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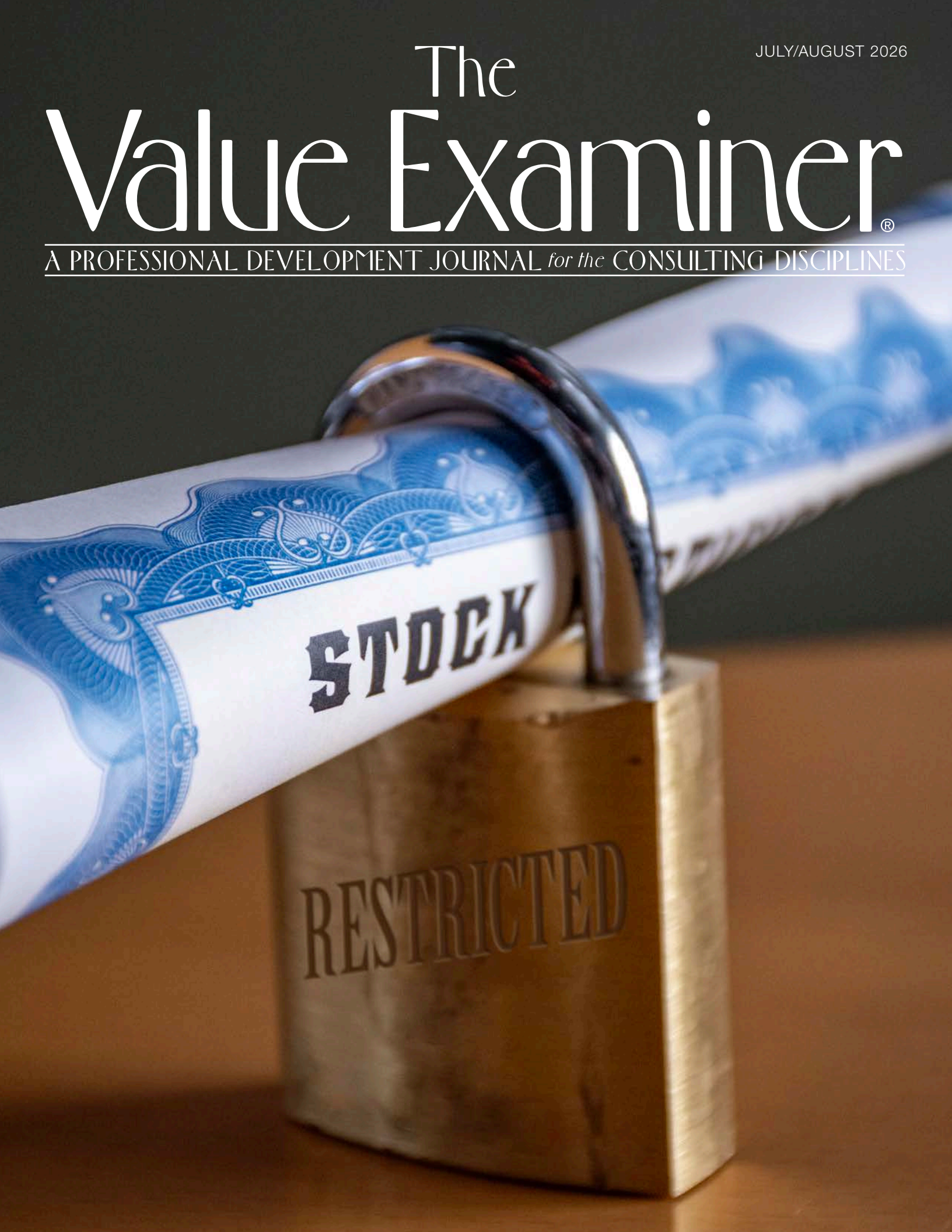

Urgent Care Centers: Finding Value in the Continuum of Care (Part II of II)

By Todd A. Zigrang and Jessica L. Bailey-Wheaton

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).

Part I[2] of this two-part article examined the competitive and reimbursement dynamics shaping UCC valuation in 2026. Part II explores 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.

Regulatory Environment

Healthcare organizations face a range of federal and state legal and regulatory constraints that affect their formation, operation, procedural coding and billing, and transactions. The provisions most directly relevant to UCC valuation are state licensure and accreditation frameworks together with the federal fraud and abuse laws—primarily the Anti-Kickback Statute (AKS) and the physician self-referral law (the Stark Law).

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.

2 Todd A. Zigrang and Jessica L. Bailey-Wheaton, "Urgent Care Centers: Finding Value in the Continuum of Care (Part I of II)," *The Value Examiner*, May/June 2026, 34–38.

Fraud and abuse laws, specifically those related to the AKS and Stark Law, may have the greatest impact on the operations of healthcare providers.

Licensing and Accreditation

Most states do not impose licensure requirements specific to urgent care as a facility category, though Massachusetts' December 2024 legislation is an early move in that direction and may signal a broader trend. The Urgent Care Association (UCA) offers two voluntary certifications: Category I (requiring licensed physicians on site during operating hours) and Category II (requiring licensed providers, including physicians and midlevel providers, on site during operating hours). The American Academy of Urgent Care Medicine also operates an accreditation program for UCCs that meet its standards for physician supervision, scope of services, and compliance with federal, state, and local regulations.

Fraud and Abuse Laws

Fraud and abuse laws, specifically those related to the AKS and Stark Law, may have the greatest impact on the operations of healthcare providers. The AKS and Stark Law are generally concerned with the same issue: the financial motivation behind patient referrals. However, while the AKS broadly applies to payments between providers or suppliers in the healthcare industry and relates to any item or service that may be paid for under any federal healthcare program, the Stark Law specifically addresses referrals from physicians to entities with which the physician has a financial relationship for the provision of defined services that are paid for by the Medicare program.[3] Additionally, while violation of the Stark Law carries only civil penalties, violation of the AKS carries both criminal and civil penalties.[4]

Enacted in 1972, the AKS makes it a felony for any person to "knowingly and willfully" solicit or receive, or to offer or pay, any "remuneration," directly or indirectly, in exchange for the referral of a patient for a healthcare service paid for by a federal healthcare program,[5] even if only one purpose of the arrangement is to offer remuneration deemed illegal under the AKS.[6] A person need not have actual knowledge of the AKS or specific intent to commit a violation,[7] only an awareness that the conduct in question is "generally unlawful."[8] A violation of the AKS is sufficient to state a claim under the False Claims Act (FCA).[9]

Criminal violations of the AKS are punishable by up to 10 years in prison, criminal fines up to $100,000, or both, and civil violations can result in administrative penalties, including exclusion from federal healthcare programs, and civil monetary penalties plus treble damages.[10] If the AKS violation triggers FCA liability, defendants can incur additional civil monetary penalties of $14,308 to $28,619 per violation (per 2025 U.S. Department of Justice inflation adjustments), plus treble damages.[11] Due to the broad nature of the AKS, legitimate business arrangements may appear to be

3 "Comparison of the Anti-Kickback Statute and Stark Law," Health Care Fraud Prevention and Enforcement Action Team (HEAT), Office of Inspector General (OIG), U.S. Department of Health and Human Services, accessed April 23, 2026, https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf.

4 Ibid.

5 Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. § 1320a-7b(b)(1).

6 "Re: OIG Advisory Opinion No. 15-10," letter from Gregory E. Demske, Chief Counsel to the Inspector General, to [Name Redacted] (July 28, 2015), 4–5, https://oig.hhs.gov/documents/advisory-opinions/699/AO-15-10.pdf; U.S. v. Greber, 760 F.2d 68, 69 (3d. Cir. 1985).

7 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 6402, 10606, 124 Stat. 119, 759, 1008 (March 23, 2010).

8 Jennifer A. Staman, "Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview," Congressional Research Service, September 8, 2014, 5, https://sgp.fas.org/crs/misc/RS22743.pdf.

9 Patient Protection and Affordable Care Act.

10 Criminal Penalties for Acts Involving Federal Health Care Programs; Civil Monetary Penalties, 42 U.S.C. § 1320a-7a(a).

11 False Claims, 31 U.S.C. § 3729(a)(1)(G); Scott D. Stein and Catherine Steward, "Department of Justice Announces 2025 Inflationary Adjustments to FCA Penalties," *FCA Blog*, Sidley, July 7, 2025, https://fcablog.sidley.com/2025/07/07/department-of-justice-announces-2025-inflationary-adjustments-to-fca-penalties/.

prohibited.[12] Congress has created statutory exceptions and delegated authority to the Department of Health and Human Services (HHS) to protect certain arrangements through safe harbors.[13] In a December 2020 final rule, the HHS Office of Inspector General (OIG) released several revisions to the AKS, including new safe harbors for value-based arrangements whose requirements ease as participants take on more financial risk.[14]

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physician or an immediate family member has a financial relationship for the provision of designated health services (DHS).[15] When a prohibited referral occurs, entities may not bill for services resulting from the referral.[16] DHS include inpatient and outpatient hospital services, radiology and certain other imaging services, radiation therapy services and supplies, certain therapy services, durable medical equipment, and outpatient prescription drugs.[17] Civil penalties include overpayment or refund obligations, civil monetary penalties up to $31,670 per service plus treble damages (as adjusted for inflation in 2026), and exclusion from Medicare and Medicaid.[18] In December 2020, the Centers for Medicare & Medicaid Services (CMS) released a final rule revising the Stark Law definitions of fair market value, general market value, and commercial reasonableness, and creating new permanent exceptions for full financial risk, meaningful downside risk, and value-based arrangements.[19]

For valuation purposes, the practical implication remains unchanged: Compensation arrangements between physicians and UCCs must not exceed fair market value, must not take into account the volume or value of referrals, and must be commercially reasonable. The severe penalties available under the AKS, the Stark Law, and the FCA continue to raise the risk profile assigned by a hypothetical investor valuing a UCC.

12 "Re: OIG Advisory Opinion No. 15-10," 5.

13 Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule, 64 Fed. Reg. 63518, 63520 (November 19, 1999).

14 Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 85 Fed. Reg. 77814–77815 (December 2, 2020).

15 Jennifer O'Sullivan, "CRS Report for Congress: Medicare: Physician Self-Referral ('Stark I and II')," Congressional Research Service, updated September 27, 2007, https://www.everycrsreport.com/reports/RL32494.html; Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn.

16 Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn(a)(1)(A).

17 Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn(a)(1)(B); Definitions, 42 C.F.R. § 411.351.

18 Limitation on Certain Physician Referrals, 42 U.S.C. § 1395nn(g); Annual Civil Monetary Penalties Inflation Adjustment: Final Rule, 91 Fed. Reg. 3665, 3671 (January 28, 2026).

19 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492, 77510–77528 (December 2, 2020).

The federal policy environment for Medicare telehealth has been highly unstable since the PHE ended in May 2023.

Technological Environment

Telehealth

Telehealth was a marginal modality in urgent care before the COVID-19 public health emergency (PHE)—fewer than 30% of urgent care organizations offered it pre-pandemic—and is now effectively universal: Approximately 94% of urgent care organizations offered telehealth by 2022, according to the UCA.[20] UCCs have integrated telehealth primarily as a front door for lower-acuity conditions, for follow-up after in-person visits, and for remote patient monitoring, each of which can improve center throughput without displacing higher-margin in-person volume.

The federal policy environment for Medicare telehealth has been highly unstable since the PHE ended in May 2023. Following six short-term legislative extensions—most recently via the Continuing Appropriations Act, 2026 (enacted in February 2026)—the current stable window for most Medicare telehealth flexibilities runs through December 31, 2027.[21] Among the flexibilities extended through that date: home as an originating site, expanded practitioner eligibility (including occupational therapists, physical therapists, speech-language pathologists, and audiologists), Federally Qualified Health Center and Rural Health Clinic distant-site services, audio-only services for most nonbehavioral conditions, and waiver of the in-person visit requirement for behavioral telehealth. Several flexibilities are now permanent, including audio-only behavioral telehealth, removal of frequency limits on certain inpatient and critical care telehealth consultations, direct supervision via real-time audio and video, and virtual teaching-physician presence.[22]

Two features of the current regime warrant flagging for valuation work. First, the repeated short-term extensions mean that Medicare telehealth policy cannot yet be treated as durable; the series of late-2025 and early-2026 lapses—including a 43-day gap during the October–November 2025 federal shutdown—demonstrates that legislative risk remains live. Second, the Drug Enforcement Administration's fourth temporary extension (finalized December 31, 2025) permits telemedicine prescribing of Schedule II–V controlled substances without a prior in-person evaluation through December 31, 2026. A permanent "special registration" rule for telemedicine proposed in January 2025 has not been finalized as of this writing.

Health Information Technology and Artificial Intelligence

Technological innovation continues to reshape the U.S. healthcare delivery system, accelerating in pace and scope since the widespread deployment of electronic health records (EHRs) and now increasingly driven by artificial intelligence (AI), interoperability mandates, and digital quality reporting requirements. The Office of the National Coordinator for Health Information Technology (ONC) finalized its Health Data, Technology, and Interoperability (HTI-1) rule in January 2024, establishing the first federal transparency framework for clinical decision support AI with 31 required source attributes for predictive decision support interventions.[23] Subsequent rules (HTI-2 through HTI-4) addressed information-blocking exceptions, reproductive health protections, and electronic prior authorization certification. A proposed HTI-5 rule, released in December 2025, would materially roll back HTI-1's AI transparency requirements; the rule has not been finalized as of this writing.

20 "Telehealth Adoption Rises Steadily in Urgent Care," *Journal of Urgent Care Medicine*, November 1, 2023, https://www.jucm.com/telehealth-adoptionrises-steadily-in-urgent-care/.

21 Danielle Tangorre and Conor Duffy, "Continuing Appropriations Act, 2026: Another Lifeline for Medicare Telehealth Flexibilities," *Health Law Diagnosis*, February 2026, https://www.healthlawdiagnosis.com/2026/02/continuing-appropriations-act-2026-another-lifeline-for-medicare-telehealth-flexibilities/.

22 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.

23 Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1) Final Rule, 89 Fed. Reg. 1192 (January 9, 2024).

The demand for urgent care services, combined with continued industry growth, makes UCCs attractive acquisition targets for both financial and strategic buyers.

For UCCs, the most operationally relevant recent development is the rapid adoption of ambient AI clinical documentation tools. The American Medical Association's 2026 Augmented Intelligence Research Report found that physician AI use nearly doubled from 38% in 2023 to 72% in 2026,[24] and peer-reviewed evidence now supports meaningful productivity and wellness gains. A 2025 *JAMA Network Open* study of 263 clinicians found ambulatory burnout fell from 51.9% to 38.8% within 30 days of ambient scribe deployment,[25] while a January 2026 UCSF analysis of 1.2 million encounters found AI scribe adopters generated approximately 1.81 additional work relative value units (RVUs) per week—equivalent to roughly $3,000 in annualized revenue per physician at 2025 Medicare Physician Fee Schedule (MPFS) rates—without an observed increase in claim denials.[26] A February 2026 Stanford study examining ambient AI use in an academic emergency department found adoption concentrated in lower-acuity and telemedicine zones,[27] a distribution pattern that maps closely onto the typical UCC workflow and suggests comparable productivity gains are reasonably achievable in the urgent care setting.

Three countervailing considerations bear on the near-term economic impact for UCCs. First, several commercial payors began automated evaluation and management (E/M) downcoding programs in late 2025 for level 4–5 visits where documentation is deemed insufficient; because UCC revenue is heavily weighted toward higher-level E/M codes, this may offset some of the productivity gains associated with ambient documentation. Second, CMS's WISeR Model—an AI-powered prior authorization demonstration running January 2026 through December 2031 in six states—will increase friction for downstream services even though it exempts emergency and urgent services themselves. Third, interoperability obligations continue to expand; the Trusted Exchange Framework and Common Agreement had reached more than 10,600 live organizations and 115 million documents exchanged by late 2025,[28] and the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) began to take effect in January 2026. These mandates add compliance cost but also expand the data assets underpinning any UCC platform's acquisition appeal.

Valuation Considerations

The demand for urgent care services, combined with continued industry growth, makes UCCs attractive acquisition targets for both financial and strategic buyers. The urgent care market is highly fragmented, providing the opportunity for acquirers to achieve scale and operational synergies.

24 "2026 Physician Survey on Augmented Intelligence," American Medical Association, March 2026, 5, https://www.ama-assn.org/system/files/physician-ai-sentiment-report.pdf.

25 Kristine D. Olson et al., "Use of Ambient AI Scribes to Reduce Administrative Burden and Professional Burnout," *JAMA Network Open* 8, no. 10 (October 2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2839542.

26 A. Jay Holmgren et al., "Ambient Artificial Intelligence Scribes and Physician Financial Productivity," *JAMA Network Open* 9, no. 1 (January 2026), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2843524#google_vignette.

27 Eric Preiksaitis et al., "Adoption of Ambient Artificial Intelligence Scribes in an Academic Emergency Department," *Annals of Emergency Medicine*, February 9, 2026.

28 "New Designated QHIN, New SOPs, and More," The Sequoia Project, TEFCA Recognized Coordinating Entity, December 11, 2025, https://rce.sequoiaproject.org/new-designated-qhin-new-sops-and-more/.

While the value drivers identified for UCCs are similar to those of many other outpatient enterprises, several dynamics specific to UCCs and related freestanding outpatient facilities should be taken into consideration during the appraisal process. The following discussion outlines the principal subject-specific factors that, together with the reimbursement and regulatory environment described above, shape the indication of value assigned to a UCC or portfolio of UCCs.

Scope of Services

The scope of services provided by a UCC is a key element impacting its indication of value. Common medical needs treated by UCCs include non-life-threatening illnesses (colds, influenza, simple bacterial infections); minor physical injuries (minor burns, lacerations, sprains, and certain small fractures); vaccinations (seasonal influenza and travel vaccines); school and sports physicals; and basic laboratory services, including testing for sexually transmitted infections. UCCs that expand their scope to include occupational medicine, physical therapy, behavioral health, and certain specialty primary care functions may be able to realize economies of scale: Variable expenses increase incrementally with additional service volume, while fixed overhead remains flat, lifting contribution margin up to the point where capacity constraints require additional capital investment. Further, on-site diagnostics and imaging, e.g., X-rays and EKGs, allow for immediate diagnosis and treatment, increasing revenue opportunities and reducing the need for referrals to other facilities.

Location and Capacity

Multi-location operators with regional concentration typically receive higher multiples due to scalability, brand strength, and operational efficiencies. Additionally, patient convenience and visibility are critical to a UCC's success, so location is vital. Favorable locations include areas where the patient base has ready access, near residential neighborhoods, employment centers, and schools. UCCs may be located in freestanding buildings, shopping centers, medical office buildings, or mixed-use developments. Capacity is closely related: The number of exam or treatment rooms, together with turnover rate per room, drives the upper bound of revenue for a given location. UCCs averaged roughly seven exam rooms per center in prior UCA benchmarking, though specific averages should be validated against the most recent benchmarking data in any engagement.[29]

Profit Margins and Operational Efficiency

UCCs that generate increased profit/EBITDA margins resulting from efficient scheduling, optimized provider productivity, and effective billing practices, typically indicate a higher value. Human resources costs—wages and benefits for physicians, midlevel providers, and support staff—typically represent the largest category of operating expense. Additional operating expense considerations include the size of the facility (number of exam rooms, patient volume), the UCC's ability to manage supply costs, whether the center directly employs or contracts with providers, and whether third-party management is in place. The proportion of fixed to variable expenses should be analyzed carefully, as each type of expense behaves differently under the revenue projections used to derive value. As noted above, ambient AI documentation tools have begun to reduce per-encounter documentation time meaningfully, an operational efficiency that appraisers should consider when developing prospective cost structures.

Payor Mix and Reimbursement Yield

As noted in the reimbursement discussion,[30] commercial payors continue to account for a majority of UCC volume, with Medicare and Medicaid combined at approximately 22%. This tilt toward commercial payors insulates UCCs more than many provider types from year-to-year Medicare rate volatility, though commercial rates themselves are increasingly influenced by public payor benchmarks. Appraisers should specifically examine payor contract terms, mix stability, and the share of revenue derived from cash and occupational medicine, each of which can influence both the projected reimbursement yield and the discount rate applied.

Market Rivalries and Consolidation

While still highly fragmented, the UCC industry has experienced, and continues to experience, increased consolidation through mergers and acquisitions (M&A) by hospitals, health systems, and corporate and private equity (PE)-backed operators. Consolidation reduces direct competition in local markets and has increased the number of joint ventures between UCCs and hospitals. Partnerships between UCCs, hospitals, and retail clinics improve patient flow, reduce ER congestion, and expand service offerings. Affiliation and integration among smaller UCCs may allow these providers to obtain greater negotiating leverage with managed care and commercial payors, enhancing profitability. Hospital M&A more broadly has continued

29 Urgent Care Association, "Urgent Care Industry White Paper: The Essential Nature of Urgent Care in the Healthcare Ecosystem Post-COVID-19," August 2023, https://urgentcareassociation.org/wp-content/uploads/2023-Urgent-Care-Industry-White-Paper.pdf.

30 Todd A. Zigrang and Jessica L. Bailey-Wheaton, "Urgent Care Centers: Finding Value in the Continuum of Care (Part I of II)," *The Value Examiner*, May/June 2026, 36–38.

at elevated levels. According to healthcare consulting firm KaufmanHall, approximately 43.5% of 2025 hospital transactions involved a financially distressed party—the highest share the firm has recorded—a dynamic that is pushing additional ambulatory assets, including UCCs, into the transaction pipeline.[31]

Income Approach Considerations

The income approach is often relied on for the valuation of UCCs. It is most appropriate when the UCC has a stable operating history and future profitability is reasonably expected. Important considerations include:

- Provider mix and continuity (post-transaction)
- Owner economic contributions and fair market value replacement compensation
- Capital expenditure needs
- Risk-adjusted discount rate

In developing the discount rate used to convert a UCC's projected net economic benefits to present value, appraisers must consider the opportunity cost of alternative investments and the idiosyncratic risk specific to the subject enterprise. Subject-specific risk factors for most UCCs include (but are not limited to) the uncertainty of the projected revenue stream based on the probability of achieving projected visit volume and reimbursement yield; the probability of achieving industry-benchmark operating and financial performance; the competitive dynamics of the local market (including proximity to competing UCCs, retail clinics, freestanding emergency departments, and hospital emergency departments); and the subject UCC's historical operating performance relative to benchmarks. Market analysts increasingly highlight two additional risks: (1) regulatory risk associated with PE ownership structures and state-level oversight regimes, and (2) reimbursement risk associated with commercial payor E/M downcoding programs.

Market Approach Considerations

The market approach-based M&A method is also often employed and relied on for the valuation of UCCs, at least for a reasonableness test of income approach value indications. The M&A method utilizes prices at which urgent care centers have transacted as an indication of the subject UCC's value. The EBITDA multiples for urgent care centers can vary significantly based on factors such as the center's revenue, profitability, regional density/location, and market conditions.

31 Kristofer Blohm, Courtney Midanek, and Anu Singh, "Hospital and Health System M&A in Review: Uncertainty Transitions to Continued Momentum in 2025," KaufmanHall, January 15, 2026, https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-2025-ma-review-uncertainty-transitions-continue.

Smaller, single centers are typically subject to higher operational risk resulting from decreased service offerings and significant reliance on the owner/operator. Pricing multiples for these centers can range from 3x to 7x EBITDA. Larger, multi-location centers generating annual revenue of $10 million-plus typically have increased geographic reach and profit certainty. Pricing multiples for these centers can range from 6x to 10x EBITDA or greater.[32]

Asset Approach Considerations

Asset approach-based methods focus on the value of the business's assets under hypothetical sale conditions instead of its earning potential. Therefore, these methods are generally used when the business has no established earnings or future likelihood of earnings (in other words, the business is "worth more dead than alive"). This is not the case with most UCCs. As a result, asset approach-based methods often fail to attribute adequate value to the "highest and best use" of the UCC's assets (both tangible and intangible).

Conclusion

The UCC industry has expanded exponentially in recent years, outgrown the regulatory frameworks that governed it a decade ago, and absorbed wave after wave of capital deployed by corporate and PE sponsors. At the same time, the reimbursement environment has become more intricate: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) now produces differential conversion factors; annual "doc fix" legislation has made the MPFS conversion factor effectively unpredictable from year to year; and post-PHE telehealth policy is running on short-term extensions that require periodic congressional action to avoid lapse. The regulatory environment has likewise shifted, with states such as Massachusetts moving toward direct licensure of UCCs as a facility category.

For appraisers, these developments mean that several traditionally "stable" assumptions—payor mix, reimbursement trajectory, regulatory overhead, and competitive intensity—now require fresher data and more careful scenario analysis than they did in the prior cycle. The ability of UCCs to operate in a continuum of care under a value-based reimbursement paradigm, their comparative insulation from Medicare rate risk, and their emerging role as platforms for ambient AI documentation and virtual care all suggest continued strategic relevance in the outpatient delivery system. Whether the sector's recent wave of consolidation ultimately produces the operational efficiencies and margin expansion that have driven peak-cycle valuation multiples, however, remains to be seen. VE

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32 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.