URGENT CARE ASSOCIATION

COLLEGE OF URGENT CARE MEDICINE®

Urgent Care Centers Should be Better Utilized for Non-Emergent, Urgent Health Episodes

PROBLEM

Emergency Departments (EDs) are chronically overwhelmed with patients, making it difficult for them to efficiently and effectively treat everyone who walks through their doors. Many patients who present at EDs have diagnoses that could be appropriately treated in less acute, less expensive, and often less distressing settings, such as urgent care centers (UCCs). For example, individuals with allergic reactions, lacerations, sprains and fractures, common respiratory illnesses (e.g., flu or RSV), bacterial infections (e.g., strep throat, urinary tract infections or foodborne illness), need timely care, but may not need the full scope of services provided by an ED. When these patients present at the ED, they often are triaged as least emergent and wait a long time for diagnosis and treatment. Insurers, including Medicare and Medicaid, also pay more for ED visits than UCC visits, while patients and their families spend more money and resources than may be necessary.

Potential overuse or inappropriate use of EDs has been a national concern for many years, particularly among those insured by Medicaid.[1] There are multiple reasons patients go to the emergency room for non-emergent concerns: lacking a relationship with a primary care provider or care team, a lack of after-hours or timely access to a provider, and other access barriers such as transportation.[2] Other themes associated with higher-than-average ED use especially among Medicaid enrollees include negative personal experiences with the healthcare system, challenges associated with social determinants of health, and significant chronic mental and physical disease burden.[3]

A 2021 Report to Congress by the U.S. Office of the Assistant Secretary for Planning and Evaluation (ASPE), highlighted efforts by the Centers for Medicare and Medicaid Services (CMS) and others to discourage inappropriate use of EDs, for example by requiring higher insurance copayments for ED use as a financial disincentive, patient education to encourage patients to seek care in other settings, expanding access to primary care services, focusing on superusers (often Medicaid enrollees) or hotspots, and encouraging other providers to expand access through evening and weekend hours.[4]

SOLUTION

Studies show that urgent care centers (UCCs) already prevent around 24.5 million emergency room visits annually, which not only reduces the burden on emergency rooms, but also saves patients and the healthcare system time and money.[5] A 2019 report by the Medicare Payment Advisory Committee (MedPAC) found that about one-third [500,000] of ED claims involving nonurgent care (or 2 percent of Medicare physician ED claims) could be appropriately treated in

[1] Zhou, R., et al. 2017. The Uninsured Do Not Use The Emergency Department More—They Use Other Care Less. *Health Affairs*. Vol. 36, No. 12. https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0218.
[2] Centers for Medicare and Medicaid Innovation. Transforming Clinical Practice Initiative (TCPi). Reducing Unnecessary Emergency Department Visits. https://www.cms.gov/priorities/innovation/files/x/tcpi-changepkgmod-edvisits.pdf.
[3] Capp, R. et al. 2016. Reasons for Frequent Emergency Department Use by Medicaid Enrollees: A Qualitative Study. *Academy of Emergency Medicine*. Apr;23(4):476-81. https://pubmed.ncbi.nlm.nih.gov/26932230/#:~:text=We%20identified%20three%20key%20themes,mental%20and%20physical%20disease%20burden.
[4] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. 2021. Trends in the Utilization of Emergency Department Services, 2009-2018. https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf.
[5] Allen, L, et al. 2019. Urgent Care Centers and the Demand for Non-Emergent Emergency Department Visits. *National Bureau of Economic Research*. https://www.nber.org/papers/w25428.

a UCC or other lower cost, non-ED setting, and that when a hospital ED treats a nonurgent condition, the Medicare program and beneficiaries spend between 3 and 20 times more per episode than when a UCC treats the same condition.[6] Even more burden could be shifted from EDs to UCCs if UCCs were better utilized, and more patients could receive high-quality care with shorter wait-times and in a less-costly setting. A 2016 study of Medicare claims data concluded that in markets where the rate of UCC use for nonurgent care increased, the use of hospital EDs for nonurgent care decreased.[7]

As the 2021 ASPE Report notes, UCCs "generally do not require appointments and are frequently open longer than other primary care providers, typically seven days a week, with extended evening hours. Therefore, they can fill a gap for patients whose condition does not require a visit to the ED but whose regular providers are closed or for those who do not have a regular source of care." In fact, UCCs have the resources, staff and equipment to address more severe concerns than most primary care offices.

MedPAC found that shifting a subset of claims for nonurgent care from EDs to UCCs would result in significant program and beneficiary savings, but would require addressing beneficiary decision-making and the availability of care in these settings.

Thus, CMS should develop incentives to encourage Medicare beneficiaries and Medicaid enrollees to better utilize UCCs for non-emergent, urgent care needs. CMS could promote UCC utilization as an alternative to EDs and primary care (1) by improving beneficiary access by incentivizing UCC development and proliferation through differentiated reimbursement, and (2) with improved patient education programs. Patients may seek care in UCCs more often with a better understanding of which services are best addressed in UCCs versus EDs, physician offices and retail health clinics.

WHY URGENT CARE CENTERS

Nationwide, there are over 14,000 UCCs and they can be found in all 50 states and the District of Columbia. However, many centers can be found in states with large urban centers, while many states with large rural areas have significantly less. For example, the entire state of North Dakota has only 12 UCCs. UCCs are open beyond typical physician office hours, and some operate 24/7, much like an ED. A 2022 survey of Urgent Care Association (UCA) members found that 67% are open 7 days a week and another 11% are open every day except Sunday.[8]

Moreover, unlike many physician offices and retail clinics, UCCs generally offer high and medium acuity services, including x-ray and diagnostic services. According to a UCA report, 53% of their members self-identified as a median/moderate acuity center and another 12% as being a higher complexity acuity center. Today, 85% of UCCs have x-ray services. Almost half of UCA members offer in-house pharmaceutical dispensing. Urgent care centers have also expanded their diagnostic testing services in recent years, and now test for infectious diseases with strep, RSV, and COVID-19 among the most common tests performed.

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[6] Medicare Payment Advisory Commission. 2019. Report to the Congress: Options for slowing the growth of Medicare fee-for-service spending for emergency department services. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch11_medpac_reporttocongress_sec.pdf.

[7] Corwin, G. S., D. M. Parker, and J. R. Brown. 2016. Site of treatment for non-urgent conditions by Medicare beneficiaries: Is there a role for urgent care centers? American Journal of Medicine 129, no. 9 (September): 966–973. https://www.amjmed.com/article/S0002-9343(16)30341-2/fulltext.

[8] Urgent Care Association. 2022 UCA Benchmarking Report. https://urgentcareassociation.org/resources/2022-uca-operations-benchmarking-report/.