Urgent Care: Bringing Our Value Proposition to the Payer Community

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UCAOA' s most recent Benchmarking Survey data indicated the median number of patient visits per day in an urgent care center was 32, down slightly from the prior year; however, based on the current database of urgent care centers in the United States, this would translate to urgent care centers caring for nearly 85 million visits per year.

The Centers for Disease Control and Prevention's 2012 National Ambulatory Medical Care Survey[1] quantifies outpatient physician office visits as follows: total visits, 928.6 million; visits/100 persons, 300.8; percentage of visits made to primary care physicians, 54.6%. Therefore, assuming ambulatory care visits remained consistent with activity reported in 2012 and primary care visits represent 54.6% of all visits (or 507 million), urgent care would represent over 16% of all primary care visits and over 9% of all outpatient physician visits.

Statistically, it would seem urgent care has earned its seat at the table as we discuss reform.

Recent studies conducted in Massachusetts and Colorado concluded that 40% of emergency department visits were for nonemergent conditions that could be more appropriately and cost-effectively cared for in less acute settings, including urgent care centers. One illustrated that ED visits per 1,000 residents were reduced by 30%[2] in markets where urgent care centers or retail clinics had a presence.

All this should be cause for great optimism, yet our phones ring with members pleading for help. The contracting and credentialing process has become so protracted that it threatens the viability of many start-ups, particularly if they did not have the foresight to begin the process early in their development. Networks are being narrowed in many areas, principally by denying access to *new* entrants. Contract language specific to urgent care centers now often dictates staffing models and hours of operation, and places limitations on wellness and follow-up care despite the fact that many of our patients do not have a primary care provider.

These new rules of participation extend far beyond those of state medical boards charged with public protection. Established urgent care organizations may be exhaling a sigh of relief that this isn't their problem—but what happens when that contract comes up for renewal?

We *all* have a responsibility to demonstrate our worth. While UCAOA will continue to have dialogue nationally, most payer negotiations are at the state or regional level. So, what can you do?

- Be **relentless** in demonstrating how you are innovating and how your strategies align with the payer's.
- **Integrate** with the greater healthcare community. If the patient has a PCP, work to establish reasonable communication methods that ultimately reduce costs, eliminate redundant testing, and improve health.
- Demonstrate how your center supports **ED diversion strategies**.
- **Provide data.** Urgent care can provide information payers don't have access to, or simply haven't collected. How many of their members say they do not have a PCP? If they have a PCP, was he or she accessible when care was needed? How many sought care after 5:00 PM during the week or on weekends—and what savings from an ED visit were therefore realized? How many of their members received radiography, lab, or other services, often delivered outside of the office visit as part of the payer's global fee?
- Use the data to **educate** payers on the value your centers bring and **seek opportunities for improvement**.
- **Share** your successes and best practices, as well as barriers, with UCAOA's Payer Relations Committee.

Our voice deserves to be heard—and our continued growth depends on us speaking out. ■

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References

1. Centers for Disease Control and Prevention. National Center for Health Statistics. Ambulatory care use and physician office visits. Available at: http://www.cdc.gov/nchs/fastats/physician-visits.htm. Accessed January 10, 2017.
2. Opportunities to Increase Quality and Efficiency: Avoidable Hospital Use. In: *Massachusetts Health Policy Commission 2015 Cost Trends Report*. 2015;Section III:57–64.