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## Retail Clinics: Policy Implications and Recommendations for State and Federal Action

### **Executive Summary**

Over the last decade, retail clinics have emerged as a new model of healthcare delivery. Patients favor their convenience, limited scope of services, and transparent pricing. Regulation of retail clinics varies based on state nurse practice laws and Medicaid reimbursement policy. To expand access to primary care and preventive services, states should examine their regulatory approach to retail clinics. Policy options include allowing market forces to shape the role of retail clinics, expanding the scope of practice for nurse practitioners, and altering state Medicaid reimbursement for retail clinic services. Changing reimbursement is equitable, feasible, and an efficient approach to integrating an innovative delivery model into the existing health system.

The purpose of this comment is to provide the Federal Trade Commission with evidence for encouraging state action regarding retail clinics, to protect healthcare consumers and maintain competition among emerging providers in the healthcare market.

### **Background**

Americans are increasingly turning to retail clinics for their healthcare needs. The number of retail clinics nearly doubled between 2007 and 2010; there are over 1,200 nationwide

today<sup>16</sup>. In 2009, there were 1.3 retail clinic visits nationally, up from 800,000 in 2008<sup>2</sup>. Retail clinics provide basic healthcare, preventive services, offer extended evening and weekend hours, and are located in pharmacies or supermarkets. Retail clinics mainly employ nurse practitioners and physician assistants. They typically accept most forms of insurance, and charge transparent prices for out of pocket costs.

Retail clinic use varies by demographics: younger adults and minority families use retail clinics most frequently, followed by older adults<sup>2</sup>. Only 39% of patients report having an established primary care physician outside of the retail clinic, and an estimated 16-27% of users are uninsured<sup>16</sup>. Patients cite short wait times and transparent pricing as reasons for visiting retail clinics over other care settings like urgent care centers or private physician practices<sup>16</sup>. Despite the growing presence of retail clinics, visits to retail clinics represent a small portion of overall outpatient care<sup>2,13</sup>.

There is conflicting evidence about the effect of retail clinics on healthcare spending. For example, retail clinics deter an estimated 27% of emergency room visits<sup>8,15</sup>, which translates to \$4.4 billion in savings<sup>15</sup>. However, because retail clinics lower cost of care per episode<sup>3,10</sup>, there is some evidence showing how retail clinics induce additional demand for healthcare, which may contribute to overall spending<sup>12,6</sup>.

Professional organizations and interest groups remain divided on the cost-savings issue. The American Medical Association, the American Academy of Family Physicians, and the American Academy of Pediatrics argue against the use of retail clinics, citing disruptions in continuity of care<sup>2</sup>. Hospitals support the growth of convenient clinics. Several providers, including Allina Health and Cleveland Clinic, have integrated their delivery systems with existing retailers like MinuteClinic<sup>2</sup>. Many policymakers favor retail clinics for their efficiency,

low cost, emphasis on preventive services, and potential to treat newly insured individuals under the ACA.

Retail clinics play a unique role in the changing health care system, and states determine the regulatory environment for clinic operation and expansion. State scope of practice laws and Medicaid reimbursement policies affect patient access and opportunities for clinics to expand into new markets.

## **Evidence**

Data were gathered from a variety of scholarly, professional, and news sources. Google Scholar and PubMed were used to access journals such as *Health Affairs*, *Annals of Internal Medicine*, and *the American Journal of Managed Care*. These publications drew on primary data, claims and reimbursement data, stakeholder interviews, and population level health outcomes in order to illustrate how retail clinics impact individuals and the health system overall. The *National Conference of State Legislatures* was useful in comparing state-by-state legislation specifically addressing retail clinics. Statements by the *American Association of Nurse Practitioners* and *the American Academy of Pediatrics* clarified how interest groups react to the expansion of retail clinics. Finally, policy papers written by organizations such as *RAND Corporation* and *Commonwealth Fund* provided a general overview of the pertinent policy issues. News articles and blog posts reflected public opinion but were not a major influence in the policy options provided in this paper. Common search terms included (retail clinics) plus various terms including but not limited to (cost), (trends), (scope of practice), (primary care), and (Medicaid).

## **Problem**

States vary in their Medicaid reimbursement policy and Scope of Practice Laws, which affect the growth and use of retail clinics, especially in low-income and underserved areas. Currently, 97% of retail clinics accept private insurance, 93% accept Medicare, but only 60% accept Medicaid<sup>7</sup>. 71% of Medicaid beneficiaries pay out-of-pocket for retail clinic costs. Medicaid agencies do not always distinguish between retail clinics and individual providers, and prior authorization presents a barrier to patient access<sup>11</sup>. Furthermore, Medicaid managed care plans have yet to integrate retail clinics into their networks<sup>11</sup>. Compared to Medicare recipients and the commercially insured, Medicaid beneficiaries face greater barriers in using retail clinic services.

Despite evidence on the high quality, low cost care provided by retail clinics, state Medicaid programs fail to acknowledge this new model of care as an opportunity to fill patient demands for primary care, preventive services, and chronic disease management. In 2008, only 12.5% of clinics were located in medically underserved areas, suggesting room for expansion<sup>11</sup>. Twenty-seven states plan to expand Medicaid as part of implementation of the Affordable Care Act<sup>9</sup>, and many policymakers argue that nurse practitioners can alleviate primary care provider shortages. Individuals recently insured through Medicaid expansion may benefit from extended hours when looking for a point of entry into the healthcare system. Overall, low-income areas may be a favorable new market for retail clinics if the regulatory environment promotes access to these services.

State scope of practice laws also have an effect on clinic operations and the scale of potential cost savings. Currently, seventeen states allow nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, and prescribe medications<sup>1</sup>. States requiring a high level of physician oversight may limit cost savings offered by employing independent nurse practitioners<sup>8</sup>. Also, low Medicaid reimbursement for NPs may discourage clinics from opening additional sites in low-income or medically underserved areas<sup>16</sup>.

States have not capitalized on the opportunity retail clinics provide in improving population health outcomes. Several policy options can support retail clinic growth and remove patient barriers to access.

## **Policy Options and Criteria for Selection**

### *Maintain the Status Quo*

Given the ongoing implementation of the Affordable Care Act, state and federal budgetary constraints, and upcoming federal election, agencies may not have adequate resources to prioritize reforming regulation of retail clinics. Private retail clinics will continue to expand and operate without additional government regulation. Long-term impacts will depend on how the market adjusts to regulatory infrastructure currently in place. Retail clinics can acquire patients that are newly insured through the exchanges while continuing to partner with hospitals and physician groups. However, this option may not incentivize retail clinics to serve Medicaid or low-income patients. If state Medicaid programs do not strategically integrate retail clinics into their networks, use of retail clinics will remain primarily among the privately insured. Also, in states where interest groups oppose the growth of retail clinics, consumers may continue to face limited options when seeking care after hours or on weekends. This option does not require

additional government oversight, is politically neutral, and will allow the market to shape the future of retail clinics.

### *Reform State Nurse Practice Acts: Grant Nurse Practitioners Autonomy in Retail Clinics*

Advanced practice nurses represent a vital feature of the retail clinic model, but state practice acts restrict nurses from practicing without physician oversight. Variation in state laws is a barrier to retail clinics expanding geographically. With all states granting nurse practitioners full autonomy, retail clinics would not have to hire additional physicians for oversight, which may result in increased cost savings. For retail clinic operators, hiring independent nurse practitioners as opposed to physicians can allow retailers to charge affordable prices for those paying out of pocket. New programs brought forth by the ACA to train and education nurse practitioners will ensure an adequate workforce for retail clinics. Autonomous nurse practitioners are well positioned to provide highly demanded primary care and chronic disease management services. Expanding state scope of practice laws for nurse practitioners will complement and facilitate the success of the expanding retail clinic industry.

Expanding scope of practice is technically feasible and would require legislation removing requirements for physician oversight in settings where nurses provide a limited scope of services. The political feasibility of this option will vary across states. Lobbying efforts by various professional organizations such as physician groups may slow the legislative process. This option asserts the value that advanced practice nurses should practice to the full extent of their education and training, and allows new players to enter the healthcare market and deliver quality, cost effective care.

### *Expand Medicaid Enrollees' Access to Retail Clinics*

Many state Medicaid programs have yet to address the role that retail clinics can play in serving their beneficiaries. Medicaid patients would likely benefit from retail clinic coverage that includes vaccines, preventive care, or education on chronic disease management. While states expand Medicaid, retail clinics can serve as a point of entry for newly insured patients. Currently, retail clinic services are not distinguished from individual providers, forcing Medicaid patients to pay out of pocket for visits to retail clinics. From the perspective of retail businesses, low Medicaid reimbursement rates are a disincentive to expanding into underserved areas. The federal government should work with state Medicaid programs to adjust reimbursement rates and provider status for retail clinics in order to remove access barriers for their enrollees.

This option will require financial resources and may not be politically favorable with interest groups that are concerned with care fragmentation in an already vulnerable population<sup>5</sup>. Also, state governments trying to control Medicaid costs may not want to expand coverage for enrollees. However, implementing this option would expand equitable access to retail clinics beyond the privately insured or uninsured populations. For pharmacies located in urban areas, increased Medicaid reimbursement may encourage them to increase outreach to marginalized populations. This option would require dual action on behalf of states and the federal government in acknowledging retail clinics as a unique healthcare provider. Given that Medicare already expanded coverage for retail clinics for its beneficiaries, CMS can use existing regulatory procedures to carry out this option.

## **Recommendation**

At the federal level, CMS should strategize how state Medicaid programs can partner with retail clinics to expand healthcare access for enrollees. State Medicaid agencies should consider reimbursing retail clinics as an independent type of provider, and remove the pre-authorization requirement. To encourage care coordination, Medicaid programs can partner with retail clinics to strengthen referral procedures to primary care doctors and specialists already within their network. To protect competition among providers, reimbursement and copays should be standardized for similar services, regardless of care setting. Upon expanding coverage to include services delivered in retail clinics, state Medicaid agencies and Managed Care plans ought to inform their beneficiaries of the initiative. Retail clinics, managed care companies, as well as state and federal Medicaid agencies can work together to share data regarding overall service utilization, vaccination rates, and where patients seek care for chronic disease management. A collective effort by both public and private entities can help retail clinics expand their role in the market, serve the Medicaid population, and contribute to meeting public health goals.

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