

Policy Memo

To: US Federal Trade Commission (FTC)

From: Charline Gay

RE: Reducing barriers to the expansion of retail clinics

Date: 22 April 2014

Executive Summary

The role of retail clinics in the current healthcare market is being greatly contested among healthcare providers. While many physician groups argue that retail clinics are harmful and disrupt traditional primary care, other experts point out that retail clinics can save the US healthcare system a significant amount of money, increase access to consumers, and ease the burden on emergency care departments. There is a need for federal guidance on this hotly contested issue. The purpose of this comment is to inform policymakers of the current growth trends of retail clinics, explain which consumers use retail clinic services and why, and present evidence-based policy options that will benefit consumers and the healthcare industry overall.

Background

The US healthcare system is undergoing great change. The passage of the Patient Protection and Affordable Care Act (ACA) and the opening of the Health Insurance Marketplace have boosted the role of the patient as a consumer¹. From telemedicine to urgent care centers, new forms of healthcare delivery systems are

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emerging in the healthcare market to meet increasing consumer demand¹. Retail clinics have expanded over the past decade as an alternative form of healthcare delivery².

Located inside retail pharmacies like CVS, or supermarkets and large retailers like Walmart and Target, these retail clinics are staffed with non-physician clinicians (nurse practitioners, physician assistants) and offer various health services³. They provide basic preventative health services, vaccinations, prescription drug renewals, and treat simple ailments such as sinus and ear infections³. Table 1 summarizes the top reasons why consumers visit retail clinics³.

Table 1

Among U.S. Families Using a Retail Clinic in Past 12 months, Primary Reason for Visit, 2010

	2010
New Illness or Symptom	69.1%
Vaccination	25.8
Prescription Renewal	21.0
Physical Exam for School, Camp or Employment	12.7
Care for Ongoing Chronic Condition	†
Other	†

Note: Categories are not mutually exclusive; respondents could select multiple categories.

† Estimates not reportable because of high relative standard errors.

The retail clinic business originated from Minneapolis, MN during May in 2000⁴. The first shop was initially called QuickMedx and subsequently, the MinuteClinic. A central component in retail clinics is a computer kiosk serving as a patient self-service tool⁴. In 2009, CVS MinuteClinic occupied 41% of the retail clinic market, followed by Take Care at 31%⁵.

Research shows that Americans are paying closer attention to retail clinics over the years. Retail clinics have proliferated rapidly, from about 818 clinics in 36 states in 2007 to 1,260 clinics in 42 states in 2010³. The proportion of American

families using retail clinic services has also increased, tripling from 1% in 2007 to 3% in 2010³, and more families (about 29%) are living in closer vicinity to retail clinics⁶. Yet, while 4.1 million families reported using retail clinics in 2010, the use of retail clinics compared to other forms of care is modest³.

Retail Clinics: Disruption or Solution?

There is growing concern among physician groups about the role of retail clinics in the healthcare system. Providers worry that retail clinics will induce greater consumer demand due to the convenient access, disrupt patient care coordination because of lack of follow-up and care continuity, and deliver lower quality of care compared to the traditional primary care setting⁴. However, others argue that retail clinics have the potential to solve the access issues facing many consumers². Retail clinics are convenient and easy to access, offer quick services at lower prices, have transparent pricing, and are open for extended hours on weekends and evenings³. Proponents of retail clinics also argue that greater coordination and collaboration between retail clinics and community resources could potentially reduce disease exacerbations, unnecessary hospitalizations, and adverse drug reactions².

There is need for federal leadership and guidance on role of retail clinics. There is growing concern that retail clinics will further fragment patient care and deliver lower quality of care. In response to these concerns, the Federal Trade Commission or other federal entities can take the lead in designing policy that

would encourage retail clinics to play a complementary role instead of a disruptive one in traditional primary care.

Policy Options

In 2010, the RAND Corporation did extensive research on the role and policy implications of retail clinics⁷. Below are three useful policy options proposed by RAND experts:

(1) Create policies to encourage coordination between retail clinics and other

healthcare providers: This would involve promoting the integration of retail clinics into accountable care organizations (ACO), collaborations with other hospitals, and increasing coordination of health information technology between clinics and other healthcare providers.

(2) Encourage retail clinic establishments in underserved communities:

Retail clinics are less prevalent in low income and underserved communities. Table 2 below illustrates that access to retail clinics increases with family income³.

Table 2

	2010
ALL FAMILIES	28.8%
INCOME	
Below 200% of Poverty	24.7*
200% to less than 400% of Poverty	27.6*
400% to less than 600% of Poverty	29.8*
600% of Poverty or Higher (R)	37.2

(3) Ensure that retail clinics are held accountable to the same standards as

other healthcare providers: Physicians are reasonably concerned about

potentially lower standards and quality of care being delivered in retail clinics.

Policymakers can hold retail clinics to same standards of accreditation, quality measurements, provider credentialing, and reimbursement as physician offices. This would equalize the playing field while ensuring quality care for patients.

The Recommendation

The recommended policy option is based on feasibility and potential for impact. Options 2 and 3 lack feasibility and face greater policy resistance. Although the establishment of retail clinics in underserved communities might improve access for lower income families, there is the possibility that retail clinics may not flourish in low-income areas. Retail clinics are more appealing to consumers with higher deductible plans because these consumers are more sensitive to costs. High-income families are more likely to use retail clinic services because they can afford the out-of-pocket costs⁷. Thus, out-of-pocket expenditures may deter low-income families from using retail clinics. Even if the government intervenes, retail clinics will still lack incentive to settle in more underserved neighborhoods due to revenue concerns.

Secondly, although holding retail clinics to same standards as other health providers has its merits, the potential impact of this policy option is questionable. Even though physician groups are raising concern, there is evidence that retail clinics do provide quality care at lower prices with no apparent adverse effects when compared to traditional physician providers⁸. The concern among physicians is mostly a competition issue, rather than a quality issue. In fact, most primary care

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physician offices don't apply quality practices of peer reviews and patient follow-ups². Even if retail clinics prove to deliver quality care and are held to same standards as physician offices, it is unlikely that the concern in the physician community will diminish. It is more of a competition issue as opposed to a quality issue.

Encouraging collaboration between retail clinics and other healthcare providers, particularly hospitals and ACOs, is the most promising option for policymakers. It's feasible because the goals of retail clinics and ACOs compliment each other. Both entities strive to deliver efficient and quality care. These partnerships will also reach more consumers in the healthcare industry.

Retail Clinics and ACOs: Opportunity for Collaboration

There is growing recognition in the healthcare market for the need of partnerships between retail clinics and hospital systems, and these partnerships are already happening. The Cleveland Clinic, UCLA Health System, and Sharp Healthcare of San Diego have already partnered with CVS to run MinuteClinics inside their retail stores³. Furthermore, the proportion of investor-owned retail clinics is declining (from 24% in 2007 to 16% in 2010), while the share of retail clinics owned by hospital systems is rising, doubling from 9% in 2007 to 18% in 2010³.

Besides hospitals, federal guidance should focus on partnering retail clinics with ACOs. The Affordable Care Act promotes the ACO model as the answer to cost control and efficiency⁹. Under this model, physicians, hospitals, and other healthcare providers form networks to coordinate and assume responsibility for overall cost

and care of a defined beneficiary population⁵. Providers are awarded bonuses when care is delivered efficiently⁹. The goals of an ACO are to control and save costs while operating efficiently in delivering care³. There are 428 ACOs in existence and approximately 14% of the US population is currently served by an ACO⁹.

Collaboration between retail clinics and ACOs can yield significant cost savings and improve patient care coordination. Research has shown that 27% of all emergency department visits could be managed at retail clinics or urgent care centers⁶. Patients can be diverted to retail clinic sites to receive the same type of care they would have received in the ER⁶. Under this approach, potential cost savings are estimated to be approximately \$4.4 billion annually⁶. The US healthcare system would benefit greatly from this approach. ACOs would save money, reduce patient wait time and the duplication of services, and decrease unnecessary and costly ER visits^{3,6}.

However, federal regulation and guidance is crucial for making this model a success. Policymakers must address the various barriers to retail clinic proliferation and ACO integration. Next steps should include expanding the scope of practice for nurse practitioners. It is difficult for retail clinics to expand in states where scopes of practice laws are restrictive towards nurse practitioners³. Since this area of regulation is under state jurisdiction, Health and Human Services (HHS) should work with state policymakers towards expanding the role of nurses. In addition, Centers for Medicare and Medicaid Services (CMS) should offer financial incentives to ACOs for partnering with retail clinics. Financial incentives favoring the use of retail clinics already exist. Currently, some employers reduce copayments

for retail clinic visits compared to physician office visits³. CMS can increase capitated payments to ACOs for partnering with retail clinics.

In summary, the US healthcare system is faced with a number of challenges. The high cost of care and difficulties in accessing care continue to bother policymakers and consumers². These problems are partly the result of fragmentation in healthcare delivery. Clinicians don't talk to each other and when they try, it is often difficult to communicate. New forms of healthcare delivery will continue to emerge in the healthcare market. Telemedicine, urgent care centers, and retail clinics are examples of this trend. Federal policymakers must take the lead in ensuring that retail clinics, hospitals, physician offices, and patients communicate effectively and collaborate efficiently.

Citations

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