March 4, 2019

The Honorable Robert Wilkie
Secretary
Department of Veterans Affairs
810 Vermont Avenue
Washington, DC  20420

RE:  RIN 2900–AQ47 Urgent Care

Dear Secretary Wilkie:

The Urgent Care Association (UCA) welcomes the opportunity to provide comment in response to the proposed rule published Jan. 31, 2019 in the Federal Register implementing Section 105 “Access to walk-in care” of the VA MISSION Act of 2018. Specially, UCA offers comments on the Department of Veterans Affairs’ (VA) definition of urgent care and the scope of urgent care services that eligible veterans could obtain from qualifying non-VA entities or providers.

Since the early 1980s, urgent care centers have been providing care to patients throughout the United States. Adding roughly 500 new centers each year, the urgent care industry continues to grow and meet patient preference for on-demand access to affordable and convenient care. As of February 2019, UCA’s database includes 8,925 urgent care centers with a presence in all 50 states, making them a health care site of service for an estimated 89 million patient visits annually. In contrast, according to UCA’s 2018 benchmarking report, there were 1,968 retail clinics in the United States, an actual decrease of one percent of what was reported the prior year.\(^1\)

**Definition of Urgent Care**

Section 105 of Public Law 115–182 refers to the benefit as walk-in care, which adequately describes on-demand care provided by urgent care facilities and retail clinics — meaning that appointments are not necessary to receive care. For the purpose of these regulations, the Department is proposing to define urgent care to include those services that are furnished by walk-in retail health clinics or urgent care facilities, as designated by the Centers for Medicare and Medicaid Services (CMS). While the VA proposes to refer to care provided at both urgent care facilities and walk-in retail health clinics as “urgent care,” there are clear distinctions between retail clinics and urgent care facilities. Therefore, it will be critical that the Department enter into adequate contracts with both

\(^1\) Ibid.
urgent care facilities and retail health clinics to ensure that veterans have access to providers that can offer care for the full scope of non-emergent illnesses and injuries.

There is some overlap between urgent care facilities and retail clinics for the most common conditions treated, such as upper respiratory infections, pharyngitis, and urinary tract infections. However, urgent care facilities provide services for illnesses and injuries that are outside the scope of retail clinics, including musculoskeletal trauma, fractures and lacerations. Most urgent care facilities also provide intravenous fluids and nearly all provide onsite X-ray, CLIA waived or CLIA moderate laboratory testing and phlebotomy services.

Consistent with the law, the benefit should be referenced to as “walk-in care” with a clear distinction between retail clinics — those situated in pharmacies, grocery stores, and “big-box stores” such as Walmart and Target — that are recognized by place of service (POS) code 17 and urgent care facilities that are recognized by Medicare’s POS 20.

The Department proposes that it will publish a website containing information on urgent care, including the names, locations, and contact information for qualifying non-VA entities or providers within an eligible veteran’s community. The Department proposes that the website would also include a list of services and other general information on the urgent care program established under this section. Because urgent care facilities are equipped to manage patients across a broader scope of services compared with retail clinics, it is important that the distinction between retail clinics and urgent care facilities be apparent to veterans seeking care for non-emergent illnesses and injuries.

**Covered Services**

Consistent with Section 105(h) of Public Law 115–182, the proposed rule provides that urgent care (or “walk-in care”) may only be furnished as episodic care for eligible veterans needing immediate non-emergent medical attention, but does not include longitudinal care. Because “episodic care” is not defined in the law, the VA proposes to define the term “episodic care” as care or services provided for a particular health condition, or a limited set of particular health conditions, without an ongoing relationship being established between the eligible veteran and qualifying non-VA entities or providers. The VA further proposes that episodic care would be only for a particular health condition (or a flu shot) or a limited set of particular health conditions, to be addressed in a single visit, and would not include preventive services (other than flu shots, and therapeutic vaccines that are furnished in the course of treatment of another condition). This definition fails to recognize the role of urgent care facilities in the health care delivery system and continuity of care and could create a barrier to necessary follow-up care subsequent to an urgent care encounter for illness or injury.

UCA strongly disagrees with the VA’s proposal that episodic care is addressed in a single visit. CMS describes an episode of care, or episode, as the set of services provided to treat a clinical condition or procedure — not as services provided in a single visit. Episodic care, at a minimum, should include

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necessary follow-up care for an episodic event that does not require longitudinal care over an extended period of time. Accessibility to urgent care facilities should not change when follow-up care is required as a clinical best practice. For example, a diagnosis of pneumonia could become complicated and continuity of care disrupted if follow-up care is not allowed with the provider who initiated treatment or is not otherwise readily accessible.

The rule reflects a very limited understanding of urgent care facilities. It is important policymakers view urgent care centers not only as a tool to reduce the costs of treating individuals with non-emergent acute care needs, but also as a source for primary and preventive care services. Despite policy efforts aimed at strengthening access to primary care, many consumers are “medically homeless.” In addition to filling gaps in access to primary care, the majority of urgent care centers, based on UCA’s member survey, have a mechanism in place to connect patients to a medical home. Urgent care centers also have an important role to play in preventive care, ranging from influenza vaccines to diabetes and hepatitis screenings. Irrational barriers — such as those being proposed in this rule — in the health care system such as disallowing urgent care centers to provide follow-up care after an acute care visit or preventive care should be removed so urgent care facilities are not restricted from playing a role in improving the health of our nation’s veterans. Urgent care facilities serve an essential role as part of the primary care safety net across the country. Arbitrary barriers limit their ability to effectively improve the health of those they serve.

In September 2018, UCA offered to the Department to be resource with regard to implementation of Section 105. While the VA did not avail itself if this offer, we hope that will change as the Department works to finalize this rule. Should you require additional information, please contact Camille Bonta, UCA policy consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

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