April 21, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9949-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-9949-P; Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond

Dear Administrator Tavenner:

The Urgent Care Association of America (UCAOA) welcomes the opportunity to provide comment on the proposed rule regarding requirements applicable to health insurance issuers under the Affordable Care Act for 2015 and beyond (79 Fed. Reg. 55, March 21, 2014). Specifically, the UCAOA wishes to address the March 14, 2014 Centers for Medicare and Medicaid Service's (CMS) *2015 Letter to Issuers in the Federally-facilitated Marketplace*s which was released simultaneous to this proposed rule.

UCAOA represents more than 6,000 individual members working at more than 2,000 urgent care clinics throughout the United States. According to UCAOA survey data, an urgent care center receives on average 342 patient visits per week, making it a dominant point of service for health care for millions of Americans. Urgent care centers provide walk-in, extended-hour access for acute illness and injury care that is either beyond the scope or availability of the typical primary care practice. Providers in urgent care centers are commonly physicians trained in family, emergency or pediatric medicine, as well as non-physician practitioners including physician assistants and nurse practitioners.

As noted in the March Letter to Issuers, Pursuant to 45 C.F.R. 156.230(a)(2), an issuer of a Qualified Health Plan that has a provider network must maintain a network that is sufficient in number and types of providers, including providers who specialize in mental health and

substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

We support CMS' decision to begin assessing provider networks using a "reasonable access" standard, through which it will identify networks that fail to provide access without unreasonable delay as required by 45 C.F.R. 156.230(a)(2). Per the Letter to Issuers, CMS will focus most closely on those areas which have historically raised network adequacy concerns, which may include primary care providers, hospital systems, oncology providers and mental health providers.

In applying its "reasonable access" standard, UCAOA asks CMS to consider the role of urgent care centers in Qualified Health Plan networks.

Among the most common conditions treated in urgent care centers are fevers, upper respiratory infections, urinary tract infections, sprains and strains, lacerations, contusions, and back pain. Most centers also treat fractures and provide intravenous fluids, as well as offer onsite X-ray, lab and pharmacy services. Also, many urgent care centers offer primary care and preventive services such as immunizations and physicals.

While many of the acute conditions treated in urgent care centers are conditions that can also be treated in the primary care office setting, patients who seek care in urgent care centers (the majority of whom have private insurance) do so for a variety of reasons, including lack of a primary care physician, the need for after hours and weekend care, and convenience. It is well known that there is a primary care physician shortage today, which will grow to 45,000 by 2020.[1] Also, 53 percent of insured Americans note difficulty with same day or next day care and almost 57 percent have difficulty with evening, weekend and holiday care except for the costly emergency room.[2]

When applying the reasonable access standard, CMS should consider whether the issuer provides enrollee access without delay to acute care services in sites of services other than the hospital emergency department, including urgent care centers. We suggest that while primary care providers are trying to offer open access scheduling to include acute care services, the reality is that in many markets, there are insufficient primary care providers to meet

[1] Physician Shortages to Worsen without Increases in Residency Training. American Association of Medical Colleges; https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf. Accessed online April 20, 2014.
[2] 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.

demand or they simply do not offer certain types of acute care services, such as X-ray and care for minor lacerations. On the other hand, UCAOA estimates that existing urgent care centers have the capacity to fulfill the growing need for both episodic primary care and non-emergent visits. Lacking access to a primary care physician or urgent care center, patients will seek care for acute non-emergent conditions in the more costly hospital emergency department. It is estimated that as much as 27 percent of all emergency department visits are for non-emergent care. According to a study published in *Health Affairs*, shifting non-emergency cases from the emergency department to alternative sites, such as urgent care centers could yield savings of $4.4 billion annually to the health care system.[3]

Additionally, as part of its continuous monitoring of network adequacy, a Qualified Health Plan should be required to provide enrollee access to urgent care centers for services that are not reasonably accessible through the Plan's primary care provider network but which fit within the scope of services provided by urgent care centers, e.g., immunizations, medication refills, physicals, post-hospital discharge visits, follow up outpatient issues instead of costly home health visits, etc.

We believe there is significant value to be gained by both patients and the health care system from recognition of the role urgent care centers play in health care delivery, and, specifically, in supporting primary care providers. UCAOA therefore appreciates your consideration of its comments as it applies its new standards for determining provider network adequacy and looks forward to a continued dialogue with CMS. Should you have questions or require additional information, please do not hesitate to contact me at (214) 537-5569 or Camille Bonta, UCAOA's Washington Representative, at (202) 320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

Nathan Newman, MD, FAAFP
President
Urgent Care Association of America

[3] Weinick R., Burns R, Mehrotra A. Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics. *Health Aff* Sept. 2010 vol. 29 no. 9 1630-1636.