

Valuation of Urgent Care Centers in an Era of Reform

As demand for healthcare services continues to grow, the site at which these services are performed is experiencing a simultaneous transformation from the inpatient (e.g., hospital) setting to the outpatient setting.¹ This transformation is being driven by factors such as: (1) technological advancements; (2) an increasingly *consumer-driven* and *convenience-driven* healthcare delivery environment; (3) pressure from payors; (4) patient demand; and, (5) the entrance and diversification of new and different outpatient enterprises. One such example of a growing subset of outpatient enterprises includes urgent care centers (UCCs) and other retail clinics. UCCs have become vitally important healthcare resources for people across the U.S., with approximately two new walk-in clinics opening up every single day; it is estimated that there are 8,154 UCCs as of 2018.² Compared to a hospital emergency department (ED), UCCs offer some advantages, e.g., shorter wait times and lower costs of care, which may make UCCs a convenient alternative for those patients who do not need an ED's services.³ For hospital EDs, this may be a blessing, as they are often overwhelmed by non-emergency patients who have limited options for access to healthcare services.⁴

While the services offered by UCCs and retail clinics may overlap, the two facilities are typically differentiated by the level and scope of care provided, as well as their location and ownership structure.⁵ Urgent care may be characterized as healthcare that is delivered to treat an acute illness on a walk-in basis, while retail clinics, which also offer walk-in services, may be characterized as providing healthcare services for the treatment of non-acute illnesses and conditions. UCCs can be affiliated with a larger hospital or healthcare system, or operated as an independent freestanding facility, and are influenced by certain market forces and value drivers. These unique value drivers impact the typical valuation approaches, methods, and techniques that are often utilized in determining the value of UCCs in the current healthcare delivery system.

URGENT CARE CENTERS OVERVIEW

In contrast, UCCs are typically freestanding facilities that may be owned and operated by a group of physicians, and may be eligible for one of two certifications offered by the *Urgent Care Association of America* (UCAOA): (1) *Category 1* – certifies that licensed physicians are on site

during the clinic's hours of operation; and, (2) *Category 2* – certifies that licensed providers, i.e., physicians and midlevel providers (NPs and PAs), are on site during the clinic's hours of operation. To qualify as either a *Category 1* or a *Category 2* certified UCC, facilities must meet the following minimum criteria:

- (1) Accepting and advertising that “walk-ins” of all ages are welcome;
- (2) Providing *x-ray* and *phlebotomy* services;
- (3) Maintaining, on site, licensed providers who can: (a) obtain and read an electrocardiogram (EKG) and x-ray; (b) administer *per os* (orally), intramuscular (IM), and intravenous (IV) medication/fluids; and, (c) perform minor procedures;
- (4) Keeping on site the following equipment: (a) an automated external defibrillator (AED); (b) oxygen; (c) a drug cart; and, (d) a working phone;
- (5) Maintaining two or more examination rooms;
- (6) Maintaining a separate waiting area and patient specific restrooms;
- (7) Staying open seven days a week, for over four hours a day, for a total of 3,000 hours per year;
- (8) Maintaining a Medical Director who is a licensed physician; and,
- (9) Performing both administrative and medical activities in an ethical manner.⁶

In addition to *certification*, UCCs may also seek facility *accreditation* through survey bodies such as the *Urgent Care Association of America* (UCAOA),⁷ the *American Academy of Urgent Care Medicine* (AAUCM),⁸ the Accreditation Association for Ambulatory Health Care (AAAHC),⁹ the *National Urgent Care Center Accreditation* (NUCCA),¹⁰ and *The Joint Commission*.¹¹

Accreditation is awarded to those facilities that are found to be in compliance with AAUCM standards, including, but not limited to:

- (1) Having been in operation for at least six months;
- (2) Maintaining a supervisory physician who is responsible for the care provided at the practice;
- (3) Maintaining compliance with all federal, state, and local regulations; and,

- (4) Submitting an accreditation survey every three years that is completed through *documentation* and/or *on-site observations*.¹²

VALUE DRIVERS

While the value drivers identified for UCCs are similar to that of other healthcare outpatient enterprises, there are several specific dynamics related to UCCs and other freestanding outpatient enterprises that should be taken into consideration during the appraisal process.

Scope of Services

The scope of services provided by a particular freestanding outpatient enterprise is a key element impacting the overall indication of value attributed to that enterprise. While each UCC differs slightly in terms of the services that they offer, the most common medical needs that a UCC can provide include:

- (1) Non-life threatening illnesses: The UCC is the prime site of service for patients who are not sure whether they have a cold, the flu, or some scary-sounding self-diagnosis. UCCs typically have licensed family care physicians or nurse practitioners on site and they can provide the quality treatment similar to what may be found at a traditional physician's office.
- (2) Minor physical injuries: UCCs are ideal for any injury that is not life-threatening. This may include minor burns, lacerations, sprains, or small fractures.
- (3) Vaccinations: This includes seasonal flu vaccines to region-specific vaccines for those planning an international trip.
- (4) School and sports physicals: Most UCCs and other walk in clinics allow patients to schedule these appointments in advance, and there are plenty of family practitioners who can provide physical fitness exams for children and adults.
- (5) STD testing: UCCs may include a laboratory and can accommodate the testing for sexually transmitted diseases (STDs) or sexually transmitted infections (STIs).

In addition to the added revenue opportunities created by expanding the scope of services, a UCC may be able to create value through economies of scale. As more revenue is produced by the additional services rendered, only the variable portion of each expense would increase, while the fixed portion remains constant, thereby increasing the incremental benefit generated by each additional service. Note that this incremental benefit would only increase up to the point of capacity, where additional capital costs would reduce the benefit generated by the additional services.

Location

Patient convenience and visibility are important factors to the success of a UCC; therefore, its location is vital. Favorable locations include areas where its patient base has the most access, e.g., near home, the office, and schools. Within these areas, UCCs are often in

freestanding buildings, but are also located in shopping malls, medical office buildings, and other mixed-use buildings.

Capacity

Capacity is another key element that impacts the value attributable to UCCs. One measure of capacity for UCCs is the amount of physical space utilized in the provision of services. For example, the number of exam rooms available in a UCC, as well as average turnover rate, can be used as measures of capacity. These metrics can be compared to normative industry benchmark survey data related to comparable enterprises and UCCs. UCCs have, on average, seven exam/treatment rooms.¹³

Payor Mix

The typical payor mix in 2016 for UCCs (by percent of overall patient visits), as reported by the UCAOA 2017 Benchmarking Survey, is as follows:

- (1) Commercial Payors – 67%
- (2) Medicare/Medicaid – 17%
- (3) Cash Payments – 12%
- (4) Other (including workers' compensation, TRICARE, direct bill employer services) – 4%¹⁴

Licensing

Most states do not require a license for UCCs. However, as UCCs become more popular, states may impose regulations on UCCs, in order to set a minimum standard of care.¹⁵

Operating Expenses

Human resources/personnel costs (wages and benefits) associated with the staff required to operate the UCC typically represents the largest operating expense incurred by UCCs. Physician and non-physician provider compensation comprise the majority of a UCC's personnel expense.

Additional considerations regarding the operating expenses incurred by a UCC include:

- (1) The *size of the facility*, e.g., the number of examination rooms and the number of cases;
- (2) The *ability of the UCC to manage supply costs*;
- (3) Whether the center *directly employs* or *contracts* with physician and non-physician providers; and,
- (4) Whether the *management of a UCC is performed by a third party*.¹⁶

In addition to the types of operating expenses incurred by a UCC, the amount of *fixed* and *variable* expense should be considered when performing an appraisal, as each type of expense is projected differently.

Similar to trends impacting other healthcare entities, UCCs may benefit from increased utilization of administrative related technology, e.g., *electronic health record* (EHR) systems, which can reduce the economic operating costs associated with the provision of administrative tasks and duties. Note that the underlying trend of operating expenses for most healthcare

enterprises is rising, due to increases in medical care input costs, which are exerting downward pressure on the profit margins of these facilities.

Market Rivalries and Competitors

The UCC industry (and the healthcare industry as a whole) has been, and is forecasted to continue, experiencing significant consolidation, through mergers and acquisition by both hospitals and corporations. This trend toward consolidation decreases the competition and rivalry among UCCs, and has also resulted in an increase in the number of joint ventures between UCCs and hospitals. Affiliation and integration among smaller UCCs may allow these providers to obtain greater negotiating leverage and the potential to gain access to better managed care and commercial contracts, enhancing their profitability and increasing their indication of value.¹⁷ The typical ownership structure in 2016 for UCCs (by percent of all UCCs) is as follows:

- (1) Corporate Entity – 39%
- (2) Joint Venture with a Hospital – 16%
- (3) Hospital-Owned – 15%
- (4) Owned by Two or more Physicians – 14%
- (5) Owned by a Single Physician – 10%
- (6) Non-Physician Investors – 3%
- (7) Physician Investors – 2%
- (8) Other – 1%¹⁸

Subject Specific/Non-Systematic Risk

While an investor in a particular UCC would have additional investment opportunities available to them, e.g., government bonds, equity indexes, the discount rate utilized to present value all of the expected future net economic benefits should consider these opportunity costs, as well as any idiosyncratic risk associated with an investment in the specific subject enterprise. This subject specific/non-systematic (idiosyncratic) risk for freestanding outpatient enterprises would include the various risk factors that are inherent in and specific to the enterprise being valued, as well as the enterprise's operational performance compared to the most probable performance of similar enterprises as reported in normative industry benchmark survey data. Subject

specific/non-systematic risk factors for most UCCs include, but are not necessarily limited to:

- (1) The *uncertainty related to the continuity of the projected revenue stream* based on the probability of achieving the projected productivity volume and the efficacy of the projected reimbursement yield utilized in the analysis;
- (2) The *risk related to the probability of achieving industry indicated operational and financial benchmarks* utilized in the analysis; and,
- (3) The *competitive marketplace* within which the UCC operates, including its location; and,
- (4) The *historical operations* of the UCC in comparison to the industry benchmarks.

CONCLUSION

The value of UCCs is significantly tied to the greater U.S. healthcare industry, rapidly evolving in the modern era of healthcare reform. The ability of UCCs to operate in a continuum of care in the new value-based purchasing paradigm may determine their viability as an ongoing enterprise in the future. The number of healthcare services provided at UCCs continues to increase, due to rapidly evolving technological advances that allow many services and procedures to be performed in a safe, high quality, and, often, less costly environment than at many hospital-based EDs and physician offices. At the same time, the transactional environment of UCCs is also changing, as they are increasingly being acquired by hospitals and health systems. Further, in addition to the increased hospital employment of physicians, the overall healthcare transactional market is likely to continue experiencing increased transactional activity as a result of healthcare reform initiatives, as physician practices, and other outpatient enterprises, participate in such integration activities as accountable care organizations, medical homes, and co-management arrangements. UCCs are well positioned to be a major player in the future model of healthcare delivery as these initiatives continue to develop.

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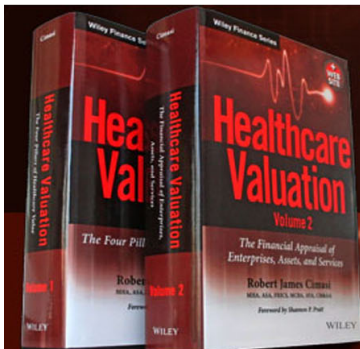
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