November 28, 2017

The Honorable James Mattis
Secretary
U.S. Department of Defense
1400 Defense Pentagon
Washington, DC 20301-1400

Summited online at http:// www.regulations.gov

RE: DOD–2017–HA–0039; Establishment of TRICARE Select and Other TRICARE Reforms

Dear Secretary Mattis:

On behalf of the Urgent Care Association of America (UCAOA), I am writing in response to the interim final rule published in the *Federal Register* on September 29, 2017 that establishes TRICARE Select and other TRICARE Reforms. Specifically, UCAOA offers comments on the implementation of Section 704 of the Fiscal year 2017 National Defense Authorization Act which improves access to urgent care for TRICARE Prime beneficiaries.

Since the early 1980s, urgent care centers have been providing care to Americans throughout the United States. Today there are an estimated 7,600 urgent care centers in the United States. According to UCAOA's most recent benchmarking survey, urgent care centers provide more than 88 million patient visits per year making these patient-centric destinations a dominant point of service for health care for millions of Americans. UCAOA's membership is diverse, ranging from physician owned single centers, to large multi-site organizations. A growing sector of urgent care centers are owned by hospitals and health systems as an integral part of their ambulatory care strategy.

Urgent care centers are a valued and essential part of health care delivery in communities across the United States. Urgent care centers provide walk-in, extended-hour access for urgent and primary care services. The top diagnoses seen in an urgent care center are consistently pharyngitis, upper respiratory infections, urinary tract infections, gastrointestinal disorders, lacerations and other illnesses and injuries that are non-emergent. Most centers also care for

work and non-worked related musculoskeletal injuries, including trauma and fractures, provide intravenous fluids, and provide a comprehensive scope of services that includes onsite X-ray, laboratory and phlebotomy services. Urgent care centers do not care for life (or limb) threatening situations, but stabilize patients while securing emergency transport.

The interim final rule states that the Secretary will determine annually the specific number of urgent care visits that will be allowed without a referral. The rule, however, does not provide detail on what basis the Secretary will determine the appropriate number of urgent care visits allowed without a referral. The UCAOA believes urgent care should be used as appropriate and not as a substitute for a patient's medical home. Co-management with a patient's dedicated primary care provider is a central tenet of urgent care delivery. According to UCAOA's 2016 Benchmarking Study, 85 percent of respondents indicated they have a mechanism in place to align patients with a medical home or primary care provider when they do not have one. Ninety-one percent of surveyed urgent care centers responded that they communicate information regarding the patient encounter to an existing external clinical provider. Thirty-three percent of respondents indicated that they were affiliated with a multi-specialty practice that also provided primary care and may also share a common electronic medical record. **UCAOA does not believe that limits should be placed on the number of urgent care visits without a referral or prior authorization. Instead, TRICARE should address potential overuse of urgent care on a beneficiary case-by-case basis, including an assessment of primary care access barriers in the community.** Should the Secretary desire to establish a set allowance of urgent care visits without a referral or prior authorization, the importance of ensuring immediate access to care for acute medical conditions should be balanced with potential overuse.

UCAOA believes that not only will access to urgent care services without referral help meet the health care needs of TRICARE beneficiaries, but that it has the potential to reduce health care costs to the TRICARE system. A study evaluating three years of BCBS of Texas data was published in the February 2017 *Annals of Emergency Medicine.* It found that 12 of the most common diagnoses treated in the hospital emergency department were also in the top 20 diagnoses for urgent care centers.[1] **However, the cost to patients with the same diagnosis were on average almost 10 times higher at hospital-based emergency departments relative to urgent care centers.** For example, the diagnosis of "other upper respiratory infections," the cost was $1,074 in the hospital emergency department and $165 in the urgent care center. Urgent care centers are a cost-effective alternative to the emergency department for non-emergent services.

As the Department finalizes and implements its policy for improving access to care through the use of urgent care, the UCAOA offers itself as a resource and as a potential partner in beneficiary

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[1] Ho V, Metcalfe L, Dark C, et al. Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers. Ann Emerg Med. 2017. https://www.researchgate.net/publication/313785002_Comparing_Utilization_and_Costs_of_Care_in_Freestanding_Emergency_Departments_Hospital_Emergency_Departments_and_Urgent_Care_Centers

and provider outreach and education. Should you have any questions, please contact Camille Bonta, UCAOA policy advisor, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

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