February 28, 2019

The Honorable Lamar Alexander
Chairman
Health, Education, Labor and Pensions Committee
U.S. Senate
Washington, D.C. 20510

Dear Chairman Alexander:

On behalf of the Urgent Care Association (UCA) we appreciate your solicitation of actions that Congress could take to address rising health care costs. As you aptly state in your Dec. 11, 2018 letter to stakeholders, driving down the cost of health insurance means addressing the cost drivers in our health care system. The UCA appreciates the opportunity to lend its voice to this discussion.

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 2018, the total number of urgent care centers in the United States reached 8,774, up eight percent from 8,125 in 2017, making them a health care site of service for an estimated 89 million patients annually.

All Americans should have access to affordable and comprehensive health care coverage. The reality is, however, that health care affordability requires attacking the cost drivers in our system without compromising access or quality. One cost driver is health system failure to incentivize site appropriate health care and the inability of consumers to make informed decisions on where to access care because transparency is lacking.

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.

Consider these statistics:

- According to the 2015 Colorado Health Access Survey, roughly 40 percent of emergency department visits in Colorado occur for non-emergency reasons.\(^1\) Analysis of 2014 commercial health insurance claims in the Colorado All Payer Claims Database suggests that Colorado could save an average of $1,150 per visit, equating to more than $800 million per

\(^1\)Colorado Health Institute Colorado Health Access Survey 2015 -
year in annual savings if patients used a clinic, such as an urgent care center, or doctor’s office for non-emergent care.

- According to a report issued by the Massachusetts Health Policy Commission in 2015, a high share of emergency department visits in the state stem from limited access to care after normal operating hours of the doctor’s office. The report also found the presence of a retail or urgent care clinic nearby reduced use of emergency departments by 30 percent.

- An analysis of insurance claims processed by Blue Cross Blue Shield of Texas from 2012 to 2015, published in the February 2017 Annals of Emergency Medicine, found that 15 of the 20 most common diagnoses treated at freestanding emergency departments and 12 of the most common for hospital-based emergency departments were also in the top 20 for urgent care centers. However, prices for patients with the same diagnosis were on average almost 10 times higher at freestanding and hospital-based emergency departments relative to urgent care centers. For example, the cost was $1,074 for a diagnosis of upper respiratory infection in the hospital emergency department and $165 in the urgent care center — 6.5 times the price paid at urgent care centers.

- The National Bureau of Economic Research published a paper — the funding for which was made possible by a grant from the Agency for Healthcare Research and Quality — that estimates the daily closure of nearby urgent care centers leads to a 1.43 percent increase in the rate of privately insured non-emergent visits immediately following closure. This extrapolates to about 2.4 million emergency department visits per year.

While there are a number of factors that contribute to emergency department overuse, the lack of price and information transparency is a major contributor. Many consumers don’t understand the cost for accessing care in a free-standing or hospital emergency department, which both charge facility fees, will be far greater than the cost of accessing care for the same condition in the urgent care center.

Alongside empowering consumers with information to make wise health care decisions, states, the federal government and commercial payers have other policy levers — including provider reimbursement and patient cost sharing — that can be utilized to drive health care to the most cost effective site of service. State Medicaid programs and commercial payers have begun experimenting with emergency department diversion programs to facilitate site-appropriate care. UCA is encouraged that the Center for Medicare and Medicaid Innovation (CMMI) has decided to launch a five-year program — the Emergency Triage, Treat and Transport (ET3) program — that will pay participating ambulance providers for transporting patients to alternative destination sites, such as urgent care centers, rather than hospital emergency departments when emergency services are not required. With laboratory and radiology services onsite, urgent care centers provide a wide range of treatments for non-emergency, non-life threatening situations. Many

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2 2015 Cost Trends Report; Massachusetts Health Policy Commission.
3 2015 Cost Trends Report; Massachusetts Health Policy Commission. Residents shown all live within 5 miles of an emergency department. Residents who do not live within 5 miles of an emergency department are excluded from 30 percent reduction figure.
offer health care services such as physical therapy, occupational medicine, in-house pharmaceutical dispensing and concussion screening, making them ideal destinations for EMS transport of non-emergency patients. According to the UCA 2018 Benchmarking Report, 98 percent of patients presenting at urgent care centers are in the appropriate care setting, with only 2 percent needing emergency department diversion.

An apparent barrier to directing patients to more site appropriate care for non-emergent needs is the Emergency Medical Treatment and Active Labor Act (EMTALA) which requires that Medicare-participating hospitals that offer emergency services provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. Whether hospitals fear transgression or face real risk of violating EMTALA, we believe the law stands in the way of price transparency and other innovative approaches to move patients out of the emergency department and should be re-examined.

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, the majority of urgent care centers, based on UCA’s member survey, have a mechanism in place to connect patients to a medical home. Urgent care centers also have an important role to play in preventive care, ranging from influenza vaccines to diabetes and hepatitis 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.

Initiatives to encourage use of urgent care centers must be met with a discussion of urgent care center payment adequacy. An overburdened primary care workforce, compounded by historically low Medicaid reimbursement rates, are contributors to the use of hospital emergency departments by Medicaid patients. Even in states where Medicaid and Medicare payment parity exists, it is largely limited to primary care providers. Consequently, because many urgent care centers employ physicians trained in emergency medicine, they do not qualify for enhanced Medicaid payments in states where it exists. To reduce demand for nonemergency care in costly emergency departments, services provided to Medicaid patients in urgent care centers should be reimbursed at least Medicare rates.

Lastly, 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 are inadequate and Medicaid reimbursement is lacking. 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.

The UCA looks forward to continuing to engage in a dialogue with you and the Committee on reducing health care costs and how urgent care centers can be part of the solution. Should you
require additional information, please contact Camille Bonta, UCA policy consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

Laurel Stoimenoff, PT, CHC
Chief Executive Officer
Urgent Care Association

Sean McNeeley, MD, FCUCM
President
Board of Directors