June 27, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P)

Dear Acting Administrator Slavitt:

The Urgent Care Association of America (UCAOA) appreciates the opportunity to respond to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS-5517-P).

Since the early 1980s, urgent care centers have been providing care to Americans throughout the United States. Today, there are an estimated 7,000 urgent care centers in the United States. According to UCAOA’s most recent benchmarking survey, an urgent care center receives 333 patient visits per week on average, making urgent care centers a dominant point of service for health care in this country 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 the availability of the typical primary care practice or clinic. Among the most common conditions treated in urgent care centers are fevers, upper respiratory 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 and lab services. Urgent care centers do not care for life (or limb) threatening situations, but will stabilize patients in need of emergency transport. The majority of urgent care centers employ family practice and emergency physicians, as well as non-physician practitioners, including registered nurses, X-ray technicians, physician assistants and nurse practitioners.

Urgent care centers serve people in urban, suburban and rural communities across the country. For centers that accept Medicare, beneficiaries comprise about 8-12 percent of urgent care visits. As the Medicare population increases and the primary care workforce becomes more strained, the UCAOA estimates that existing urgent care centers have the capacity to meet beneficiaries’ episodic primary care and non-emergency department needs. However, for urgent care centers to remain a site of service option for Medicare beneficiaries, it is critical that Medicare not inadvertently create disincentives for urgent care centers to care for this population.

Urgent care centers not only help meet the health care needs of Medicare beneficiaries, but urgent care centers also have the potential to reduce health care costs to the government. A study published in Health Affairs found that up to 27.1 percent of all emergency department visits, for conditions such as minor acute illnesses, strains, and fractures, could take place at urgent care centers and retail clinics at a potential cost savings of approximately $4.4 billion annually.¹ There are other studies, such as the Colorado Hospital Association study that estimated that as much as 40 percent of hospital emergency room visits occur for non-emergency reasons.²

Some of the services currently being reimbursed by Medicare when provided by hospital emergency department could be provided in urgent care centers at a lower cost. Furthermore, when Medicare beneficiaries with acute care needs delay care, the result can be an exacerbation of the condition, which requires greater medical resources. And, utilizing

¹ Weinick R, Burns R, Mehrotra A. Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics; Health Aff September 2010 vol. 29 no. 9 1630-1636. http://content.healthaffairs.org/content/29/9/1630.full

urgent care centers as access points for after hours and overflow care could reduce the costs of readmission rates for hospitalization, home health and would lower administrative costs via delivery of care in the appropriate setting. More urgent care centers are being included into hospital systems, educational institution systems and integrated health systems as access points for primary care overflow, after hours care and a major point of entry into the health systems in many communities.

According to a report issued by the Massachusetts Health Policy Commission in 2015, a high share of emergency department visits in the state stem from limited access to care after normal operating hours of the doctor’s office. The report also found that the presence of a retail or urgent care clinic nearby reduced use of emergency departments by 30 percent.\(^3\)

UCAOA appreciates that existing quality improvement programs would be better streamlined under MIPS and that CMS has made some accommodations for small practices. However, we do not believe these accommodations go far enough for small practices, and, in particular for eligible clinicians who practice in urgent care centers.

**Low-Volume Reporting Threshold**

CMS is proposing to define MIPS eligible clinicians or groups who do not exceed the low-volume threshold as an individual MIPS eligible clinician or group who, during the performance period, have Medicare billing charges less than or equal to $10,000 and provides care for 100 or fewer Part B-enrolled Medicare beneficiaries.

We appreciate that CMS is attempting to create a threshold so physicians with low revenues and small Medicare populations will not be unduly burdened or disadvantaged. We believe, however, that most eligible clinicians in the urgent care center setting are not well positioned at this time to succeed under MIPS, for a variety of reasons including limited applicability of measures and infrastructure. Urgent care centers are structured, equipped and staffed to effectively and efficiently assess all patients with episodic, non-emergent medical needs. Consequently, if providers in the urgent care center setting do not meet the low-volume reporting threshold, we believe that urgent care centers will make a cost-benefit decision of forgoing MIPS or refuse to accept Medicare.

UCAOA urges CMS to exempt eligible clinicians for the first year of MIPS who bill under Place of Service (POS) 20 from MIPS. POS 20 is defined as a 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. UCAOA is eager to work with CMS to identify more appropriate metrics for eligible clinicians who practice in the urgent care center setting for future MIPS years. Until such time, we strongly urge CMS to consider how the proposed MIPS requirements could reduce Medicare patient access to urgent care centers for their acute care needs when they cannot access a primary care physician in a timely manner.

Alternatively, we believe the low-volume threshold should be modified. We wish to reference the American Medical Association (AMA) analysis of data from the 2015 and 2016 Physician Quality Reporting System (PQRS) program which found that more than 25 percent of physicians with Medicare Part B charges less than $40,000 were subject to a payment adjustment. Once physician Medicare revenues reach the $40,000-$100,000 range, physicians were considerably less likely to earn a penalty. **UCAOA therefore supports the AMA’s recommendation to set the low-volume threshold at $30,000 and to eliminate a minimum patient count from the low-volume threshold definition.**

**Lower Reporting Burden for Urgent Care Centers**

In addition to modifying the low-volume threshold, CMS should also provide for exceptions and lower thresholds throughout the proposed rule for eligible clinicians who practice in urgent care centers (POS 20). Specifically, UCAOA suggests the following:

**Quality Performance Category**

- Maintain the reporting threshold for quality measures to the current PQRS threshold of 50 percent.
- Reduce the number of measures upon which urgent care center providers would need to report successfully from the proposed six to four.
- Exempt eligible clinicians in urgent care centers from the population-based quality measures.
- Create a measure specialty set for urgent care clinicians who typically provide episodic care for non-emergent illnesses and injuries.

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\(^3\) 2015 Cost Trends Report; Massachusetts Health Policy Commission. Residents shown all live within 5 miles of an emergency department. Residents who do not live within 5 miles of an emergency department are excluded from 30 percent reduction figure.
Resource Use Performance Category

• Exempt eligible clinicians in urgent care centers from the entire resource use category. In addition to problems with the reliability of the resource use measures, there is no cost measure alternative (e.g., episode groups) at this time or in the foreseeable future for urgent care center eligible clinicians other than the current value-modifier cost measures.

• Alternatively, the minimum case threshold for attribution of the resource use measures should be increased for urgent care center providers.

Clinical Practice Improvement Activity Performance Category

• UCAOA supports CMS’ proposal to provide accommodation for MIPS small groups (consisting of 15 or fewer eligible clinicians). UCAOA suggests that CMS adjust its proposal to allow small groups to report on two medium-weighted CPIAs or one high-weighted CPIA to receive a CPIA score of 100 percent.

Advancing Care Information Performance Category

• Eligible clinicians who utilize an electronic health record (EHR) in the urgent care center setting, regardless of whether that EHR is certified technology, should receive full credit under the advancing care information (ACI) category. The most important component of an EHR system for urgent care centers is interoperability. Once EHR interoperability is widespread, we believe it would be reasonable for urgent care centers to be held to an interoperability standard.

• Alternatively, CMS should either eliminate the performance component from the overall ACI score or reduce the weight of the performance score and increase the weight of the base score.

Conclusion

UCAOA, as the leading resource for urgent care centers across the country, believes that over time there is a greater likelihood that Medicare will constitute a larger share of urgent care center payer mix as a result of an aging baby boomer population that, due to their commercial insurance experience, is familiar with urgent care centers as a source of care when access to their primary care provider is limited. We therefore are eager to work with CMS to devise a MIPS program that is meaningful to eligible clinicians who practice in urgent care centers.

Should you desire additional information, please contact Camille Bonta, UCAOA consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,

[Signature]

Steve Sellars
President
Urgent Care Association of America