July 17, 2018

The Honorable Ronald Mariano
House Majority Leader
State House, Room 343
Boston, MA, 02133

The Honorable Bruce E Tarr
Senate Minority Leader
State House, Room 308
Boston, MA 02133

The Honorable Jason Lewis
House Assistant Minority Leader
State House, Room 511
Boston, MA 02133

The Honorable Jeffrey Roy
Vice Chairperson
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

The Honorable James Welch
Chairperson
Joint Committee on Health Care Financing
Room 413-B
Boston, MA 02133

The Honorable Randy Hunt
State House, Room 136
Boston, MA 02133

Dear Majority Leader Mariano, Minority Leader Tarr, Assistant Minority Leader Lewis, Chairperson Welch, Vice Chairperson Roy, and Representative Hunt:

On behalf of the Urgent Care Association (UCA) and the North East Regional Urgent Care Association (NEURCA), we are writing to express our opposition to several urgent care-related provisions contained in H.4639, an *Act to Enhance Access to High Quality, Affordable and Transparent Healthcare.*

Since the early 1980s, urgent care centers have been providing care to patients throughout the United States. There are an estimated 8,100 urgent care centers in the United States, with approximately 170 centers located in Massachusetts, accounting for an estimated 2.5 million patient visits annually to Massachusetts urgent care providers. Without access to urgent care centers, most of these patients would seek care in hospital emergency departments at considerably greater cost to patients and the health care system overall.

Urgent care centers provide walk-in and extended-hour access for acute illness and injury care that is either beyond the scope and/or the availability of that commonly offered in a typical primary care practice setting. Many of the same non-emergency conditions treated in a hospital emergency department can be treated in an urgent care center at significantly lower cost. The cost of urgent care in Massachusetts is estimated to be roughly one-fifth that of a hospital emergency department visit for comparable diagnoses, saving the Massachusetts health care system approximately $1.3 billion per year.

Provisions contained in H.4639, as delineated below, serve as a barrier to entry for new urgent care centers and will unnecessarily increase the cost of care and administrative burden on existing urgent care providers. In fact, provisions in H.4639 would undercut the progress in reducing the number of hospital emergency department visits in Massachusetts for non-emergency medical situations. A 2015 report issued by the state (*Massachusetts Health Policy Commission 2015 Cost Trends Report*) found that a high share of hospital emergency department visits statewide stem from limited availability of care after usual medical office hours have finished. The report also highlighted that the presence of a nearby retail clinic or urgent care center reduced costly hospital emergency department use by 30 percent, underscoring the fact that urgent care medicine is a low cost, high-value proposition that works for the best interests of the patient and the health care system.

Section 65 — Definition of Facility

This section includes urgent care centers alongside hospitals in the definition of "facility" for the purposes of complying with reporting requirements for healthcare-associated infections, serious reportable events, and serious adverse drug events.

Urgent care centers are structured the same as an office-based physician practice and, like these practices, are prohibited from billing a facility fee. It is unclear why the Legislature would propose requiring the reporting of information not required of other office-based physician practices. Reporting of infections and serious adverse events are routinely and appropriately required of hospitals and ambulatory surgery centers (ASCs) because of the risk profile attached to the care these facilities provide, and the requirements for oversight of these higher risk endeavors. The same cannot be said of urgent care, either in Massachusetts or nationwide.

We direct you to the CMS/Medicare place of service (POS 20) definition for urgent care that differentiates urgent care from a hospital or hospital emergency room.

<u>Urgent care centers should be excluded from Section 65</u>.

Sections 66 and 67 — Definitions of Urgent Care Services and Urgent Care Centers

UCA and NERUCA have no objection to setting in statute a definition of urgent care services and urgent care centers; however, the definitions as included in H.4639 are deeply flawed. For example, the bill would define urgent care services, in part, as those *"available to the general*

public during times of the day, weekends or holidays when primary care provider offices are not customarily open." This definition mistakenly assumes that urgent care services are not sought during weekday working hours (8am-5pm). In fact, patients with suffering from a variety of non-emergent trauma are routinely referred by primary care practices to urgent care centers or emergency hospital departments because they are not equipped to handle these types of medical situations. And while preventive and routine services are not by definition "urgent," urgent care centers do on occasion, and depending upon circumstances, provide preventive and routine health care services and so should not be statutorily limited in this regard.

It is important that policymakers view urgent care centers not only as a tool to reduce health care costs, but also as an important entry point for consumers into the health care system and as a source for primary and preventive care services. Despite extensive policy efforts aimed at strengthening access to primary care, many consumers are "medically homeless." A study by the Commonwealth Fund found that three in four adults say they have difficulty obtaining timely access to a doctor when medical care is needed. Those surveyed cited difficulty getting same- or next-day doctor appointments when sick, obtaining medical advice from a physician during normal working hours, and getting medical care outside normal business hours (without a visit to an emergency department). *(Schoen C, Osborn R, Squires D, and Doty Michelle, Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries. Health Aff no. (2013). 10.1377/hlthaff.2013.0879.)*

In addition to filling gaps in access to primary care, based on industry surveillance, a significant majority of urgent care centers nationally have an established mechanism in place to connect patients to a medical home. Urgent care centers play an important role in preventive care, ranging from influenza vaccines to diabetes, HIV, and hepatitis screenings. It is important that barriers not be unintentionally erected, restricting urgent care centers from playing an important role in improving population health.

We recommend that the Legislature seek expert input from within the urgent care industry prior to adopting a definition of urgent care, and consider the following language that the UCA and NERUCA have both previously accepted and put forth with respect to this definition:

The practice of medicine specific to an expanded operating hours environment that is staffed and equipped to diagnose and treat a broad spectrum of acute, non-life or limb threatening illness and injury. Urgent care centers are enhanced by on-site radiology and laboratory services and operate in a location distinct from a freestanding or hospital-based emergency department. Care is rendered under the direction of an allopathic or osteopathic physician. Urgent care centers accept unscheduled, walk-in patients seeking medical attention during all posted hours of operation, with operational hours that include evenings, weekends, and most holidays.

Section 66 — Licensing of Urgent Care Centers

The legislation, as drafted, would allow a one-time provisional license to an applicant for an urgent care center if the urgent care center holds a current accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC), the Urgent Care Association of America, or

The Joint Commission, or holds a current certification for participation in either Medicare or Medicaid. Our organizations appreciate the significance that recognition of accreditation from the Urgent Care Association, as well as from AAHC and The Joint Commission brings; however, UCA and NERUCA have never supported licensing of medical practices beyond the various permitting procedures already in place and required for any other medical practice to open and operate. However, should urgent care specific licensing become law, it should not be restricted to a one-year provisional license for an office practice that already has and maintains appropriate accreditation. Requiring urgent care centers that already meet rigorous accreditation standards and certifications to also meet separate rules, regulations and practice standards established by the state poses unnecessary cost and administrative burdens on urgent care center operations without evidence that separate licensing requirements would have any added incremental benefit to public health, welfare, or safety, and would only serve to drive up the costs associated with delivery of urgent care services while at the same time slowing down the delivery of these services.

Urgent care centers should not be subject to any additional licensure beyond that which is required of any other office-based medical practice.

Section 77 — Specialty Clinic Assessment

UCA and NERUCA vehemently oppose the imposition of an 8.75 percent tax on specialty clinic charges, including on urgent care centers, and urge that it be removed in its entirety from the proposed legislation. Many urgent care centers are privately owned proprietary interests. The business of urgent care is based on a high-volume, low-profit margin model, with practice margins typically in the 2-3 percent range. An 8.75 percent tax on billed services in reality translates to a 15-20 percent reduction in a practice's receivables, as amounts billed do not come close to matching actual payments received from third party and government payers. Therefore, assessment of an 8.75 percent tax will very likely be a terminal event for the urgent care industry in Massachusetts. It should be noted that since the introduction of H.4639, NERUCA has been notified by two of its member practices in neighboring New England states with previously announced plans to expand into Massachusetts, that they are putting their proposals on hold, pending the legislation's out come.

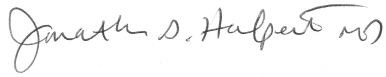
Urgent care centers should not be subject to any tax or tariff. A tax based upon billed medical services and that fails to consider the effects a tax would have upon receivables should never be brought for consideration.

Conclusion

UCA and NERUCA applaud the Massachusetts legislature's desire to improve health care access for the people of Massachusetts, and we stand ready to work with you and your colleagues to help achieve this goal. However, we are deeply disappointed with the apparent shortsightedness with which the urgent care provisions in H.4639 were drafted. In this regard, we respectfully ask that you take our concerns and recommendations into consideration as you deliberate H.4639 and

any companion bills. We stand ready to serve as a resource to you and as a partner in health care reform in Massachusetts. Should you have any questions or require additional information, please do not hesitate to contact us.

Sincerely,



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