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INSPIRING HEALTHY ACTS

URGENT CARE CENTERS

A Growing Component of the Healthcare System

Introduction

Urgent care centers (UCCs) — outpatient clinics that offer urgent, unscheduled medical care for patients whose conditions are non-life-threatening — have long existed in the United States as part of the care continuum for non-emergency medical conditions. Although the growth of UCCs was slow for many years, the urgent care industry is now rapidly expanding.[1] There were 14,382 UCCs in the U.S. in 2023, 122 of which were in Arkansas.[2] This growth has been driven by consumer demand for convenient and timely access to care, an increase in multi-site operators, and evolving partnerships between UCCs and healthcare systems. Compared to baby boomers, millennials are twice as likely to prefer UCCs over traditional ambulatory care settings — i.e., settings where medical services are provided on an outpatient basis, such as primary care clinics. This preference reflects the value millennials place on conveniences such as online access and flexible scheduling, their comfort with telemedicine, and shifts in patient-provider relationships and financial considerations including insurance coverage. This is a generational shift that could influence the future structure and delivery of healthcare services.[3]

The COVID-19 pandemic has impacted UCCs by accelerating their utilization, alongside telehealth services, for convenient, non-urgent care, giving patients a broader array of healthcare options (see Figure 1). Nevertheless, primary care clinics, often functioning in Arkansas under the patient-centered medical homes (PCMH) model,[a] remain the recommended

[a] The PCMH model is a coordinated, team-based care model that integrates collaborative patient-provider relationships. The PCMH program aims to support primary care in Arkansas by enhancing the patient experience, promoting preventive and long-term disease management, reducing costs, and emphasizing primary care clinics as the first point of contact for care.

FIGURE 1.[5] CARE SETTINGS AND PROVIDED SERVICES[b]

Primary Care Providers
Routine care, chronic disease management, health maintenance, minor illness care, and injury care, with the ability to refer for specialty care.

Retail Clinics
Minor illness care (sore throat, upper respiratory infection), immunizations, and minor injury care (sprains, strains, and simple lacerations). In a growing trend, some retail clinics have expanded their services to include lab and X-ray capabilities, although this is not universal.

Urgent Care Centers
Treatment for the same conditions as retail clinics, treatment for non-life-threatening conditions with ability to x-ray, intravenous fluids therapy, repetitive-dose aerosol breathing treatments, and at some centers, advanced diagnostics including computed topography (CT) scans for head injuries, kidney stones, and abdominal complaints.

Freestanding Emergency Departments
Care for all levels of injury (excluding major trauma), ability to treat and stabilize but not admit on an inpatient basis, all levels of medical care including advanced imaging (CT, plain film radiography, ultrasound), and full-service lab.

Rural Emergency Hospitals
Range of services including emergency care, short-term observation, basic imaging, laboratory tests, and sometimes outpatient surgery services. These hospitals serve as initial stabilization points for patients but do not have inpatient beds.

Acute Care Hospitals
Comprehensive care for all levels of illness and injury, including major trauma, with the ability to admit patients on an inpatient basis.

first point of contact for non-emergency care, providing benefits like long-term health monitoring and coordinated care that are less commonly available in urgent care settings.[4]

This explainer discusses various ambulatory care settings, UCC workforce and ownership characteristics, the UCC regulatory environment, and care coordination considerations.

Workforce Changes

The first UCCs were established by emergency medicine physicians as a convenient alternatives to emergency rooms (ERs), and they initially offered a broad range of complex procedures.[6] However, changes in reimbursement models and the needs of the COVID-19 pandemic have led many centers to focus on less severe cases.[7] The workforce composition in UCCs has shifted significantly, with 84% of providers in 2022 being non-physician providers (e.g., physician assistants, advanced practice registered nurses, or APRNs), up from 30% in 2009, when physicians dominated the field.[8] This shift in staffing has changed the breadth of services UCCs can provide.

[b] Not all services mentioned in Figure 1 may be available at every location within a category. For instance, advanced diagnostics such as computed topography (CT) scans may not be offered at all UCCs. Some specialized settings for care may not be listed (e.g., pediatric clinics, geriatric centers).

Ownership Transition

Ownership of UCCs has also undergone substantial changes. In 2008, physicians owned 54% of UCCs, while hospitals owned 25%, and the remainder were largely owned by corporate entities.[9] By 2022, physician ownership decreased to 27%, hospital ownership (or joint ventures with hospital systems) rose to 53%, and corporate entities, including private equity groups, owned 15% of UCCs.[2] However, 2023 saw these trends reverse: Physician ownership rose to 52%, while hospital and joint-venture ownership declined to 33%. Despite the rise in sole ownership, many healthcare systems continue to integrate UCCs into their services.[10] This integration aims to provide cost-effective, accessible care and is often part of a broader strategy that includes ancillary, specialty, and primary care to create a continuum of care that improves patient outcomes. An example of a strategic partnership is Baptist Health's collaboration with Urgent Team to expand access to urgent care services in communities.[11]

FIGURE 2: OPERATIONAL MODEL

- UCC operational models vary significantly.
- Hospital-affiliated UCCs may be located within the hospital facility and are mandated to serve all patients.
- Non-hospital UCCs may not accept all patients, with exceptions as required by state regulations.

FIGURE 3: COMMON FEATURES SHARED BY URGENT CARE CENTERS

Accessibility and Convenience[2]

- Provide walk-in, no-appointment-needed services.
- Offer extended hours, including evenings and weekends.
- Offer services beyond the scope of typical primary care clinics.

Patient Care

- Specialize in managing acute illnesses and injuries, particularly respiratory and COVID-related cases since 2020.
- May offer easier access and shorter wait times compared to ER visits,[12] with average visits under one hour compared to four hours at ERs.[13]

Service Utilization

- Serve patients with various healthcare needs and insurance types, but may not be obligated to accept some patients, such as those on Medicaid or Medicare or the uninsured.

Billing and Reimbursement

- Employ varied billing practices, with many UCCs billing insurance directly and requiring patients to pay copays or deductibles at the time of service, while others might require payment up front.
- Operate on a fee-for-service basis, generally bill and get reimbursed more than primary care clinics but less than ERs.
- Integrate global rates — a fixed amount per visit regardless of the complexity of the encounter — to supplement fee-for-service billing for more predictable revenue streams.[2]

Out-of-Network Considerations

- May result in patients facing balance billing, which occurs when the UCC is out-of-network and insurance does not cover the full cost of care, leaving the patient responsible for the difference.

Urgent Care Center Regulation

Although UCCs offer medical services similar to those offered in ambulatory care settings, the extent to which UCCs are subject to the same regulatory guidelines varies by state. Hospital-based UCCs are generally subject to the same regulatory requirements as their hospital owners. However, for non-hospital-based UCCs, there are increasing concerns regarding the lack of regulation by states to ensure patient safety and quality of care. In Arkansas, for example, non-hospital-based UCCs are not regulated by any state agency, although healthcare providers employed by UCCs are governed by their respective health professional boards. Several national organizations offer accreditation and certification of UCCs, but this is not currently a requirement for operation in Arkansas.

Arkansas has implemented requirements for UCCs enrolled as providers in the Medicaid program. For example, in Arkansas, Medicaid will reimburse a hospital-associated UCC for up to four healthcare visits per year for Medicaid beneficiaries without an assigned primary care provider.[14] Beneficiaries cannot be turned away due to the absence of an assigned primary care provider.

Some states have implemented regulatory frameworks for UCCs. Table 1 provides examples of state regulations in Arizona, New Hampshire, and Vermont.

TABLE 1. STATE REGULATION OF URGENT CARE CENTERS[15]

AZ	In Arizona, UCCs are classified as "outpatient treatment centers" that are not hospitals but operate 24 hours a day and provide care for urgent, immediate, or emergency conditions. The centers must comply with several requirements, including: ○ Be licensed. ○ Make pricing for direct payments available either online or on request. ○ Inform patients about physician availability. ○ Adhere to a set of state-defined operational rules, which include training and reporting requirements.
NH	New Hampshire requires non-emergency walk-in care centers, including UCCs, to be licensed. These centers provide medical care for non-life-threatening emergencies without requiring an appointment or an intention to establish an ongoing care relationship. These centers are also required to have at least one licensed medical professional, such as a physician or APRN, on-site during operation hours.
VT	In Vermont, all non-emergency walk-in centers, including UCCs, are required accept patients regardless of insurance status or type of health coverage.

Urgent Care Center Considerations

Many healthcare consumers face long wait times for appointments with PCPs or costly care in emergency rooms for non-emergent conditions. Individuals seeking treatment for minor illnesses or injuries may view UCCs as a convenient and cost-effective option. Although UCCs may satisfy this demand, the primary care community has expressed concerns about their impact on the continuity of care, as highlighted in Table 2, which notes recommendations from the American Medical Association[16] for improvement. As the UCC industry continues to grow and evolve, policymakers should consider whether oversight of UCCs is needed to improve continuity of care, access to necessary medical services, and regulation to ensure safe and appropriate patient care. Also, by recognizing the emerging preference for UCCs as a source of care — particularly among younger populations — primary care providers in traditional settings may recognize an opportunity to adapt and attract patients who value convenience as a component of patient-centered care.

TABLE 2. URGENT CARE CENTER CHALLENGES

Continuity of Care	○ May disrupt the comprehensive management of chronic conditions. ○ There is a risk of inadequate follow-up care after UCC visits. ○ May lack complete medical histories to make informed healthcare decisions.
Access	○ May not offer all necessary medical services. ○ Are not legally obligated to provide care for every population, which could impact underserved communities.
Regulation	○ Regulatory standards for UCCs vary significantly across states. ○ Some areas, like Arkansas, do not require UCCs to have accreditation or certification.
American Medical Association Recommendations	○ Assist patients without a primary care provider in finding one and coordinate with existing providers to ensure continuous care, including appropriate follow-up. ○ Share patient medical records and visit summaries with primary care physicians and other healthcare providers, with patient consent. ○ Clearly communicate the scope of services offered, including the qualifications of healthcare providers and the extent of physician supervision. ○ Employ local physicians as medical directors or supervisors to oversee clinical care, with their roles and qualifications made transparent to patients.

Conclusion

The growth of UCCs in Arkansas and across the U.S., accelerated by the COVID-19 pandemic, is altering the landscape of healthcare access and delivery. In response, several states have enacted laws requiring UCCs to, for example, be licensed, provide transparency, ensure access regardless of insurance status, and outline reimbursement guidelines. UCCs can offer convenient and timely care, but a focus on care coordination and follow-up is key to integrating UCCs into the broader health system to ensure they enhance overall access while effectively complementing continuity of care provided by PCMHs. This strategic approach underscores the potential of UCCs to support a more integrated, patient-oriented healthcare experience.

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