



URGENT CARE

MAKING “CONVENIENT CARE” THE RIGHT CARE FOR ALL:

*Improving State Oversight
of Urgent Care Centers
and Retail Health Clinics*

This issue brief is a joint product of Community Catalyst and the National Health Law Program. It was prepared by Tess Solomon, MPH; Kelly Jo Popkin, MPH, JD; Amy Chen, JD; Lois Uttley, MPP; and Susannah Baruch, JD



I. INTRODUCTION

A growing number of health care consumers are turning to urgent care centers and retail health clinics, which have rapidly proliferated across the country in recent years and are sometimes referred to as “convenient care.” Urgent care centers have played a particularly critical role in meeting the high demand for COVID-19 testing and are likely to be actively involved in providing COVID 19 vaccines.

However, health care advocates and policymakers are only now beginning to scrutinize oversight of these clinics and consider whether they are serving a fair share of low-income or uninsured consumers and are providing an appropriate array of services, including urgent reproductive and sexual health care. This brief draws from a survey of regulation of urgent care centers and retail health clinics in all 50 states to assess the current state of oversight for these increasingly key players in the health care delivery system.

Urgent care centers are walk-in clinics focused on minor illnesses or injuries; they treat conditions similar to those treated in primary care. Large-scale operators of urgent



care centers include CityMD and GoHealth, which often partner with hospital systems. Reports from across the country show that urgent care clinics have been inundated by the demand for coronavirus tests.¹ By late October 2020, urgent care centers were providing 725,000 tests per week, which accounted for 10 percent of total testing in the U.S. at that time.²

Retail health clinics are smaller-scale clinics that offer a more limited set of services in retail settings such as drug stores and supermarkets. Major operators of retail clinics include CVS, which operates more than 1,100 clinics nationwide, and Walgreens, which

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- 1 Daysog, R. (2020, March 13). Walk-in healthcare clinics ‘overwhelmed’ by coronavirus testing requests. Hawaii News Now. <https://www.hawaiinewsnow.com/2020/03/14/walk-in-healthcare-clinics-overwhelmed-by-coronavirus-testing-requests/>; Fuller, C. (2020, November 6). COVID-19 spike stretches Urgent Care centers. WLWT. <https://www.wlwt.com/article/covid-19-spike-stretches-urgent-care-centers/34592215>; CBS New York Staff, (2020, November 18). COVID Testing In NYC: New Yorkers Waiting In Long Lines At Urgent Care Centers Across City. CBSLocal <https://newyork.cbslocal.com/2020/11/18/covid-testing-nyc/>; News 12 Staff. (2020, November 20). Demand in rapid COVID-19 testing leads to long lines at urgent care centers. Bronx News <https://bronx.news12.com/demand-in-rapid-covid-testing-leads-to-long-lines-at-urgent-care-centers>
 - 2 Molla, R. (2020, November 19). Covid-19 is turning urgent care centers into America’s favorite clinics. Vox. <https://www.vox.com/recode/21562230/urgent-care-center-covid-19-testing-vaccine-health-care>

Even before increased demand due to COVID, this segment of the health care industry had been growing rapidly. However, state oversight has lagged behind, raising challenges for consumers and advocates.

operates more than 400. Their delivery of COVID-related care has also been significant and has contributed to the growing reach and popularity of retail health. CVS Health alone administered 6 million COVID-19 tests between March and September 2020. Of those seeking tests, 70% were not previously CVS Health customers.³

Even before increased demand due to COVID, this segment of the health care industry had been growing rapidly. The number of urgent care centers increased from just under 7,000 in 2015 to over 10,000 in 2020.⁴ The retail health clinic sector has grown at an even faster rate, from 700 in 2013 to more than 2,700 in 2019.⁵

However, state oversight of this segment of the health care system has lagged behind, raising challenges for consumers and advocates. Some patients who visit urgent

care centers or retail health clinics may discover too late that their Medicaid coverage or private health insurance is not accepted, and that there is no charity care policy, leaving them with unexpected medical bills. Others may encounter restrictions on reproductive and sexual health care services at urgent care centers or retail clinics operated by religiously-affiliated health systems. Equitable access is also a concern, as urgent care centers and retail health clinics may be absent from low-income neighborhoods that are already medically underserved, and instead proliferate in middle-class neighborhoods that tend to have more consumers with private health insurance coverage.

As visits to primary care providers decrease and visits to urgent care providers grow, there are increasing concerns about quality and continuity of care, as well as adequate coordination between an individual's primary care provider and any urgent care centers that have provided episodic care.⁶ Improved government oversight is needed to ensure that this burgeoning health care sector provides care that meets the needs of all health consumers, without discrimination or religious interference.

This issue brief provides an overview of existing and proposed state regulation of

3 Minemyer, P. (2020, November 06). Merlo COVID-19 testing, return to work platform have 'expanded the universe' of CVS customers. Fierce Healthcare. <https://www.fiercehealthcare.com/payer/merlo-covid-19-testing-return-to-work-platform-have-expanded-universe-cvs-customers>

4 Thakar, S. (2019, February 22). US urgent care centers experience 8% growth. Health Exec: For Leaders of Provider Institutions. <https://www.healthexec.com/topics/care-delivery/us-urgent-care-centers-experience-8-growth>; Finnegan, J. (2020, February 26). Now more than 9,000 urgent care centers in the U.S., industry report says. FierceHealthcare. <https://www.fiercehealthcare.com/practices/now-more-than-9-000-urgent-care-centers-u-s-industry-report-says>

5 Gaur, K., Sobhani, M., & Saxon, L. (2019, September 30). Retail Healthcare Update: Disrupting Traditional Care by Focusing on Patient Needs. Journal of MHealth. <https://thejournalofmhealth.com/retail-healthcare-update-disrupting-traditional-care-by-focusing-on-patient-needs/>

6 Ganguli, I., Shi, Z., Orav, E. J., Rao, A., Ray, K. N., & Mehrotra, A. (2020). Declining use of primary care among commercially insured adults in the United States, 2008–2016. *Annals of internal medicine*, 172(4), 240-247.; Neighmond, P. (2016, March 07). Can't Get In To See Your Doctor? Many Patients Turn To Urgent Care. NPR. <https://www.npr.org/sections/health-shots/2016/03/07/469196691/cant-get-in-to-see-your-doctor-many-patients-turn-to-urgent-care>

urgent care centers and retail health clinics, with particular attention to the impact of this growing and largely unregulated health care sector on access to basic health care services for vulnerable communities. The brief provides recommendations for potential development of strengthened oversight, as well as specific policy options and models. The issue brief is based on the results of a 50-state survey conducted for the National Health Law Program (included in the Appendix).

Summary of Major Findings

Most states do not issue facility licenses for urgent care centers or retail health clinics. Rather, these entities are generally operated under either an individual physician's license or, in the case of those affiliated with a hospital, under that hospital's license, thereby avoiding targeted oversight from state departments of health.

- A few states (Arizona, Illinois, Indiana, Maryland, New Hampshire, South Dakota and Vermont) have pursued regulation to tackle the central issues of coverage, transparency and the types of services offered at urgent care centers and retail health clinics. These regulations could serve as models for other states.
- Without state regulation requiring them to serve low-income communities or state Certificate of Need oversight to help ensure equitable distribution of such facilities, individuals and families who are uninsured or who rely on Medicaid coverage could be unable to access care at urgent care centers and retail clinics. A total of 36 states and D.C. have Certificate of Need systems that oversee and approve many institutional health provider

transactions and could potentially be used to oversee convenient care providers.

- In the absence of licensing and other regulatory oversight, access to reproductive and sexual health care at these facilities could be at risk. Large Catholic health systems are already entering the market and operating both urgent care centers and retail clinics that do not provide basic reproductive and sexual health care services that meet medical standard of care. Facilities

Robust state oversight is needed to ensure that community health needs are met, including meaningful efforts to reduce racial and ethnic health disparities and provide convenient access to reproductive health services that meet the standard of care.

affiliated with Catholic systems would also likely refer patients to their affiliate Catholic hospitals for acute care, which have the same deficiencies in access to comprehensive reproductive and sexual health care services.

Key Recommendations

- State licensing requirements and Certificate of Need programs should be updated to apply to this growing market. Robust state oversight is needed to ensure that community health needs are met, including meaningful efforts to reduce racial and ethnic health disparities and provide convenient access to reproductive health services that meet the standard of care.

- Urgent care centers and retail clinics should be required to contract with Medicaid, and given targets for percentage of service to Medicaid-insured and uninsured consumers as a condition of state Certificate of Need approval.
- States should set up accreditation processes to enforce standardization across sites, mandate the provision of basic health care services and enforce nondiscrimination provisions.
- States should require care coordination among urgent care centers, retail clinics, primary care services and hospitals to promote a strong continuum of care and ensure the highest quality of care.
- Health care and consumer advocates should advocate for more equitable distribution of these facilities in low-income neighborhoods, not just middle and upper class neighborhoods.

II. THE EXISTING STATE REGULATORY LANDSCAPE

Licensing of Urgent Care Centers and Retail Health Clinics

URGENT CARE CENTERS

The vast majority of states do not issue facility licenses for urgent care centers. In the 40 states that have chosen not to issue such facility-specific licenses, most urgent care centers are operated under either an individual physician's license or a hospital license. Without specific licensing requirements, these centers are largely able to evade the scrutiny of state departments of health. Facilities operating under a physician's license have oversight by a state medical board only insofar as disciplining any criminal convictions, medical negligence or misbehavior of the individual physician.⁷

In certain states, urgent care centers that operate under a hospital license would be subject to a state department of health's regulatory purview only as an extension of that hospital, and therefore are only subject to limited review or diminished direct oversight. Without specific licensing requirements for both hospital-owned and physician-owned urgent care centers, urgent care centers often avoid the targeted scrutiny in the Certificate of Need process that oversees hospital

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transactions and the regulatory "check" a Certificate of Need system sets in place.

Of the states that do license urgent care centers, a few have determined that these facilities fall within pre-existing licensing categories, such as under the broad definition of "clinic" in Florida or the "organized ambulatory-care facility" in Rhode Island. Massachusetts considers providers of urgent care to be ambulatory care providers who must be licensed as either a clinic or hospital satellite. Other states have established licensing requirements specific to urgent care centers. For example, Connecticut requires state inspection every three years. New Mexico and New York issue different licenses for urgent care centers depending on certain characteristics. For example, in New Mexico,

⁷ Bovbjerg, R., Aliagathe, P & Gittler, J. (2006, February). State Discipline of Physicians: Assessing State Medical Boards through Case Studies (U.S. Department of Health and Human Services Report). Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/basic-report/state-discipline-physicians-assessing-state-medical-boards-through-case-studies>

Even among states that do require licensing for urgent care centers, there are exemptions from those requirements that may let physicians and hospitals circumvent labor-intensive state licensing processes. In Rhode Island, for example, urgent care centers owned and operated by individual physicians, physician groups or hospitals may be carved out of the “organized ambulatory-care facility” licensing requirement. Massachusetts also provides exemptions for urgent care centers operated by solo and group practices.

Some states allow for large-scale hospitals and health systems to avoid urgent care center licensing requirements and the regulatory safeguards that they impose on physicians for the protection of consumers. For example, Florida exempts from licensing those entities that are owned by corporations with at least \$250 million in annual sales and operated by a Florida-licensed health care practitioner, as well as those entities that employ 50 or more MDs or DOs who bill under a single tax ID number. Similarly, in spite of its case-by-case licensing process for urgent care centers, New Mexico has allowed many of these facilities to operate as extensions of hospital licenses.

RETAIL HEALTH CLINICS

Retail health clinics are similarly under-regulated, with 45 states not issuing any form of licensing for these facilities. In Arizona, Florida, New Hampshire and Rhode Island, retail clinics are licensed under the same category as urgent care centers.

In some cases, retail health clinics are not licensed but are bound by state regulations. Massachusetts has created a unique set of regulations for retail clinics, known as “limited



service clinics,” but does not apply these regulations to urgent care centers, which are licensed as clinics or hospital satellites. The “limited service clinic” regulations expressly limit retail clinics from referring patients to non-primary care providers or from serving as a patient’s primary care provider. They also limit the clinics to providing a specific set of services.

A few states with stringent “corporate practice of medicine” laws also place some regulatory requirements on urgent care centers and retail clinics even though state departments of health have chosen not to explicitly license or regulate them. In Tennessee, retail clinics must be established as a medical corporation owned by a specific physician. In West Virginia, a certificate of authorization from the Board of Medicine is required to practice medicine through a corporation, professional corporation or professional limited liability company. If a corporation runs an urgent care center or retail health clinic, it would be required to obtain this certificate to ensure that the medical practice is separate from the non-medical ownership.

III. IMPACT ON PATIENTS OF LACK OF REGULATION

Service to Uninsured and Medicaid-insured Patients

Urgent care centers and retail clinics offer health care without an appointment, and often provide extended hours to accommodate busy schedules. This convenience factor can be particularly helpful for hourly shift workers and employees without paid time off, who may be better able to access care in the

Physician-owned urgent care centers or retail health clinics operating within pharmacies are allowed to turn away sick patients solely on the basis of their insurance status.

evenings or on weekends. Such facilities could be tremendously helpful for uninsured individuals and Medicaid enrollees, who could access basic primary care services at times that fit into busy work schedules.¹¹

However, without regulatory pressure, urgent care clinics are less likely to accept Medicaid patients, whose care is typically reimbursed at lower rates than that provided by private

insurers.¹² In 2019, a national urgent care lobbying group estimated that 30-40 percent of urgent care centers refuse to treat Medicaid patients.¹³ Furthermore, the treatment obligations of the Emergency Medical Treatment And Labor Act—which requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay—do not apply unless an urgent care center is owned by a hospital. As a result, physician-owned urgent care centers or retail health clinics operating within pharmacies are allowed to turn away sick patients solely on the basis of their insurance status.

In 2013, a study conducted by the New York State Commissioner of Health on the provision of services at urgent care centers and retail clinics operating within pharmacies found that “urgent care providers are not subject to the Emergency Medical Treatment and Labor Act (EMTALA). Consequently, urgent care providers are not required to accept patients without regard for the ability to pay, and it is unclear how many urgent care providers accept Medicaid. This barrier could limit could the potential for use of urgent

11 Godman, H. (2016, January 15). Retail health clinics: The pros and cons. Harvard Health Blog. <https://www.health.harvard.edu/blog/retail-health-clinics-the-pros-and-cons-201601158979>

12 Takach, M., & Witgert, K. (2009). Analysis of State Regulations and Policies Governing the Operation and Licensure of Retail Clinics. National Academy for State Health Policy, 29.

13 Kowalczyk, L., McCluskey, P. D., (2019, January 12). Urgent care centers proliferate in Mass., but fewer low-income patients have access—The Boston Globe. BostonGlobe.Com. <https://www.bostonglobe.com/metro/2019/01/12/urgent-care-centers-proliferate-mass-but-fewer-low-income-patients-have-access/FATkqt70tDc0sHFupk7eSJ/story.html>

care centers to reduce avoidable emergency department visits and health care spending in the Medicaid population.”¹⁴ Uninsured or Medicaid patients might seek care at an urgent care center instead of an emergency room, not knowing that the facility has no legal obligation to stabilize any patient who walks through the door. A patient in an emergency situation could be turned away.

In addition to quality-related clinical decisions, business interests also shape where urgent care centers and retail clinics are located rather than community need. These facilities tend not to be located in low-income communities, but rather are concentrated in communities of privately insured patients.¹⁵ In New York for example, only 33 of the 366 urgent care centers operating in the state in 2015 were located in medically underserved areas.¹⁶ Similarly, in Massachusetts, an analysis by the state’s Health Policy Commission in 2019 found that 58 percent of urgent care centers and 72 percent of retail clinics were located in ZIP codes where residents earn above the median income.¹⁷ This uneven distribution is likely to exacerbate health inequities and further compound barriers to access.

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Provision of Sexual, Reproductive and LGBTQ-inclusive Care

Without the regulatory check of licensing in place, hospital and health systems operating urgent care centers or retail clinics could choose not to provide reproductive and sexual health care services that meet the standard of care, or could have policies that serve discriminate against LGBTQ+ patients and families. Religiously-based service restrictions could result in people being unable to obtain birth control, emergency contraception, STD testing, PrEP or other basic reproductive and sexual health services in their local urgent care center or retail clinic. Facilities operated by Catholic health systems may also follow policies that prohibit delivery of LGBTQ+-affirming care.

14 New York State Department of Health. (2017). Health Care Delivery Models in New York State: A Study of Retail Clinics, Urgent Care Providers and Major Physician Practices. https://www.health.ny.gov/press/reports/docs/health_care_delivery_studies.pdf

15 Le, S. T., & Hsia, R. Y. (2016). Community characteristics associated with where urgent care centers are located: a cross-sectional analysis. *BMJ open*, 6(4), e010663. <https://pubmed.ncbi.nlm.nih.gov/27056591/>

16 Ji Eun Chang, MS, Suzanne C. Brundage, SM, Gregory C. Burke, MPA, & Dave A. Chokshi, MD, MSc. (2015). Convenient Care: Retail Clinics and Urgent Care Centers in New York State. United Hospital Fund. <https://nyshealthfoundation.org/wp-content/uploads/2017/11/united-hospital-fund-convenient-care-report.pdf>

17 Massachusetts Health Policy Commission. (2018). HPC DataPoints, Issue 8: Urgent Care Centers and Retail Clinics | Mass.gov. <https://www.mass.gov/info-details/hpc-datapoints-issue-8-urgent-care-centers-and-retail-clinics>

The failure of Hy-vee grocery stores in Iowa and Nebraska to provide reproductive health care provides a key example of how a robust licensing process is critical. Both Iowa and Nebraska have critical coverage gaps in contraceptive services as a result of anti-choice legislation that excluded Planned Parenthood and other entities that also provide abortion, from receiving Title X funding. As a result, over 170,000 low-income individuals in Iowa and over 108,000 low-income individuals in Nebraska live in counties where there is not reasonable access to a health center offering the full range of contraceptive methods.¹⁸

The retail clinics located within Hy-vee grocery stores in these states have a unique opportunity to fill this gap in the market by providing direct pay, low-cost birth control pills and other forms of contraception, without the need for appointments, and in a convenient location. However, because of the religious affiliation of Catholic Health Initiatives, the large-scale Catholic hospital system that owns and operates the Hy-vee clinics, reproductive and sexual health care is not offered at these retail clinics.¹⁹ ²⁰ Hy-vee stores in Nebraska also house clinics owned and operated by Catholic Health Initiatives (which is now part of CommonSpirit Health, the nation's largest Catholic health system).²¹

In Utah, urgent care centers are specifically exempt from having to provide emergency contraception to survivors of sexual assault.

Without clear standards for services that should be provided at urgent care centers or retail clinics, patients have no way of knowing which reproductive and sexual health services these clinics will or will not provide, and at what cost. For the most part, states have not pushed clinics towards providing greater transparency for consumers. This has led to some egregious outcomes. For example, in Utah, urgent care centers are specifically exempt from having to provide emergency contraception to survivors of sexual assault. This is permitted so long as the urgent care center provides the sexual assault survivor with a nearby hospital address, along with oral and written information regarding emergency contraception.²² Should states require licensed retail clinics to provide contraception, in addition to other limited health services, these clinics could become important resources for people in urgent need of birth control or emergency contraception.²³

18 Power to Decide (2019, April). Birth Control Access 2020. Power to Decide <https://powertodecide.org/what-we-do/access/birth-control-access>

19 Leys, T. (2017, July 10). Clinics that limit birth control are listed as providers in new state family planning plan. Des Moines Register. <https://www.desmoinesregister.com/story/news/health/2017/07/08/clinics-limit-birth-control-listed-providers-new-state-family-planning-plan/459128001/>

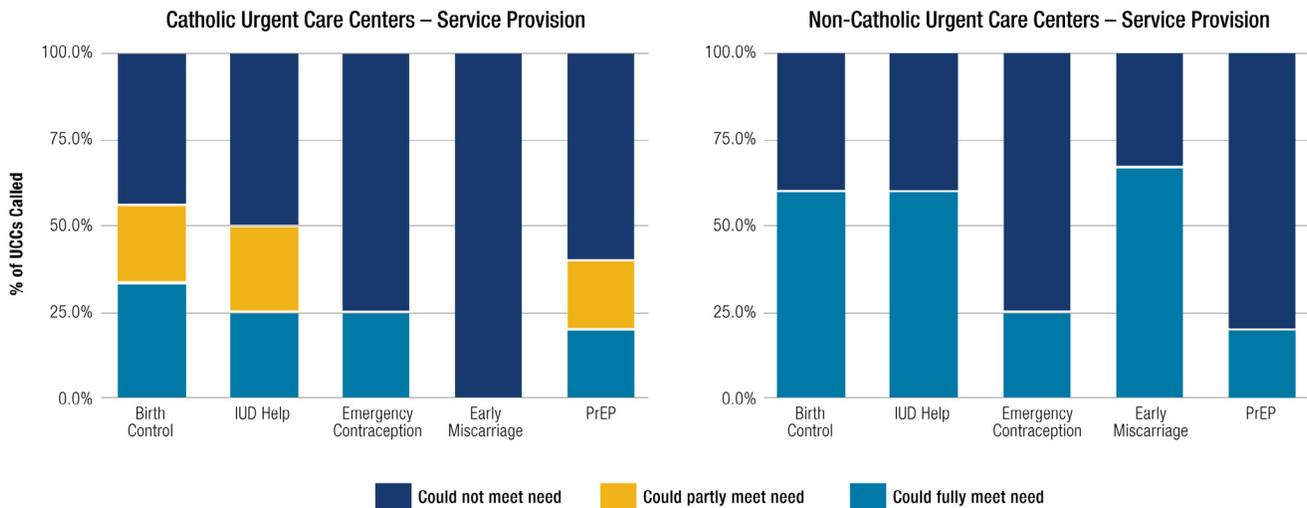
20 MercyOne (n.d.). Urgent Care Services. Mercy One. <https://www.mercyone.org/desmoines/find-a-service-or-specialty/urgent-care>

21 CHI Health (n.d.). Initiatives: Quick Care. CHI Health. <https://www.chihealth.com/en/services/quick-care.html>

22 Emergency contraception services for a victim of sexual assault. Utah Code Ann. § 26-21b-201 (2010) https://le.utah.gov/xcode/Title26/Chapter21B/26-21b-S201.html?v=C26-21b-S201_1800010118000101

23 Emergency contraception services for a victim of sexual assault. Utah Code Ann. § 26-21b-201 (2010) https://le.utah.gov/xcode/Title26/Chapter21B/26-21b-S201.html?v=C26-21b-S201_1800010118000101

Comparison of Catholic vs Non-Catholic Urgent Care centers in Provision of Reproductive Health Services



EXISTING CONVENIENT CARE CLINICS IN CATHOLIC HEALTH SYSTEMS

Most Catholic hospitals operate under the Ethical and Religious Directives (ERDs), which prohibit the provision of key reproductive health services, including contraception, sterilization, abortion, and infertility services. Catholic health systems have been known to deny some LGBTQ+-inclusive care, such as gender-affirming surgeries.

Four out of the 10 largest health systems currently in the United States are Catholic entities. These giant systems are actively expanding into this market. Already, CommonSpirit Health, the largest Catholic system, operates 115 urgent care clinics, Ascension operates 96, Trinity operates 59, and Providence St Joseph operates 72. Among these four Catholic health systems alone, there are 342 urgent care centers that are likely to be subject to the ERDs and therefore restricting access to basic

reproductive and sexual health care. Major operators of retail clinics have also partnered with large Catholic health systems to deliver care. Existing partnerships include Kroger Health’s partnership with Ascension and Walgreens’ partnership with Providence St Joseph Health.

In 2016, Community Catalyst and NHeLP conducted a secret shopper study to investigate how religious restrictions impact services at urgent care centers that are owned or managed by Catholic health systems. A total of 38 urgent care centers were included across California and New York: 18 Catholic-affiliated and 20 non-Catholic, non-religious centers. The investigation found that Catholic urgent care centers were frequently unable to provide birth control refills, assist patients having problems with their IUDs, or help patients with what appeared to be early miscarriage signs. In contrast, non-Catholic affiliated urgent care centers frequently provided these services.

IV. TARGETED REGULATION

Some states have pursued additional regulation to specifically tackle issues of coverage, transparency, and services offered within the urgent care and retail clinic landscape.

Coverage

Some of the most significant coverage regulations are in Vermont, where urgent care centers and retail clinics are forbidden to discriminate on the basis of insurance status or type of health coverage, ostensibly



mandating care for the uninsured. Vermont also has established a working group to consider changes to licensing requirements for these facilities.

Other states have addressed coverage issues by including services rendered at urgent care centers in their Medicaid programs. For example, Indiana's expanded Medicaid program includes coverage at urgent care center services. Maryland's Medicaid program covers certain medically necessary services rendered at urgent care centers, provided the facility satisfies certain requirements, including the presence of at least one qualified physician during hours of operation, adequate medical record documentation, and clearly defined patient care policies.²⁴

Transparency

Some states have passed legislation to make price and service information available to consumers. Arizona requires urgent care centers to make "direct pay" price information available online or by request. Other states have barred the use of facility names such as "emergency," "emergent," or their derivatives, so that health care facilities cannot misrepresent their facilities as emergency

24 Covered Services. MD. Code Regs. § 10.09.77.04 www.dsd.state.md.us/comar/comarhtml/10/10.09.77.04.htm



departments.²⁵ Illinois had previously prohibited the use of the word “urgent” by urgent care and other health care facilities, but lifted this ban in 2015.²⁶

Services & Providers

Some states have used legislation to regulate the services required and the types of providers eligible to provide them. New Hampshire requires at least one physician on-site during operating hours, and Arizona requires urgent care centers to post a sign in the waiting room if a licensed physician is not on site.²⁷ South Dakota has allowed nurse practitioners to open urgent care centers without formalized contracts with physicians.²⁸

Private payers are also setting standards prior to contracting with urgent care centers, requiring certification or accreditation based on national standards and best practices for safety, quality, and scope of services.²⁹

25 Emergency Medical Treatment Act. 210 Ill. Comp. Stat. 70/2(b) <https://ilga.gov/LEGISLATION/ILCS/ilcs3.asp?ActID=1231&ChapterID=21#:~:text=No%20hospital%2C%20physician%2C%20dentist%20or,therefor%2C%20nor%20because%20of%20the>

26 Ellen Jean Hirst. (2015, January 15). Illinois puts “urgent” back in name of urgent-care centers. Chicagotribune.Com. <https://www.chicagotribune.com/business/ct-urgent-care-facility-names-0113-biz-20150109-story.html>

27 Non-Emergency Walk-In Care Centers. N.H. Code. Admin. R. Ann. He-P 806.16(a) <https://www.dhhs.nh.gov/oos/bhfa/documents/he-p806.pdf>; Urgent Care Centers; posting requirements. Ariz. Rev. Stat § 36-432. <https://law.justia.com/codes/arizona/2015/title-36/section-36-432/>

28 J.T. Fey. (2018, April 27). New type of clinic opening on May 1. Watertown Public Opinion. https://www.thepublicopinion.com/news/local-news/new-type-of-clinic-opening-on-may/article_503b3d94-4a28-11e8-a0a4-53f58f9301b2.html

29 Cindi Lang, MS, RN. (2017, February 13). Urgent care center accreditation now required by multiple payers. Becker’s Hospital Review. <https://www.beckershospitalreview.com/payer-issues/urgent-care-center-accreditation-now-required-by-multiple-payers.html>

V. ADDITIONAL ATTEMPTS AT REGULATION

A number of states have tried but failed to pass additional regulation for urgent care centers and retail clinics. Proposed legislation has included encouraging research on this growing segment of the health care industry, regulating the type and location of services offered, and increasing transparency. These proposals date back to 2008 and have continued through 2020 with little success.

Legislation in Indiana and North Carolina, in 2009 and 2007 respectively, would have provided for studies on urgent care centers and retail clinics, and the adequacy of state regulations.³⁰ The Indiana law would have required the state to conduct a study to determine the number of health clinics in



In 2018 in Illinois, a comprehensive bill was proposed to require permits for retail health clinics and limit the scope of services to minor, noninvasive, and nonsurgical care. The bill failed in large part due to concerted opposition from CVS.

the state, the number of health clinics that are regulated by the state, the adequacy of the state regulations for health clinics, and whether any additional standards are necessary. The North Carolina law would have required the Legislative Research Commission to conduct a study on store-based retail health clinics.

In 2018 in Illinois, a comprehensive bill was proposed to require permits for retail health clinics; limit the scope of services to minor, noninvasive, and nonsurgical care; allow nurse practitioners to provide care without physician supervision in certain circumstances; and ban the sale of tobacco and alcohol in facilities that house these clinics.³¹ The bill failed in large part due to concerted opposition from CVS. Similar efforts to ban the sale of the

³⁰ S. Bill 216, 2009 Sess. (Ind. 2009); S. Bill 1256, 2017 Sess. (NC. 2007)

³¹ H. Bill 5372, 2009 Sess. (Ill. 2009) <https://www.ilga.gov/legislation/billstatus.asp?DocNum=5372&GAID=9&GA=95&DocTypeID=H-B&LegID=36672&SessionID=51>



tobacco products in establishments where medical services are offered failed in both Tennessee and Washington in 2008 and 2009.³²

In Rhode Island and Pennsylvania, bills were proposed to limit the ability of retail services and health services to be co-located. The Rhode Island bill, proposed in 2008, would have specifically prohibited licensing a facility that maintains a health clinic on the same premises as a licensed pharmacy, ostensibly outlawing pharmacy “minute clinics.”³³ The Pennsylvania bill, proposed in 2008, would have prohibited any applicant for a retail license to offer clinical health care services.³⁴

New York’s Public Health and Health Planning Council (PHHPC) in 2013 issued numerous recommendations for improved regulation

of both urgent care centers and retail health clinics, which were not adopted by the state legislature.³⁵ Those recommendations included:

- restriction of use of the term “urgent care” to those providers offering urgent care services as defined and approved by the Department of Health,
- clear signage describing the services provided,
- certification and/or accreditation by Department-approved accrediting organizations,
- full Certificate of Need review for hospital-owned urgent care centers,
- policies and procedures for referring patients,
- the use of certified electronic health records,
- a current list of primary care providers (including preferred providers of medical care homes and Federally Qualified Health Centers,
- the renaming of retail health clinics to “limited service clinics,” and
- a minimum list of basic services to be included and excluded.

New Jersey proposed legislation in 2017 and 2018 to require retail health clinics to develop policies and procedures identifying services provided by the clinics. This legislation also failed to pass.

32 H. Bill 3502. 2008 Sess (Ten. 2008); H.Bill 2257. 2009 Sess (Wash. 2009) <https://app.leg.wa.gov/bills/summary?billnumber=2257&year=2009>

33 H. Bill 7676, 2008 Sess. (Rhode Island, 2008)

34 H. Bill 2788, 2008 Sess (Penn, 2008) <https://www.legis.state.pa.us/cfdocs/billinfo/billinfo.cfm?syear=2007&sind=0&body=H&type=B&bn=2788>

35 Public Health and Health Planning Council. (2014). NYS Public Health and Health Planning Council: Oversight of Ambulatory Care Services—PHHPC Ambulatory Care Services Recommendations (p. 24). https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2014-01-07/docs/ambulatory_care_services_recommendations.pdf

[A Massachusetts bill introduced in 2019] would have required urgent care centers to be licensed as clinics, require urgent care clinics to provide care to low-income patients who use MassHealth and to offer behavioral health services.

Our review of legislation in all 50 states found no attempts to specifically address the provision of high-quality, comprehensive reproductive and sexual health services at these clinics.

Attempts to regulate this growing sector of the health system are ongoing at the state level. Most significantly, in Massachusetts, regulation of urgent care centers and retail health clinics was included in a wide-ranging

health care bill that was filed by Governor Charlie Baker in 2019.³⁶ That bill would have required urgent care centers to be licensed as clinics, provide care to low-income patients who use MassHealth, and offer behavioral health services.³⁷ While that bill has not advanced, pieces of this priority were included in a 2020 bill entitled “An Act Promoting a Resilient Health System that Puts Patients First” that passed into law.³⁸ This law prevents MassHealth and related managed care organizations from requiring a referral for urgent care services. While the bill does not require urgent care clinics to accept MassHealth, it may expand access at facilities that already accept this insurance. The law also requires urgent care centers to connect patients to PCPs if they do not have one.

36 H. Bill 4134, 2019 Sess. (Mass. 2019) <https://malegislature.gov/Bills/191/H4134>

37 Office of Governor Charlie Baker and Lt. Governor Karyn Polito. (2019, October 18). Baker-Polito Administration Announces Health Care Legislation Aimed at Addressing Key Challenge. Mass.gov. <https://www.mass.gov/news/baker-polito-administration-announces-health-care-legislation-aimed-at-addressing-key>; Priyanka Dayal McCluskey. (2020, January 20). State seeks to rein in largely unregulated urgent care industry—The Boston Globe. BostonGlobe.Com. <https://www.bostonglobe.com/business/2020/01/20/state-officials-seeks-rein-rapidly-growing-urgent-care-industry/w5Bs7qiFsk6lyh6qfSGlyL/story.html>

38 An Act Promoting a Resilient Health System that Puts Patients First. Chapter 260. Mass. Acts § Section 39. <https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260>

VI. RECOMMENDATIONS

The urgent care and retail clinic provider landscape needs greater oversight and regulation to ensure that this growing service market can adequately meet the health care needs of vulnerable groups. Uneven and minimal licensing and regulations of these clinics leads to inequity in access and gaps in service offerings. We recommend that legislators and health advocates pursue the following:

- State licensing requirements and Certificate of Need programs should be updated to apply to this growing market. Certificate of Need programs can be a valuable tool for ensuring that health system transactions are based on key health planning goals, including equity and consumer access to services. Robust state oversight is needed to ensure that community health needs are met.
- Urgent care centers and retail clinics should be required to contract with Medicaid, and given targets for percentage of service to Medicaid-insured patients as a condition of Certificate of Need approval.
- States should set up accreditation processes to enforce standardization across sites, mandate the provision of basic health care services, including LGBTQ+-affirming reproductive and sexual health care, and enforce nondiscrimination provisions.
- States should require care coordination among urgent care centers, retail clinics, primary care services, and hospitals, including the use of electronic health records that can travel with their patients to their non-clinic appointments or ER visits. Clinics could be required to provide connections to primary care physicians for patients without one. Such regulation would help ensure that urgent care centers and retail health clinics serve as part of the continuum of care, working in cooperation with other healthcare services.
- Health care and consumer advocates should advocate for more equitable distribution of these facilities in low-income neighborhoods as well as middle- and upper- class neighborhoods.

VII. CONCLUSION

Urgent care centers and retail health clinics are increasingly important players in the health care system, growing rapidly in both numbers and patient usage. The trend away from primary care services and towards urgent care has accelerated during the pandemic, as people have relied on urgent care centers for COVID-19 testing and other types of care. Existing state regulation does not do enough to prevent discrimination at these facilities or to guarantee access to health care, including urgent reproductive and sexual health care, for low-income communities. In order for urgent care centers and retail health clinics to effectively and equitably meet the health needs of all communities, greater oversight is needed.

As we witness the increasing presence and popularity of urgent care, now is the time to forge regulation that adequately accounts for the important role of this market in providing health care and shaping health outcomes. Targeted regulation that ensures the quality of care provided, comprehensive coverage of services, and equal access to care at urgent care centers and retail clinics is more essential than ever.

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