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# Urgent Care Centers: A Solution to Overuse of Hospital Emergency Rooms— Valuation Considerations

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## Background

Urgent care centers (UCCs) provide medical services for patients requiring prompt care for low-acuity medical conditions. Extended operating hours, often including weekends, facilitate access to necessary care, which may otherwise have been sought at hospital emergency rooms (ERs) at costs that can be on average three to four times more expensive for patients.<sup>1</sup> In the 2017 Urgent Care Association (UCA) Survey (UCA 2017 Survey), the top diagnosis codes for urgent care visits were related to acute upper respiratory infections, acute sinusitis, acute pharyngitis, cough, and fever. These diagnoses often resulted in the need for injections, rapid strep tests, flu tests, and urinalysis.<sup>2</sup> Addressing these non-life-threatening conditions in an urgent care setting reduces the pressure on hospitals from both a cost and capacity standpoint.

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1 According to PYA experience and research at <http://www.physicianoneurgentcare.com/what-is-urgent-care/urgent-care-cost.php> and <https://www.cigna.com/cmga/urgent-care/emergency-room-vs-urgent-care>.

2 UCA 2017 Benchmarking Report.

## Demand for UCCs Up and Increasing

*Health Affairs*, a peer-reviewed journal of health policy thought and research, estimated that 13.7% to 27.1% of ER visits could have been managed/addressed in urgent care settings.<sup>3</sup> UCCs also have lower costs of care, averaging \$150 compared with ER care at \$1,350.<sup>4</sup> With insurance plans increasingly requiring higher deductibles, copayments, and coinsurance, patients are more cognizant of costs they will incur, thus self-directing toward the lower-cost care option UCCs afford. Convenience is another factor influencing demand, as UCCs offer shorter wait times and extended operating hours. A comprehensive study by physicians at Brigham and Women's Hospital confirmed these observations. Published by the *JAMA Internal Medicine Journal*, the study evaluated private insurance claims data between 2008 and 2015 of more than 20-million acute care visits and found a 36% decrease in ER visits and a 140% increase in visits to UCCs during this period.<sup>5</sup>

Apart from a general shift away from ERs toward UCCs for acute care patient visits, PYA observes that some UCCs are offering services such as wellness visits, employment screening, immigration physicals, concussion screening, and telemedicine services to boost visit volume and maximize the use of available capacity.<sup>6</sup> This strategy is especially meaningful given that a minimum level of staffing is always required at UCCs almost every day of the year.

DocuTap, a provider of technology solutions, including practice management and electronic medical records systems, reviewed data from 2013 through 2017. It found that UCCs that provided employer services, which include occupational medicine and/or workers' compensation insurance services, had much higher daily visits (32 visits per day) than those that did not (19 visits per day).<sup>7</sup> These services comprised 14% of all urgent care visits in 2017, up from 8% in 2013.<sup>8</sup> PYA has recently observed that physician-owned UCCs providing occupational medicine services typically schedule a part-time physician dedicated to performing these services. Thus, these services do not incur a fixed overhead expense, as physicians are able to set up appointments in advance. However, PYA notes that reimbursements for these visits tend to be lower than that of sick visits.<sup>9</sup>

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3 <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2009.0748>.

4 <https://www.staffcare.com/uploadedFiles/convenient-care-white-paper.pdf>.

5 <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2698143>.

6 <http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/benchmarking/2016BenchmarkReport.pdf>.

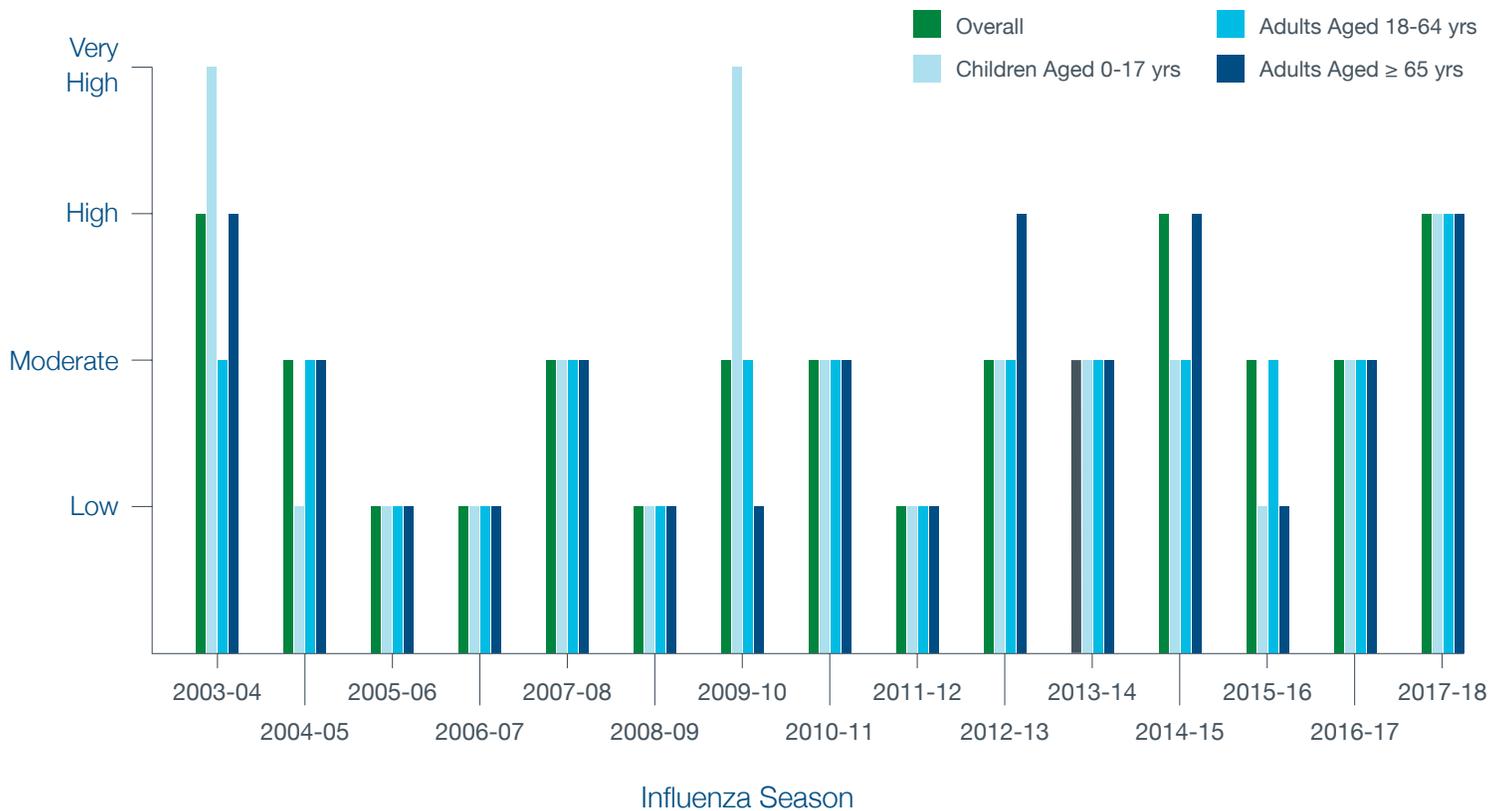
7 <https://www.beckershospitalreview.com/patient-flow/5-urgent-care-occupational-medicine-trends.html>.

8 Ibid.

9 [https://docutap.com/blog/an-analysis-of-employer-services-in-urgent-care-over-five-years?utm\\_source=ucaccess&utm\\_medium=affiliate&utm\\_campaign=blog&utm\\_term=data](https://docutap.com/blog/an-analysis-of-employer-services-in-urgent-care-over-five-years?utm_source=ucaccess&utm_medium=affiliate&utm_campaign=blog&utm_term=data).

Demand has also been fueled by the severity of flu season, as reflected in Figure I. While the more broad-spread and severe flu seasons over the last two years may have resulted in higher patient volumes at UCCs, an important operational question is whether these encounters represent a new demand norm.

Figure I: Influenza season severity classification, “by age group and season”– United States, 2003-04 through 2017-18



Source: <https://www.cdc.gov/flu/professionals/classifies-flu-severity.htm>.

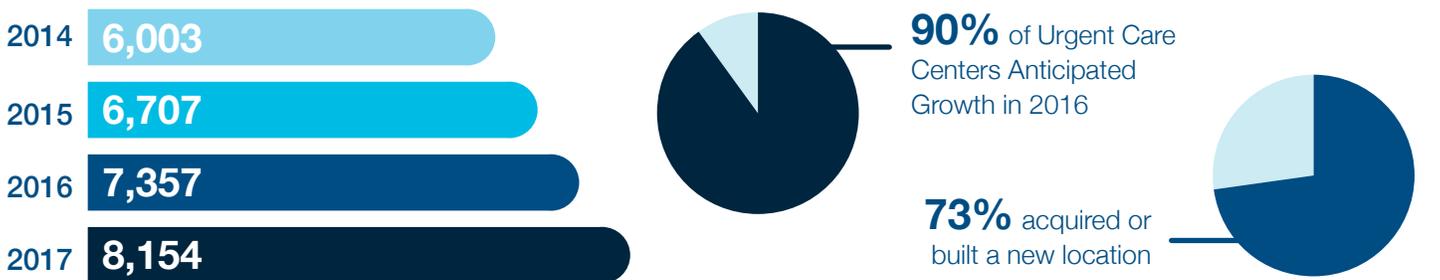
## PYA Valuation Considerations:

- The presence of occupational medicine services can fill schedule gaps, allow for the use of idle resources, and lead to higher cash flow.
- The predominance of occupational medicine services over sick visits, on the other hand, can result in lower net revenue per hour and, as such, lower valuation multiples.
- When reviewing revenue growth trends as part of a valuation exercise, consider the possibility that the flu season patterns may change, and that 2017 and 2018 revenue may not be indicative of normalized levels.

## Robust Supply

According to the UCA 2017 Survey, there were 8,154 UCCs in the country as of mid-year 2017, not including potential additional operations in retail centers, which have similar hours but are not full-fledged UCCs providing the same range of services.<sup>10</sup> This reflects an almost 12% increase in the number of UCCs from the prior year as seen in **Figure II**. Nine out of ten UCCs surveyed anticipated growth at their centers, with 73% of respondents having acquired or built facilities in new locations in 2016. (Note: The UCA 2017 Survey is based on 2016 data, with the exception of the number of UCCs reported which is as of mid-year 2017).

Figure II: UCC Growth Trend



Source: <https://www.ucaoa.org/page/UCBenchmarking>.

UCCs exhibit many forms of ownership, ranging from (i) physician ownership, (ii) hospital ownership, (iii) corporate ownership, and (iv) joint ventures in any combination. Ownership can be influenced by location, level of competition, and legal requirements, such as the prohibition of the corporate practice of medicine. Suburban locations continue to be the most popular settings for UCCs, but it's expected that the number of UCCs in urban locations will grow as millennials select more urban residences.<sup>11</sup>

Large urgent care chains are plentiful in the United States. American Family Care (AFC) is the largest provider of UCCs in the United States with 200 sites in 26 states. AFC opened its first UCC in Alabama in 1986, and since then has grown both organically and through acquisitions. Operated by Dignity Health, U.S. HealthWorks is the largest health-system-owned chain, with 173 sites in 21 states. Premier Health (Premier) is an example of an Urgent Care Management Company with ownership interests in more than 50 UCCs across four states and Puerto Rico.<sup>12</sup> Premier often partners with local hospitals to acquire smaller physician-owned UCCs, forming joint ventures it typically manages.

### PYA Valuation Considerations:

- Current market capacity and the potential for competition from new UCCs are important considerations when valuing UCCs. As patients select UCCs based primarily on convenience, market share may be easily lost with the opening of a new UCC in the vicinity.

<sup>10</sup> [https://c.ymcdn.com/sites/ucaoa.site-ym.com/resource/resmgr/benchmarking/2017\\_benchmarking/UCAOA-BenchmarkSurvey17\\_v4.pdf](https://c.ymcdn.com/sites/ucaoa.site-ym.com/resource/resmgr/benchmarking/2017_benchmarking/UCAOA-BenchmarkSurvey17_v4.pdf).

<sup>11</sup> Ibid.

<sup>12</sup> <https://www.healthdatamanagement.com/list/30-largest-urgent-care-center-chains-in-healthcare>.

## Barriers to Entry

Capital requirements, regulatory hurdles, and the need for trained clinical staff create both financial and operational barriers to entry. The estimated average cost to start a new UCC is between \$850,000 and \$1 million and can reach upward of \$1.5 million.<sup>13</sup> Additionally, the need for provider coverage regardless of patient volume is likely to result in losses during the ramp-up stage, thus requiring the additional financial wherewithal to absorb losses in the initial years.

States with certificate of need (CON) programs may limit the construction, acquisition, and expansion of UCCs and services.<sup>14</sup> However, in many states, UCCs can be operated as physician practices, thus avoiding the need to obtain CONs. Additionally, UCCs can often begin small, and then expand with additional exam rooms, if necessary.

As indicated earlier, there are numerous corporate entities operating UCCs around the country. Hospitals that open and operate UCCs typically have the financial resources to stay in the market despite losses, as UCCs help them fulfill their mission to serve the community's needs, and reduce the burden on their ERs.

### PYA Valuation Considerations:

- The current competitive environment for UCCs, especially in the more urban areas, is not likely to change. The potential for new entrants and reduced market share must be considered when performing UCC valuations.



13 <https://docutap.com/blog/how-much-does-it-cost-to-start-an-urgent-care>.

14 IBISWORLD, Urgent Care Centers in the US, July 2018.

# UCC Staffing Models

The UCA 2017 Survey reported the top staffing models for UCCs as shown in Figure III.

Figure III: Top Reported Staffing Models



Source: UCA 2017 Survey.

While the top three models shown involve the presence of a physician, in PYA's experience, profitability of UCCs is generally higher when mid-level providers manage the majority of patient interactions. In fact, PYA observes an increasing awareness of the importance of mid-level providers in operating a profitable UCC. As presented in the UCA 2017 survey, changes in provider staffing models from 2015 to 2016 show a large decrease in the presence of on-site physicians. Facilities reporting "physicians as the only providers" and other facilities reporting "physicians always on site with [physician assistants] PAs or [nurse practitioners] NPs," both decreased by half. In contrast, facilities reporting "physicians not always on site" more than doubled from 30% to 64%. These staffing changes can lower costs significantly and improve profits.<sup>15</sup>

## PYA Valuation Considerations:

- Analyzing provider staffing is one of the most important steps in performing a UCC valuation. This analysis should not only include the number and type of providers, but also fair market value compensation for the providers.
- Evaluating provider compensation for consistency with fair market value compensation is critical in ensuring reliable valuation conclusions. This is especially so when the facilities are owner-operated.

## Reimbursement

UCCs, like primary care practices, can bill using standard evaluation and management codes based on the level of service provided. However, Medicare and many insurance companies are shifting from fee-for-service to “case rate”—a flat reimbursement per visit regardless of the following:

- New versus established patients
- Level of service
- X-ray
- Supplies
- Laboratory services

Unless there is a carve-out for laboratory and/or x-ray, these services would be included in the flat rate. Therefore, for UCCs under flat rate contracts with payers, laboratory and x-ray services can become costs without directly associated revenue.

The UCA 2017 Survey reported a slight decrease in collections per visit (for sickness or injury)—from \$133 per visit in 2015 to \$131 in 2016. When all other types of visits (physicals, vaccinations, drug screenings, etc.) were reported, the collections per visit were \$124 in 2015 and \$122 in 2016.<sup>16</sup>

When analyzing reimbursement levels as part of the due-diligence process, PYA recognizes the importance of ensuring that UCCs utilizing mid-level providers are billing for these services in accordance with “incident-to” billing guidance provided by the Centers for Medicare & Medicaid Services, as well as private insurers. According to the *Journal of Urgent Care Medicine*, “It is very rare in the urgent care setting for visits to qualify for incident-to billing. First, a supervising physician must physically be on site during the visit. Second, even with a physician on site, not all visits performed by [a non-physician provider] NPP will qualify for ‘incident-to’ billing. For example, if the NPP sees a new patient without the history, physical exam, assessment, and plan being reviewed by the physician face-to-face with the patient, the visit will need to be billed under the National Provider Identifier (NPI) of the non-physician provider.”<sup>17</sup> These services are reimbursed by Medicare at 85% of the physician fee schedule.<sup>18</sup>

### PYA Valuation Considerations:

- Performing some level of due diligence as it relates to billing and coding is important when contemplating UCC acquisitions.
- Benchmarking historical per-visit reimbursement to industry data can help provide high-level insights on service mix, billing, coding and collection practices, and profitability of a UCC.
- If existing billing practices are not consistent with what is anticipated post-acquisition, if applicable under fair market value standards, cash flow projections should be adjusted to reflect appropriate billing and coding practices.
- Trends in reimbursement for urgent care services should also be evaluated.

<sup>16</sup> UCA 2017 Benchmarking Report.

<sup>17</sup> <https://www.jucm.com/the-incidentals-of-incident-to-billing/>. NPP is defined as nonphysician providers in the source.

<sup>18</sup> Ibid.



## Daily Visits

The significance of fixed-cost expenses incurred in the operations of UCCs implies the need for a certain number of minimum daily visits to ensure profitability, beyond which the incremental profit margin per visit increases. This threshold varies based on the number and type of providers, number of examination rooms, center opening hours, and the revenue per visit. According to the UCA 2017 Survey, 90% of respondents indicated that patients spent less than 30 minutes waiting to see a provider and less than 60 minutes to complete the entire visit. On average, the UCCs reported over 15,000 patient care visits per year, three patient care visits an hour, and 50 patients per day (which can include lab work and other types of services).

### PYA Valuation Considerations:

- When evaluating short-term and long-term growth rates, it is important to understand if the projected growth is related to changes in volume or reimbursement, or both, and determine if there is sufficient support for these assumptions. Capacity availability/limitations and trends in reimbursement should be carefully considered to ensure that expectations for growth are well-supported.

## Collection Policies

Most UCCs owned by corporate entities and physicians tend to be structured as for-profit entities and have strict policies concerning payments. They may accept only patients with certain insurance plans, insist on cash payment prior to being seen (if there is no insurance), and have stricter collection policies. Hospitals, on the other hand, often operate UCCs as a means of reducing the pressure on their ERs. As such, and especially in less affluent neighborhoods, these hospitals are often lax on enforcing payment, or receiving proof of insurance, at the time of service, as the alternative might be to receive these patients at the ERs, where services will have to be provided at a higher cost. In PYA's experience, hospital-owned UCCs are typically not sold to a third party without the hospital retaining an equal or majority ownership interest in the UCC. This ensures that patients do not lose access to the UCC and migrate to the hospital ED. UCC joint ventures between hospitals and UCC operators may continue to retain many of the collection policies.

### PYA Valuation Considerations:

- When evaluating hospital-owned UCCs, it is important to understand existing collection policies to determine if any process-related efficiencies (e.g., collection efforts prior to service and after-the-fact) and/or policy changes (e.g., accepting patients without insurance) can be reasonably expected of the operator of the UCC post-transaction.
- While buyer-specific synergies should not be considered in the context of fair market value, collection policies that any reasonable acquirer will be able to correct with relative ease can be evaluated for consideration within the fair market value framework.

## A Final Note

The valuation of healthcare entities poses unique challenges due to the regulatory environment within which these entities operate. Additionally, each type of healthcare entity comes with its own unique operational considerations, and UCCs are no exception. The importance of provider type/staffing levels, and considerations of incident-to billing are examples of the nuances that need to be contemplated.

The growth in number of UCCs across the country is expected to continue, alleviating bottlenecks in hospital ERs and allowing patients easier access to immediate quality healthcare. PYA has the expertise and experience with UCC valuation opinions, due diligence, coding compliance, reimbursement analysis, and related advisory services to assist with clients' needs as they work toward making well-informed decisions in today's complex operating environment.

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