URGENT CARE ASSOCIATION®

August 19, 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

Re: CMS-1848-P: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program Proposed Rule

Dear Administrator Oz:

On behalf of the Urgent Care Association (UCA), we are responding to the Calendar Year (CY) 2027 Physician Fee Schedule (PFS) proposed rule.[1]

UCA would like to build upon our multi-year dialogue with the Centers for Medicare & Medicaid Services (CMS) concerning leveraging urgent care centers (UCCs), and in particular enhanced urgent care centers (eUCCs), to enable migration of clinically appropriate, lower-acuity acute care services from hospital emergency capability to lower acuity settings, like UCCs. CMS engaged on this issue across the previous two rulemaking cycles, including through the CY 2025 request for information and an extensive discussion in the CY 2026 proposed and final rules.[2] We are disappointed that CMS did not propose a policy to begin this access-enhancing, cost-saving potential in the CY 2027 proposed rule. We continue to believe that such an approach furthers the administration's goals of reducing wasteful spending, ensuring care is delivered in the most appropriate site of service free from provider-driven financially motivated considerations, and improving access to care in rural communities. We urge CMS to consider this policy in future rulemaking.

In addition, UCA opposes CMS's modifier-25 proposal that would reduce payments in cases where an office and outpatient (O/O) evaluation and management (E/M) service is provided by the same physician (or a physician in the same clinical practice) on the same day as a 0-, 10-, or 90-day global procedure. We request that CMS not finalize this proposal, as the policy does not align with how care is provided in UCCs and potentially threatens UCCs' continued ability to serve patients by providing multiple services during one visit.

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[1] Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program Proposed Rule. Fed. Reg. 91 (July 16, 2026). 43842.

[2] 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.

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eUCC Policy Discussion

The Importance of Promoting eUCCs

UCCs play an increasingly important role in the health care system as accessible, lower-cost alternatives to hospital emergency departments (EDs).[3] 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 are the defining features of the eUCC model and the reason these entities can be a safe and effective alternative to higher-cost settings.

We have posited that CMS can adjust Medicare payment policies to encourage the proliferation of eUCCs and enable clinically appropriate care to migrate from higher-cost hospital EDs to lower-cost eUCCs, reducing total Medicare spending while preserving access and quality. A Medicare-specific cost-effectiveness analysis using Healthcare Cost and Utilization Project (H-CUP) data and Medicare payment rates estimated that shifting appropriate non-emergent ED utilization to urgent care could generate billions of dollars in annual Medicare savings, with estimated savings varying substantially based on assumptions regarding the proportion and types of visits redirected.[4]

The current PFS methodology does not specifically recognize the incremental infrastructure and operational readiness required of eUCCs, thereby creating a potential payment disincentive to maintaining or expanding the capabilities that allow these centers to serve as alternatives to hospital EDs. Under the current PFS, Medicare payment does not recognize the higher indirect practice expense (PE) associated with sustaining the eUCC model. As such, UCC operators and developers are discouraged from developing eUCCs that can serve as alternatives to EDs. 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 support the continued development of eUCC capacity that can serve as a clinically appropriate alternative to hospital EDs.

[3] 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

[4] The analysis is available here: https://www.ispor.org/docs/default-source/intl2022/mkaispor-pdf.pdf?sfvrsn=1018de2e_0.

Targeted Policy Solution

To best encourage development of eUCCs as a viable and sustainable solution to alleviate capacity in EDs, UCA has previously proposed a targeted, pragmatic policy:

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

This approach is deliberately narrow. 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 PE 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 or outpatient evaluation and management visit.

UCA is open to alternative approaches to an add-on code, such as a payment modifier, that would achieve the same goal. No matter what approach CMS decides to take, an additional payment would directly align 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—a goal that CMS has increasing articulated as the agency continues to explore how practice costs vary among different settings of care.[5] UCA also recognizes that any new payment mechanism must include appropriate safeguards to ensure that additional payment is limited to sites that actually maintain the enhanced capabilities CMS intends to support. Objective qualification criteria, combined with a distinct POS code, would give CMS greater visibility into these services and allow the agency to monitor utilization and spending.

The Approach is Supported by the Majority of Stakeholders

Through two rounds of engagement and comment solicitation on this issue, most stakeholders have generally supported our proposal to encourage eUCC development and proliferation as an alternative to hospital EDs, and to encouraging that development and proliferation by establishing a targeted add-on code for eUCCs. In the CY 2026 PFS final rule, CMS acknowledged comments from the CY 2025 rulemaking cycle stating 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.[6] CMS also stated that it would take comments from the CY 2026 PFS proposed rule comment solicitation into consideration for possible future rulemaking.[7] We are hopeful that CMS will continue exploring this issue and use the

[5] Fed. Reg. 91 (July 16, 2026). 43860.
[6] Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program Final Rule. Fed. Reg. 90 (November 5, 2025). 49297.
[7] Ibid.

broad support around the policy recommendation to propose a concrete policy change in next year's rule.

Modifier-25 Proposal

In the CY 2019 PFS proposed rule, CMS proposed to reduce payment by 50% for the least expensive 0-day global procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended modifier -25. Based on comments received on the proposal, CMS ultimately decided not to finalize that policy. For CY 2027, CMS revisits this proposal and applies it more broadly by proposing to pay the most expensive service at 100%, and all other surgical procedure(s) or E/M visit(s) at 50%, when a separately identifiable office or outpatient (O/O) E/M visit is furnished by the same physician on the same day as a 0-, 10-, or 90-day global procedure.

UCA opposes this policy, as it does not reflect how care is often provided in UCCs. The fundamental goal of urgent care encounters—and what we believe represents our inherent value to patients— is to evaluate the patient and, when appropriate, diagnose and treat them in that same visit. For example, during a typical UCC visit, a clinician would first formally evaluate the patient and then perform a minor procedure such as a laceration repair, an incision and drainage procedure, or a foreign-body removal. The proposed policy would significantly undercompensate the actual work involved in both the E/M service and the procedure and penalize exactly the kind of efficient, coordinated care that benefits patients by allowing evaluation, diagnosis, and medically necessary treatment to occur during a single encounter. It creates a disincentive for clinicians to diagnose and definitively treat a patient's condition during the same encounter—the opposite of the efficiency CMS should encourage in lower-cost ambulatory settings.

Finally, as described previously, care provided at UCCs, especially eUCCs, is undervalued—and adding this payment cut on top of an already flawed payment system will harm UCCs and affect our ability to serve patients. **UCA therefore strongly urges CMS not to finalize this proposal.**

Conclusion

We appreciate CMS's thoughtful consideration reflected in prior rulemaking and hope that CMS will move forward with a policy that promotes the proliferation of eUCCs in the near future. We also hope that CMS reconsiders the modifier-25 proposal and does not finalize it in the CY 2027 PFS final rule.

Sincerely,

Steve Sellars
Chief Executive Officer