REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-JUN-21

Subject: Urgent Care Centers

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

Similar to retail health clinics, urgent care centers (UCC) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public's desire and expectation of prompt, available, and convenient care.[1] The Council noted that American Medical Association (AMA) policy is largely silent on UCCs and the extent UCCs should play a role in meeting the health care needs of patients.

This report, initiated by the Council, provides background on UCCs, notes the various types of ownership models, outlines the extent of physician oversight and physician employment in the centers, summarizes relevant policy, and proposes new recommendations that expand upon the current body of policy on stand-alone health care clinics.

BACKGROUND

UCCs are free-standing same-day clinics focused on caring for patients who need expedient medical care but who are not experiencing a life-threatening emergency. In 2019, there were more than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018.[2] They provide unscheduled, episodic care to patients. These centers usually provide services such as treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory infection.[3] Additionally, the number of stand-alone care settings such as UCCs and retail health clinics continues to grow each year as patients look for and expect timely care and convenience. These settings are usually open daily, evenings, and weekends making them an attractive alternative to primary care physician offices for unplanned visits.

Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs indicates that 55 percent of their patients are covered by private health insurance and 22 percent by either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers' compensation.[4] UCCs usually require upfront payment for services from uninsured patients creating a barrier to care for these patients.

In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act obligations to see, treat, or stabilize patients without regard for the patient's ability to pay.[5]

URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

In addition to convenience, proponents of UCCs state that the centers generate health care system cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-urgent. An additional 24 percent of visits are classified as semi-urgent.[6] Therefore, it seems that the utility of UCCs does not lie in their ability to provide substitutive care.

UCCs also have the potential to divert patients away from their usual source of care or patients might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the patient-physician relationship. There are also worries, in an attempt to save money, insurers are encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation. Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a corresponding increase to the cost to the health care system. Accordingly, although UCCs have a role to play in the health care system, it is critical that this role is clearly defined and put into practice to avoid increased health care costs and care fragmentation.

URGENT CARE CENTER OWNERSHIP

Initially, when UCCs started to emerge in the early 2000s, they generally were opened by physicians, physician practices, and medical groups. However, more recently, the proliferation of UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008, 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital ownership grew to 37 percent in 2014. At times, because of a UCC's connection to a hospital, it is effectively treated less as a separate extension of that hospital.[7]

UCC developers and health systems have also started partnering with private equity firms and payers.[8] For example, UnitedHealth Group (UHG) and its Optum medical care services unit purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of clinics and UCCs will increasingly be "wired together" throughout the country.[9]

PHYSICIAN OVERSIGHT

According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of facilities employing at least one full-time physician.[10] Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.[11] Physician employment at UCCs tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.[12] Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse practitioners and physician assistants to provide the majority of care.

RELEVANT AMA POLICY

UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the

number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual, company, or other entity establishing or operating a retail health clinic must have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at retail health clinics.

Council on Medical Service Report 7-A-17 further articulated AMA retail clinic policy (i.e., Policy H-160.921) by supporting that a retail health clinic must help patients who do not have a primary care physician or usual source of care to identify one in the community; must use EHRs to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent; must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; should use local physicians as medical directors or supervisors; clinics should neither expand their scope of services beyond minor acute illnesses nor expand their scope of services to include infusions or injections of biologics; and should have a well-defined and limited scope of services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include in any marketing materials the qualifications of the onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

The AMA also has established policy that addresses the patient-physician relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of every health care system should be available to the consumer (Policy H-165.985).

The AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health

professionals such as nurse practitioners and physician assistants function under the supervision of a physician (e.g., Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure, and the discretion of the physician team leader. Policy H-160.906 defines "physician-led" in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

LEGISLATIVE ACTIVITY

Early in the emergence of UCCs, state regulation largely focused on defining "urgent care," articulating services included within the definition, and accreditation standards. More recently, as the number of UCCs has increased, states are starting to pursue a more active role in urgent care regulatory oversight. For example, some states give state health agencies the authority to license UCCs.[13]

AMA ACTIVITY

With respect to scope of practice issues, the AMA has established the Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to oppose the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

DISCUSSION

The Council believes that UCCs can play a role in meeting the health care goals of high quality, efficient care. Nonetheless, striking a patient-centered balance between the use of UCCs and traditional physician visits, including the ED, requires coordination between the various health care settings. Coordination leads to better outcomes and protects against duplicative care. The Council believes that UCCs can serve as a health care access point when a patient's usual source of care is unavailable. Therefore, in its recommendations, the Council emphasizes that the design and use of UCCs, just like retail clinics, should serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. Accordingly, the Council recommends a set of principles to guide the use of UCCs similar to those on retail health clinics (Policy H-160.921).

The Council recommends that a UCC must help patients who do not have a primary care physician or usual source of care to identify one in the community. Given that it is critical that UCCs take responsibility for ensuring continuity of care, the Council further recommends that UCCs must transfer a patient's medical records to his or her primary care physician or other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving provider is capable of receiving it. Additionally, the Council recommends that UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.

Moreover, it has been shown that policies that support patient-centered medical home activities in UCCs can help protect against fragmentation of care.[14] Accordingly, the Council recommends that UCCs work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made. The Council also notes the importance of the patient-centered medical home (PCMH) and the fact that many physicians are expanding

hours and scheduling to provide patients with enhanced access to care. To underscore the effectiveness of PCMHs and physicians' continued commitment to provide more comprehensive access to care, the Council recommends reaffirming Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology codes, including those that already exist for off-hours services. Physicians spend a significant amount of off-hours time messaging and otherwise communicating with patients, and they should be incentivized and supported to continue doing so.

Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and recommends emphasizing the importance of physician-led care by not only reaffirming Policy D-35.985 advocating for the physician-led team, but also recommending that UCCs use local physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming Policy H-385.926 supporting physicians' choice of practice and method of earning a living.

As previously stated, UCC capabilities range significantly. As such, the Council believes it is imperative that each center have a well-defined and limited scope of clinical services, provide a list of services provided by the center, provide the qualifications of the on-site providers prior to services being rendered, the degree of physician supervision of non-physician providers, and include in any marketing materials the qualifications of the onsite health care providers. Moreover, the Council believes that a physician should not be attributed to the spending for services that a patient receives at a UCC if the physician could not reasonably control or influence that spending.

The Council believes that UCCs can serve as a convenient way for patients to receive medical care that does not require life-saving interventions. However, it is critical that patients understand the limits of UCCs and not confuse them for an ED.[15] Therefore, the Council recommends that UCCs be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or as a way to describe the type of care provided. Further, the Council wholeheartedly supports patient education on the role of alternative sources of care such as UCCs. Patients should be notified if physicians are providing off-hours care and told what to do in urgent situations when their physician may be unavailable. Moreover, patients should be informed of the differences between a UCC and an ED. Additionally, the Council is interested in the volume of patient transfers to an ED after a UCC visit and will monitor this issue.

When health care is provided episodically, opportunities to develop or nurture the patient-physician relationship may be missed. Therefore, it is vital to ensure that there is care coordination between the UCC and a patient's usual source of care. Emphasizing the patient-physician relationship is critical to achieving the quadruple aim. To that end, the Council's recommendations aim to ensure that UCCs can be a modern component of patient-centered care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient's primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:

    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;

    b. UCCs must transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;

    c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;

    d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;

    e. UCCs should use local physicians as medical directors or supervisors;

    f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and

    g. UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)

6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)

7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)

Fiscal Note: Less than $500

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