March 13, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Oz:

On behalf of the Urgent Care Association (UCA), this letter provides pre-rulemaking input for the Calendar Year (CY) 2027 Physician Fee Schedule (PFS).

These comments build on UCA's prior pre-rulemaking and rulemaking submissions over multiple years regarding Medicare payment for urgent care services, and in particular for enhanced urgent care centers (eUCCs). The Centers for Medicare & Medicaid Services (CMS) has now engaged on this issue across two rulemaking cycles, including through the CY 2025 request for information and the extensive discussion in the CY 2026 proposed and final rules.[1] We appreciate that engagement and the seriousness with which CMS has considered stakeholder input. **UCA is hopeful that CMS will take the next step: a policy proposal in the CY 2027 PFS rulemaking cycle. Specifically, UCA urges CMS to propose a new HCPCS add-on code for evaluation and management (E/M) visits furnished in eUCCs, coupled with a new Place of Service (POS) code to identify those centers, that would be effective starting in CY 2027.**

<u>The role of enhanced urgent care and the payment misalignment</u>

Urgent care centers (UCCs) play an increasingly important role in the health care system as accessible, lower-cost alternatives to hospital emergency departments (EDs).[2] Within this broader category, eUCCs represent a distinct ambulatory care setting situated between physician offices and hospital EDs, serving higher-acuity, unscheduled patients who might otherwise seek care in EDs. These centers maintain extended hours, walk-in capacity, enhanced on-site diagnostic and therapeutic capabilities often not available in physician offices or traditional UCCs, including point-of-care testing, imaging, and minor procedures such as laceration repair and management of orthopedic injuries, and staffing models that can accommodate unpredictable surges in demand. Those capabilities and that overall level of readiness are not incidental— they

[1] See, e.g., 89 Fed. Reg. 61,746-61,747; 89 Fed. Reg. 97,930-97,932; 90 Fed. Reg. 32,374-32,375; 90 Fed. Reg. 49,296-49,297.
[2] 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

are the defining features of the eUCC model and the reason these centers can safely and effectively divert patients from higher-cost settings.

Yet under the current PFS, Medicare payment does not recognize the higher indirect practice expense (PE) associated with sustaining the eUCC model. UCA has previously noted that eUCC visits often involve higher intensity and cognitive effort related to rapid triage, diagnosis, and management of undifferentiated patients. While those providers work considerations remain important, the primary and persistent misalignment in payment stems from the way indirect PE is allocated under the PFS. As a result, the additional infrastructure and operational readiness required to sustain the eUCC model are not adequately reflected in Medicare payments. Addressing this misalignment would not only improve payment accuracy but also support the continued development of eUCC capacity that can serve as a clinically appropriate alternative to hospital EDs.

Why a targeted add-on code and POS designation is the right solution

UCA is proposing a targeted, pragmatic solution:

- A CMS-administered add-on code that would be reported with office/outpatient E/M visits furnished in eUCCs, paired with a POS code that would allow CMS to identify which sites qualify.

This approach is deliberately narrow. It does not require restructuring the E/M code set, creating a new specialty, or rebuilding PE/HR data. Instead, it operates entirely within CMS's existing statutory and methodological authority and directs additional payment only to those sites that actually maintain the enhanced infrastructure and readiness that policy makers want to encourage. The proposed add-on code would be limited to recognizing the additional practice expense associated with maintaining enhanced urgent care infrastructure and operational readiness in qualified eUCC settings; it would not duplicate the practitioner work already reflected in the underlying office/outpatient E/M visit.

Importantly, this approach also aligns with CMS's broader policy objectives. It supports site-of-service efficiency by reinforcing care delivery outside hospital EDs, preserves coding and claims processing simplicity, and allows CMS to manage budget neutrality in a transparent and targeted way. Most importantly, it creates a durable, administrable mechanism to better align payment with real-world resource use.

Why the current indirect practice expense methodology cannot solve this on its own

Our proposed solution flows directly from how indirect PE is currently allocated under the PFS. Today, CMS assigns indirect PE based on specialty codes on the claim and specialty-specific PE/HR data. Urgent care is not recognized as a distinct specialty and does not have urgent care–specific PE/HR inputs. Moreover, eUCCs do not fit neatly into the PFS's traditional facility

versus non-facility dichotomy. The CY 2026 refinements to the indirect PE methodology further underscore this point. As CMS has recognized, the current framework does not always allocate indirect costs in a way that aligns cleanly with how modern care sites actually operate. eUCCs are a clear example of this broader structural limitation in the methodology, not a narrow or isolated edge case.

Why alternative approaches fall short

Through two rounds of engagement and comment solicitation on this issue, most stakeholders have generally supported our proposal to establish a targeted add-on code for eUCCs. Some stakeholders have suggested alternative solutions that we wish to address. For example, some have suggested that new CPT codes might be the appropriate solution. We disagree. CPT codes are designed to describe physician work and assign *direct* PE inputs; they are not a tool for fixing systemic *indirect* PE allocation shortcomings. Creating new CPT codes would take years, introduce administrative complexity for providers and payers, and offer no assurance of Medicare coverage or appropriate payment. CMS has seen the challenges of this approach in the telehealth E/M context, where new codes were created at CMS's urging but later not paid, resulting in fragmented coding pathways and unnecessary burden.[3]

Similarly, while one might imagine developing PE/HR data specific to eUCCs, CMS currently lacks a practical and reliable mechanism to apply those inputs without both a distinct specialty code and a sufficiently discrete, high-volume code set. In other words, PE/HR reform alone cannot solve this problem under the current PFS structure.

We also want to address concerns raised about our analogizing our proposal to G2211. We do not view G2211 as a perfect analogy for our proposal. Rather, G2211 illustrates CMS's recognition that E/M-dominant practices face structural impediments under the PFS. Like CMS's intentions with G2211, enhanced urgent care is a case needing a *CMS*-administered payment policy solution.

We have provided additional responses to other commenters in Appendix C.

Access, after-hours care, and why an hours-restricted payment would miss the point

We caution against an hours-restricted payment approach. We believe that attaching incentive payments to specific hours of operation could lead to undesirable behavioral patterns and potential abuses (e.g., driving volume to hours that are rewarded with higher reimbursement).

[3] 90 Fed. Reg. 49323.

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Conclusion

We appreciate CMS's continued engagement on this issue and the thoughtful consideration reflected in prior rulemaking. We would welcome the opportunity to work with CMS on implementation details.

Sincerely,

Steve Sellars
Chief Executive Officer
Urgent Care Association

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Appendices

A. Illustrative coding and place of service framework for enhanced urgent care centers
B. Illustrative proposed rule language
C. Responses to prior stakeholder comments

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Appendix A: Illustrative coding and place of service framework for enhanced urgent care centers

Proposed Place of Service (POS) Code

POS Code	Description
20 – Urgent Care Facility	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.
XX – Enhanced Urgent Care Center	Location, distinct from a hospital emergency room, an office, or a clinic, that operates during and beyond typical business hours, including evenings, weekends, and holidays; provides diagnostic services (including radiography and laboratory testing) and therapeutic services (including minor procedures and other urgent interventions);, and is intended to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Illustrative HCPCS Add-On Code Descriptor

The descriptor for a new HCPCS add-on code recognizing the additional complexity and resource requirements associated with enhanced urgent care services could read as follows:

> *HCPCS Code GPXXX: Resources inherent in furnishing office/outpatient evaluation and management services for urgent, unscheduled, non-emergent care in an enhanced urgent care center (List separately in addition to office/outpatient evaluation and management visit, new or established.)*

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Appendix B: Illustrative proposed rule language

The following section sets forth draft proposed rule language for CMS's consideration to recognize eUCC services under the PFS. It is intended to illustrate one potential approach for establishing a new POS code and related add-on payment policy for office/outpatient E/M visits furnished in qualifying eUCCs.

Payment for Services in Enhanced Urgent Care Centers

Background

In the CY 2025 PFS proposed rule, we sought comment on urgent care centers, noting that hospital emergency departments (EDs) are often used by beneficiaries to address non-emergent urgent care needs that could be appropriately furnished in less acute settings, but where other settings, such as physician offices, urgent care centers, or other clinics, are not available or readily accessible (89 Fed. Reg. 61,746–61,747). We stated that we were interested in system capacity and workforce issues broadly, including how entities such as urgent care centers can play a role in addressing some of the capacity issues in EDs.

In response to that discussion, commenters stated that the current place of service (POS) definitions are inadequately differentiated, particularly if CMS wishes to encourage the proliferation of the types of urgent care centers that can provide suitable alternatives to EDs. Commenters noted that the current POS code for urgent care centers, POS 20, does not adequately distinguish between urgent care centers that furnish services more akin to those provided in a typical physician office and those that maintain broader operating hours, greater walk-in and same-day capacity, and enhanced diagnostic and therapeutic capabilities. Commenters suggested that a new POS code describing "enhanced" urgent care centers could better identify those settings that are designed to absorb unscheduled urgent demand, including both after-hours demand and urgent, same-day demand that arises during regular business hours when physician offices may be unable to accommodate patients on a timely basis.

In the CY 2026 PFS proposed rule, we continued that discussion and sought comment on whether separate coding and payment is needed for evaluation and management visits furnished in urgent care centers, including whether an add-on code would be appropriate or whether a new set of visit codes would be more practical, and whether a new POS code should be considered for "enhanced" urgent care centers (90 Fed. Reg. 32,374–32,375). We also noted that many PFS services have site-of-service payment differentials between facility and non-facility settings, and that we were interested in understanding how practice costs, including indirect PE, may vary among different non-facility settings of care and whether either the code set or the PE methodology might be improved to better recognize the relative resources involved in furnishing services across these settings.

In the CY 2026 PFS final rule, we summarized comments indicating that Medicare's fee-for-service payment systems may not adequately recognize the resource costs associated with urgent care centers that maintain extended hours and enhanced diagnostic and therapeutic capabilities, and we stated that we would take those comments into consideration for possible future rulemaking (90 Fed. Reg. 49,296–49,297). In response to these discussions, commenters and other interested parties have continued to suggest that CMS consider a new POS code for "enhanced" urgent care centers, together with a new optional add-on code to recognize the additional practice expense resources involved when practitioners furnish office/outpatient E/M services in such settings.

We continue to believe that urgent care centers can play an important role in improving timely access to care and may serve as clinically appropriate alternatives to hospital EDs for certain urgent, non-emergent conditions. We also recognize that a subset of urgent care centers do maintain expanded clinical capabilities and operational readiness relative to physician offices and many other urgent care centers. These settings not only maintain broader operating hours, but also maintain staffing models, walk-in capacity, same-day scheduling capacity, and on-site diagnostic and therapeutic capabilities that allow practitioners to evaluate and treat a broader range of urgent, non-emergent conditions on an unscheduled basis. To the extent that these settings can appropriately absorb urgent, low-acuity demand that might otherwise present to hospital EDs, improved recognition of these resource costs under the PFS may support beneficiary access to timely care in lower-acuity settings, where clinically appropriate by incentivizing more UCCs to expand diagnostic and therapeutic capability and operating hours. Such a policy could also help alleviate overcrowding in EDs and lead to lower overall healthcare costs.

We believe it may be appropriate to incentivize more UCCs to operate as enhanced UCCs by recognizing these resource costs through a targeted payment policy under the PFS, and that these changes would both improve claims identification from these settings and better account for the additional practice expense associated with furnishing office/outpatient E/M services in them. We recognize that broader refinements to the indirect PE methodology may warrant consideration in future rulemaking; however, we believe that a targeted add-on code, together with a distinct POS code, would provide an administratively feasible interim approach under the current PFS framework. Therefore, effective starting in CY 2027, we are proposing to establish a new optional add-on code for office/outpatient E/M visits furnished in qualifying enhanced urgent care centers, together with a new POS code to identify these settings for claims reporting, utilization analysis, and future policy refinement.

Establishment of HCPCS Code GPXXX and POS XX

For CY 2027, we are proposing to establish a new HCPCS add-on code, HCPCS code GPXXX, to describe the additional resource costs associated with furnishing urgent, unscheduled, non-emergent care in qualifying enhanced urgent care centers. We are proposing that HCPCS code

GPXXX be reported in addition to office/outpatient E/M visits, new or established, when those services are furnished in a qualifying enhanced urgent care center.

We believe an add-on code is the most administratively feasible approach because it would allow us to recognize the additional resource costs associated with maintaining broader operating hours, walk-in and same-day access, and enhanced diagnostic and therapeutic capability, while preserving the existing office/outpatient E/M code structure. Because these additional costs are associated with maintaining the readiness of the setting across urgent care encounters, rather than only a subset of visits, we believe it is appropriate to structure this policy as an add-on code reported with qualifying office/outpatient E/M visits furnished in enhanced urgent care centers. We also believe that pairing this code with a new place of service code would improve our ability to identify these settings in Medicare claims data and monitor utilization and payment over time.

Our proposed descriptor for HCPCS code GPXXX is as follows:

> GPXXX *Resources inherent in furnishing office/outpatient evaluation and management services for urgent, unscheduled, non-emergent care in an enhanced urgent care center (List separately in addition to office/outpatient evaluation and management visit, new or established.)*

We are also proposing to establish a new POS code, POS XX, to identify enhanced urgent care centers.

Our proposed descriptor for POS XX is as follows:

> *POS XX – Enhanced Urgent Care Center: Location, distinct from a hospital emergency room, an office, or a clinic, that operates during and beyond typical business hours, including evenings and weekends; provides diagnostic services (including radiography and laboratory testing) and therapeutic services, including minor procedures; and is intended to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.*

For purposes of this proposal, we are considering enhanced urgent care centers to be those urgent care settings that furnish services beyond those typically associated with physician offices and many urgent care centers, including broader operating hours, the capacity to accommodate unscheduled and same-day urgent demand, and enhanced diagnostic and therapeutic capability. We seek comment on whether additional objective operational criteria, such as minimum hours of operation, required on-site diagnostic capabilities, staffing characteristics, or other claims-verifiable criteria, would be needed to operationalize this policy.

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Valuation of HCPCS Code GPXXX

In considering the valuation of proposed HCPCS code GPXXX, we believe a crosswalk to an existing PE-only add-on code billed in conjunction with office/outpatient E/M services is the most appropriate initial valuation methodology. Proposed HCPCS code GPXXX would be billed in addition to office/outpatient E/M visits and is intended to recognize the additional practice expense associated with maintaining the infrastructure, staffing, and operational readiness required to furnish urgent, unscheduled, non-emergent care in qualifying enhanced urgent care centers. Because the principal payment issue addressed by this code relates to practice expense, rather than to a distinct increment of physician work separate from the underlying E/M visit, we believe it is appropriate to base valuation on an existing add-on code that similarly reflects additional practice expense resources furnished in conjunction with an office/outpatient E/M service and that can serve as an administratively feasible proxy for this purpose.

Thus, for CY 2027, we are proposing the creation of a new add-on G code, HCPCS code GPXXX (*Additional resource costs inherent in furnishing office/outpatient evaluation and management services for the diagnosis and treatment of an unscheduled, ambulatory patient's urgent, non-emergent illness or injury in an enhanced urgent care center (List separately in addition to office/outpatient evaluation and management visit, new or established)*) to be billed with an office/outpatient E/M visit furnished in an enhanced urgent care facility to account for the additional practice expense resources associated with maintaining operational readiness, unscheduled access capacity, and enhanced diagnostic and therapeutic capability. For an add-on G code, we believe that CPT code 99415 (*Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)*) with a non-facility PE RVU of 0.68, MP RVU of 0.01, and no work RVUs, is an appropriate crosswalk reference to capture the additional practice expense resources involved in furnishing office/outpatient E/M visits in enhanced urgent care centers. Although the resource inputs underlying CPT code 99415 are not identical to those associated with furnishing services in enhanced urgent care centers, we believe CPT code 99415 provides an administratively feasible PE-only add-on proxy within the office/outpatient E/M family. Accordingly, we are proposing to crosswalk the practice expense and malpractice RVUs for HCPCS code GPXXX to those assigned to CPT code 99415, while assigning no work RVUs to HCPCS code GPXXX. We believe this approach would appropriately recognize the additional practice expense associated with furnishing office/outpatient E/M visits in enhanced urgent care centers while avoiding overlap with the physician work already accounted for in the underlying E/M visit.

We seek comment on this proposed valuation methodology, including whether CPT code 99415 is the most appropriate valuation analogue, whether an alternative PE-only add-on code would better recognize the additional practice expense associated with furnishing urgent, unscheduled,

non-emergent care in enhanced urgent care centers, and whether alternative objective criteria would be needed to identify qualifying enhanced urgent care centers for purposes of reporting HCPCS code GPXXX.

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Appendix C: Responses to prior stakeholder comments

The following section responds to specific not-fully-supportive stakeholder comments submitted in the CY 2026 PFS rulemaking, and clarifies why we continue to believe a targeted add-on G-code and POS designation remains the most appropriate policy solution.

1. *American College of Physician (ACP)*

ACP does not believe that an add-on G code, modeled after G2211, will support CMS's efforts to address the problem. ACP is concerned that developing a G code based on G2211 could blur its original intent and misapply the policy framework specifically designed for longitudinal care. We also want to ensure that this initiative does not lead to unintended consequences, like the potential for misuse or overuse of the new code, or a misunderstanding of G2211's requirements. This could jeopardize the foundation of G2211, which aims to acknowledge the complexity of care provided by physicians during visits in the context of longitudinal care. Instead of moving forward with the creation of this new G code, we recommend that CMS consider utilizing the existing ED CPT codes and associated G codes. These are already well-structured to capture the urgent, acute nature of the care provided in these settings. We understand that the current policy requires ED E/M codes to have a 24-hour facility designation. If CMS determines that additional resources are needed for enhanced UCCs, we encourage the agency to explore options that would enable these facilities to report ED-type codes. One possibility could be expanding the criteria for where ED codes are applicable to include enhanced UCCs that operate with extended hours and enhanced capabilities. Alternatively, creating a distinct PoS code for enhanced UCCs, while aligning it with the existing ED E/M facility codes, could also ensure that the payment structure reflects the acute needs of this care, without conflating it with G2211.

- **UCA response:** We appreciate ACP's concern regarding the appropriate use of G2211 and agree that that code was designed to recognize the complexity associated with longitudinal, relationship-based care. However, ACP appears to misunderstand our reference to G2211. We are not proposing that CMS create a code analogous to G2211 that would describe longitudinal care or otherwise create ambiguity regarding when G2211 itself should be reported. Rather, our reference to G2211 was intended only as an example of CMS using a targeted add-on code to address a structural payment issue within the PFS.

  With respect to ACP's suggestion that enhanced UCCs report ED E/M codes, this approach would not address the underlying payment issue and could, in fact, reduce payment relative to current office/outpatient E/M codes. Under the PFS, ED and inpatient E/M codes are valued as facility-based services, with total RVUs that are intentionally lower than non-facility office/outpatient E/M services because the associated PE costs are

assumed to be paid to the facility under the OPPS or IPPS. As a result, allowing enhanced UCCs to bill ED or inpatient E/M codes would reduce total Medicare payment relative to current office/outpatient E/M codes, even before considering differences in time thresholds across visit levels.

More fundamentally, expanding the use of facility-based E/M codes would not resolve the underlying methodological issue at the core of this discussion—namely, that eUCCs incur materially higher indirect PEs than physician offices, but are not recognized as such under the current indirect PE allocation framework. A targeted add-on G-code therefore remains the most administratively feasible and policy-consistent mechanism to address this gap, as it allows CMS to recognize additional indirect costs without restructuring the E/M code set or misapplying facility-based payment assumptions.

2. *American Geriatrics Society (AGS)*

AGS does not believe such coding or payment is necessary or appropriate. Urgent care centers may be appropriate sites of service in some instances but they are not intended to serve as focal points for all needed health care services or to build a longitudinal relationship with patients. The services furnished at urgent care centers are E/M services that can be appropriately reported and paid under the existing E/M codes. There is no need for additional procedure coding or payment for services furnished in this setting. Before CMS considers alternative payment mechanisms, it may be useful for CMS to establish a place of service code for "enhanced" facilities to identify the E/M, diagnostics and treatment services furnished in those facilities as well as the types of conditions treated and assess payment adequacy relative to other settings where urgent care is provided, e.g. offices.

- **UCA response:** We appreciate AGS's emphasis on preserving the policy intent of G2211 and agree that the code was established to recognize the additional complexity associated with longitudinal, relationship-based care, rather than to broadly increase payment for all E/M services. As we have previously noted, references to G2211 in prior comments were intended as an analogue, not a direct template. G2211 reflects CMS's recognition that the existing E/M code set does not fully account for certain structural characteristics of practices that predominantly furnish E/M services. Enhanced UCCs face a similar structural issue not because they furnish longitudinal care, but because they incur materially higher indirect PEs than are recognized under the current PFS methodology. We agree with AGS that UCCs are not intended to serve as longitudinal care settings, and we do not suggest that the policy rationale for G2211 should be extended wholesale to urgent care services.

  While the E/M services furnished in enhanced UCCs can be appropriately described using existing office/outpatient E/M codes, the adequacy of payment for those services is a separate question. The concern raised in our comments is not that urgent care visits require new visit-level coding, but that the current allocation of indirect PE assumes a

physician office cost structure that does not reflect the operational realities of enhanced UCCs. These costs are not captured through physician work RVUs or direct PE inputs and therefore cannot be addressed through existing E/M codes alone. For this reason, we view a targeted add-on G-code not as an expansion of E/M coding, but as a targeted payment policy mechanism that allows CMS to better align indirect PE with the settings in which care is furnished. This approach preserves the integrity of the existing E/M code set while enabling CMS to address a known limitation of the indirect PE allocation methodology.

We appreciate AGS's suggestion that a distinct POS code could be useful for analytical purposes. However, we do not believe it is necessary to delay action on payment accuracy pending the creation of a new POS code, particularly where CMS has other mechanisms available to identify and assess enhanced UCCs.

3. *American Medical Association's (AMA)*

The AMA urges CMS not to propose an add-on G-code or new E/M family of G-codes for E/M visits furnished in the urgent care center. Rather, the AMA encourages interested parties to bring an application to the CPT Editorial Panel to develop appropriate coding for these medical services. The AMA questions CMS' rationale for creating an add-on code to pay more for E/M services furnished in urgent care centers compared to physician practices or hospital outpatient departments. It appears that urgent care centers are seeking higher payment akin to a facility fee at a time when CMS is otherwise proposing to reduce indirect practice expense for facility-based services.

- **UCA response:** We appreciate the AMA's perspective and its longstanding proprietary and exclusive role in stewarding the CPT code set, as well as its emphasis on ensuring that coding changes appropriately reflect the services furnished. However, the payment challenges facing enhanced UCCs are not rooted in inadequate code descriptions or visit-level differentiation, but in the way indirect PE is allocated under the PFS. The existing E/M code set already accurately describes the services furnished in urgent care settings; the issue is that the current PFS methodology does not recognize the higher indirect costs associated with enhanced urgent care operations. While CPT codes may be effective tools for capturing differences in physician work or direct PE, they are not well suited to address differences in indirect PE, which are determined primarily through CMS's payment methodology. Absent a distinct specialty designation or a separate indirect PE framework for UCCs, new CPT E/M codes would still be subject to the same indirect PE assumptions as existing office/outpatient E/M services. As a result, pursuing CPT-based solutions would not resolve the underlying payment misalignment and could introduce additional complexity without improving payment accuracy.

  We do not view the proposed add-on G-code as analogous to a facility fee, nor as an attempt to replicate hospital outpatient department payment. Unlike facility fees, which

are paid under separate Medicare payment systems, the proposed add-on G-code would remain entirely within the PFS and would be designed to address indirect PEs incurred by clinicians practicing in non-facility settings. In fact, the need for this policy arises precisely because enhanced UCCs are paid as physician offices, despite having cost structures that differ materially from traditional office-based practices. We recognize CMS's broader efforts to refine indirect PE allocation, including recent adjustments affecting facility-based services. Enhanced UCCs highlight a complementary issue: under the current methodology, services furnished in these settings are assigned indirect PE assumptions that do not reflect their operating costs, resulting in consistent underpayment. A targeted add-on G-code allows CMS to address this payment issue directly, without restructuring the E/M code set, fragmenting CPT coding, or relying on mechanisms that are ill-suited to capture indirect PE. For these reasons, we continue to believe that a CMS-administered payment policy solution, rather than a CPT coding initiative, is the most efficient and appropriate path forward.

4. *MedPAC*

Establishing higher payments for urgent care centers could encourage more volume to shift from hospital EDs to urgent care centers. However, those higher payments could also encourage volume to shift from clinician offices to urgent care centers, which could be an unintended consequence of such a policy. Therefore, to the extent CMS proceeds with such a policy, targeting any additional payments to cases most likely to generate shifts from hospital EDs to urgent care centers (or other non facility settings) would be desirable. For example, while interested parties suggested allowing an add-on code to be billed with all evaluation and management office visits at "enhanced" urgent care centers, a more targeted approach could involve allowing clinicians at urgent care centers (or other non facility settings)to bill an add-on code only to the extent that care was furnished outside of normal business hours (when many clinician offices are closed) More targeted approaches that pay based on the characteristics of the service (e.g., an after-hours service) rather than characteristics of the facility also have the benefit of not creating additional payment differentials in Medicare based on the site of care and are therefore more consistent with the Commission's long-held support for site-neutral payments.

- **UCA response:** We appreciate MedPAC's thoughtful consideration of the potential site-of-care effects associated with any policy that increases payment for services furnished in urgent care settings, including the risk that higher payments could encourage shifts not only from hospital EDs, but also from clinician offices. We agree that Medicare payment policy should avoid creating inappropriate incentives for site-of-care shifts. At the same time, creating incentives to develop eUCC capacity does not inherently encourage such shifts.

  Importantly, patients typically self-select urgent care rather than being directed there by clinicians. Unlike many other site-of-service decisions within Medicare, urgent care utilization is largely driven by patient access needs—most commonly when patients are

unable to obtain timely appointments with their primary care provider. As a result, clinicians generally do not have the ability to "shift" visits from the office setting to urgent care in response to payment differentials, because urgent care encounters are typically initiated by patients seeking immediate or same-day care.

In addition, MedPAC's focus on after-hours availability does not fully capture the role eUCCs play in improving access to care. While extended hours are one component of the model, eUCCs also invest in staffing, scheduling flexibility, and operational readiness to accommodate walk-in patients and same-day visits. These capabilities allow urgent care centers to absorb unscheduled demand for acute but non-emergent conditions—demand that might otherwise result in ED visits—regardless of whether the visit occurs during traditional office hours or evenings and weekends. The infrastructure required to support unscheduled care, including staffing, diagnostics, and operational readiness, is incurred continuously across all hours of operation, not solely on evenings or weekends.

Limiting payment based on time-of-day would therefore fail to align with how eUCC services are actually delivered. It could also introduce new and unintended incentives, such as encouraging providers to delay care until a qualifying hour or to structure operations around payment thresholds rather than patient needs. It would also require CMS to operationalize and audit visit-level time-based eligibility criteria that are not currently captured in Medicare claims data, increasing administrative complexity without a clear improvement in targeting.

Moreover, this approach does not align well with the underlying cost structure of enhanced UCCs. The additional costs associated with extended hours, walk-in capacity, staffing, and on-site diagnostics are fixed and ongoing, not incurred only during evenings or weekends. Restricting additional payment to a subset of visits would therefore fail to account for the infrastructure costs that must be supported across all urgent care encounters.

We agree with MedPAC's longstanding support for site-neutral payment policies. Importantly, the proposed add-on G-code would not create a separate payment system or facility-level payment but would operate entirely within the PFS to address indirect PE incurred by clinicians furnishing services in non-facility urgent care settings. The goal is not to pay more simply because care is furnished in an eUCC, but to support the development of eUCC capacity that can serve as a clinically appropriate alternative to hospital EDs.

To the extent CMS remains concerned about potential shifts in billing patterns, we note that the agency already has multiple program integrity and monitoring tools at its disposal, including POS reporting, service mix analysis, and claims-based utilization reviews. These tools would allow CMS to identify anomalous shifts in utilization over

time and make adjustments as needed, without requiring overly restrictive eligibility criteria at the outset. In our view, the most effective approach is to adopt a targeted, administratively feasible payment policy that improves payment accuracy for enhanced UCCs while preserving CMS's ability to monitor utilization and refine the policy over time. A modest add-on G-code applied broadly to qualifying eUCC visits best meets these objectives.