

Retail Clinics: Options for New York State

Background

As a result of the Affordable Care Act, it is estimated that, starting in 2014, approximately one million previously uninsured New Yorkers will have access to health insurance. A major challenge will be providing high-quality primary care to these newly insured individuals. Already an estimated 2.3 million New Yorkers are “underserved” for primary care services due to the mal-distribution of physicians in certain geographic areas.

Retail-based health clinics, typically located in pharmacies, supermarkets and big-box retailers, offer basic health care for minor ailments ranging from skin infections to sore throat and earaches, and may include basic wellness and screening services (for chronic condition such as diabetes and high cholesterol). Retail clinics may be a way to expand primary care access prior to full health reform implementation.

There are 17 retail clinics in New York State that have established as physician offices and, as such, are not regulated. Massachusetts is currently the only state that regulates retail clinics.

Pros:

- Offer consumers a convenient, easily accessible option for obtaining basic health care.
- Extended business hours - often open 7 days a week, including evening hours
- Increase access to primary care in the face of a primary care provider shortage
- Reduce inappropriate or unnecessary emergency room use
- Lower costs to patients and insurers than other types of providers (physician offices, urgent care, emergency rooms) due to lower overhead and use of less expensive “mid-level” practitioners such as nurse practitioners to provide care.

Cons:

- Undermine continuity and coordination of care provided
- Concerns about ability of clinic staff to accurately diagnose and appropriately treat conditions
- Potential incentive to over-prescribe medication due to their co-location in pharmacies

1. Naming Convention

Options:

- Choose name that conveys the scope of services provided.

Pros:

- Name intended to inform and not mislead the general public.

Cons:

- None

State Models:

- Massachusetts is the only state to regulate retail clinics and refers to them as “limited services clinic” regulations.
- Kentucky is proposing licensing for retail clinics under the title “minor care health clinics.”

2. Scope of Services

Options:

- Define the scope of services that retail clinics can provide that require only a focused history and physical examination intended for episodic care related to an illness or for immunizations. The scope of services should require a minimal set of services such as adult immunizations.
- Prohibit services to certain groups such as infants or the pediatric population.
- Require extended hours and weekend availability such as 7 days a week with 12 hours weekdays and 8 hours weekends.

Pros:

- Retail clinics are not intended to be patient-centered medical homes.
- Certain patient populations may have special health care needs.
- Increase access to treatment for a variety of minor health conditions.

Cons:

- Even if the scope of services is limited, individuals with contagious disease may seek care from a retail clinic. Possible public health issues when patients with contagious diseases are in a commercial, retail environment with little or no isolation (e.g., fever, rashes, mumps, measles, strep throat, etc.).

State Models:

- Massachusetts is the only state to regulate retail clinics and developed the “limited service clinic” (LSC) regulations. Services cannot be provided to children less than 24 months of age. Also cannot provide childhood immunizations.
- Kentucky is proposing licensing regulations for retail clinics that allow them to perform only those services that the state defines as “minor health care” and retail clinics will be prohibited from treating patients younger than 18 months.
- Examples of various retail clinics’ scope of services in California:
 - MinuteClinic provides the typical array of retail clinic services – treatments for common illnesses, chronic disease screening, and vaccination – and in California also provides tuberculosis testing.
 - QuickHealth is staffed by physicians, in addition to some mid-level practitioners, and therefore can provide a wider scope of acute and chronic care services.
 - Lindora Clinics focus on weight loss and chronic disease management while also offering a limited range of acute care services.
 - Sutter Express Care is the retail clinic arm of Sutter Health, a non-profit network of hospitals and physicians in northern California offering the typical scope of retail clinic services.

3. Create a separate licensure category

Options:

- Add retail clinics under the category of Article 28 diagnostic or treatment centers.
- Single license to a clinic corporation or require each clinic location to obtain own license?

Pros:

- Licensure will distinguish retail clinics from private physician offices and other health care facilities and allow the state nuanced regulation of retail clinics.

Cons:

- Licensure and more stringent regulation may inhibit investment in retail clinics and slow expansion.

State Models:

- Retail clinics in Arizona are licensed by the Department of Health services under the category of Outpatient Treatment Centers.
- Kentucky is proposing licensing retail clinics under the title “minor care health clinics.”
- New Hampshire plans to license retail clinics and they will fall under the category of “outpatient clinics, laboratories, and collection centers.”

- Florida has a unique licensure structure for corporate-owned clinics established to prevent fraudulent business practices and “to prevent significant cost and harm to consumers.” Florida requires applicants to pay a \$2,000 licensure fee that is required again at renewal of licensure and change of ownership; and provide evidence of sufficient assets, credit, and projected revenues to cover liabilities and expenses for the first 12 months of operation. Florida does not license retail clinics that are owned by licensed health care practitioners – but in Florida retail clinics can be owned by nurse practitioners.

4. Certificate of Need

Options:

- Require Certificate of Need in order to achieve the following:
 - Ensure public need and financial feasibility.
 - Ensure providers have appropriate license, training and experience.
 - Require compliance with architecture and engineering requirements.
- Streamline or waive certain Certificate of Need requirements?

Pros:

- Regulations can be tailored specific to retail clinics.

Cons:

- Certificate of Need (CON) approval and more stringent regulation may inhibit investment in retail clinics and slow expansion.

State Models:

- Massachusetts is the only state to regulate retail clinics and developed “limited service clinic” regulations. In 2006, the state realized that its existing clinic regulations did not match the retail clinic model. The regulations address issues regarding physical space and fragmentation of medical care. The Massachusetts Department of Public Health hired a full-time nurse practitioner to oversee all aspects of the limited service clinic licensure including reviewing all clinic policies and procedures to verify compliance and making site visits to verify that construction is consistent with submitted plans. Policies for the clinics include:
 - Clinics will make referrals to primary care practitioners including physicians, nurse practitioners, and community health centers;
 - Clinics must maintain rosters of primary care providers who are accepting new patients;
 - Clinics must develop a process to identify and limit, if necessary, the number of their repeat encounters with individual patients;
 - With patient consent, the retail clinic will provide a copy of the visit encounter to the patient’s primary care practitioner;

- Retail clinics must provide a toll-free number that will enable a caller to speak with a live practitioner during off-hours.
- Kentucky is proposing licensing for retail clinics under the title “minor care health clinics.”

5. Consumer transparency

Options:

- Require signage that states the services provided. Prohibit descriptions that imply comprehensive or emergency care.
- Require signage to indicate that prescriptions and over the counter supplies, etc., can be purchased from any business and do not need to be purchased on-site.
- Prohibit retail clinics from providing any incentive, inducement and payments to clinical staff for referring or recommending to patients’ items or services provided by the host retail provider.
- Impose marketing and advertising restrictions. Retail clinics could not advertise connections to larger healthcare systems.

Pros:

- Consumers will not be confused as to the services provided.
- Consumers will not be misled that prescriptions, over-the-counter supplies and other items must be purchased at the host site.

Cons:

- Concern that practitioners in retail clinics located in pharmacies will over-prescribe or selectively prescribe both prescription and over-the-counter medications that are for sale at the host store.

State Models:

- Massachusetts model previously described.

6. Quality of Care

Options:

- Regulate quality standards:
 - Use of clinical guidelines developed by medical organizations.
 - Participation in ongoing quality improvement and quality assurance processes.
 - Third party accreditation.
 - Reporting of patient safety and quality data.

Pros:

- Ensure evidence based medicine practices are followed.

Cons:

State Models:

7. Medicaid Managed Care Program

Options:

- Medicaid managed care plans should certify retail clinics as providers.
- Medicaid managed care plans should include and contract with retail clinics in their networks.
- Before admitting a retail clinic to its network, the plan could determine whether its members have a need for the service in the clinic's area.

Pros:

- Provide a convenient, cost-effective point of care for Medicaid beneficiaries for minor illnesses.

Cons:

- Many Medicaid beneficiaries also have chronic conditions which cannot be managed at a retail clinic.
- Retail clinics are typically locating in metropolitan areas, rather than in underserved or rural areas.
- Community Health Centers may not be able to compete for the short supply of nurse practitioners in the state with probable higher salaries offered by retail clinics.

State Models:

- Idaho and Illinois both use primary care case management programs to manage their Medicaid beneficiaries and indicate that retail clinics could be used by beneficiaries if prior authorization was received from the primary care provider. Retail clinic operators said prior authorization is a significant hurdle for patients and can significantly deter their use of retail clinics.
- Illinois Medicaid has been reimbursing for services at retail clinics, but with a new managed care model underway, this may change. Now, most Medicaid and All Kids³² beneficiaries who are not enrolled in a voluntary managed care organization will be required to receive health care through Illinois Health Connect.

- Arizona indicated that if services are emergent or urgent, then the care plans would be obligated to pay for those services at retail clinics. But if the services provided are routine and should have been obtained from the member's primary care provider, then the health plan could deny payment for those services.

8. Safety net

Options:

- Require retail clinics to establish in underserved and/or rural areas.
- Encourage community health centers to become providers in retail settings.

Pros:

- Community health centers are used to locating in underserved communities.

Cons:

- Retail clinics are primarily locating in metropolitan areas, rather than in underserved and/or rural areas. Population density is a key consideration underlying clinic location decisions.
- Retail clinics could undermine the geographic Health Profession Shortage Area (HPSA) designation that allows physician to receive increased Medicare and Medicaid reimbursement.
- Retail clinics will treat patients with lower level acuity. This change may disrupt primary care practitioners' patient mix – they will see more complex patients that require more lengthy appointments and could potentially undermine their financial stability.

State Models:

- According to the Massachusetts Department of Public Health, the Commissioner of Health has encouraged community health centers to open limited service clinics. None have done so.

Representatives from the Massachusetts League of Community Health Centers said they would want a limited service clinic operated by a community health center to be part of a health center's cost structure and receive a Medicaid cost-based reimbursement encounter rate for FQHCs. Paying the Community Health Center a lower rate to reflect their overall lower cost structure is not sufficient to support the health centers' costs.

9. Stabilization of Medical Home

Options:

- Promote medical homes by requiring retail clinics to make referrals to primary care providers for all patients.

- Each clinic must maintain a roster of primary care practitioners in the clinic's geographic area who are currently accepting new patients and provide each patient who does not have a primary care practitioner with a referral from the list. The roster must include community health centers and other providers that serve Medicaid and low-income customers.
- Develop policies and procedures designed to identify and limit the number of repeat encounters with patients.
 - Require prior authorization from the primary care provider for patients who exceed a specified number of encounters.
- Ensure interoperable systems and sharing of patients' health information with the patient's primary care practitioner and specialists, as needed. The retail clinic must connect to the Statewide Health Information Network for New York (SHIN-NY) to ensure patients' health information is available to all authorized clinicians.

Pros:

- Overall continuity of care could be facilitated by requiring retail clinics to explicitly connect to the larger health care delivery system.
- Require Medicaid and low-income customers to be informed about and referred to other treatment options, such as community health centers.
- Require retail clinics to have an electronic medical record system sufficient to gather and communicate the patient's information to primary care and specialty physicians to ensure that central health record contains all pertinent patient information.

Cons:

- Any financial incentives to visit a retail clinic (eg, lower co-pay) could undermine the medical home concept.
- Certain provider groups tend to feel that a retail clinic:
 - is a poor substitute for a regular source of comprehensive primary care
 - fail to adequately communicate with primary care providers about services delivered
 - ultimately undermine the doctor/patient or medical home relationship
- Use of tests for the purpose of diagnosis without proper follow-up.

Insurance/Retail Models:

- BlueCross and BlueShield of Minnesota waived retail clinic co-payments, making the cost to the patient cheaper than the cost to a primary care physician.
- Take Care retail clinic representative reported that within 24 hours of their visit all patients receive a follow-up phone call from the nurse practitioner who provided treatment to check on the patient's health and treatment status. Clinic operators stated that all patients leave with a copy of their visit record and, if consent is given, a copy is also faxed to their primary care provider's office. Clinic operators also stressed efforts to help patients find a primary care provider if they did not have one already and some said they keep lists of nearby providers who are accepting new patients.

10. Commercial and Medicaid Managed Care Reimbursement

Options:

- Encourage retail clinics to accept private and public insurance.
- Evaluate financial incentives to visit retail clinics.

Pros:

- Increase access to basic primary care services.

Cons:

- Any financial incentives to visit a retail clinic (e.g., lower co-pay) could undermine the medical home concept.

State Models:

- BlueCross and BlueShield of Minnesota waived retail clinic co-payments, making the cost to the patient cheaper than the cost to a primary care physician.