

*I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University.*

### Summary

Retail Clinics have steadily increased their presence in the health care market since their inception in 2000. Retail clinics provide low cost, easy access, and quick service that has attracted patients from all demographics. From 2007-2010 retail clinics utilization rates for families increased from 1% of the population to 3%. Concentrated in more affluent areas, retail clinics are utilized more frequently by individuals that are at least six times above the poverty level. Opponents of the retail clinics claim that the services provided are of low quality, and that the model creates fragmentation of care. Many states support these claims and thus pass legislation that decreases the scope of practice and autonomy of Physician Assistants and Nurse Practitioners, the two professions that allow retail clinics to provide low cost services. Nevertheless, retail clinics are projected to expand into areas such as chronic disease and medication management, as well as direct-to-employer insurance programs. Additionally, with the expansion of Medicaid under the ACA retail clinics will be in higher demand given the limited availability of primary care physicians. However, for retail clinics to become true “disruptive innovation” regulatory barriers that limit the scope of practice for nurse practitioners and physician assistants must be addressed. More importantly, retail clinics should increase their presence into low income communities.

### Background

Retail clinics made significant gains in the health care market by 2007, increasing market growth by over 300% from inception in 2000[1]. Since, the increase has gone from 818 clinics in 36 states in 2007 to 1,260 in 42 states in 2010[2]. Approximately 69% of consumers utilize clinics for new illness or symptom, 25% of visits are for vaccinations, and 21% of visits are for prescription refills[3]. The retail clinic model looks to provide easy access and convenient care, at a low and transparent cost through utilization of Nurse Practitioners and Physician Assistants that care for patients with mild illnesses and preventive care[4]. Utilization of retail clinics is mostly due to the lack of access to primary care provider clinics. Thus, almost half, about 45%, of visits in a retail clinic occur when physician offices are closed, including the weekend or during the weekday hours[5]. Both access and cost are important to those from a lower socioeconomic status, however, most retail clinics are situated in more affluent areas. Those that have income six times the poverty level, approximately 36%, have more access to retail clinics than those that are only two times the poverty level, approximately 25%[6].

Additionally, as of 2008, 97% of clinics accept private insurance, 93% accept Medicare, and 60% accept Medicaid[7]. And approximately 16% of employees from large employers had used the clinics 2008. The changes in health insurance legislation due to the ACA expansion will likely increase the number of individuals with insurance, specifically Medicaid, which will lead to increased utilization of retail clinics in the future. The already limited number of primary care physicians will lead more individuals to seek health care at the retail clinics. Similarly, it is estimated that insurance companies could save 4.4 billion dollars annually from increased utilization of retail clinics by members[8]. Each visit for a retail clinic saves the insurer approximately \$50-\$55[9]. Insurance companies have capitalized on these savings and urged members to use retail clinics by reducing barriers to these services. Thus, many insurance companies have lowered or omitted cost-sharing mechanisms for members that utilize retail clinics.

Projections for the future of retail clinics show that utilization and growth will increase in the coming years[10]. Factors include the expansion of health insurance to a larger percent of the population due to the ACA, as well as the increase in support by insurance companies due to the cost savings. Retail clinics are projected to expand scope of care and increase revenue by moving into care management and referral management services for chronic diseases and acute specialties[11]. Additionally, and most importantly, some states are expanding the scope of practice for nurse practitioners (NP) and physician assistants (PA), which is the crux of the retail clinic model. Similarly, some states are attempting to pass legislation that limits the scope of practice for NP's and PA's, with the hopes of preserving the relationship between patient and physician. Resistance from providers claiming that services provided at retail clinics fragment care and are a detriment to the progress made thus far with healthcare legislation[12].

There are two major types of regulatory barriers that impact retail clinics. The first, limits the scope of practice for providers, including the number of providers a physician can oversee at any one location. This means that retail clinics must employ a particular number of physicians to oversee other providers. This regulatory barrier affects the number of patients a retail clinic must see to break even. The second regulatory barrier for retail clinics is the licensure and accreditation of the facility. States vary dramatically in the way in which the retail clinics are accredited, licensed and inspected. The regulation of accreditation, licensing and inspection creates geographic variation depending on the state and the scope of practice allowed for practitioners as well as the regulating body that enforces quality.

Increased access to low cost and efficient services is met with resistance by medical professionals because of the uncertainty of the quality of services, and the possible impact on the patient physician relationship. Additionally, many primary care physicians are concerned about the possible shift in patient mix because patients with mild conditions may utilize retail clinics more often. More importantly, a growing concern is the retail clinics ability to undermine medical home models and fragment care[13]. At the same time state legislation limits the scope of practice of NP and PA providers which limits the effectiveness of retail clinics. With the expansion of the ACA and the increase of individual's with insurance, primary care services will be even more difficult to access without retail clinics. Since retail clinics are situated in more affluent areas, those with Medicaid coverage after the ACA expansion will be least likely to utilize services when demand for primary care increases.

#### Reduce regulatory scope of practice restrictions

Currently, many states limit the ability of NP's and PA's to treat patients and prescribe medications independently without the oversight of a physician. The success of retail clinics depend on the ability of the clinic to save money by employing NP's and PA's instead of physicians. If legislation decreases the barrier to NP's and PA's, the retail clinics can expand access to care for individual's in lower income communities, as well as those with new Medicaid coverage.

Limiting the scope of practice for NP's and PA's may increase costs for services and for insurance companies because the providers may not be able to adequately treat patients for mild conditions. Limiting the types of services that can be provided by an NP or a PA may lead patients to seek care at other facilities after being screened by the retail clinic[14]. Reducing the scope of practice restrictions for NP's and PA's will allow the providers to care for all the needs of their patients without having to increase medication prescriptions or testing[15]. Also, even with the low reimbursement from Medicaid, retail clinics will still be able to maintain viability given the reduction in cost to employ NP's and PA's versus

physicians.

#### Expand access in low income communities

The current model for retail clinics includes providing a higher percentage of services to those in affluent areas[16]. The retail clinic model provides easy and low cost services to individuals but is significantly driven by the fact that it attracts commercially insured patients or those that can pay in full out of pocket. The retail clinics can meet the demand for primary and preventive services from those with Medicaid coverage if they expanded to areas with lower income. Patients in lower income communities will likely utilize services on weekends and evenings when primary care physicians are not available. This will shift the utilization from the emergency room to the retail clinic, which increases savings for the government.

#### Become a part of the medical home model

Retail clinics focus on episodic care, which on the face seems counter to the focus on comprehensive care in the medical home model[17]. However, with the increased utilization of electronic medical records (EMR), retail clinics can communicate more efficiently and effectively with health care organizations. Meaning, patients that are treated at retail clinics can still be followed-up by their PCP, and their visits at the retail clinic become a part of the package that is included in the medical home model.

Increasing the communication between retail clinics and other health care organizations or physician clinics will give patients easy access to care for simple acute conditions and preventive care. Additionally, patients will be monitored by their medical home team which will have access to all records from the retail clinic. Collaboration through medical records improves quality of care provided by retail clinics, maintains sufficient access to care for patients, and lowers costs to the patient and the insurer.

### **Recommendation**

#### Expand access in low income communities

The increase in Medicaid enrollees will call for more primary care and preventive services in low income communities. Retail clinics have the opportunity to expand services to low income communities where current retail services already exist. Regardless of the scope of practice for NP's or PA's, retail clinics in lower income communities will likely have a higher return on investment than previous years given the increase in newly insured individuals. As patients shift from self-pay to Medicaid or commercial insurance, utilization of services will increase. Retail clinics can prove their legitimacy and ability to provide quality care through the expansion of services to other areas. It is recommended that the retail clinics:

- • Expand acute care services and preventive to lower income communities
- • Include chronic care and referral management services in communities with a higher percentage of Medicaid enrollees
- • Develop relationships with providers in these communities to refer patients for follow-up
- • Enhance EMR capabilities to efficiently communicate with other providers as to not further fragment care

Retail clinics have the ability to address the problem of low access to primary care services. Expanding the retail clinic model to encompass individuals from low-income communities has the potential to improve the health of the populations, reduce costs of health care services for the government, as well as solidify the necessity for retail clinics in the new health care market.

- [1] [https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us\\_chs\\_RetailClinics\\_111209.pdf](https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_RetailClinics_111209.pdf)
- [2] <http://www.hschange.org/CONTENT/1392/>
- [3] <http://www.hschange.org/CONTENT/1392/>
- [4] <http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx>
- [5] Health Affairs: Scope of Practice Laws for Nurse Practitioners cost savings that can be achieved in retail clinics
- [6] <http://www.hschange.org/CONTENT/1392/>
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