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.

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[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,

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[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.

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[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,

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May 15, 2026