URGENT CARE ASSOCIATION

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November 22, 2019

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

The Urgent Care Association (UCA) appreciates your commitment and that of the Committee's Rural and Underserved Communities Health Task Force to identify policy approaches to improve health care outcomes in underserved communities.

The UCA welcomes the opportunity to respond to your Request for Information on priority topics that affect health status and outcomes. In that regard, we are responding to your information request by answering the following questions:

- **What should the Committee consider with respect to patient volume adequacy in rural areas?**

- **What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where (a) patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? (b) there is broader investment in primary care or public health? and (c) the cause is related to a lack of flexibility in health care delivery or payment?**

- **What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?**

BACKGROUND

Since the early 1980s, urgent care centers have been providing care to patients throughout the United States. Adding roughly 500 new centers each year, the urgent care industry continues to

grow and meet patient preference for on-demand access to affordable and convenient care. UCA benchmarking finds as of November 2019, the total number of urgent care centers in the United Sates reached 9,564, making them a health care site of service for an estimated 125 million patients annually.

Urgent care centers provide walk-in, extended-hour access for acute illness and injury care that is either beyond the scope and/or the availability of the typical primary care practice or clinic. Many of the same non-emergent conditions treated in a hospital emergency department or free-standing emergency department can be treated in an urgent care center at significantly lower cost. In fact, a study published in the February 2017 *Annals of Emergency Medicine* found that 12 of the most common diagnoses treated in the hospital emergency department were also in the top 20 diagnoses for urgent care centers. However, the cost to patients with the same diagnosis were on average almost 10 times higher at hospital-based emergency departments relative to urgent care centers. For example, to treat a urinary tract infection, the cost was $2,122 in the hospital emergency department and $153 in the urgent care center.[1]

It is important policymakers view urgent care centers not only as a tool to reduce health care costs, but also as an important entry point for consumers into the health care system and as a source for primary and preventive care services. Despite policy efforts aimed at strengthening access to primary care, many consumers are "medically homeless." In addition to filling gaps in access to primary care, nearly all urgent care centers, based on UCA's member survey, have one or more mechanisms in place to connect patients to a medical home. Urgent care centers can also identify patients where gaps in care exist, such as in the management of diabetes and high blood pressure — keeping them from becoming costly problems — as well as keeping patients up to date on immunizations and preventive screenings. Irrational barriers — found mostly among commercial payers — in the health care system, such as disallowing urgent care centers to provide follow-up care after an acute care visit, should be removed so urgent care centers are not restricted from playing a role in improving population health.

Urgent care centers offer a solution to improving access to care in rural and underserved parts of the country. Unfortunately, very few urgent care centers can justify the costs involved with setting up a fully functioning care facility in areas where opportunities for strong patient volume do not exist and Medicaid reimbursement is inadequate. In these underserved areas, and in locations where community hospitals are struggling to remain viable, urgent care centers offer a solution if proper incentives are provided.

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[1] Ho V, Metcalfe L, Dark C, et al. Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers. Ann Emerg Med. 2017. https://www.researchgate.net/publication/313785002_Comparing_Utilization_and_Costs_of_Care_in_Freestanding_Emergency_Departments_Hospital_Emergency_Departments_and_Urgent_Care_Centers

What should the Committee consider with respect to patient volume adequacy in rural areas?

According to UCA members, urgent care centers need to have a minimum volume of 25-28 patients per day to commit to a rural community, which translates to a community with a minimum population of 10,000. There are many communities that would benefit from urgent care centers and the health care services they provide, but barriers, most notably reimbursement, make locating in rural areas financially impractical. Urgent care centers do not receive a facility fee like hospitals or free-standing emergency departments, and favorable payment and regulatory structures for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) make them more fiscally viable in rural areas.

Despite efforts to advance the health of rural Americans, gaps in access to care persist. Across the country, there are more than 17 million people who live in rural counties without a RHC, more than 15 million in rural counties without a FQHC, and nearly 4.5 million in rural counties without an acute care hospital.[2] And, there are 660,893 individuals living in rural counties without any FQHC, RHC, or acute care hospital.

A study published in 2018 found that between 2007 and 2014 there was a more than 80 percent increase in FQHCs. The study revealed, however, that most of the newly certified FQHCs (81 percent) located in urban areas and were much less likely to be in areas where the population is below poverty, raising questions of the impact the expansion and federal expenditures have had on improving access in rural areas.[3]

Even in locations where FQHCs or RHC's are located, health care access can still be difficult and reductions in emergency department use may not be realized.[4]

These trends may seem to suggest that changes in reimbursement are needed to attract more primary care providers, including advanced practice clinicians (APCs), such as nurse practitioners (NPs) and physician assistants (PAs), to rural areas.

Policy changes that could make it more financially viable for urgent care centers to locate in rural areas and fill gaps in care for these medically underserved areas could include:

- Services provided to Medicaid patients in urgent care centers should be paid at Medicare rates. Even in states where Medicaid and Medicare payment parity exists, it is largely limited to primary care providers. Because many urgent care centers employ physicians trained in

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[2] Rural Health Research Gateway https://www.ruralhealthresearch.org/alerts/211

[3] Chang C., Bynum J., Lurie J. Geographic Expansion of Federally Qualified Health Centers 2007-2014; J Rural Health 2018 Oct 23. doi: 10.1111/jrh.12330. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6478577/

[4] Kelleher K, Gardner W. Are FQHCs the Solution to Care Access for Underserved Children? PEDIATRICS Volume 138, number 4, October 2016:e20162479. https://pediatrics.aappublications.org/content/pediatrics/138/4/e20162479.full.pdf

emergency medicine, they do not qualify for enhanced Medicaid payments in states where it exists.

- As state governments have steadily increased NPs' and PAs' scopes of practice and because it can be difficult to recruit physician to rural areas, NPs and PAs play important roles in the delivery of health care in rural and other underserved areas. Therefore, in rural areas it is essential that NPs and PAs be paid at the same rate as a physician when providing and billing for a health care service. Under current Medicare policy, services provided and billed by an NP or PA are paid at 85 percent of the fee schedule rate. Urgent care centers must have a larger population (and higher daily volume) to offset the discounted payment rates for services delivered by these providers. It is important to eliminate the discounted payment rate for NPs and PAs providing care in urgent care centers in rural areas if urgent care center operators are to invest in distressed communities with small populations and lower patient volumes.

- For purposes of billing evaluation and management (E/M) visits, the Centers for Medicare and Medicaid Services distinguishes patients as "new" and "established." An established patient is one who received professional services from the physician/non-physician practitioner or another physician of the same specialty who belongs to the same group practice within the previous three years. This distinction is important in the office setting, since new patient codes carry higher relative value units. Patients seen in the hospital emergency department, however, are always defined as new. Patients in rural communities often have no continuity of care and their visits to the emergency department are often for non-emergent medical conditions that are or could be treated by urgent care center providers. Allowing urgent care center providers to treat all patients as "new" patients for the purposes of billing would also provide an inducement to urgent care centers to invest in rural areas.

What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where (a) patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers? (b) there is broader investment in primary care or public health? and (c) the cause is related to a lack of flexibility in health care delivery or payment?

As an example, Oklahoma and Kansas lost approximately four hospitals in 2019. Urgent care center operators in these states have not witnessed community health centers or FQHCs developed to take the place of the closed hospital. An urgent care center can offer comparable services, be nimbler, have better patient hours, and not have to meet the regulatory requirements to be categorized as an FQHC. These regulations can serve as a barrier to locating in rural communities. However, these markets could be highly attractive to urgent care centers if inadequate reimbursement rates are addressed, including through the suggested policy changes outlined above.

What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

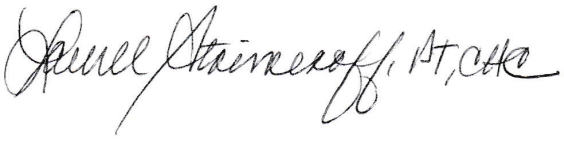
Health care providers, including urgent care centers, are challenged by hiring NPs and PAs. In some rural markets, salaries for these providers are not far different from a new family practice physician in an urban market. Urgent care centers need to be able to pay more to attract and retain APCs in rural markets, especially in markets where the next populated city is two to three hours away. If urgent care centers in rural areas have inadequate volume and reimbursement is not adequate, it is very difficult to attract providers to sustain the delivery of care.

CONCLUSION

The UCA looks forward to continuing to engage in a dialogue with you, members of the Committee, and the Rural and Underserved Communities Health Task Force on improving access to health care and improving outcomes in rural and other underserved areas and how urgent care centers can be part of the solution. Specifically, we would be happy to introduce you to urgent care centers operators who have successfully entered rural markets, as well as those who have failed and the barriers to success. For more information or to arrange a meeting, please contact Camille Bonta, UCA policy consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

Richard Park, MD
President
Board of Directors Urgent Care Association



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