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# **Urgent Care Centers:** Finding Value in the Continuum of Care (Part I of II)

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Urgent care may be characterized as healthcare delivered to treat acute, non-life-threatening illness or injury on a walk-in basis. Urgent care centers (UCCs) occupy a distinct niche in the continuum of care, positioned between the primary care physician's office and the hospital emergency department (ED) in terms of acuity and cost. UCCs typically operate with extended hours, accept walk-in patients without appointments, and provide basic diagnostic imaging and laboratory services to treat conditions such as upper respiratory infections, musculoskeletal injuries, and dermatological complaints.[1]

UCCs are often conflated with retail clinics and onsite employer clinics. While services overlap, the categories are differentiated by level and scope of care, location, and ownership structure. Urgent care handles higher-acuity cases than retail clinics but does not treat trauma. UCCs may be affiliated with a larger hospital or health system (i.e., provider-based) or operate as independent freestanding facilities. Staffing generally includes physicians, physician assistants (PAs) and nurse practitioners (NPs).

This two-part article examines the competitive, reimbursement, regulatory, and technological dynamics shaping UCC valuation

1 "Options for Slowing the Growth of Medicare Fee-for-Service Spending for Emergency Department Services," chap. 11 in *June 2019 Report to the Congress: Medicare and the Health Care Delivery System*, Medicare Payment Advisory Commission, June 2019, 385, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch11_medpac_reporttocongress_sec.pdf.

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in 2026, as well as the subject-specific value drivers and risk factors that valuation analysts should weigh when analyzing an investment in a UCC or portfolio of UCCs.

## Competitive Environment

The urgent care sector has matured rapidly. Between 2014 and 2023, the number of UCCs more than doubled, from 7,220 to 14,928.[2]

UCCs compete for patients with hospital EDs, freestanding EDs, retail clinics, primary care offices, and increasingly with virtual-first and direct-to-consumer telehealth providers. The structural drivers of UCC growth identified a decade ago remain in force: physicians drawn to shift-based schedules without long-term panel responsibility; patients attracted by evening and weekend hours, walk-in access, and predictable pricing; and significant cost savings over EDs for comparable diagnoses.

The competitive picture changed meaningfully following the COVID-19 public health emergency (PHE). UCCs captured a larger share of acute ambulatory demand both during and after the PHE, with commercial-insured urgent care spending rising approximately 50% from 2018 to 2022, driven primarily by higher utilization rather than higher per-visit pricing.[3] The Advisory Board reported that of the 430-plus UCCs that opened in the first half of 2025, roughly 40% were hospital-affiliated—a notable pivot from the prior decade, when corporate and private equity (PE) operators dominated new openings.[4]

### Ownership Concentration and Private Equity Investment

The ownership composition of the UCC industry has shifted materially since the mid-2010s, when physician-owned and corporate-owned centers predominated. Hospital and health system ownership, whether direct or through joint ventures, has grown significantly, while PE-backed platforms now control a meaningful share of the UCC footprint. As of May 2025, PE-owned centers totaled 2,622, representing approximately 18% of the industry, up from 2,359 a year earlier.[5]

Headline transactions illustrate the scale of capital now deployed in the sector. Walgreens Boots Alliance's (WBA's) VillageMD closed its $8.9 billion acquisition of Summit Health-CityMD in January 2023, creating one of the largest multispecialty provider groups in the U.S., with approximately 680 locations across 26 markets.[6] In August 2025, Sycamore Partners completed its take-private acquisition of WBA in a transaction valued at up to $23.7 billion, splitting the combined company into five standalone entities and positioning VillageMD—including the Summit Health-CityMD urgent care footprint—as a standalone PE-owned platform.[7] Hospital-driven consolidation has also intensified: HCA Healthcare's 2022 purchase of MD Now (59 Florida locations) and 2023 acquisition of 41 FastMed/MedPost clinics in Texas have been followed by deals including Ardent Health's 2025 acquisition of 18 NextCare centers in New Mexico and Oklahoma.[8]

2 Urgent Care Association, *Urgent Care Industry White Paper* (2023), 4, https://urgentcareassociation.org/wp-content/uploads/2023-Urgent-Care-Industry-White-Paper.pdf.

3 Kelsey Burke, "Urgent Care Spending Increased by 50% over 5 Years Driven by Higher Use," Health Care Cost Institute, January 28, 2026, https://healthcostinstitute.org/all-hcci-reports/urgent-care-spending-increased-by-50-over-5-years-driven-by-higher-use/.

4 "Acquisitions, Joint Ventures Reshape Urgent Care Landscape," Advisory Board, August 25, 2025, https://www.advisory.com/daily-briefing/2025/08/25/urgent-care-ec.

5 Alan A. Ayers, "Private Equity Investment in Urgent Care, By Number of Centers, 2025," *Journal of Urgent Care Medicine*, June 30, 2025, https://www.jucm.com/private-equity-investment-in-urgent-care-by-number-of-centers-2025/.

6 VillageMD, "VillageMD Finalizes Acquisition of Summit Health-CityMD, Creating One of the Largest Independent Provider Groups in the U.S.," press release, January 5, 2023, https://www.villagemd.com/press-releases/villagemd-finalizes-acquisition-of-summit-health-citymd-creating-one-of-the-largest-independent-provider-groups-in-the-u.s.

7 Heather Landi, "Sycamore Partners Closes Acquisition of Walgreens, Splits into 5 Standalone Companies," Fierce Healthcare, August 28, 2025, https://www.fiercehealthcare.com/finance/sycamore-partners-closes-acquisition-walgreens-splits-pharmacy-retailer-5-standalone.

8 HCA Healthcare, "HCA Healthcare Purchases MD Now Urgent Care with Its 59 Locations in Florida," press release, January 4, 2022, https://investor.hcahealthcare.com/news/news-details/2022/HCA-Healthcare-Purchases-MD-Now-Urgent-Care-With-Its-59-Locations-in-Florida/default.aspx; "Ardent Health Ramps Up Ambulatory Care M&A with Urgent Care Clinics Deal," *Ambulatory Surgery Center News*, January 4, 2025, https://ascnews.com/2025/01/ardent-health-ramp-ups-ambulatory-care-ma-with-urgent-care-clinics-deal/.

Reported valuation multiples vary widely by scale: single-site clinics or small portfolios with less than $10 million in revenue have traded at 3x–7x earnings before interest, taxes, depreciation, and amortization (EBITDA); regional groups between $10 and $50 million in revenue have traded at 6x–11x EBITDA; and larger platforms above $50 million in revenue have traded at 10x–15x EBITDA or higher.[9]

## Reimbursement Trends

The U.S. government is the largest payor of medical costs, through Medicare and Medicaid. In 2024, Medicare and Medicaid accounted for approximately $1.118 trillion[10] and $931.7 billion[11] in healthcare spending, respectively, with total national health expenditures reaching $5.3 trillion, or 18% of gross domestic product. Given their prevalence in the healthcare marketplace, these public payors often act as price setters, providing a benchmark for private reimbursement rates.[12]

UCCs may be reimbursed under the Medicare Physician Fee Schedule (MPFS) or, in the case of hospital-owned off-campus provider-based UCCs, under the Outpatient Prospective Payment System (OPPS). UCCs also face less direct pressure from public payors than many other provider types because commercial payors continue to account for the majority of UCC volume.

### Medicare Reimbursement of Physician Services

For reimbursement purposes, Medicare treats services provided at UCCs the same as services provided in a physician office. Medicare uses the Resource-Based Relative Value Scale (RBRVS) system, which assigns Relative Value Units (RVUs) to individual procedures based on the resources required. Each procedure is assigned RVUs for three resource categories: physician work (wRVUs), practice expense (PE RVUs), and malpractice (MP RVUs). Each RVU component is adjusted by a locality-

9 Will Hamilton, "Urgent Care Valuation Multiples and M&A Trends 2026," Scope Research, April 17, 2026, https://www.scoperesearch.co/post/urgent-care-valuation-multiples-and-m-a-trends-2025.

10 "NHE Fact Sheet," Centers for Medicare & Medicaid Services, last modified January 14, 2026, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

11 Ibid.

12 Roger Feldman et al., "Medicare's Role in Determining Prices Throughout the Health Care System," Mercatus Center, George Mason University, October 2015, https://www.mercatus.org/research/working-papers/medicares-role-determining-prices-throughout-health-care-system.

*UCCs also face less direct pressure from public payors than many other provider types because commercial payors continue to account for the majority of UCC volume.*

specific Geographic Practice Cost Index (GPCI), summed, and multiplied by a conversion factor (CF) to produce the payment amount:

$$\text{Payment} = [(wRVU \times GPCI^{work}) + (PE\ RVU \times GPCI^{pe}) + (MP\ RVU \times GPCI^{mp})] \times CF$$

The number of MPFS payment localities currently stands at 112 following the full implementation of California's reconfiguration from nine statewide localities to 27 (32 for payment purposes) under the Protecting Access to Medicare Act of 2014.[13]

The CF is updated annually pursuant to the schedule established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[14] Beginning in 2026, MACRA provides differential statutory updates: a 0.75% baseline for qualifying alternative payment model participants (QPs) and 0.25% for all other physicians. For 2026, this baseline was supplemented by a 2.5% one-year temporary increase enacted by the One Big Beautiful Bill Act (OBBBA), plus a 0.49% positive budget-neutrality adjustment.[15] The result is two 2026 conversion factors—$33.5675 for QPs and $33.4009 for non-QPs—representing the first year since MACRA's enactment that Medicare has paid physicians at different rates based on alternative payment model participation.[16]

Recent federal legislation has produced volatility in the CF from year to year. After a mid-year positive adjustment in 2024 from the Consolidated Appropriations Act, 2024, the CF fell 2.9% at the start of 2025 when no year-end "doc fix" legislation was enacted to cancel the physician reimbursement rate decrease, before recovering to $33.40–$33.57 in 2026.[17] The pattern underscores the degree to which congressional action, rather than the MACRA formula, has come to dictate annual MPFS updates, a dynamic analysts should acknowledge when developing multi-year revenue projections.

**Medicare Reimbursement of Outpatient Services**

Technical services provided at hospital-owned, off-campus provider-based UCCs are generally reimbursed under the OPPS. Most individual medical services—identified via Healthcare Common Procedure Coding System (HCPCS) codes—are grouped into an ambulatory payment classification (APC) based on similar clinical characteristics and resource costs. Each APC is scaled by a relative weight and multiplied by the OPPS CF, then adjusted for local wage variation by applying the hospital wage index to the labor-related portion (approximately 60%) of the payment rate.

For 2026, the OPPS payment rate was updated by 2.6%, based on the 3.3% hospital market basket increase minus a 0.7 percentage point productivity adjustment (see Table 1).[18]

13 "Medicare PFS Locality Configuration," Centers for Medicare & Medicaid Services, last modified February 25, 2026, https://www.cms.gov/medicare/payment/fee-schedules/physician/locality-configuration.

14 Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101, 129 Stat. 87, 89–90 (April 16, 2015).

15 Centers for Medicare & Medicaid Services, "Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule," fact sheet, October 31, 2025, https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-final-rule-cms-1832-f; One Big Beautiful Bill Act, Pub. L. No. 119-21, § 71202 (July 4, 2025).

16 Centers for Medicare & Medicaid Services, "Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule."

17 "Five Years of Decline in the Medicare Conversion Factor (2020–2025)," American Medical Association, last updated June 2025, https://www.ama-assn.org/system/files/medicare-conversion-factor-chart.pdf; "2026 MPFS Final Rule Increases Physician Payments," *Health Capital Topics* 18, no. 11 (November 2025), https://www.healthcapital.com/hcc/newsletter/11_25/HTML/MPFS/convert_mpfs_final_rule.php.

18 Centers for Medicare & Medicaid Services, "Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Final Rule," fact sheet, November 21, 2025, https://www.cms.gov/newsroom/fact-sheets/calendar-year-2026-hospital-outpatient-prospective-payment-system-opps-ambulatory-surgical-center.

Separately, the 2026 final rule also implements a –0.5 percentage point $340 billion remedy offset to the OPPS CF for non-drug items and services, to recoup approximately $7.8 billion in 2018–2022 overpayments identified following the Supreme Court's ruling in *American Hospital Association v. Becerra*.[19]

## Table 1: Historical OPPS Payment Update Adjustments

| Calendar Year | Market Basket Update | Productivity (MFP) Adjustment | Final Update Factor |
|---|---|---|---|
| 2021[20] | 2.4% | 0.0% | +2.4% |
| 2022[21] | 2.7% | 0.7% | +2.0% |
| 2023[22] | 4.1% | 0.3% | +3.8% |
| 2024[23] | 3.3% | 0.2% | +3.1% |
| 2025[24] | 3.4% | 0.5% | +2.9% |
| 2026[25] | 3.3% | 0.7% | +2.6% |

Part II of this series will explore the regulatory and technical environments currently shaping the valuation of UCCs, as well as the relevant value drivers and risk factors that valuation analysts should weigh when analyzing an investment in a UCC or portfolio of UCCs. VE

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20 Centers for Medicare & Medicaid Services, "CY 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule," fact sheet, December 2, 2020, https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0.
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