**Urgent Care Association of America**

October 28, 2016

By Email: Reg.Testimony@state.ma.us

Monica Bharel, M.D., Commissioner

Massachusetts Department of Public Health 250 Washington Street, 2nd Floor

Boston, MA 02108

Re: Proposed Amendments to 105 CMR 140.000: Licensure of Clinics Dear Commissioner Bharel:

On behalf of the Urgent Care Association of America (UCAOA) and its members, and in collaboration with the North East Regional Urgent Care Association (NERUCA) and its members, we appreciate the opportunity to provide comment on the Massachusetts Department of Public Health’s (the “Department”) proposed amendments to the revision to the Licensure of Clinics regulations (the “Regulations”) at 105 CMR 140.000.

UCAOA/NERUCA supports the Department’s efforts to update the Regulations, as the Department works to achieve Massachusetts’ health care policy goals, including improved access, quality, and cost control. We believe that urgent care medicine and its involved practitioners and centers play a critically important role in helping to meet these objectives.

As a matter of public information, UCAOA/NERUCA offers the following general comments regarding the nature of urgent care practice, as derived from our common experience as urgent care providers, owners, managers, and operators, and prior interactions with other states' regulatory bodies, having previously considered similar regulatory changes.

* Urgent Care Medicine is an integral and effective part of the health care delivery system. UCAOA believes that great care must be taken to avoid inadvertently dissuading patients from utilizing the exceptionally safe and reliable method of care delivery that 21st Century urgent care practice has come to represent.
* We define Urgent Care Medicine as acute health care for mild to moderate illness and injury for patients of all ages, and not requiring hospital emergency department level evaluation and management.
* An Urgent Care Center practices Urgent Care medicine on a walk-in basis, 7 days a week, with hours extended beyond that typically encountered in a primary care physician’s office.
* Urgent Care Centers provide medical capabilities beyond that which is typically found in a primary care physician’s office, such as diagnostic medical imaging, laboratory services, wound care and suturing, splinting, intravenous hydration, and medication administration.
* We question the Department’s reasoning in singling out the urgent care model; urgent care is ambulatory medical care and should not be subjected to regulatory oversight in addition to the oversight for ambulatory medicine providers, generally.
* Cost of urgent care estimated to be 1/5th to 1/3rd that of an ED visit for similar diagnoses.
* Urgent care medicine is not a substitute for primary care, and must include active referral of patients to and coordination with the health care network, including the medical home.
* The practice of urgent care medicine incorporates a philosophy of early assessment and intervention, as a means of preventing worsening health conditions and complications including potentially preventable hospitalizations.
* Many urgent care centers in Massachusetts possess Certification or Accreditation from the Urgent Care Association of America. Credentialing of urgent care organizations by an appropriate body assures that to be designated as an urgent care provider, the practice must meet certain basic criteria including:
* Open 7 days a week
* Patients always seen on a walk-in basis
* On-site x-ray and laboratory capabilities
* Appropriate signage
* Physician on site at all times or available for consultation by an on-site Physician’s Assistant or Nurse Practitioner, at all times.
* Urgent Care is a readily available and exceptionally viable means for patients to access high quality and cost effective acute healthcare services. As such, patients having the right to exercise choices in making decisions about their health care needs should not be otherwise discouraged from doing so.

Specific to the changes proposed in the most recent iteration of Massachusetts regulation, we respectfully offer the following comments:

**140.020: Definitions**

The current definition of Transfer of Ownership, with the proposed clarification concerning privately-held corporations, provides clear criteria by which licensed clinics may evaluate whether a contemplated action would constitute a Transfer of Ownership under the Regulations. The Department proposes to add the following language:

Transfer of ownership also means any change in the ownership interest or structure of the clinic or the clinic’s organization or parent organization(s) that the commissioner determines to effect a change in control of the operation of the clinic. ... The commissioner may, in his or her discretion, determine a proposed transaction does not rise to the level of a transfer of ownership.

The addition of this proposed language essentially negates the current definition, removing the regulatory certainty that clinics should be able to rely upon in evaluating potential changes. Practically speaking, the proposed language would make it impossible for clinics to determine, based upon the Regulations, whether a contemplated change rises to the level of a Transfer of Ownership. Clinics should be able to continue to rely upon a clearly stated regulatory definition of Transfer of Ownership. Therefore, we urge the Department to delete this proposed

language.

Notice of Intent Form. As written, this section references long term care facilities.

**140.121: Period of License**

140.121(B). We respectfully recommend that the Department retain the flexibility to issue a provisional license.

**140.302: Patient Records**

The Department proposes to add the following requirement with respect to urgent care clinics:

(H) Each urgent care clinic shall provide a copy of the medical record of each visit to the patient at the end of the visit or as soon as available and, with the patient’s consent, provide a facsimile or electronically transmitted copy of the medical record of the visit to the patient’s primary care provider, if any. Such copies or transmission shall be provided at no charge to the patient.

As currently written, this section (and the preceding section (G) that is applicable to all clinics), does not contemplate or support the portability of medical records electronically as the Baker administration has advocated, or under the objectives of Meaningful Use requirements:

*“Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.”* <https://www.healthit.gov/providers-professionals/achieve-meaningful-use/core-measures/electronic-copy-of-health-information>

Having electronically available records, accessible through a secure patient portal, promotes the portability and security of medical records. However, given the current infrastructure limitations that many Massachusetts urgent care providers are currently burdened with, mandating access to medical records through an electronic portal represents an unreasonable requirement. Requiring records be made available upon request and subsequently deliverable via print or electronic means provides a more immediately achievable target.

**140.308(E)** – As written, this section appears to apply to hospitals.

UCAOA applauds the Department’s interest in urgent care medicine, and shares your commitment to assuring quality, affordable, and accessible health care for the people of Massachusetts.

The remarkable growth of the urgent care practice model is a response to community health needs, consumer preference for quality, convenient care, and is complementary to primary, specialty, and emergency health care. A robust urgent care program only bolsters the need for an effective and enhanced primary care referral network. NERUCA is concerned about any changes in policy, statute, or regulation that may infer the opposite.

UCAOA thanks you and the Department staff for your consideration of our comments.



Steven Sellars, Board President

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