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# Understanding the Impacts of Health-Care Reform on Urgent Care: Care Utilization, Population Health and Integration, and Reimbursement

**Urgent message:** Urgent care plays a vital role in reducing medical expenses and improving population health by enabling the right care, at the right place, by the right provider, at the right price.

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## Introduction

Health-care reform, quality of care, and costs are center stage topics for politicians and the general public. As medical providers and administrators in the United States, we share in the challenge of understanding this complex system. Whereas traditional approaches in the fee-for-service environment focused on "sick care," population health promotes prevention and healthy lifestyles. Under discussion here are the assessment of previous health-care utilization patterns, allowing the prediction of future urgent care needs; understanding the critical need for integration of urgent care programs into health-care systems, allowing for reduction in costs and improved patient access; and reviewing new Medicare reimbursement models in relation to urgent care center fiscal stability and success. Care improvement through integration of urgent care centers will play a critical role in our future health-care environment.[1–3]




The intent of the Patient Protection and Affordable Care Act (PPACA) was to provide care for uninsured Americans and gain control of health-care expenditures through care integration, improved technology, and population health management. Massachusetts was one of the first states to have success with provision of health insurance to the majority of its residents; though patients had insurance, access to providers was limited because of the predominance of a Medicaid product.[4] Without access, provision of care becomes difficult.

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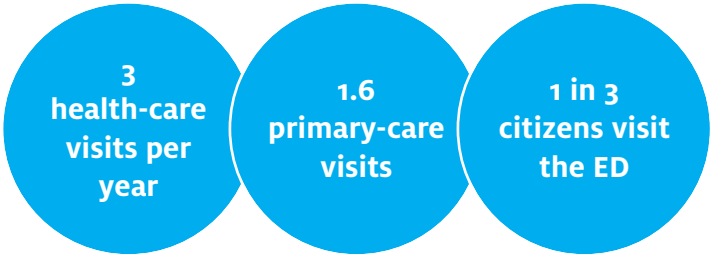
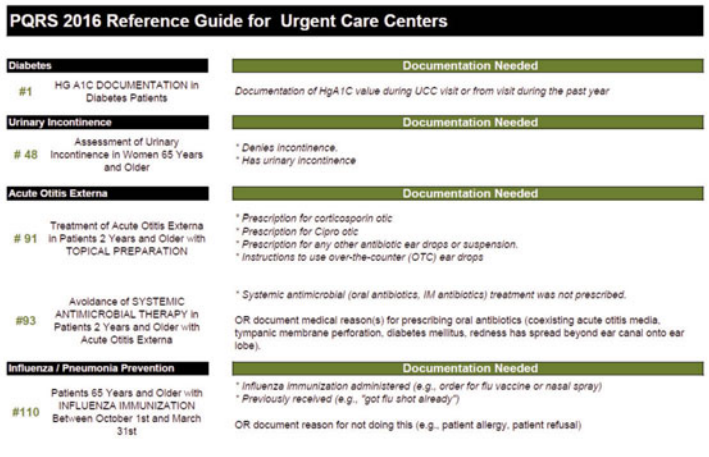
**Figure 1. Average annual health-care utilization for U.S. citizens.**




ED, emergency department.

**Figure 2. Example of urgent care Physician Quality Reporting System (PQRS) measures for reporting.**



PQRS 2016 Reference Guide for Urgent Care Centers

| | | |
|---|---|---|
| **Diabetes** | | **Documentation Needed** |
| #1 | HG A1C DOCUMENTATION in Diabetes Patients | *Documentation of HgA1C value during UCC visit or from visit during the past year* |
| **Urinary Incontinence** | | **Documentation Needed** |
| # 48 | Assessment of Urinary Incontinence in Women 65 Years and Older | * Denies incontinence.<br>* Has urinary incontinence |
| **Acute Otitis Externa** | | **Documentation Needed** |
| # 91 | Treatment of Acute Otitis Externa in Patients 2 Years and Older with TOPICAL PREPARATION | * Prescription for corticosporin otic<br>* Prescription for Cipro otic<br>* Prescription for any other antibiotic ear drops or suspension.<br>* Instructions to use over-the-counter (OTC) ear drops |
| #93 | Avoidance of SYSTEMIC ANTIMICROBIAL THERAPY in Patients 2 Years and Older with Acute Otitis Externa | * Systemic antimicrobial (oral antibiotics, IM antibiotics) treatment was not prescribed.<br>OR document medical reason(s) for prescribing oral antibiotics (coexisting acute otitis media, tympanic membrane perforation, diabetes mellitus, redness has spread beyond ear canal onto ear lobe). |
| **Influenza / Pneumonia Prevention** | | **Documentation Needed** |
| #110 | Patients 65 Years and Older with INFLUENZA IMMUNIZATION Between October 1st and March 31st | * Influenza immunization administered (e.g., order for flu vaccine or nasal spray)<br>* Previously received (e.g., "got flu shot already")<br>OR document reason for not doing this (e.g., patient allergy, patient refusal) |

## Care Utilization

The primary reasons for reform include controlling the escalation of health-care costs and provision of health coverage for the uninsured. As many health care providers and patients are aware, health care in the United States is more expensive than in most other industrialized nations, surpassing $8000 per capita. Premiums and out-of-pocket costs have increased even though reform has occurred. The reasons for this are multifactorial: the increased use of technology, pharmaceutical expenses, overutilization, poor coordination of care, fraud, and medical malpractice, along with many others. Expenses are decreased by either reducing utilization or reducing utilization costs.[2]

Understanding utilization is critical to understanding health care. According to statistics from the Centers for Disease Control and Prevention, the average citizen visits a physician office three times per year, with approximately 1.6 visits to primary-care providers, 0.8 to medical specialists, and 0.6 to surgical specialists.[4] Emergency department (ED) use averages one visit for every three citizens, or just over 120 million patient visits per year (**Figure 1**). As the population ages, this utilization shifts upward toward 1.66 visits for primary-care providers.[5]

Using those statistics, predictive modeling suggests that a hypothetical locality of 100,000 citizens would require at least one ED caring for about 33,000 patients (one visit for every three citizens) and a primary-care network that can manage approximately 160,000 visits.

Primary-care offices often maintain panels of 2000 to 4000 patients per provider, with the specific number depending on the level of office support available, the use of advanced practice providers, and the average age of the patient in the practice.[5] An older population predicts higher resource utilization and more complicated (higher-medical-acuity) office evaluations, more urgent care visits, and more ED visits.[5] Based on Medicare fee schedules, reimbursement is at a fixed rate and lower than for commercial products. This concept is critical to understand when opening an urgent care center in New York City compared with one in Miami. The higher number of Medicare patients in the latter location leads to higher utilization of urgent care services by the Medicare population and potentially lower reimbursement compared with commercial carriers.

In business and medicine, product utilization increases or decreases according to market fundamentals and the need for service. When there is high demand for a product (i.e., health care for epidemic influenza), utilization increases. Unlike the case with business product demand, the price of health care does not respond in similar fashion, because of fixed or negotiated reimbursement under specific insurance products. Insurance carriers often increase patient deductibles and out-of-pocket costs in an attempt to control utilization. As health-care (out-of-pocket) costs increase, utilization may decrease or become more selective. Patients seek lower-cost alternatives with similar quality (e.g., an urgent care center vs. an ED) and easier access (telemedicine vs. urgent care). Medical utilization may be pre-

dictable on the basis of the already-mentioned statistics and may assist in determining the need for further facilities, including urgent care centers. Typically, minor illness and injury volumes are predictable and do not change unless access decreases (local closure of a physician office, urgent care center, or ED), the local population increases (e.g., new industry moves to the area), or epidemic illness occurs. Population health management attempts to shift utilization toward *prevention* of illness rather than *treatment* of illness.

**Table 1. Urgent Care Opportunity with Medicare Population Health**

| Description | Code | Medicare Fee Schedule[a] |
|---|---|---|
| Post-discharge follow-up | 99495 | $163 |
| Post-discharge follow-up, high risk | 99496 | $231 |
| Smoking cessation | 99406 | $11–$15 |
| Weight-loss counseling (nutrition) | 97802 | $30–$40 |
| Immunization | G0008/G0009 | $8 |
| Influenza | 90686 | $12–$24 |
| Health risk stratification examination (initial preventive physical examination) | G0402 | $150–$200 |
| Electrocardiogram | G0366 | $15–$25 |

[a]Reimbursement may vary by geographic region.

## Population Health and Integration

According to Don Berwick, MD, of the Institute for Healthcare Improvement, the aims of population health are improving the overall health-care experience, improving the health of specific populations, and reducing the total per capita costs of care.[6] Physicians, urgent care centers, and hospitals attempt to reduce variability, costs, and errors through the standardization of health practice. In addition to creating additional points of patient access to care, urgent care centers help to reduce the unit cost of care and direct new patients into the integrated hospital system.[7]

Integration occurs in the form of accountable care organizations serving Medicare populations, clinically integrated networks serving a locality and marketing directly to employers (i.e., eliminating insurance carriers), or local health systems attempting to improve health management for populations that include their own employees.[2,3] Previously, patients were cared for by independent providers (physicians) and multiple health-care organizations that functioned under different platforms, imaging and medical records systems, and accounting systems. By using the same platform and electronic medical record systems, providers and hospitals can reduce errors, duplication, and costs.[2,3] An integrated spectrum of care progresses from the physician office to urgent care, emergency care, inpatient care, and post-acute care.[8,9]

Post-acute care within 2 to 4 weeks of hospital discharge may help reduce patient readmissions and improve outcomes for this high-risk population. Less than half of readmitted patients are seen by their primary-care physician before being readmitted to the hospital.[10] Post-acute care programs are structured to reduce readmission cases with early assessment of recently discharged patients. By integrating with the hospital case-management program, urgent care centers easily provide critical assessment of these frail patients by reviewing the plan of care, examining the patient to ensure that their health is continuing to improve, and ensuring that discharge medications are taken correctly. Further, primary-care appointments are scheduled, and any additional social needs are evaluated. Two recently added Medicare codes, 99495 and 99496, define the protocol of patient phone calls, face-to-face evaluations, and specific documentation requirements (**Table 1**). The new paradigm for population health attempts to reduce the need for hospitalization and post-discharge assessment, focusing on preventive care and early health risk identification.

Health risk assessment and early identification of illness are identified by a health risk assessment examination (HRAE) or an initial preventive physical examination (IPPE). These IPPEs are specifically designed for new Medicare enrollees, but patients not having Medicare coverage may require similar examinations depending on the coverage requirements. Urgent care centers have become the physical examination experts, providing assessment for Department of Transportation, flight, sports, immigration, and school physicals. Performing HRAEs and IPPEs in urgent care centers is a logical and cost-effective option when followed by appropriate referral to primary-care providers for assignment to medical homes (**Table 2**). This reduces the burden and workload for primary-care providers in the same organization. The examination also allows for electrocardiography performance, diabetes

| Table 2. Health Risk Stratification Categories |
|---|
| **Category 1 (high risk for acute event in short term)**<br>• One or more chronic diseases<br>• Multiple disease risk factors<br>• Poor socioeconomic factors |
| **Category 2 (further development of chronic illness)**<br>• No or one chronic disease<br>• Three or more risk factors<br>• Socioeconomic factors |
| **Category 3 (generally well)**<br>• One or more risk factors<br>• Risk factors may be unknown<br>• Patient education for risk factors |
| **Category 4 (truly well)**<br>• No illness<br>• No risk factors<br>• No socioeconomic issues |

testing, and lipid screening, along with several other separate and billable services.

Besides the IPPE, other shared initiatives between urgent care and primary care can involve health promotion through wellness, immunizations, healthy-lifestyle education, weight-loss and smoking-cessation classes, and workplace health and occupational medicine programs. Each of these can be provided in the cost-effective urgent care environment. Many urgent care centers are integrated into larger health systems that use preventive-care screening initiatives prompted by embedded computer technology. These prompt alerts may be identified by all providers within the system and may be forwarded to patients via electronic notification, improving health compliance and preventive-care goals.

Under the Health Information Technology for Economic and Clinical Health Act of 2009, the government allocated over $19 billion to provide assistance to health-care providers and systems. The benefits from these common data pools and integrated electronic medical records are becoming more evident. Clinicians have the ability to instantaneously review recent and remote test results, previous medical problems, and medical regimens that the patient has undergone. This information results in decreased duplication of testing, improved communication among providers, and the ability to extract large volumes of data for analysis. Clinical researchers can synthesize small volumes of data and develop recommendations for future treatment modalities. Massive data aggregation allows for near real-time analysis of patient data and the ability to assess disease-management trends.[6,11] The new field of health-care analytics permits data synthesis and improved predictions of patient outcomes, complications, and costs of care. These predictions promote a cost-efficient system and care-management modification when data are utilized correctly.

## Reimbursement

Reimbursement changes play a key role in reduction of overall health-care costs. Understanding these payment changes and demographic shifts with payors becomes critical to financial viability. Although Massachusetts has one of the most successful universal coverage programs in the country, the majority of patients were enrolled in state Medicaid programs, resulting in a 4% increase in ED utilization.[12] Though patients had Medicaid coverage, provider access panels did not expand, which caused limited availability of primary-care resources. Since implementation of the PPACA, we have seen a similar shift in EDs and urgent care sites, with a decrease in the self-pay population being directly correlated to an increase in Medicaid volume. Contrary to the Massachusetts experience, ED volumes have not significantly changed. This may be related to the significant expansion of urgent care centers and federally qualified health-care centers, allowing for improved access.

Under the PPACA, major reimbursement changes include pay for performance, penalties for patient readmission, and bundled payment. Understanding these modalities and additional chargeable codes under population health helps systems maintain financial viability.

The Physician Quality Reporting System (PQRS), developed in 2006 by the Centers for Medicare & Medicaid Services (CMS), ties reimbursement to quality performance of selected initiatives. Medicare initiatives under the PQRS provide incentives for those that report performance and meet or exceed set goals. Yet according to data from the 2015 Benchmarking Survey of the Urgent Care Association of America (which is based on 2014 data), less than 50% of urgent care sites participate in this program.[13] In 2015, successful PQRS participation required reporting on at least nine measures covering at least three National Quality Strategy domains.[7] CMS guidelines requires providers who bill for any Medicare Part B face-to-face services to also report on cost-cutting measures. Incentive payment requires reporting on nine measures over three domains, although to avoid penalty, providers must report on three measures over one domain (one of nine includes an outcome measure). Future reimbursement is tied to both reporting and performance on these initiatives (**Figure 2**). Under

the PQRS, providers and groups may face up to a 6% reduction in Medicare payments. Lack of participation will result in decreased reimbursement starting in 2017 for Medicare-billable cases.

An additional modality is bundled payment for specific procedures, including hip and knee replacements. Reimbursement is provided to one entity, most likely the hospital; this payment must then be split between the health-care institution and all providers involved. Medicare patients average about 10% of the urgent care visits. Financial impacts may be greater under these reimbursement changes, with areas of Florida and other locations catering to a higher Medicare population.

## Discussion

Harris suggests that ED visits may be reduced by 30% through diversion to other health-care alternatives.[2] A more conservative estimate would be 20% of the overall ED population, resulting in a savings of about $5 billion. Though many have developed promotional slogans for population health changes, I suggest and introduce a care concept of the "Right Patient, cared for at the Right Place, by the Right Provider, charged the Right Price," or RP[4].

Administrators and providers of urgent care must understand health-care demographics and utilization in order to determine expansion alternatives. Reviewing population density, utilization, and internet mapping technology (locating medical facilities and urgent care centers), operators and prospective owners can assess medical need for urgent care centers. Returning to the example of the hypothetical city, with a population of 100,000, the ED could easily divert 20%, or 6600 patients with lower-acuity needs, to urgent care. In addition, after-hours care, episodic illness and injury care, routine physical examinations (sports, Department of Transportation, immigration, etc.), and occupational medicine could easily add another 10,000 visits. In that hypothetical situation, more than two urgent care sites could lead to saturation.

Many larger cities have approached the saturation point for urgent care services, with expansion of sites simply resulting in a dilution of the same client base. Therefore, smaller cities seem to provide more opportunity. Further, significant saturation will likely occur when there are more than 12,000 urgent care clinics across the nation. Growth will be challenging, and financial success may be limited. Integration with the local health-care system provides additional opportunity and patient volume in a mutually beneficial relationship between the system and urgent care centers.

## Conclusion

The domains of urgent care and population health share common goals and support the RP[4] concept. With health system integration, urgent care centers provide care for the minor episodic injury and minor illness populations at a cost-effective price. Providing after-hours, weekend, and holiday access makes urgent care centers an invaluable resource by reducing the need for the use of EDs and reducing expense to the patient and the system. Health promotion through HRAEs, immunizations, and smoking-cessation and weight-loss programs and counseling is a critical component of population health and is easily integrated into urgent care. Urgent care centers become accessibility portals for overburdened primary-care offices and saturated EDs. Health system integration provides a common platform for technology and electronic health records, leading to improved care, reduction in duplication, and decreased costs. Proper understanding of health-care utilization reduces the potential for local urgent care center saturation. Finally, understanding new reimbursement methods becomes critical to financial viability. Urgent care as an industry and "new" specialty must be at the negotiating table alongside health-care systems, specialists, and primary-care providers. ■

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