

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Ave., SW  
Washington, D.C. 20201

September 9, 2024

**Re: CMS-1807-P Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments**

Dear Administrator Brooks-LaSure:

Thank you for soliciting comments on payment for services furnished in urgent care centers (UCCs). Our comments respond to this solicitation found in section I.4 of the proposed rule beginning on page 61,746 of the July 31, 2024, *Federal Register* notice.

Overcrowding and wait times in emergency departments (EDs) continue to pose a challenge to our healthcare system. According to the Centers for Medicare & Medicaid Services' (CMS) most recently released data in 2022, the median time patients spent in EDs was 2 hours, 40 minutes nationwide, up from 2 hours, 18 minutes in 2014.<sup>1</sup> Overcrowding in EDs contributes to healthcare staff burnout, poor clinical outcomes including medical errors, and excessive costs.<sup>2</sup>

There are many reasons for ED overcrowding, including insufficient hospital beds available for patient admissions and workforce shortages. One prominent reason is inappropriate use of EDs for urgent, non-emergent health care services that can be provided in less acute, lower cost settings.

As the comment solicitation recognizes, UCCs are well-poised to be part of the solution by providing treatment for urgent, non-emergent care needs. However, a global policy solution is needed to encourage UCCs to locate in underserved communities, and to encourage UCCs to expand their hours of availability and service offerings. CMS is best positioned to advance these policy solutions and should begin to develop policies that incentivize UCCs to expand availability and service capability so that they can be a care alternative for beneficiaries with urgent, non-emergent health care needs.

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<sup>1</sup> Allen, L., et al. (2019). *Urgent Care Centers and the Demand for Non-Emergent Emergency Department Visits*. National Bureau of Economic Research. <http://www.nber.org/papers/w25428>

<sup>2</sup> Kelen, G. D., et al. (2021). Emergency department crowding: the canary in the health care system. *NEJM Catalyst*. <https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217>

One policy option available to CMS that could incentivize such “enhanced” UCCs would be to recognize the factors that enable UCCs to serve as an appropriate alternative to the ED for beneficiaries’ urgent, non-emergent health care needs and create a payment structure in which such UCCs are differentially compensated.

Our detailed comments in response to the questions posed in the comment solicitation follow below.

### **Background**

A considerable amount of scholarship and research supports treating patients with urgent, non-emergent care needs in UCCs. A 2019 report by the Medicare Payment Advisory Committee found that one-third (500,000) of nonurgent ED claims could be appropriately treated in an UCC at one-third the cost.<sup>3</sup> A 2019 National Bureau of Economic Research study found that up to one-half of the annual 137 million ED visits could be treated at a less-emergent facility, which could result in \$1 billion in annual health care savings.<sup>4</sup>

At present, there are not enough UCCs, and not enough UCCs in the right places, to provide alternatives to, and alleviate pressure on, EDs. In recent surveys of UCCs, only 22 percent said they had locations in rural areas, and the target catchment area of existing UCCs has decreased in mileage over time.<sup>5,6</sup>

There also are not enough UCCs of the type that can serve as appropriate alternatives to the ED for urgent, non-emergent health care needs. Many UCCs are open extended hours, including evenings and weekends. In one survey of UCCs conducted in 2022, respondents reported that 67% of their centers were open every day of the week.<sup>7</sup> And many UCCs offer enhanced diagnostic services like laboratory and x-ray capability. In a 2022 survey of UCCs, 85% of UCC respondents reported that they offered x-ray services.<sup>8</sup> UCCs that are available and capable of being alternatives to EDs will be utilized as such by patients. But if patients only have access to UCCs that are open from 9a-5p on weekdays, for example, or that are unable to diagnose and treat a broad range of urgent, non-emergent conditions, they will have no choice but to seek care from EDs when needs beyond the availability or capability of the physician office or the UCCs in their community arise.

### **Enhanced Diagnostic and Therapeutic Services and Extended Hours Are Needed to Meet Urgent, Non-Emergent Care Needs**

CMS asks, in its comment solicitation, what types of services would alternative settings to EDs need to offer to meet beneficiaries’ non-emergent, urgent care needs?

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<sup>3</sup> Medicare Payment Advisory Commission. (2019). *Options for slowing the growth of Medicare fee-for-service spending for emergency department services* (p. 394). [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch11\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch11_medpac_reporttocongress_sec.pdf)

<sup>4</sup> Allen, L., et al. (2019). *Urgent care centers and the demand for non-emergent emergency department visits* (p. 19). National Bureau of Economic Research. <http://www.nber.org/papers/w25428>

<sup>5</sup> Urgent Care Association. (2023). *Urgent Care Association Benchmarking Report: Finance* (p. 3).

<sup>6</sup> Urgent Care Association. (2022). *Urgent Care Association Benchmarking Report: Operations* (p. 13).

<sup>7</sup> Urgent Care Association. (2022). *Urgent Care Association Benchmarking Report: Operations* (p. 8).

<sup>8</sup> Urgent Care Association. (2022). *Urgent Care Association Benchmarking Report: Operations* (p. 31).

Alternative settings would need to offer the urgent, but not emergent care often sought at EDs. According to MedPAC, “8 of the 20 most common conditions treated at UCCs were also among the 20 most common conditions treated at hospital EDs: urinary tract infections, cough, hypertension, back pain, pneumonia, dizziness, chest pain, and shortness of breath.”<sup>9</sup> Physician offices often are not suited or suitable to treat these conditions, or are not available to patients when they need care. UCCs, in contrast, can manage a wide variety of urgent, non-emergent conditions, including allergic reactions, lacerations, sprains and fractures, common respiratory illnesses (e.g., flu or RSV), and bacterial infections (e.g., strep throat, urinary tract infections or foodborne illness). A 2022 survey of UCCs, found that many UCCs offer enhanced diagnostic services.<sup>10</sup> Most UCC survey respondents also reported offering strep, COVID-19 antigen, RSV, urine microscopy, and hemoglobin A1C testing capabilities.<sup>11</sup> These results are borne out by extrapolated Medicare claims data, which for 2022 show professionals billing Place of Service (PoS) code 20 for UCCs billing evaluation and management, general laboratory, molecular testing, nononcologic injections and infusions, and standard x-rays as the top categories of Healthcare Common Procedure Coding System (HCPCS) codes billed.

Importantly, and in contrast to the physician office setting, many UCCs offer these services with extended operating hours and short wait times. In a survey of UCCs conducted in 2023, respondents reported being open during extended hours, including evenings and weekends.<sup>12</sup> In that same survey, 47% of respondents reported a “door to provider” time of 11-20 minutes and 37% reported a time of 21-30 minutes.<sup>13</sup> For the vast majority of visits, respondents reported that the entire patient visit was complete within 1 hour.<sup>14</sup>

### **Current Place of Service Codes Do Not Adequately Differentiate Enhanced UCCs**

CMS also asks, does the current “Urgent Care Facility” Place of Service code (POS 20) adequately identify and define the scope of services furnished in such settings? Is this place of service code sufficiently distinct from others such as “Walk-in Retail Health Clinic (POS 17) and “Office” (POS 11)? If not, how might these Place of Service code definitions be modified?

Current PoS definitions are inadequately differentiated, especially if CMS wishes to encourage proliferation of the type of UCCs that can provide suitable alternatives to EDs. PoS 11 generally refers to physician offices that provide diagnostic and therapeutic care in an office setting, by appointment, typically during regular business hours. PoS 17 generally refers to clinics that are attached to retail operations, such as pharmacies, grocery stores or big box stores, and provide low-acuity primary and preventive health care, such as vaccinations. PoS 20 refers to UCCs but does not adequately differentiate between those that offer services more akin to the typical general practitioner’s office and those that offer enhanced diagnostic and therapeutic services and extended hours.

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<sup>9</sup> Medicare Payment Advisory Commission. (2019). *Options for slowing the growth of Medicare fee-for-service spending for emergency department services* (p. 388). [https://www.medpac.gov/wp-content/uploads/import\\_data/scrape\\_files/docs/default-source/reports/jun19\\_ch11\\_medpac\\_reporttocongress\\_sec.pdf](https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch11_medpac_reporttocongress_sec.pdf)

<sup>10</sup> Urgent Care Association. (2022). *Urgent Care Association Benchmarking Report: Operations* (p. 8).

<sup>11</sup> Urgent Care Association. (2022). *Urgent Care Association Benchmarking Report: Operations* (p. 33).

<sup>12</sup> Urgent Care Association. (2023). *Urgent Care Association Benchmarking Report: Finance* (pp 23-24).

<sup>13</sup> Urgent Care Association. (2023). *Urgent Care Association Benchmarking Report: Finance* (p. 22).

<sup>14</sup> Urgent Care Association. (2023). *Urgent Care Association Benchmarking Report: Finance* (pp. 23-24).

| Place of Service Codes   |   |   |
|--|---|---|
| 11- Office   | 17 - Walk-in Retail Health Clinic   | 20 – Urgent Care Facility   |
| Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. | A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. | Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. |

To begin to identify UCCs that are positioned to help alleviate ED overcrowding, CMS needs more precision in available PoS codes. CMS could achieve this by adding a new PoS that describes “enhanced” UCCs that offer specific diagnostic and therapeutic services and that operate outside typical business hours. For example, CMS could adopt a new PoS for Enhanced Urgent Care Centers as follows:

*Location, distinct from a hospital emergency room, an office, or a clinic, that operates during and outside of typical business hours, provides diagnostic (both radiography and laboratory) and therapeutic (both surgical and nonsurgical) services, and whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.*

Adding a new PoS code, while leaving the current PoS 20 code intact, would allow for clearer evaluation of the impacts on ED utilization of having such an “enhanced” UCC in proximity to an ED. It would also allow for differentiated payments to be made to those UCCs that offer a higher level of service and access while still differentiating UCCs that would continue to bill PoS 20 from other care settings, such as retail clinics.

**Existing Codes Do Not Accurately Reflect the Costs of Services Furnished in UCCs**

CMS asks, does the existing code set accurately describe and value services personally performed by professionals and costs incurred by the facility in these settings?

Medicare’s fee-for-service payment systems do not recognize and adequately value services furnished in UCCs. The reasons for this are structural. First, there is currently no distinct Medicare benefit category or payment system specifically for care furnished in UCCs or other settings that fall in between EDs and physician offices in terms of service offerings and operating hours, meaning that UCCs are not, under Medicare, paid a facility fee for the services they furnish. That means that, under fee-for-service Medicare, a UCC’s reimbursement for services

furnished to a beneficiary—including for overhead costs—is the same as reimbursement for professional services in a physician’s office.

Second, while there is some overlap in the types of professional services furnished in UCCs and physician offices, UCCs that operate for extended hours and that have enhanced diagnostic and therapeutic capabilities incur additional costs to provide these services. These additional costs are not adequately accounted for in Physician Fee Schedule (PFS) ratesetting, including the practice expense (PE) methodology. The relative value units (RVUs) and Medicare reimbursement rates assigned to services under the PFS reflect the typical physician work (time and intensity) and resource costs (direct and indirect PE) incurred by the specialty types that provide the service. This includes indirect costs (administrative labor, office expense, and all other expenses), which CMS allocates at the code-level based on a weighted average of the specialty-specific indirect percentages (expressed as direct and indirect PE per hour [PE/HR]) for the specialty types that furnish the service. Because there is no PE/HR value for UCCs, there are therefore no specialty-specific indirect percentages to reflect the unique overhead costs incurred by UCCs, which are different from the overhead costs incurred for a physician office. While there are specialty-specific indirect percentages for specialty types that furnish services in UCCs (e.g., primary care, emergency care), these data may not accurately reflect the direct-indirect ratios for these specialty types practicing in UCCs specifically, and particularly in enhanced UCCs, as opposed to office settings.

CMS recognizes that there are important differences in resource costs for professional services based on the site of care where the service is delivered. For example, there are distinct evaluation and management (E/M) service codes for (among others) offices, EDs, inpatient hospitals, and nursing facilities with values that reflect the specific physician work and resource costs incurred when an E/M service is furnished in that specific site of care. The same is not true for E/M services furnished in UCCs. There are no E/M services to specifically describe and/or value and reimburse for the physician work and resource costs typically incurred by the specialty types that furnish E/M services in UCCs. Instead, UCCs report office/outpatient E/M services (99202-99205, 99211-99215), which are most commonly furnished in physician offices, and therefore reflect the physician work and direct and indirect PE incurred when these services are performed in physician offices, not UCCs. While office E/M services account for 45% of all services furnished in UCCs, under the current ratesetting methodology, reimbursement for these services more accurately reflects office costs compared to UCC costs.

To adequately compensate UCCs for these costs, and to incentivize growth among UCCs with enhanced capabilities that are best poised to alleviate overcrowding in EDs, CMS should consider creating a G code(s) that professionals furnishing services at enhanced UCCs could report when the new “enhanced” urgent care PoS code is present on the claim. This G code could be billed in addition to the E/M and/or other codes billed by enhanced UCCs and could be valued to compensate enhanced UCCs for their additional expenses.

### **UCCs Are Well-Posed to Advance Equity in Access to Health Care**

CMS asks, how might potential strategies to reduce overcrowding and wait times in EDs advance equity in access to health care services?

EDs have long served as a safety net to those seeking care, which in part contributes to inappropriate use of ED resources. Research shows that some communities default to EDs because there are no proximate, convenient options to receive basic healthcare services.<sup>15</sup> Incentivizing expansion of UCCs available to underserved communities can expand access to care for populations that have historically turned to EDs at high rates. The main factors influencing an individual's decision to visit an ED for a non-emergent condition include age, gender, race, insurance status and type, social support, health status, personality, previous healthcare experiences, and norms of the culture and community.<sup>16</sup> Each one of these factors provides an opportunity for improving health equity and addressing existing disparities.

For the last several years, for example, the National Center for Health Statistics has found that the ED visit rate was highest for patients insured by Medicaid or the Children's Health Insurance Program and lowest for patients with commercial insurance.<sup>17</sup> Medicaid was the most common primary expected source of payment of ED care from 2014 through 2021 (the final year of the study), particularly among Black and Hispanic people.<sup>18</sup> Patients insured by Medicaid may be more likely to use an ED because of lower socioeconomic status coupled with more severe health conditions as well as systematic barriers to care.<sup>19</sup> Likewise, research shows a strong relationship between Medicaid patients' social determinants of health and ED use.<sup>20</sup> Medicaid patients in accountable care organizations were similarly more likely to visit an ED and to be high-frequency ED users if they had high social risks, needs, or both.<sup>21</sup> However, Medicaid and CHIP Payment and Access Commission findings from 2011 Medicaid data suggest that more than 74% of ED visits for both adults and children covered by Medicaid were considered to be preventable.<sup>22</sup>

People who are part of certain communities may similarly benefit from expanded access to UCCs that can meet their urgent, non-emergent health care needs. Rural populations, for example, often suffer from lack of options within a certain geography. Over 100 rural hospitals

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<sup>15</sup> Parast, L., et al. 2022. Racial/Ethnic Differences in Emergency Department Utilization and Experience. *Journal of General Internal Medicine*, 37(1): 49-56. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8021298/>.

<sup>16</sup> Uscher-Pines, L., et al. 2014. Deciding to Visit the Emergency Department for Non-Urgent Conditions: A Systematic Review of the Literature. *American Journal of Managed Care*, 19(1):47-59. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4156292/>. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4156292/>.

<sup>17</sup> National Center for Health Statistics. (2024). *FastStats - Emergency department visits*. U.S. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/fastats/emergency-department.htm>.

<sup>18</sup> Santo, L., et al. (2024). *Trends in emergency department visits among people younger than age 65 by insurance status: United States, 2010–2021* (National Health Statistics Reports No. 197, pp. 1-2). <https://www.cdc.gov/nchs/data/nhsr/nhsr197.pdf>.

<sup>19</sup> Maeng, D., et al. (2017). Patterns of multiple emergency department visits: do primary care physicians matter? *The Permanente Journal*, 21, 16-063. <https://doi.org/10.7812/TPP/16-063>.

<sup>20</sup> McCarthy, M., et al. (2021). The Influence of Social Determinants of Health on Emergency Department Visits in a Medicaid Sample. *Annals of Emergency Medicine*, 77(5), 511–522. <https://doi.org/10.1016/j.annemergmed.2020.11.010>.

<sup>21</sup> Mayes, K. D., et al. (2024). Social risk, social need, and use of the emergency department. *JAMA Network Open*, 7(1), e2352365. <https://doi.org/10.1001/jamanetworkopen.2023.52365>.

<sup>22</sup> Medicaid and CHIP Payment and Access Commission. (2016). *Potentially preventable events: Comparing Medicaid and privately insured populations* (p. 15). <https://www.macpac.gov/wp-content/uploads/2016/12/Potentially-Preventable-Events-Comparing-Medicaid-and-Privately-Insured-Populations.pdf>.

have closed over the last decade, forcing people to have to travel about 20 miles farther for common services.<sup>23</sup>

Finally, ED utilization may also increase when communication is not clear enough for those of varying levels of health literacy to assess when to seek care in an ED versus another setting.<sup>24</sup> Improved access to information, especially from trusted payers like CMS, could help patients determine the best care setting for each situation, regardless of education or literacy.

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Thank you for your consideration. We appreciate your attention to this important issue and look forward to working collaboratively with CMS to explore policy solutions to reduce inappropriate use of emergency services, reduce ED wait times, lower overall healthcare costs, and improve patient outcomes.

Sincerely,



Lou Ellen Horwitz  
Chief Executive Officer  
Urgent Care Association

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<sup>23</sup> U.S. Government Accountability Office. (2020). *Rural hospital closures: affected residents had reduced access to health care services* (Report No. GAO-21-93, p. 14). Report to the Ranking Member, Committee on Homeland Security and Governmental Affairs, United States Senate. <https://www.gao.gov/assets/gao-21-93.pdf>.

<sup>24</sup> Bakare, O., et al. (2023). Medicaid coverage and emergency department utilization in Southeastern Pennsylvania. *Cureus*, 15(9), e45464. <https://doi.org/10.7759/cureus.45464>.