

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 06-JUN-21

Subject: Urgent Care Centers  
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Referred to: Reference Committee G

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

6  
7 This report, initiated by the Council, provides background on UCCs, notes the various types of  
8 ownership models, outlines the extent of physician oversight and physician employment in the  
9 centers, summarizes relevant policy, and proposes new recommendations that expand upon the  
10 current body of policy on stand-alone health care clinics.

## 11 12 BACKGROUND

13  
14 UCCs are free-standing same-day clinics focused on caring for patients who need expedient  
15 medical care but who are not experiencing a life-threatening emergency. In 2019, there were more  
16 than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018.<sup>2</sup>  
17 They provide unscheduled, episodic care to patients. These centers usually provide services such as  
18 treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have  
19 X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services  
20 offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory  
21 infection.<sup>3</sup> Additionally, the number of stand-alone care settings such as UCCs and retail health  
22 clinics continues to grow each year as patients look for and expect timely care and convenience.  
23 These settings are usually open daily, evenings, and weekends making them an attractive  
24 alternative to primary care physician offices for unplanned visits.

25  
26 Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and  
27 patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75  
28 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs  
29 indicates that 55 percent of their patients are covered by private health insurance and 22 percent by  
30 either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers’  
31 compensation.<sup>4</sup> UCCs usually require upfront payment for services from uninsured patients  
32 creating a barrier to care for these patients.

33  
34 In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments  
35 (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act  
36 obligations to see, treat, or stabilize patients without regard for the patient’s ability to pay.<sup>5</sup>

1 URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

2  
3 In addition to convenience, proponents of UCCs state that the centers generate health care system  
4 cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an  
5 avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-  
6 urgent. An additional 24 percent of visits are classified as semi-urgent.<sup>6</sup> Therefore, it seems that the  
7 utility of UCCs does not lie in their ability to provide substitutive care.

8  
9 UCCs also have the potential to divert patients away from their usual source of care or patients  
10 might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the  
11 patient-physician relationship. There are also worries, in an attempt to save money, insurers are  
12 encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation.  
13 Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a  
14 corresponding increase to the cost to the health care system. Accordingly, although UCCs have a  
15 role to play in the health care system, it is critical that this role is clearly defined and put into  
16 practice to avoid increased health care costs and care fragmentation.

17  
18 URGENT CARE CENTER OWNERSHIP

19  
20 Initially, when UCCs started to emerge in the early 2000s, they generally were opened by  
21 physicians, physician practices, and medical groups. However, more recently, the proliferation of  
22 UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008,  
23 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by  
24 physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital  
25 ownership grew to 37 percent in 2014. At times, because of a UCC's connection to a hospital, it is  
26 effectively treated less as a separate extension of that hospital.<sup>7</sup>

27  
28 UCC developers and health systems have also started partnering with private equity firms and  
29 payers.<sup>8</sup> For example, UnitedHealth Group (UHG) and its Optum medical care services unit  
30 purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC  
31 growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of  
32 clinics and UCCs will increasingly be "wired together" throughout the country.<sup>9</sup>

33  
34 PHYSICIAN OVERSIGHT

35  
36 According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a  
37 combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent  
38 of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of  
39 facilities employing at least one full-time physician.<sup>10</sup> Of the physicians practicing in UCCs, about  
40 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8  
41 percent are internal medicine physicians.<sup>11</sup> Physician employment at UCCs tends to attract  
42 physicians wishing to work part-time hours and those looking to transition into retirement.<sup>12</sup>  
43 Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse  
44 practitioners and physician assistants to provide the majority of care.

45  
46 RELEVANT AMA POLICY

47  
48 UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975,  
49 H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all  
50 modes of health care delivery and financing, with the growth of any one system determined by the

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

3  
4 AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and  
5 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual,  
6 company, or other entity establishing or operating a retail health clinic must have a well-defined  
7 and limited scope of clinical services; use standardized medical protocols derived from evidence-  
8 based practice guidelines; establish arrangements by which their health care practitioners have  
9 direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care  
10 with practicing physicians within the local community; establish a referral system with physician  
11 practices or other facilities for appropriate treatment if the patient's conditions or symptoms are  
12 beyond the scope of services provided by the clinic; inform patients in advance of the qualifications  
13 of the health care practitioners who are providing care, as well as the limitation in the types of  
14 illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines  
15 and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of  
16 communicating patient information and facilitating continuity of care; and encourage patients to  
17 establish care with a primary care physician to ensure continuity of care. Additionally, Policy  
18 H-160.921 states that health insurers and other third-party payers should be prohibited from  
19 waiving or lowering copayments only for patients that receive services at retail health clinics.

20  
21 [Council on Medical Service Report 7-A-17](#) further articulated AMA retail clinic policy (i.e., Policy  
22 H-160.921) by supporting that a retail health clinic must help patients who do not have a primary  
23 care physician or usual source of care to identify one in the community; must use EHRs to transfer  
24 a patient's medical records to his or her primary care physician and to other health care providers,  
25 with the patient's consent; must produce patient visit summaries that are transferred to the  
26 appropriate physicians and other health care providers in a meaningful format that prominently  
27 highlight salient patient information; should work with primary care physicians and medical homes  
28 to support continuity of care and ensure provisions for appropriate follow-up care are made; should  
29 use local physicians as medical directors or supervisors; clinics should neither expand their scope  
30 of services beyond minor acute illnesses nor expand their scope of services to include infusions or  
31 injections of biologics; and should have a well-defined and limited scope of services, provide a list  
32 of services provided by the clinic, provide the qualifications of the on-site health care providers  
33 prior to services being rendered, and include in any marketing materials the qualifications of the  
34 onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with  
35 interested stakeholders to improve attribution methods such that a physician is not attributed the  
36 spending for services that a patient receives at a retail health clinic if the physician could not  
37 reasonably control or influence that spending.

38  
39 The AMA also has established policy that addresses the patient-physician relationship, physician  
40 extenders, and continuity of care. The AMA encourages policy development and advocacy in  
41 preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has  
42 extensive policy on guidelines for the integrated practice of physicians with physician assistants  
43 and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947  
44 encourages physicians to be available for consultation with physician assistants and nurse  
45 practitioners at all times, either in person, by phone, or by other means. Policy H-425.997  
46 encourages the development of policies and mechanisms that assure continuity and coordination of  
47 care for patients. Finally, the AMA believes that full and clear information regarding benefits and  
48 provisions of every health care system should be available to the consumer (Policy H-165.985).

49  
50 The AMA has extensive policy related to the health care team. Several policies reinforce the  
51 concept of physicians bearing the ultimate responsibility for care and advocate that allied health

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

10

11 LEGISLATIVE ACTIVITY

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13 Early in the emergence of UCCs, state regulation largely focused on defining “urgent care,”  
 14 articulating services included within the definition, and accreditation standards. More recently, as  
 15 the number of UCCs has increased, states are starting to pursue a more active role in urgent care  
 16 regulatory oversight. For example, some states give state health agencies the authority to license  
 17 UCCs.<sup>13</sup>

18

19 AMA ACTIVITY

20

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

25

26 DISCUSSION

27

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

37

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

46

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

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

8  
9 Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and  
10 recommends emphasizing the importance of physician-led care by not only reaffirming Policy  
11 D-35.985 advocating for the physician-led team, but also recommending that UCCs use local  
12 physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming  
13 Policy H-385.926 supporting physicians' choice of practice and method of earning a living.

14  
15 As previously stated, UCC capabilities range significantly. As such, the Council believes it is  
16 imperative that each center have a well-defined and limited scope of clinical services, provide a list  
17 of services provided by the center, provide the qualifications of the on-site providers prior to  
18 services being rendered, the degree of physician supervision of non-physician providers, and  
19 include in any marketing materials the qualifications of the onsite health care providers. Moreover,  
20 the Council believes that a physician should not be attributed to the spending for services that a  
21 patient receives at a UCC if the physician could not reasonably control or influence that spending.

22  
23 The Council believes that UCCs can serve as a convenient way for patients to receive medical care  
24 that does not require life-saving interventions. However, it is critical that patients understand the  
25 limits of UCCs and not confuse them for an ED.<sup>15</sup> Therefore, the Council recommends that UCCs  
26 be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements,  
27 or as a way to describe the type of care provided. Further, the Council wholeheartedly supports  
28 patient education on the role of alternative sources of care such as UCCs. Patients should be  
29 notified if physicians are providing off-hours care and told what to do in urgent situations when  
30 their physician may be unavailable. Moreover, patients should be informed of the differences  
31 between a UCC and an ED. Additionally, the Council is interested in the volume of patient  
32 transfers to an ED after a UCC visit and will monitor this issue.

33  
34 When health care is provided episodically, opportunities to develop or nurture the patient-physician  
35 relationship may be missed. Therefore, it is vital to ensure that there is care coordination between  
36 the UCC and a patient's usual source of care. Emphasizing the patient-physician relationship is  
37 critical to achieving the quadruple aim. To that end, the Council's recommendations aim to ensure  
38 that UCCs can be a modern component of patient-centered care.

#### 39 40 RECOMMENDATIONS

41  
42 The Council on Medical Service recommends that the following be adopted and the remainder of  
43 the report be filed:

- 44  
45 1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the  
46 physician-led health care team. (Reaffirm HOD Policy)
- 47  
48 2. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and  
49 method of earning a living. (Reaffirm HOD Policy)

- 1 3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside  
2 the medical home, all pertinent vaccine-related information should be transmitted to the  
3 patient's primary care physician and the administrator of the vaccine should enter the  
4 information into an immunization registry, when one exists. (Reaffirm HOD Policy)  
5
- 6 4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of  
7 services described by Current Procedural Terminology (CPT) codes, including those for  
8 off-hour services. (Reaffirm HOD Policy)  
9
- 10 5. That our AMA supports that any individual, company, or other entity that establishes  
11 and/or operates urgent care centers (UCCs) adhere to the following principles:  
12
  - 13 a. UCCs must help patients who do not have a primary care physician or usual source  
14 of care to identify one in the community;
  - 15
  - 16 b. UCCs must transfer a patient's medical records to his or her primary care  
17 physician and to other health care providers, with the patient's consent, including  
18 offering transfer in an electronic format if the receiving physician is capable of  
19 receiving it;
  - 20
  - 21 c. UCCs must produce patient visit summaries that are transferred to the appropriate  
22 physicians and other health care providers in a meaningful format that prominently  
23 highlight salient patient information;
  - 24
  - 25 d. UCCs should work with primary care physicians and medical homes to support  
26 continuity of care and ensure provisions for appropriate follow-up care are made;
  - 27
  - 28 e. UCCs should use local physicians as medical directors or supervisors and they  
29 should be clearly identified and posted;
  - 30
  - 31 f. UCCs should have a well-defined scope of clinical services, communicate the  
32 scope of services to the patient prior to evaluation, provide a list of services  
33 provided by the center, provide the qualifications of the on-site health care  
34 providers prior to services being rendered, describe the degree of physician  
35 supervision of any non-physician practitioners, and include in any marketing  
36 materials the qualifications of the on-site health care providers; and  
37
  - 38 g. UCCs should be prohibited from using the word "emergency" or "ED" in their  
39 name, any of their advertisements, or to describe the type of care provided. (New  
40 HOD Policy)  
41
- 42 6. That our AMA work with interested stakeholders to improve attribution methods such that  
43 a physician is not attributed to spending for services that a patient receives at an UCC if the  
44 physician could not reasonably control or influence that spending. (New HOD Policy)  
45
- 46 7. That our AMA support patient education including notifying patients if their physicians are  
47 providing extended hours care, including weekends, informing patients what to do in  
48 urgent situations when their physician may be unavailable, informing patients of the  
49 differences between an urgent care center and an emergency department, and asking for  
50 their patients to notify their physician or usual source of care before seeking UCC services,

1 and encourage patients to familiarize themselves with their anticipated out-of-pocket  
2 financial responsibility for UCC services. (New HOD Policy)

Fiscal Note: Less than \$500

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