

To: Vice President of the Foreign Trade Commission (FTC)
From: Kush Mahan, Policy Analyst at DC Think Tank

Executive Summary:

The retail clinic industry has grown in the United States through providing primary care that is accessible, cost-effective and of good quality. There are nevertheless barriers to growth facing retail clinics which are affecting their development in individual states and the nation as a whole. These barriers need to be addressed in order for the retail clinic industry to remain competitive and for millions around the country to access this effective primary care form. Changes in policy are suggested to address these barriers and enhance the industry's competitive edge. Recommendations around practitioner scope of practice laws are made to remove a major barrier affecting national and statewide growth of the industry.

Background:

There are limited primary healthcare options available in the United States healthcare delivery market. Visits to primary care physicians (PCPs), urgent care centers and the emergency department (ED) are the major primary care options and pose many challenges in their current makeup. Research demonstrates that there are various obstacles that such current primary care options pose, ranging from cost, accessibility, and the general shortage in PCPs. (Mehrotra et. al, 2009).

To address these problems in the delivery of healthcare in the US, the retail clinic industry emerged to the market in 2000. The retail clinic business model is to provide affordable, easily accessible primary care for specific conditions that were manageable largely by nurse practitioners (NPs). Conditions covered range from the flu and sinus infections, to some chronic care issues being addressed in some settings. Quality of care has not been shown to be sacrificed for such procedures, whilst cost of care in comparison to PCPs and EDs is lower (Mehrotra et al., 2009). Between the years of 2007-2009, growth in the retail clinic supply industry was as high as 350%, and usage of retail clinics grew exponentially (Mehrotra & Lave. 2012; Deloitte, 2009). With over 1,200 clinics now established nationwide, it is modeled that the number of clinics is to grow by increments of 20-25% per year through 2015 (Accenture, 2013).

With that said, there are obstacles to development of new retail clinics which could decrease their competitive edge in the healthcare delivery market. Many retail clinics have shut down, potential market competitors are deterred from entering the market, and slow developmental growth patterns in the industry has emerged (Deloitte, 2009).

Issues such as lack of awareness of the effectiveness of retail clinic care and low insurance coverage are obstacles that are hindering growth. Additionally, state by state policies regulating retail clinic scope of practice laws has further dampened nationwide competition and equitable distribution of retail clinics in the US (Retail Clinics, 2009).

As is noted by Mehrotra et al. (2009) it is these clinics that are providing quality, cost effective and accessible services for people often underserved by the primary care market. Their increased supply and competition in the healthcare delivery market is therefore vital.

Evidence:

Patients can save upwards of \$50 per episode when using retail clinics instead of PCPs (Mehrotra, 2009). Three fifths of users of retail care report limited or no access to PCP and \$4.4 billion could be saved in ED visits if patients utilized retail clinics for the same conditions (Weinick, 2010;

Mehrotra, 2008). It is noted that retail clinics additionally demonstrate no significant difference in quality (Mehrotra et al. 2009).

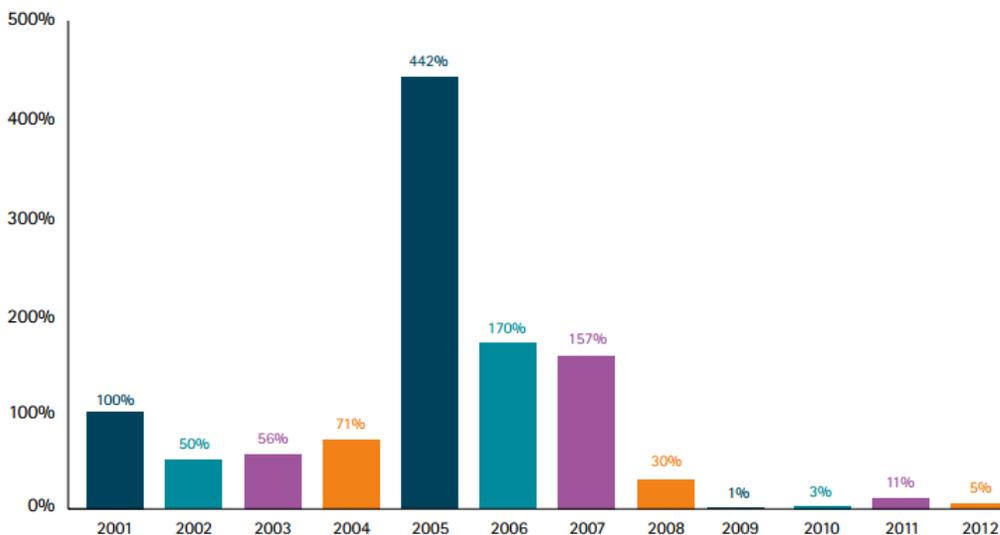
With that said, there have been stages of a drop in industry development. There was a drop from 157% growth over 2007 to 1% in 2009 (Accenture, 2013). While there are projections that growth will increase by an approximately 25% level per annum, there are barriers to growth that need to be addressed (Accenture, 2013; Deloitte, 2009).

Civilian awareness of service quality nationwide is low, with 65% expressing concerns despite evidence to the contrary (Deloitte, 2009). Major insurance schemes such as Medicaid do not sufficiently cover retail clinic care to the same extent as other forms of primary care, even with over 50 million Medicaid beneficiaries existing and struggling to access PCPs (Chang & Davis, 2013). It was reported that 71% of Medicaid users have had to pay out of pocket for retail care, with one-third of PCPs not accepting new Medicaid enrollees in 2011-12 (Weinick, 2010; Decker, 2013).

Strict policies additionally exist state by state limiting NPs independence to run clinics, requiring physician supervision and collaboration. It can be noted that states with such laws may promote less retail clinic development in comparison to those with relaxed laws. Massachusetts, who requires physician supervision in retail clinics had 13 clinics in 2009 after the large growth retail growth period, in comparison to New Jersey with 32 who request collaboration but not supervision (Retail Health Clinics, 2011). Clinics without restrictions report large cost savings and decreased operating costs in comparison to others. Without restrictions, clinics are more profitable and up to \$810 million is projected to be saved in primary healthcare by retail clinics (Spetz, et. al., 2013).

Growth Trends: (Accenture, 2013)

Figure 1
US Retail Clinics Year Over Year Growth
2001–2012



Source: Merchant Medicine

Problem:

There is an evident retail care need in society with statistics around quality, cost effectiveness, utilization trends and convenient access being positive. There is additionally a shortage of PCPs nationwide, whose care for certain conditions can be addressed in retail clinics, alleviating this shortage (Accenture, 2013).

There are nevertheless quantified barriers that could affect the development of new retail clinics. The problem exists where cumulative nationwide growth trends may be hindered, and lack of equitable distribution state by state of clinics will be maintained (Deloitte, 2009; Retail Clinics, 2009). Statistics demonstrate past inconsistency in annual growth trends and discrimination in location of growth comparing states (Deloitte, 2009; Retail Clinics, 2009). Some states have over fifty clinics, with others having zero.

Barriers thus need to be addressed to allow for market development. More patients could save upwards of \$50 on each retail care visit, whilst receiving quality care (Retail Clinics, 2009). Up to \$4.4 billion could be saved in ED visits if enough retail care existed and was used when needed. With the expected increase in primary care demand through the Affordable Care Act, increased retail clinic supply and competition in the market needs to be a focus (Weinick, 2010).

Policy options:

Policy Suggestion 1: The first suggested change of policy concerns state governors removing regulations prohibiting NPs from running retail clinics independently (Retail Clinics, 2009). It is noted that in many states NPs need to be supervised by physicians. State specific retail care regulations should be developed independent of general scope of practice laws to address this issue. Massachusetts was the first to embark on specific retail clinic laws, demonstrating that this proposed solution is technically feasible.

Value would be added through a predicted increase in individual statewide and nationwide retail clinic growth as this barrier to market entry would be removed (Retail Clinics, 2009). Supply of NPs available to run retail care clinics independently would increase, and societal cost savings could increase up to \$810million (Spetz, et. al, 2013). Strain on PCPs who are already in shortage, as well as on retail clinics' operating costs to hire PCPs, would decline. The healthcare delivery market would benefit, appeasing the FTC as competition and industry growth would be more equitable. As was noted, more relaxed policies can influence in which states large clinic generation takes place (Retail Clinics, 2009). Thus, without this policy change, equitable growth nationwide may not be sufficient, society would not be as profitable, and incentives to grow in states with strict regulatory policies would remain lower.

Trends in percentage growth change and state specific change in retail clinic generation annually can be measured to assess this policy's effectiveness.

Constraint: There are PCP concerns over fragmented care developing if NPs become major independent primary care providers, as PCPs may feel disconnected (Retail Clinics, 2009). PCPs are worried about a discontinuity of effective care when patients may need certain levels of primary care beyond conditions being treated at retail clinics. A potential solution to this would be to require feedback regulations where retail clinic NPs report data to off-site PCPs periodically who oversee quality control and advise NP referral patterns (Deloitte, 2009).

Policy Suggestion 2: A suggested option is increasing the demand for retail care through enforcing a nationwide marketing campaign supporting the quality of retail clinic care. Such healthcare marketing campaigns have proven effective and could be run by each state's Department of Health (Johnson, 2012). As was noted, nationwide knowledge of retail care quality is low. This strategy would be technically feasible as long as each state assigns an adequate budget to running the campaign.

The value it can add stems from increasing market activity and impacting the excessive ED spending that could take place at a retail clinic (Weinick, 2010). In accordance with the FTC's goals, this could incentivize further development and supply of retail clinics as competition in the healthcare delivery market would be enhanced through increased consumer demand for retail clinic care.

Trends in clinic utilization and development of clinics annually can be measurement sources for this policy action's effectiveness.

Constraint: If increased utilization of care is significant following the campaign, but other barriers such as regulations on NPs scope of practice are not addressed, the retail clinic supply may not keep up with the demand. In states with mandated physician supervision in retail clinics, there may not be a high enough supply of physicians available to supervise more clinics in order to grow more clinics. Thus, in existing clinics, obstacles such as high wait times that exist with seeing a PCP may develop with patient volume growing but clinic development not keeping up. This hinders the crucial convenience and accessibility factor of retail clinic care.

Policy Suggestion 3: State Medicaid Directors should promote alteration of reimbursement policies for Medicaid patients to receive adequate retail clinic care coverage. With the increasing enrollment of patients in Medicaid through the ACA, the retail clinic industry could benefit from adopting these consumers (Deloitte, 2009). Limited Medicaid reimbursement exists for retail clinic care, with some clinics not accepting Medicaid at all. Only 10% of Medicaid beneficiaries consequently reported to using this care in 2009 (Deloitte, 2009). Making the suggested change would provide cost effective and quality care options to Medicaid patients, whilst concurrently allowing for increased demand for retail clinics. This increased demand could lead to greater volume of visits in clinics, increased revenue in the industry, and an incentive to continue to grow retail clinics nationwide. Without doing so, Medicaid patients will continue to face the challenges that they currently do with accessing primary care, and an increased consumer potential for retail clinics would be impacted.

Utilization of care by Medicaid beneficiaries and consequent development of clinics could be sources of measurement for this policy's effectiveness. Yearly growth rates statewide and nationwide should be assessed.

Constraint: Through incentivizing increased utilization of retail clinics via Medicaid beneficiaries, safety net clinics may suffer through losing NP supply. As utilization of retail care increases, supply of NPs may also need to. NPs who staff safety net clinics may be more inclined to work at retail clinics due to potentially higher salaries (Retail Clinics, 2009). Thus, safety net clinics, who often need federal assistance for staffing, may need to be considered when enforcing this policy.

Recommendation:

The recommended policy suggestion would be for state governors to develop retail clinic scope of practice policies allowing NPs to act independently. Societal cost savings are shown to increase with NP independence and industry players are incentivized to expand their market share as financial and logistical barriers to competition in the healthcare delivery market are removed. Retail clinics can thus be stronger in their growth and crucial services to consumers will expand equitably.

In comparison to the other suggested options, this focuses directly on both nationwide and equitable statewide retail clinic development. The other policy suggestions would increase volume of care, but this could likely be concentrated in specific locations.

The FTC should thus pursue the following steps:

- Describe the problem and endorse the policy suggestion to state governors
- Work with individual state governors to tailor retail clinic care policies around the recommendation
- Project potential growth patterns and cost savings to players in the industry, incentivizing their activity in the market
- Encourage communication amongst retail clinic players, allowing them to discuss policy concerns and voice them to the FTC in a unified fashion when needed

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