



September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P)

Dear Administrator Verma:

The Urgent Care Association (UCA) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule (CMS-1693-P), published on July 27, 2018, in the *Federal Register*, regarding the proposed policy revisions to the CY 2019 Medicare Physician Fee Schedule (PFS).

Since the early 1980s, urgent care centers have been providing care to patients throughout the United States. Today there are more than 8,200 urgent care centers in the United States. According to UCA'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.

Urgent care centers provide walk-in, extended-hour access for acute illness and injury care that is either beyond the scope and/or the availability of the typical primary care practice or clinic. Many of the same non-emergent conditions treated in a hospital emergency department or free-standing emergency department can be treated in an urgent care center at significantly lower cost.

UCA offers comments on the following components of the proposed rule:

- Evaluation and Management Visits (E/M)
- Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVC11)
- Remote Evaluation of Pre-Recorded Patient Information (HCPCS code GRAS1)
- Quality Payment Program (QPP)
- Request for Information on Price Transparency

EVALUATION AND MANAGEMENT VISITS

UCA appreciates CMS' ongoing commitment to regulatory burden relief and is largely supportive of the proposed rule's changes to E/M services' documentation requirements. Specifically, **we strongly support CMS' proposals to reduce redundancy in E/M documentation by:**

- limiting documentation of the history and/or physical examination for an established outpatient visit to recording changes from the prior visit along with notation of pertinent absences of change; and
- permitting for both new and established E/M office visits that a Chief Complaint or other historical information entered into the record by ancillary staff or the patient may be reviewed and verified rather than re-entered by the physician.

We ask that CMS finalize these proposed documentation requirement changes for CY 2019, as they don't necessitate changes to coding and payment.

UCA appreciates that CMS further proposes to simplify E/M documentation burden by proposing to apply a minimum documentation standard where, for the purposes of Physician Fee Schedule payment for an office/outpatient E/M visit, practitioners could use existing documentation guidelines (history, physical exam and medical decision making), or practitioners could document for E/M payment using straightforward medical decision making (measured by minimal problems, data review and risk), or by using total visit time (i.e., unrelated to counseling or care coordination time). If current documentation guidelines and/or medical decision making are used, CMS would only require documentation to support the medical necessity of the visit and to support a level 2 CPT visit code. While appreciative of CMS' intent, **UCA does not support finalizing its proposal for a minimum documentation standard if these additional documentation changes are tied to coding and payment structures because, as elaborated**

on below, UCA recommends to CMS that the proposed changes to coding and payment for office E/M services be set aside and not finalized for CY 2019.

Additionally, there are legitimate concerns that CMS' proposals to simplify E/M documentation requirements will actually have very little effect on reducing practice burden if major changes to documentation requirements are not adopted simultaneously by other payers. Instead practitioners will be left to contend with different documentation rules, adding confusion and burden rather than reducing it. Furthermore, documentation needs are also driven by other factors necessitating more detailed documentation such as protecting from malpractice claims and ensuring continuity of patient care. In fact, CMS states in the rule, "...whatever reductions may be made to the E/M documentation guidelines for purposes of Medicare payment, physicians and non-physician practitioners will still need to document substantial information in their progress notes for clinical, legal, operational, quality reporting and other purposes, as well as potentially for other payers."

Understanding the true impact of CMS' proposed coding and payment changes for E/M services on urgent care providers is difficult because of the variation among urgent care centers and the patients they serve. Urgent care is becoming a sought-after site-of-service among the baby boom generation of Medicare beneficiaries, as well as the more mobile millennials caregivers, who are more accustomed to using urgent care centers for their acute care needs. Urgent care centers are a cost-effective site-of service for Medicare patients, and many have the capacity to serve as a regular source of care for beneficiaries. Urgent care models are ever-evolving with some of the most innovative playing a role in the care of patients with complex health care needs. It is important that changes in CMS' E/M coding and payment proposals anticipate the future and health care delivery innovation.

CMS has proposed separate add-on payments for primary (GPC1X) and complex (GCG0X) care visits, which infers that the collapsed payments for E/M visits levels 2 through 5 do not capture the complexity of primary care and specialty care. It is uncertain to the extent to which urgent care providers would utilize these codes, but **it is important, nonetheless, that the definition of primary care not be delineated by a provider's specialty.** For example, urgent care centers are routinely staffed with physicians board-certified in emergency medicine. **Equally important is that CMS not restrict the use of GCG0X either through specialty designation or other criteria.** While CMS has said that it does not intend to limit use of GCG0X to the specialties referenced in the rule (endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, and interventional pain management-centered care), the appropriate use of these codes is unclear from the proposed rule.

The UCA recognizes the American Medical Association-convened workgroup of coding and valuation experts to develop an alternative to the CMS proposal. We request that you

allow time for a deliberative process by the physician community to more greatly inform any future E/M coding and payment changes and not finalize for CY 2019 the E/M coding and payment changes at this time.

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE, E.G. VIRTUAL CHECK-IN

UCA appreciates CMS' efforts to identify virtual services that would not be limited by the telehealth geographic and originating site restrictions.

CMS proposes a new HCPCS code for physicians' services — GVC11 (Brief Communication Technology-based Service) — that captures a brief non- face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit.

Under the code, CMS would reimburse physicians and other qualified health care professionals for 5-10 minutes of medical discussion so long as the service is provided to an established patient and it does not originate from a related E/M service provided within the previous seven days. The service also cannot lead to an E/M service or procedure within the next 24 hours or soonest available appointment. **UCA supports the creation of and reimbursement for HCPCS code GVC11.**

CMS' proposal to reimburse for non-face-to-face services effective Jan. 1, 2019 is a major recognition of how communication technology is changing the delivery of health care. Although the established patient requirement may be a limiting factor for use of this service by urgent care providers, we understand that the service is intended to capture a "brief" check-in, which is reflected by the proposed RVUs of .25.

We understand CMS is seeking comment on the timeframes under which this service would be separately billable compared to when it would be bundled, and we acknowledge CMS' concern with the unintended consequences that could result by establishing strict timeframes. **Even though CMS is modeling the descriptor of GVC11 off telehealth CPT code 99441, we are concerned that the vagueness of "soonest available appointment" may create confusion among providers when determining exactly when a virtual check-in is reimbursable.** CMS may want to consider putting some additional guardrails around "soonest available appointment" or remove the language from the descriptor entirely.

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION

CMS proposes to create a new HCPCS code — GRAS1 (Remote evaluation of recorded video and/or images submitted by the patient) — that captures the remote professional evaluation of patient-transmitted information conducted via pre-recorded, patient-generated still or video images. **UCA supports the creation of and reimbursement for HCPCS code GRAS1.**

The service would be separately billable by a physician or qualified health care professional when it does not originate from a related E/M service provided within the previous seven days nor lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Unlike the virtual check-in code, UCA believes this service would lend itself well to new, rather than just established, patients. In addition to dermatological and ophthalmological services, where it might be appropriate for a new patient to receive these services, “store and forward” technology is commonly used by urgent care providers for neurologic assessment, such as eye functions and motor dysfunction, to determine triage or care. Patients will also send urgent care providers information from heart rate monitors or other devices that collect patient health marker data. **We request that the use of this code not be limited to dermatological and ophthalmological services.**

QUALITY PAYMENT PROGRAM

UCA offers the following comments on the QPP provisions of this proposed rule that are most consequential to physicians and other health care professionals providing care in urgent care centers. As UCA has expressed in the past, it would be useful, for the purposes of commenting on future QPP proposals, to understand exactly how clinicians practicing in urgent care centers are faring under CMS’ QPP policies. Therefore, **we ask CMS to distinguish in future reports and QPP analyses clinicians who bill Medicare using place of service code (POS) 20.** 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.

Quality Category: Urgent Care Measure Set

The UCA thanks CMS for proposing a new urgent care specialty measure set for use in the Merit-based Incentive Payment System (MIPS) effective in 2019. As UCA previously explained, physicians who practice in the urgent care center setting may specialize in family practice, internal, pediatric or emergency medicine. However, the current specialty measure sets for these

disciplines do not specifically relate to urgent care medicine. Delineation of a specialty measure set for urgent care medicine will assist physicians and other health care providers who practice in urgent care centers with measure selection, compliance with MIPS requirements, and, most importantly, practice improvement in a setting where tens of millions of patient visits occur annually. **UCA asks CMS finalize this new specialty measure set.**

Quality Category: Low-Volume Threshold

CMS is proposing to add a third criterion for physicians to qualify for the low-volume threshold — providing fewer than 200 covered professional services to Part B patients. CMS is also proposing a new opt-in policy that allows practices to opt-in to participate in the MIPS program or create virtual groups if they meet or exceed one or two but not all of the low-volume threshold elements (have less than or equal to \$90,000 in Part B allowed charges for covered professional services, provide care to 200 or fewer beneficiaries, or provide 200 or fewer covered professional services under the PFS).

Participating in the MIPS creates a resource burden on many clinicians practicing in urgent care centers that is not relative to their Medicare revenues. The QPP should not be a deterrent to urgent care centers caring for Medicare patients. Recognizing that some urgent care centers are purely pediatric, according to the most recent UCA Benchmarking Survey 89 percent of urgent care centers report that they are caring for Medicare patients.

Continuing to grant exceptions for clinicians for whom the administrative costs of participation in the QPP may outweigh the benefits of caring for Medicare patients is necessary and important. Adding an exclusion for clinicians to earn an exemption if they provide fewer than 200 covered professional services to Part B patients will further help many clinicians who practice in urgent care centers while also ensuring continued access to urgent care centers for Medicare recipients. **We support the addition of this criterion, as well as the opt-in policy.**

With these exclusions is the importance of ensuring the accuracy of CMS' QPP Participation Status tool which allows providers to enter their National Provider Identification number to find out their MIPS' eligibility. One large urgent care practice management company experienced several situations last year in which the tool incorrectly indicated MIPS eligibility status. It is important that this tool is accurate and that clinicians fully understand what a change in eligibility analysis between segments means.

Quality Category: Multiple Submission Method for Quality Measures

CMS proposes to allow for a combination of data collection types for the quality performance category. CMS will score the measure based on the most successful collection type. The

multiple-submission type option does not apply to web-interface reporters or facility-based measurement.

UCA supports the idea that clinicians should be able to report quality measures that are most applicable to their patients and their practice and not be limited by having to submit measure data using a single collection type. While the idea behind the multiple-collection option may be to give clinicians a larger compendium of measures to choose from, the policy may also benefit clinicians who practice in multiple sites of service. **So long as CMS keeps in place a data completeness threshold above 50 percent, it should consider allowing clinicians to achieve the data completeness threshold by combining the same measure reported using different collection mechanisms if the measure is reported in different sites of service.**

Quality Category: Small Practices and Bonuses

UCA appreciates the accommodations that CMS has made thus far for solo practitioners and clinicians in small practices participating in the MIPS. Specifically, **UCA supports allowing Medicare Part B claims measures to remain available at this time for individuals in small group practices and that claims reporting be an option, as proposed, for small practices that report as a group or virtual group.**

UCA supports the CMS proposal to maintain the three-point floor for quality measures that do not meet the data completeness requirement. We also continue to support the small practice bonus; however, we oppose moving the small practice bonus point to an eligible clinician's quality category score. **Bonus points should be added to the composite score to reduce program complexity. We also ask CMS to maintain the small practice bonus at 5 points rather than reduce the bonus to 3 points as proposed.** CMS states in the proposed rule that, for clinicians in many small practices, the Quality category weight may be up to 85 percent of the final score if the weights of the Promoting Interoperability (PI) and Cost categories are redistributed to the Quality category. With a weight of 85 percent, a small practice bonus of 3 points added to the Quality category will result in 4.25 bonus points added to a clinician's final score. The problem with this approach is that it is impossible for a clinician to know if he/she will be granted a PI exemption or be attributed cost measures — circumstances that would shift the weights of both those categories to Quality. It therefore makes it very difficult, as noted above, for clinicians to predict the maximum score that could be achieved in any one category. Being able to make accurate estimates is important when it comes to measure selection.

Improvement Activities: Timeframe for Annual Call for Improvement Activity Measures

Beginning with the CY 2019 performance period and future years, CMS is proposing to: (1) delay the year for which nominations of prospective new and modified improvement activities

would apply; and (2) expand the submission timeframe/due date for nominations. For example, an improvement activity nomination submitted during the CY 2020 Annual Call for Activities would be vetted, and if accepted by CMS, would be proposed during the CY 2021 rulemaking cycle for possible implementation starting in CY 2022. Also, beginning with the CY 2019 performance period, CMS is proposing to change the submission timeframe for the Call for Activities from February 1 through March 1 to February 1 through June 30.

Based on this new timeframe, it would take a long time to get new or modified improvement activities into the program. **We do not believe that modifications to an existing improvement activity should take two years. We urge CMS to take a modified approach to its proposal in which the timeframe to modify existing measures would be shorter than that for new measures.** For example, current improvement activity *Participation in Joint Commission Evaluation Initiative (IA_PSPA_13)* should be modified to include other accrediting bodies, not just The Joint Commission. For example, the UCA Accreditation program, which has already accredited more than 700 urgent care centers, should be recognized as an improvement activity. Making this improvement activity more generic so a greater number of evaluation entities can be recognized will lead to more improvement activity opportunities for eligible clinicians, including urgent care providers.

REQUEST FOR INFORMATION ON PRICE TRANSPARENCY

Reducing the cost of health care in the United States requires, in part, empowering patients to make wise health care decisions. We agree with the Agency that there is insufficient price transparency, which results in the inability of consumers to make informed decisions on where to access care.

A number of studies have shown that a large percentage of patients who seek care in the hospital emergency department or free-standing emergency department could be treated in the more cost-effective urgent care center setting.

Consider these statistics:

- A study published Sept. 4, 2018 in *JAMA Internal Medicine* found that between 2008 and 2015 there was a substantial increase in utilization of urgent care centers (138 percent increase) and other sites of service for low-acuity care. At the same time, there was a decrease in emergency department utilization (14 percent decrease). In contrast, the price per emergency department visit for treatment of low-acuity conditions increased by 79 percent from \$914 per visit in 2008 to \$1637 per visit in 2015, while inflation-adjusted prices per visit for treatment

of low-acuity conditions were stable for urgent care centers (\$165 per visit in 2008; \$162 per visit in 2015).¹

- According to the 2015 Colorado Health Access Survey, roughly 40 percent of emergency department visits in Colorado occur for non-emergency reasons.² Analysis of 2014 commercial health insurance claims in the Colorado All Payer Claims Database suggests that Colorado could save an average of \$1,150 per visit, equating to more than \$800 million per year in annual savings if patients used a clinic, such as an urgent care center, or doctor's office for non-emergent care.
- According to a report issued by the Massachusetts Health Policy Commission in 2015,³ 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.⁴
- An analysis of insurance claims processed by Blue Cross Blue Shield of Texas from 2012 to 2015, published in the February 2017 *Annals of Emergency Medicine*, found that 15 of the 20 most common diagnoses treated at freestanding emergency departments and 12 of the most common for hospital-based emergency departments were also in the top 20 for urgent care centers. However, prices for patients with the same diagnosis were on average almost 10 times higher at freestanding and 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 — 6.5 times the price paid at urgent care centers.⁵

While there are a number of factors that contribute to emergency department overuse, the lack of price and information transparency is a major contributor. Many consumers are frequently confused by the difference in services/cost by site of care. For some conditions, care could be rendered in a variety of settings — telemedicine, retail clinic, primary care practice, urgent care center, freestanding emergency department, hospital-based emergency department — all with different costs. **Payers, including Medicare and Medicaid, should be compelled to take steps**

¹ Poon SJ, Schuur JD, Mehrotra A. Trends in Visits to Acute Care Venues for Treatment of Low-Acuity Conditions in the United States From 2008 to 2015. *JAMA Intern Med*. Published online September 04, 2018. doi:10.1001/jamainternmed.2018.3205

² Colorado Health Institute Colorado Health Access Survey 2015 - http://coloradohealthinstitute.org/uploads/postfiles/CHAS/2015_CHAS_for_Web_.pdf

³ 2015 Cost Trends Report; Massachusetts Health Policy Commission.

⁴ 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.

⁵ 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.

to better educate their consumers about their benefits and coverage levels. Medicare should also require that hospital-owned and -operated free-standing emergency departments clearly post that a facility fee will be charged in addition to services provided by a physician or other health care provider.

CONCLUSION

UCA is the leading resource for urgent care centers across the country. 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. Therefore, we are eager to work with CMS to devise payment policies that create cost-effective access points for Medicare recipients and is meaningful to eligible clinicians who practice in urgent care centers. Should you desire additional information, please contact Camille Bonta, UCA consultant, at cbonta@summithealthconsulting.com or (202) 320-3658.

Sincerely,



Laurel Stoimenoff, PT, CHC
Chief Executive Officer
Urgent Care Association



Sean McNeeley, MD
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