data-driven analysis of this transaction to inform the work of other state agencies as well as the public, which ultimately bears the cost of our health care system.[5]

I. Need for Primary Care Capacity. Additional primary care capacity is urgently needed, but Massachusetts is also facing an affordability crisis that must be considered alongside this proposal.

In their Joint Response, the parties describe the primary care crisis and need for additional primary care capacity in Massachusetts, citing work by HPC and others and arguing that the conversion of MinuteClinic to MCPC is designed to help alleviate primary care capacity constraints in direct response to HPC recommendations.

As described in both the Preliminary and Final Reports, and in past publications like the HPC's *Dire Diagnosis* report cited by the parties, the HPC agrees that Massachusetts is in need of more primary care providers and greater and more equitable patient access to high-quality primary care. The parties' proposal has the potential to connect up to 120,000 Massachusetts residents to a primary care provider. 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 – without compromising the goals of health care affordability.[6]

Recognizing these simultaneous challenges of expanding access to primary care while improving the affordability of health care, significant changes to the health care system such as those proposed here – converting the CVS MinuteClinic locations to primary care practices within the MGB network and receiving MGB prices – must be evaluated closely. These competing challenges underlie the HPC's charge to detail the likely impact of significant market changes on health care spending, quality, and equitable access. The HPC's review process and public CMIR reports support robust and informed public discussion about how best to address such simultaneous challenges, including whether likely benefits of a transaction outweigh likely costs, the inherent risks, and how the transaction may be structured to maximize the benefits and reduce the costs.

The HPC released its Preliminary Report to further that public dialogue and to allow the parties to offer commitments to enhance the benefits of the transaction, while mitigating projected costs. The HPC appreciates the parties' willingness in its subsequent public commitments, as documented in Exhibit B, to engage with the Commonwealth to help ensure that primary care is expanded meaningfully and equitably in the state, and to reduce the immediate impact of likely spending increases.

---

[5] MASS. HEALTH POLICY COMM'N, FINAL REPORT: COST AND MARKET IMPACT REVIEW OF MASS GENERAL BRIGHAM AND CVS MINUTECLINIC PRIMARY CARE (HPC-CMIR-2025-2), (May 11, 2026), [hereinafter FINAL REPORT].

[6] This principle has been strongly endorsed by the state's Primary Care Access, Delivery, and Payment Task Force, which stated that any 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. *See* 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 June 10, 2026).

II. Cost and Market Impact. The parties acknowledge in the Joint Response that a substantial proportion of the likely spending impacts identified by the HPC are due to MGB's uniquely high rates and commit to exploring ways to mitigate these spending impacts. The parties' critique misstates key elements of the HPC's methodology and does not change the HPC's core conclusions.

Although not referenced in the Joint Response, the parties subsequently committed to "exploring ways to mitigate the spending impact of MCPC APPs joining MGB contracts, such as by phasing in the migration of MCPC APPs to the MGB contracted rate schedule over two years, prioritizing in a manner consistent with the transition of MCPC sites to the MCPC Primary Care model."[7] The HPC appreciates the parties' collaboration to mitigate concerns identified in the Preliminary Report. Absent specifics on how and how much such efforts will impact future spending, the HPC's projected spending impact of the proposed transaction remains largely unchanged.

In the Joint Response, the parties also included a number of methodological critiques, claiming that the HPC's analyses overstate the potential impact of the transaction on health care spending. The HPC closely reviewed the parties' claims and, as described in more detail below, none of the parties' critiques refute the HPC's core findings. The HPC has made one minor adjustment to the projected spending impact in response to points raised by the parties and has included additional sensitivities and clarifications in the Final Report to further demonstrate the robustness of the spending impact calculations and to address areas of apparent misunderstanding.

A. The HPC's $39.9 million projected annual commercial spending impact is not an upper bound; rather, it represents a conservative estimate that does not include other likely drivers of spending such as the likelihood of higher prices in the future due to increased bargaining leverage.

Contrary to the parties' assertion, the HPC's $39.9 million[8] projected annual commercial spending impact represents a conservative estimate of the transaction's likely spending impact. Figure II.1 below shows how the HPC's total annual spending impact would vary depending on the number of members in MCPC primary care panels, which is the key assumption underlying the scope of the HPC's spending impacts. Even if MCPC did not serve any primary care patients, the total annual spending impact would still be $12.0 million due to the repricing of MCPC's convenience care services at MGB prices, once all MCPC APPs joined the MGB contracted rate schedule. On the other end of the chart, if MCPC filled its primary care panels fully, the annual commercial spending impact would increase to $91.5 million. The HPC's estimate of a $39.9 million annual commercial spending impact uses the parties' own assumption of "moderate acceptance" of the MCPC primary care model and 35% of the full primary care patient panel being filled by year three and represents a total

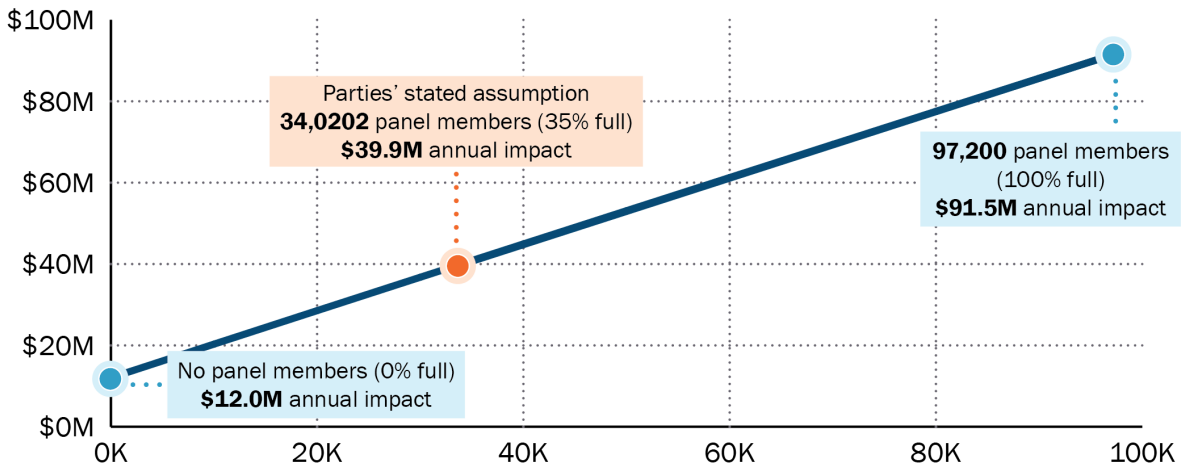
[7] Party Commitments, *supra* note 3.

[8] As described in more detail in Section II.C, the HPC did adjust its calculated spending impact from the diversion of convenience care that could no longer be accommodated at MCPC sites as primary care panels grow, reflecting that a portion of the convenience care may not need to be diverted if those patients become primary care patients of MCPC. Assuming 50% of the patients who could no longer be seen at MCPC for convenience care will no longer need convenience care for the 40% of convenience care services that "map directly onto primary care" (Joint Response, *supra* note 1, at 14), the annual spending impact from diversion of these patients to other sites would drop from $5.9 million to $5.5 million. This also results in a slight decrease in the total projected commercial spending impact from the transaction from $40.2 million annually to $39.9 million annually.

commercial spending impact that is below the midpoint of the range of possible scenarios. This impact also understates the annual spending impact beyond year three if MCPC's patient panels continue to grow beyond 35% of their maximum size. The HPC will be requiring the parties to report on their primary care panel size, including their annual volume of primary care and convenience care visits, for ongoing monitoring.

The HPC's $12.0 million to $91.5 million range itself is also conservative in two key respects, as described in Section III.A.2.d of the Preliminary Report. First, it does not incorporate the spending impact of the likely incremental increase in MGB's bargaining leverage as the result of the addition of MCPC, with up to 120,000 primary care patients (97,200 of whom are expected to be commercial), to the MGB contracting network. Second, it does not include any spending impact due to increases in the prices for convenience care provided under the contracts that CVS would negotiate independently post-transaction, once its MCPC locations obtain full clinic licensure.

Figure II.1: Total Annual Commercial Spending Impact by Number of Commercial Primary Care Panel Members



Note: These figures are conservative as they do not incorporate further increases to prices due to enhanced bargaining leverage as MGB's market share increases and MCPC begins offering new services.

The parties also claim that the HPC did not and should have quantified savings from providing primary care to patients without PCPs; chronic disease management; reduction in avoidable ED visits; reduction in racial and ethnic disparities in primary care access; and extended evening and weekend hours.[9]

The HPC's analysis *does* incorporate these types of savings in its calculation of the spending impact. By using the actual, observed experience of new primary care patients of MGB affiliates for several years after obtaining a PCP (two years on average), the HPC's analysis incorporates the real world observed changes in chronic disease management, reductions in ED utilization, reductions in hospital utilization, and more associated with having an MGB-affiliated PCP. The net effect, after incorporating such savings, resulted in a projected increase in commercial spending for the new primary care patients of $27.7 million annually. The Preliminary and Final Reports explicitly acknowledge that some of this spending may reflect appropriate and improved management of

[9] Joint Response, *supra* note 1, at 15.

health conditions.[10] Indeed, the HPC found that, while overall spending increased in the years following acquisition of an MGB-affiliated PCP, inpatient spending per member was reduced, while spending for outpatient and professional care increased to a larger degree, suggesting that some inpatient care may have been avoided through improved care management.[11]

As discussed in greater detail in the Preliminary and Final Reports, there is potential for longer-term savings, depending on the model's success, but the research literature does not support a quantitative estimate of potential savings beyond these initial few years in this case.[12] The parties do not introduce new sources to support their assertion that such savings can and should be further quantified.

B. The parties acknowledge that providing care at MGB's higher prices would result in a substantial spending impact and commit to exploring ways to mitigate this impact.

In the Joint Response, the parties acknowledge that the transaction would generate a spending impact and primarily take issue with the scope of the HPC's estimate.

Specifically, the parties assert that the HPC's primary care spending impact estimate "does not distinguish between appropriate, evidence-based utilization that occurs when a previously unattributed patient gains access to primary care…and price-driven spending resulting from care being delivered at MGB's comparatively higher rates." The parties characterize the former as "good spending" that comprises approximately $13.8 million,[13] or about half, of the HPC's $27.7 million primary care spending impact estimate.[14]

As a preliminary matter, the HPC's analysis of projected spending for MCPC's new primary care patients is intentionally designed to be an all-in figure representing projected changes in price, utilization, service mix, and provider mix – which are interrelated – based on real-world observations of changes in spending as patients have joined the primary care panels of MGB affiliates. Both the Preliminary and Final Reports acknowledge that some of this impact may reflect improved management of health conditions due to PCP access.[15] However, disaggregating "good" and "bad" spending as the parties attempt in the Joint Response is not possible in the manner suggested. Both prices and utilization vary by system and reflect decisions not only about the necessity of care, but also about the specific services and settings of care to be utilized, which have different price points and spending implications (e.g., a patient may need an inpatient stay or a provider may determine care can safely be delivered in an outpatient or physician office setting; a patient may need medication for a given condition, but a provider must choose the specific medication and dosing).

Nonetheless, the parties concede that a substantial portion of the spending impact of the transaction (38% per their calculation) results from "care being delivered at MGB's comparatively

---

[10] PRELIMINARY REPORT, *supra* note 2, at 9, 25, 34, 41, and 57; FINAL REPORT, *supra* note 5, at 35.
[11] PRELIMINARY REPORT, *supra* note 2, at 40-41; FINAL REPORT, *supra* note 5, at 42.
[12] PRELIMINARY REPORT, *supra* note 2, at 41-42; FINAL REPORT, *supra* note 5, at 42-43.
[13] The parties calculate this to be $405 PMPY, which totals $13.8 million across the 34,020 commercial patients. Joint Response, *supra* note 1, at 12.
[14] The parties calculate the "good spending" to be 62% of the HPC's primary care spending impact estimate, apparently bucketing the HPC's $5.6 million non-claims spending impact with the "good spending." Joint Response, *supra* note 1, at 12. Under the parties' own implication that MGB-specific spending is "bad spending," the HPC appropriately included the $5.6 million with the "bad spending" here.
[15] PRELIMINARY REPORT, *supra* note 2, at 9, 25, 34, 41, and 57; FINAL REPORT, *supra* note 5, at 34.

higher rates."[16] Given that other components of the HPC's total spending impact estimate are also largely price-driven, including the entirety of the impact from repricing convenience care at MinuteClinic to MGB rates, a large percentage of the projected spending increase due to the transaction would not be deemed to constitute "good spending" under the parties' rubric. The HPC appreciates the parties' commitment to exploring ways to mitigate the spending impact of MCPC APPs joining MGB contracts,[17] and it looks forward to working with the parties to explore such mitigation opportunities. The parties' statement that the migration to MGB contracted rates would occur over two years,[18] on its own, is not anticipated to change the overall spending impact of the transaction once fully implemented. As described in the Final Report, the HPC is also requiring the parties to report on the number of MCPC APPs receiving MGB rates as well as MCPC commercial prices and price increases post-transaction, to allow the HPC to monitor the impact of the transaction over time.

C. The HPC carefully considered the methodological critiques in the Joint Response and has made minor adjustments to one component of spending impact; this adjustment does not change the HPC's core findings.

As described above, the parties acknowledge that the transaction would generate a substantial spending impact but dispute the HPC's exact estimate through methodological critiques about the scale of such impact. The HPC notes that while modeling future impacts always involves some uncertainty, it has sought to use the best available data and modeling to project likely impacts. The HPC also carefully considered the parties' concerns and critiques in the Joint Response and conducted additional sensitivity analyses, which are summarized in Figure II.2 below and detailed in the Methodological Appendix included with this response and in the Final Report.[19] The HPC confirmed that these critiques do not change its core conclusions.

Figure II.2: HPC Analysis of the Parties' Methodological Concerns by HPC Mechanism

HPC Mechanism	HPC Estimate	Parties' Methodological Concerns	HPC Analysis
Repricing convenience care	$6.6M	N/A	• No changes recommended.
Spending for new primary care patients	$27.7M	• Utilization-driven spending is conflated with price-driven spending. • PCP acquisition can be health-driven. • The sample population is different from the future MCPC population due to overall health status, health status	• The HPC's spending impact is intentionally designed to be an all-in figure representing projected changes in price, utilization, service mix, and provider mix based on real world observations of changes in spending as patients have joined primary care panels of MGB affiliates. The Preliminary Report acknowledged that some of this impact may reflect improved management of health conditions due to PCP access.

[16] Joint Response, *supra* note 1, at 12.
[17] Party Commitments, *supra* note 3.
[18] *Id.*
[19] FINAL REPORT, *supra* note 5, at 35-36.

			changes that lead to PCP acquisition, COVID, and the HPC's patient attribution methodology.	• Sensitivities did not support the idea that most patients in the sample acquired a PCP due to worsening health conditions, that sample patients were different than the population expected to join MCPC, or that COVID or the HPC's patient attribution methodology inflated the HPC's spending impact. • No changes recommended.
Diversion to other providers	$5.9M in Preliminary Report Updated to $5.5M in Final Report	• Office visits were excluded from the HPC's identification of comparator providers. • Not all displaced convenience care would divert to other providers.	• Excluding office visit codes in the identification of comparator providers was appropriate; including them would have increased the HPC's impact estimate. • Sensitivities modeling alternate diversion scenarios resulted in a modest decrease in the HPC's estimated spending impact. • Notably, if half of MCPC's new primary care patients were former MinuteClinic users, and 40% of their prior convenience care volume were incorporated into their new primary care relationship and would not need to be diverted as suggested in the Joint Response,[20] the spending impact would be $5.5M. The Final Report has been updated to use this figure.	

III. Access and Quality Impact. The parties offer some new commitments that increase the potential of a positive impact on access and quality; the parties should prioritize meaningful action on their commitments to realize this potential.

A. The parties have made new commitments to support primary care access for populations with high unmet need and the successful implementation of these commitments is necessary to promote equitable access to primary care in Massachusetts.

In the Preliminary Report, the HPC identified specific MinuteClinic locations in areas of high unmet need for primary care relative to the other MinuteClinic locations in Massachusetts. The HPC invited the parties to make commitments to target support and investment to those locations in areas of higher unmet need, as well as prioritizing them for earlier transition to MCPC.

In the Joint Response, the parties list the criteria they plan to use to determine the order in which sites will transition from MinuteClinic to MCPC: current patient volume; capital investment needed to

[20] Joint Response, *supra* note 1, at 14.

meet state licensure requirements; geographic distribution with emphasis on underserved communities; and clinic proximity to provide adequate access to pediatric populations (pending further clarification from DPH).[21] Inclusion of the volume factor would count against prioritizing the three locations with the greatest unmet need (Carver, Palmer, and West Springfield), which all have patient volume below the median.[22]

The parties subsequently committed that MCPC would "prioritiz[e] the evaluation of MinuteClinic locations in Massachusetts identified by the HPC as having the greatest unmet need for primary care for conversion to full clinic licensure, subject to a site-specific assessment of the feasibility to meet Department of Public Health (DPH) clinic licensure standards."[23] The HPC appreciates the parties' commitment to prioritizing evaluation of the sites identified as higher need, and the HPC and other agencies will monitor the parties' investments and progress in providing access in high-need communities.

The Preliminary Report also highlighted that the MCPC payer mix would likely remain heavily commercial, unless the parties conducted targeted outreach to MassHealth members.[24] Although the Joint Response does not make such commitments, the parties have subsequently agreed to "develop and implement an outreach plan specifically for MassHealth patients and other underserved populations, and to otherwise work to expand MinuteClinic's proportion of MassHealth and other government payer populations."[25] The HPC appreciates this commitment, which may have potential to shift the MCPC payer mix to be less heavily commercial. The HPC expects to require ongoing reporting on these items, and it looks forward to working with the parties to monitor the progress and impact of this outreach.

B. In the Party Commitments, the parties indicate that MCPC would continue providing pediatric care, alleviating an access concern raised by the HPC in the Preliminary Report.

In the Preliminary Report, the HPC identified three potential risks to convenience care access: the elimination of access for children, the reduction in access for adults, and the potential for reduced access for all patients relative to the status quo if the MCPC model is unsustainable.

In the Joint Response, the parties state that the decision to limit services to adults reflects MinuteClinic's understanding of Massachusetts' regulations, but that they would maintain convenience care for children "[i]f permitted by the Commonwealth," including preserving access to pediatric vaccination (notably for children under age 5) and infectious disease testing and treatment.[26] DPH has confirmed to the HPC that there is no regulatory barrier to providing convenience care services to children after the transition to full clinic licensure. 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 such as MinuteClinic. The only age-specific regulation is that a full clinic must "ensure the qualifications of its

---

[21] *Id.* at 9. In the Joint Response, the parties suggest that the HPC characterized all 37 MinuteClinic locations as having the greatest unmet need statewide. *Id.* at 5. The HPC made no comparison of the MinuteClinic locations to Massachusetts as a whole, and notes that a number of sites are in relatively wealthy communities.
[22] Indeed, across all MinuteClinic locations, the HPC found a negative association between unmet need and volume.
[23] Party Commitments, *supra* note 3.
[24] PRELIMINARY REPORT, *supra* note 2, at 48.
[25] Party Commitments, *supra* note 3.
[26] Joint Response, *supra* note 1, at 7.

practitioners extend to appropriate training for the age range of patients treated at the clinic."[27] CVS subsequently reiterated that it "commits to working with DPH to address any regulatory considerations as needed to maintain access to pediatric convenience care services at all MinuteClinic locations, including after their transition to MCPC locations."[28] On the basis of this information and commitment, the HPC expects that convenience care services would be maintained for pediatric patients and appreciates CVS's commitment to maintaining these important services.

The parties suggest in the Joint Response that some of the current demand for adult convenience care may be fulfilled as part of MCPC's provision of primary care. As described in Section II above and in the Methodological Appendix, the HPC adjusted the volume of convenience care for adults that would need to be diverted post-transition based on this information, but found it to have a relatively small impact. Accordingly, the HPC continues to expect a meaningful decrease in convenience care capacity as MCPC volume shifts to provision of primary care.

C. The likelihood of the model's long-term sustainability remains uncertain.

In response to HPC's discussion of potential challenges to MCPC sustainability, the parties identify reasons that the existing MinuteClinic patient base and brand recognition, as well as the affiliation with MGB, would likely support MCPC to attract patients.[29] The HPC agrees this is possible. In the Joint Response the parties do not further offer any information about MCPC's financial performance in other states or differentiate MCPC from failed primary care initiatives launched by other retail providers, except to note the benefits of its brand.

With respect to support for the MinuteClinic APPs who would be transitioning to becoming primary care providers, the parties cite the value of MinuteClinic's centralized administrative organization, which the Preliminary Report also acknowledged as helpful.[30] The Joint Response includes no further evidence on staff retention (from other states or Massachusetts), adds no detail to or commitments regarding plans to ensure retention of existing staff, and addresses neither the unique challenges that APPs would face juggling both primary care and convenience care nor concerns about whether MCPC will provide the staffing levels needed to support a primary care practice.

D. It remains unclear whether or when MCPC would provide comprehensive primary care to all patients.

As explained in the Preliminary Report, the HPC utilized the MassHealth Primary Care Sub-Capitation Program, which is a requirement for participation in any MassHealth ACO, to evaluate whether MCPC would provide comprehensive primary care to all its patients.[31] The HPC identified areas in which MCPC's model did not represent comprehensive primary care under the MassHealth Primary Care Sub-Capitation Tier 1 criteria, including oral health screening and referral, behavioral health and substance use disorder screening, behavioral health medication management, use of the Prescription Monitoring Program, and video telehealth capability.[32]

In the Joint Response, the parties express their intention for MCPC to become a Tier 1 practice in the Sub-Capitation Program once it has sufficient MassHealth members to support participation in

---

[27] 105 CMR 140.315.
[28] Party Commitments, *supra* note 3.
[29] Joint Response, *supra* note 1, at 8. The parties do not offer details on the referenced survey, including whether it included Massachusetts CVS sites.
[30] *Id.* at 5; PRELIMINARY REPORT, *supra* note 2, at 51.
[31] PRELIMINARY REPORT, *supra* note 2, at 52-53.
[32] *Id.* at 54.

MGB's MassHealth ACO, after which it would add additional services to meet all Tier 1 requirements such as oral health screenings and expanded behavioral health screenings.[33] The parties thus suggest that they do not intend to increase the scope of their proposed primary care services to include these and other Tier 1 requirements initially excluded from their model, such as video telehealth, until they are mandated as part of MassHealth ACO participation.

As noted above, the parties commit to developing and implementing an outreach plan specifically for MassHealth patients and other underserved populations, and to otherwise work to expand MinuteClinic's proportion of MassHealth and other government payer populations. The HPC appreciates this commitment, although it remains unclear whether or when MCPC would join the MGB MassHealth ACO. Not participating in a MassHealth ACO would further limit MCPC's ability to develop a MassHealth primary care panel. The parties do not state a timeline to join the Sub-Capitation Program, and until then, MCPC may continue to fall short of this standard for comprehensive primary care for all patient populations.

In addition to general discussion of CVS's plans to meet Tier 1 criteria, the Preliminary Report highlighted CVS's decision for MCPC not to prescribe controlled substances and the impact of this decision on care delivery. The parties respond to these concerns by emphasizing that this is a design choice[34] and noting that CVS will continually evaluate whether the MCPC patient panel needs these services. MCPC subsequently elaborated on this evaluation plan, committing to "tracking and assessing referral patterns for patients with conditions that may require controlled substance management" and to providing annual reporting to the HPC on such referrals. MCPC further committed to "developing and implementing controlled substance prescribing capabilities in a measured and clinically appropriate manner should a demonstrable and sustained patient need be identified."[35]

These commitments do not address the HPC's concern that the decision not to prescribe controlled substances is likely to discourage patients who need these services from choosing MCPC for primary care in the first place. When CVS evaluates the needs of the patients who choose MCPC, it therefore may not find a high need for these services. The HPC continues to encourage the parties to develop a clear timeline for prescribing of controlled substances at all MCPC sites, given that this remains a concerning service limitation that may be a barrier for certain patients to benefit from this model.

The lack of behavioral health medication management is only one of the gaps in comprehensive primary care resulting from the decision not to prescribe controlled substances. Primary care providers commonly treat a broad range of conditions that may require prescription of controlled substances, including moderate to severe pain (e.g., due to recovery from surgery or injury, related to chronic conditions, etc.), ADHD, anxiety and panic disorders, sleep disorders, cough, diarrhea, and many others.[36] The HPC understands that almost all individual CVS clinicians in Massachusetts,

---

[33] Joint Response, *supra* note 1, at 7. The Joint Response explicitly ties adding services required in Tier 1 such as provision of oral health screening and full behavioral health screenings to the timeline for MCPC to participate in the MassHealth ACO, noting factors such as the ability to establish an attributed population with baseline performance data and the regulatory timeline for enrollment in MGB's MassHealth ACO program.
[34] As requested, the HPC has updated the Final Report to reflect the parties' statement that the decision not to prescribe controlled substances is a "design choice" rather than a gap in the model design. However, from a patient perspective, the result is the same: MCPC will not prescribe controlled substances.
[35] Party Commitments, *supra* note 3.
[36] CHARLES V. PREUSS, ET AL., PRESCRIPTION OF CONTROLLED SUBSTANCES: BENEFITS AND RISKS, (StatPearls Publ'g 2025), *available at* https://www.ncbi.nlm.nih.gov/books/NBK537318/ (last visited June 3, 2026). Note that holding a DEA registration does not require a provider to prescribe all authorized controlled substances under Schedules

including Nurse Practitioners, already hold DEA registration and Massachusetts Controlled Substance Registration.[37]

CVS's decision for MCPC not to prescribe controlled substances also likely means that MCPC will not be able to fully meet the Tier 1 criteria for behavioral health medication management. The Joint Response and Party Commitments do not meaningfully address this gap, even as the parties express their intention for MCPC to become a Tier 1 practice in the Sub-Capitation Program.

The parties have stated that, for patients requiring treatment for conditions that require controlled substance management, "MCPC providers will identify the need, initiate the appropriate referral, and manage the handoff through the centralized care coordination."[38] This is a standard practice for patients requiring specialty care referrals that are outside the scope of primary care, but it is not a substitute for providing comprehensive primary care for conditions such as the examples above, which fall within the usual scope of primary care, or for behavioral health conditions that can be managed under comprehensive primary care. To the extent that MCPC patients have or develop these conditions, this approach could result in potentially avoidable treatment delays and care fragmentation. As noted above, it is also likely to discourage patients who already need care for these conditions from choosing MCPC in the first place, with potential equity and fair access implications.

IV. Other Additions and Edits in the Final Report.

The Final Report includes several other additions and technical edits, as summarized below.

- Updated the estimated spending impact for convenience care diversions from $5.9 million to $5.5 million to reflect the parties' assertion that 40% of the convenience care volume currently provided by MinuteClinic would be incorporated into primary care visits for those MCPC patients who would have otherwise used MinuteClinic convenience care.[39]
- Acknowledged the parties' commitment to exploring ways to mitigate the spending impact of MCPC APPs joining MGB contracts.[40]
- Added a description of additional sensitivity analyses conducted for the primary care spending impact estimate, including analyses that exclude the years most affected by COVID and that implement alternative outlier cutoffs.[41]

II-V; MCPC could wait to begin prescribing certain higher-risk drugs, for example, while still being able to manage many common conditions.

[37] *MCSR for Individuals*, COMMONWEALTH OF MASSACHUSETTS, https://www.mass.gov/mcsr-for-individuals (last visited June 8, 2026). Looking specifically at the Massachusetts Controlled Substance Registration (MCSR), while clinicians may not administer or store a controlled substance at a clinic that does not itself hold an MCSR, they can still prescribe a controlled substance under their individual registration and patients can fill those prescriptions at pharmacies. *See* 105 CMR 7.00. As noted above, nearly all MCPC APPs hold individual DEA registrations and CVS could allow APPs to prescribe controlled substances for which they are registered. *Office of Health and Human Services (EOHHS) License Verification Site*, COMMONWEALTH OF MASSACHUSETTS, https://checkahealthlicense.mass.gov/ (last visited June 10, 2026). However, the parties' discussion of the issue focuses on their assessment that MCPC patients will likely not require these services, MCPC's ability to refer patients to specialists for these services, and the costs that MCPC would incur if it sought a DEA registration. The strong implication of the Joint Response is that CVS does not plan to permit individual clinicians to prescribe controlled substances, so in the absence of new information to the contrary, the HPC assumes this is CVS's intent.

[38] Joint Response, *supra* note 1, at 6.

[39] FINAL REPORT, *supra* note 5, at 10, 25, 37-39, and 60.

[40] *Id.* at 10, 25, 36, and 60.

[41] *Id.* at 36.

- Added a figure showing the range of possible total commercial spending impacts depending on the number of members in the MCPC primary care panels.[42]
- Updated the description of the attribution methodology used to identify patients who do and do not currently have a PCP.[43]
- Further explained that existing literature does not support long-term quantitative estimates of savings from patients newly receiving primary care.[44]
- Acknowledged the parties' commitment to prioritizing the evaluation of the highest-need MinuteClinic locations for conversion to full clinic licensure, subject to a feasibility assessment, and discussed the potential benefits and limitations of this approach.[45]
- Discussed the parties' commitment to conducting outreach to MassHealth patients and potential implications for long-term payer mix.[46]
- Added a brief discussion of how MCPC will likely offer pediatric convenience care, based on the Joint Response and Party Commitments.[47]
- Acknowledged the parties' identification of factors in support of long-term sustainability and remaining limitations.[48]
- Added further discussion of the limits of the MCPC model compared with comprehensive primary care standards, recognizing the parties' plans as described in the Joint Response and Party Commitments and further assessing the implications of the proposed plan not to prescribe controlled substances.[49]

V. Conclusion.

The parties provide some additional context in their Joint Response regarding implementation of the proposed model. The parties also provide meaningful commitments that would help maximize the benefits of expanded access to primary care for those populations that most need it, while mitigating some of the costs of the transaction, and the HPC appreciates the parties' willingness to implement these measures. Nonetheless, the Joint Response does not materially alter the HPC's conclusions regarding likely spending impacts, affordability concerns, market expansion of a high-priced provider system, and some remaining uncertainty regarding access benefits for underserved populations and the comprehensiveness and sustainability of the proposed care model. Accordingly, while the Final Report includes minor additions and technical edits, reflecting careful consideration of each of the points raised in the Joint Response, the HPC's core findings remain unchanged. The HPC now provides its Final Report of the analysis of this transaction to inform the work of other state agencies as well as the public, which ultimately bears the cost of our health care system.

[42] *Id.* at 40.
[43] *Id.* at 66.
[44] *Id.* at 42-43.
[45] *Id.* at 49.
[46] *Id.* at 10, 11, 44, 49, 56, 59, 60, and 61.
[47] *Id.* at 10, 11, 20, 44, 50, 59, and 61.
[48] *Id.* at 51.
[49] *Id.* at 56.

Methodological Appendix

The HPC closely examined all concerns and methodological critiques in the Joint Response and conducted additional sensitivity analyses to further test the robustness of all spending impact calculations, which are detailed in the Methodological Appendix below. After close review, the HPC affirms that its primary care spending impact methodology effectively generates an accurate spending impact estimate given the data available. The parties' concerns regarding overestimation are either based on misunderstandings of the HPC's methodology and the purpose of the CMIR review, or they are shown to have minimal impact on the HPC's spending impact calculations.

A. The HPC's multivariate regression is a reasonable approach to estimate the primary care spending impact.

The parties presents concerns in the Joint Response that the HPC's study design is fundamentally flawed because the HPC's sample population includes people who chose to acquire a PCP due to the anticipation of future health needs.[50] The parties further argue that the HPC's estimated effect is overstated because it includes spending related to the health circumstances that prompted patients to seek a PCP.

The HPC acknowledges that, if spending for patients who obtained a PCP for "health-driven" reasons would have increased even if these patients had not obtained a PCP, comparing per-member spending before and after PCP attribution may overstate the spending impact of obtaining a PCP, because a portion of the observed spending increase may have been due to worsening health status rather than the impact of obtaining a PCP. The HPC does not find that the estimated spending impact is likely to be materially overstated due to this "reverse causation effect."

First, even assuming PCP attribution is correlated with a change in health status that would increase spending, the timing of the health status change relative to the patient's PCP attribution is not obvious. A patient could experience a health shock and obtain a PCP that same year, or in a future year. For the HPC's estimated spending impact to be driven by a health shock, as the parties claim, the health shock and PCP attribution would need to occur in the same calendar year. The HPC's regression model uses annual spending per member measured by calendar year and compares spending in the years after PCP attribution to the years before attribution. As a result, to the extent that health-driven spending increases are observed in the calendar year before PCP attribution, the HPC's regression estimate is not overstated, since annual spending after attribution is compared to an increased spending level in the prior calendar year.

Second, to examine how many patients in the HPC's sample experienced a health change in the same calendar year they acquire a PCP (i.e., made a "health-driven" PCP choice that would affect the spending impact estimate), the HPC compared sample population risk scores in the year before and the year after sample patients acquired an MGB contracting affiliate PCP. If, as the parties argue, PCP attribution was caused by contemporaneous health-status changes, risk scores would increase over that time period. Instead, the HPC found that the risk score change for more than 75% of these patients was zero or negative, suggesting that patient health may not have changed in the year of PCP attribution, relative to the prior year.[51] To further test whether HPC's spending impact could be

[50] Joint Response, *supra* note 1, at 10-11.

[51] While HPC acknowledges that risk score is not a perfect measure of patient health, it is a well-established measure to delineate patient health in claims data. *See, e.g.*, *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 June 6, 2026); Grace Mackleby, et al., *Switching Medicare Plans Outside Open*

overstated due to high spending increases from a small number of "health-driven" switchers, the HPC also ran a sensitivity dropping the top 5% of patients by change in risk score (representing those most likely to have made a "health-driven" selection) in the year before and the year after they acquired an MGB contracting affiliate PCP. This sensitivity found that the estimated overall spending impact of the proposed joint venture would decrease minimally, from $27.7 million to $26.5 million annually. These analyses further rebut the claim that the estimated spending impact was inflated because the sample population of new primary care patients to MGB affiliates were primarily "health-driven" patients whose health worsened the same year.

The parties argue that the "standard" way to address this "reverse causation effect" is to use a matched event study with a difference-in-differences analysis with a properly matched control group of members who did not gain a PCP.[52] The HPC notes that this methodology would only be able to appropriately account for changes in health-driven spending over time if the control group members could be matched to switchers by likelihood of future health status changes. There are two additional issues with this approach.

First, as discussed above, at least 75% of the MGB attributed patients in the sample did not experience a measurable change in health status in the year of attribution. This fact suggests that a contemporaneous change in risk score may not be correlated with treatment, and therefore matching may not be necessary. Another well-accepted methodology to remedy potential confounders is to run a sensitivity that limits the sample to patients that have similar level of the variable of concern, which in this case would be risk score. HPC conducted this analysis by dropping patients with large risk score changes and found that the estimated spending impact was essentially unchanged.

Second, this approach conflicts with the notion advanced by the parties that a health shock causes contemporaneous PCP attribution. To conduct a matching exercise, there would need to be a sufficient share of patients who experience a health shock yet do not become attributed. If that is the case, there then must be some patients who do not have a health shock the year they are attributed, because their health shock already occurred in a prior year. Based on the HPC's analysis of risk scores before and after attribution, it seems to be the case that the vast majority of patients in the sample did not have a health shock in the year they were attributed, which reduces the concern that the spending impacts are primarily driven by changes in health status.

While not a causal analysis, the HPC's linear regression methodology is reasonable to use for the purposes of a Cost and Market Impact Review. The HPC's approach of comparing risk-adjusted spending per member across provider organizations has been traditionally used in most of the HPC's CMIR analyses to date. HPC staff economists, in consultation with outside economic experts, improved upon previous methodologies in this review by controlling for more factors that might affect per-person spending, including member fixed effects, which controls for all time-invariant individual-specific factors, as opposed to risk score alone.

Enrollment Was Increasingly Common, Especially Among Sicker Enrollees, 2015-22, 45 HEALTH AFFAIRS (2026), *available at* https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00915 (last visited June 10, 2026); Alexander Soltoff, et al., *Private Equity-Owned Hospices Report Highest Profits, Lowest Patient Care Spending Compared With Other Ownership Models*, 44 HEALTH AFFAIRS (2025), *available at* https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00327 (last visited June 8, 2026); Vilsa Curto, et al., *Health Care Spending and Utilization in Public and Private Medicare*, 11 AM. ECON. J.: APPLIED ECONOMICS (2019), *available at* https://www.aeaweb.org/articles?id=10.1257/app.20170295 (last visited June 8, 2026).

[52] Joint Response, *supra* note 1, at 11.

B. The primary care spending impact deliberately includes both utilization- and price-driven components, which are interrelated and cannot easily be disaggregated.

The HPC's $27.7 million annual estimate of the overall spending impact of previously unattributed patients becoming MCPC patients does not attempt to differentiate between the impact of utilization and the impact of price. As stated in the Preliminary Report, spending for such patients would likely change after they join MCPC due to changes in the rates for their primary care and specialty providers, and changes in their utilization patterns, reflecting both the mix of providers they would see and services they would receive. The spending impact examines up to four years of post-affiliation trends and incorporates any new spending for necessary, clinically appropriate services, as well as any savings due to the avoidance of unnecessary ED visits and other high-cost care as the result of access to care management in a primary care setting.

The parties suggest that some spending impact occurs when an unattributed person acquires any PCP, distinguishing "price-driven" spending increases from "good" spending increases that result from expected and clinically appropriate utilization changes. The parties' argument that the HPC should remove the "good" spending impact from its analysis appears to misunderstand the HPC's findings in two ways:

First, the HPC estimates the total spending impact of the transaction while acknowledging that some of this spending may be for utilization of necessary services.[53] Whether spending reflects necessary or clinically appropriate care does not determine whether it constitutes a spending impact under the CMIR framework. The HPC's role is to assess the transaction's likely effect on total health care spending, regardless of whether that spending arises from changes in utilization, prices, or both.

Second, the parties mischaracterize the full spending impact of becoming a primary care patient of other large provider groups as "good, utilization-driven spending." As discussed in the Preliminary Report, both prices and utilization patterns vary by system, and thus spending associated with becoming a primary care patient of other large systems includes both utilization and price components.

Finally, the HPC notes that the parties do not address or rebut the HPC's estimate of a $5.6 million annual increase in spending on non-claims payments as a result of the transaction;[54] the parties omit this impact entirely from their estimates presented in the Joint Response.

C. The parties do not provide evidence to support their claims that the HPC's sample population of patients who joined MGB-affiliated primary care panels in past years differs from the population likely to join MCPC primary care panels. Additional sensitivity analyses conducted by the HPC reinforce that the sample population represents a group of low-acuity patients similar to those likely to join MCPC panels.

The parties present concerns in the Joint Response related to the similarity of the sample population used in the HPC's analysis of spending for new primary care patients to the population who would join MCPC's primary care panels. The HPC's sample population comprises adults in MinuteClinic's PSA who switched from not having a PCP to having a PCP with an MGB contracting affiliate between 2019 and 2023.

---

[53] PRELIMINARY REPORT, *supra* note 2, at 35 (discussing regular use of wellness visits that may prevent avoidable ED admissions).
[54] *Id.* at 36-37.

The parties argue that the HPC's sample population includes people who chose to acquire a PCP due to the anticipation of future health needs.[55] They state that this "health-driven" choice to acquire a PCP would not apply to the people who would join MCPC's primary care panels through the parties' anticipated unique recruitment process,[56] and that therefore HPC's model assumptions are flawed. As an initial note, people acquire PCPs for many reasons, including but not limited to insurance changes that require the selection of a PCP, a new convenient office opening up, a new health issue requiring primary care management, or a decision to finally treat an ongoing health issue. The parties have not provided evidence that the new MCPC patients, who would likely include patients currently on MGB's waitlist[57] as well as patients in the MinuteClinic PSA, would choose to acquire a PCP for different reasons than the patients in the HPC's sample population.

Among patients who would make a "health-driven" choice, increased spending that would not have occurred in the absence of a PCP, as in the case of patients with relatively minor health changes who would choose to forgo care, is appropriately included in our spending impact and is not "selection bias" if the HPC's sample population is not materially different to new MCPC patients.

As discussed in Appendix Section A above, the HPC found no evidence that the sample population of new primary care patients to MGB affiliates were primarily "health-driven" in a way that would impact the spending estimate. The HPC found that the risk score change for more than 75% of these patients was zero or negative from the year before to the year after PCP affiliation. This finding is inconsistent with the parties' concern that patients in the sample were systematically motivated to acquire a PCP because of worsening health conditions. Additionally, the HPC also ran a sensitivity dropping the top 5% of patients by change in risk score (representing those most likely to have made a "health-driven" selection) over that time period, and it found that the overall spending impact would decrease only minimally.

The parties also claim that the HPC's spending impact did not account for the lower acuity of the anticipated MCPC primary care population.[58] The HPC compared the risk scores of the sample population used in the regression analysis to the risk scores of the populations from which MCPC primary care panels would likely be drawn. It found that the average risk score of the sample population in the year prior to acquiring a PCP was similar to the average risk score of both unattributed patients and unattributed MinuteClinic users in the MinuteClinic PSA, and substantially lower than the average risk score of current MGB patients.[59] Thus, the HPC did not find evidence that its spending estimate failed to take into account a lower-acuity MCPC patient population.

[55] Joint Response, *supra* note 1, at 10-11.
[56] *Id.* at 12.
[57] *Id.* at 15.
[58] *Id.* at 12-13.
[59] The HPC also conducted a sensitivity analysis within this relatively low-risk sample population to investigate whether the estimated spending increase varied with patient acuity and found no positive relationship. This may be due to the fact that higher-acuity patients among the sample population were identified as higher-acuity because they had received more healthcare prior to affiliating with a PCP, which would also have increased their pre-affiliation spending baseline.

Methodological Appendix Figure 1: Populations and Risk Scores

Population	HCC Adjusted Risk Score
HPC sample population	0.64
Unattributed patients	0.67
Unattributed MinuteClinic users	0.71
MGB Patients	1.35

Note: Aside from the HPC sample population, risk scores are averages from 2019 to 2023. The populations are limited to individuals who lived in the MinuteClinic PSA for all years for which data is available from 2019 to 2023. Unattributed patients were unattributed for all years for which data is available from 2019 to 2023. Unattributed MinuteClinic users additionally used MinuteClinic at least once from 2019 to 2023. MGB patients are individuals who were attributed to an MGB PCP for all years for which data are available from 2019 to 2023.
Source: APCD v2023.

The HPC ran additional sensitivities dropping no patients, the top 1% of patients, and the top 10% of patients by spending in each year of the data (likely representing patients with high health risk), and found minimal change to its overall spending impact.[60] Two of the three sensitivities resulted in a slightly higher estimated spending impact – by $5.2 million when no outliers are dropped and $646,000 when the top 10% are dropped – while the 1% sensitivity decreased the spending impact by $6.1 million.

The HPC acknowledges the inherent uncertainty in modeling future spending impacts. It has made all reasonable efforts to ensure its estimating sample is materially similar to future MCPC primary care patients. As discussed above, the HPC has confirmed that the risk scores of its sample are similar to the expected MCPC population of unattributed patients in the CVS PSA and it included in its analysis patients who voluntarily chose to acquire a PCP for a variety of reasons that it expects will be similar among MCPC patients. It may be the case that the MCPC patients would be different than the HPC's sample along unmeasurable characteristics or that the future environment may change in unpredictable ways that would imply a different effect of PCP acquisition on spending than measured by the HPC's model. The HPC's spending impact projection could thus somewhat underestimate or overestimate the true spending impact due to this uncertainty.

D. The HPC's analysis accounted for the potential impact of COVID through year fixed effects and a sensitivity analysis.

The parties claim that the HPC's inclusion of COVID-era data may have inflated its spending impact estimate by conflating spending increases resulting from deferred utilization following the onset of the pandemic with spending increases resulting from PCP acquisition.

The multivariate regression model the HPC used to estimate the spending impact accounts for this concern by controlling for year fixed effects. The model estimates a patient's change in annual spending relative to the change in annual spending on average across all patients across any two years. The model only estimates a spending increase associated with becoming an MGB patient if that patient's increase is higher than the average per-patient increase observed in the data for that year. For instance, if a patient joined MGB in the years after the pandemic and their spending

[60] The HPC's baseline spending impact drops the top 5% of spending outliers. PRELIMINARY REPORT, *supra* note 2, at 62.

increased, but the increase was in line with the average increase across all patients due to post-pandemic catch-up care, then the model would estimate no spending effect for this patient.

To further ensure that the impact of COVID did not bias the spending impact results, the HPC conducted a sensitivity analysis that excluded the years most affected by COVID and found no decrease in the estimated spending impact. In fact, the annual estimated impact was significantly higher, increasing from $650 to $1,042 per patient, which would increase the total primary care spending impact from $27.7 million to $41.1 million annually. The Final Report mentions this sensitivity analysis at Section III.A.2.a.

E. The HPC's method of attributing patients to PCPs did not inflate its primary care spending impact estimate.

The parties point out that the HPC's use of a narrower methodology for attributing patients to PCPs in the Preliminary Report than in the HPC's Cost Trends Report resulted in a larger sample of unattributed patients, which they argue increased the corresponding spending impact.[61] The 2025 Cost Trends Report used a methodology that attributes patients to PCPs if they have a payer-reported PCP, a provider for well visits, a provider for sick visits, or a prescriber of medication, in order to maximize the size of the sample used to examine a provider organization's spending patterns. The Preliminary Report had a different goal: to identify the full population of patients who do not have a PCP and were thus potential candidates for joining MCPC primary care panels. To do this, the HPC made a design choice to consider patients who did not have a payer-reported PCP or a primary provider of well visits to be unattributed (although such patients may have had a provider for sick visits or a prescriber), which increased the pool of unattributed patients.

The size of the pool of unattributed patients in the HPC's analysis was not directly related to the spending impact estimate. The HPC used spending for its sample population of previously unattributed patients who acquired an MGB PCP to estimate a spending impact *per patient* for those who would join the MCPC patient panels. The per-patient spending impact was then applied to the number of patients expected to become MCPC primary care patients by year three based on the parties' own volume estimates. Nonetheless, the HPC ran a sensitivity using the patient attribution methodology from the HPC's Cost Trends Report and found that the total primary care spending impact would decrease by $2.2 million annually, or $65 per person.

The parties also express concern that the HPC classified people receiving primary care from APPs as having no PCP, which the parties argue would bias the HPC's sample population of patients without PCPs.[62] The HPC has updated the Final Report to clarify that it excluded from its sample population of unattributed patients all patients attributed to any PCP, regardless of whether such PCP (physician or APP) could be linked to a provider organization.[63]

F. The results of the HPC's convenience care diversion analysis would not be materially changed by the parties' proposed adjustments to its methodology.

The HPC estimated a $5.9 million annual spending impact due to patients who would have otherwise used MinuteClinic for convenience care seeking care at other, generally higher-priced providers. The parties claim that this estimate was overstated because the HPC improperly excluded lower-cost alternative providers from its analysis by excluding office visits in its methodology for identifying

[61] Joint Response, *supra* note 1, at 13.
[62] *Id.* at 13.
[63] FINAL REPORT, *supra* note 5, at 66.

comparator providers. The parties also suggest that the spending impact from convenience care diversion should instead be $3.1 million annually, relying on the HPC-provided sensitivity that assumes all care would divert to urgent care centers.[64]

As explained in Section 2 of the Data Appendix of the Preliminary Report, the HPC identified comparator providers using MinuteClinic's top CPT codes but excluding office visit codes. This decision was made because office visit codes are used broadly throughout the healthcare system, and some providers identified using these codes were higher-cost specialists that did not seem like reasonable alternative providers for diverted convenience care visits. Rather than decreasing the spending impact as the parties claim it would, including office visit codes in the comparator identification would increase the resulting spending impact to $6.4 million annually, due to the higher prices of certain providers that frequently bill office visit codes.

The parties also suggest that not all displaced convenience care volume would require diversion, given that MCPC's primary care patients would receive convenience care as part of their primary care relationship.[65] The parties did not quantify the impact this would have on spending. The HPC's methodology assumed that the development of MCPC primary care panels would not decrease the overall demand for convenience care, given that the new MCPC primary care volume represented only a small percentage of potential convenience care users in the MinuteClinic PSA. The HPC further refined its analysis in response to the parties' suggestion that 40%[66] of the convenience care volume currently provided by MinuteClinic would be incorporated into primary care visits for those MCPC patients who would have otherwise used MinuteClinic convenience care. Based on the parties' planned recruitment methods, the HPC assumed that these patients would comprise 50% of MCPC primary care patients, resulting in a slightly reduced spending impact of $5.5 million annually.[67] This updated estimate has been incorporated into the Final Report.

Finally, the parties claim that the HPC did not account for capacity constraints that would limit potential diversion to physician offices.[68] The parties suggest that increased at-home testing or virtual care would replace some of the displaced care, although they do not provide support for or a calculation of the likely extent of this potential substitution. The parties also do not quantify the impact that such constraints might have on the HPC's spending estimate, which would need to account for the fact that virtual care is often billed at the same rates as in-person visits. The HPC modeled a sensitivity that reduced physician office diversions to 75% of its level in the Preliminary Report with corresponding increases to other comparator provider types and found that the spending impact would minimally decrease. However, it is also possible that capacity constraints on physician offices would lead to higher rates of diversion to more expensive HOPDs and EDs, increasing rather than decreasing the spending impact.

---

[64] Joint Response, *supra* note 1, at 13-14.
[65] *Id.* at 14.
[66] *Id.* at 14.
[67] Using APCD claims data, the HPC found that the average adult without a PCP in the MinuteClinic PSA who used MinuteClinic at least once from 2019 to 2023 visited MinuteClinic 0.41 times annually. Additionally, the parties state that 40% of MinuteClinic convenience care services would "map directly onto primary care" (*Id.* at 14). Based on the parties' intended recruitment processes, the HPC assumed that half of the MCPC primary care panel patients would be drawn from this pool and would have 40% of their demand for convenience care met through their MCPC PCP. This reduces the number of diverted convenience care patients from 51,030 to 48,240, which decreases the total spending impact estimate.
[68] *Id.* at 14.

G. Contrary to the parties' claims, the HPC's estimated spending impacts across analytical components are additive and designed to be mutually exclusive.

The parties claim that the HPC is double-counting utilization across analytical components and suggest that the total spending impacts should be reduced by $660,000 to $5.6 million to eliminate this double-counting.[69] It is difficult for the HPC to speak to the validity of this calculation because the Joint Response does not include any explanation of how the parties arrived at this estimate. As discussed in the prior section, the HPC conducted a sensitivity of its convenience care diversion analysis that addresses the potential overlap in population between MinuteClinic convenience care patients and future MCPC primary care patients.

The parties suggest that diverted convenience care patients would acquire PCPs of other provider organizations, which would reduce the pool of patients currently without PCPs and correspondingly reduce the HPC's $27.7 million annual primary care spending impact. This argument is not only contradicted by the parties' own insistence that primary care panels for all provider organizations are capacity constrained,[70] but it also implies that MCPC would be unsuccessful in filling even the 35% of its primary care capacity used in the HPC's estimate. The parties do not provide any additional rationales for how the HPC's spending impacts would overlap.

[69] *Id.* at 14-15.
[70] *Id.* at 14.