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## 5 URGENT CARE MODELS TO KNOW FOR 2015

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April 27, 2015

## Overview.

Urgent care centers (“UC’s”) provide walk-in, extended hour access for acute illness and injury care that is typically beyond the scope or availability of the standard primary care practice or retail clinic. This highly fragmented industry is continuing to experience some of the largest growth rates in healthcare. From 2007 to 2012, urgent care industry revenues grew at an average annualized rate of 6.3 percent to an estimated \$13.7 billion. Over the same period, the number of UC’s has grown by an average rate of 4.4 percent per year to over 9,000 centers. It is projected that an additional 3,000 urgent care centers will be added to these numbers over the next five years and revenues will exceed \$17.0 billion.

This rapid growth is being driven by the healthcare consumer’s continued desire for accessible and affordable medical care and has been accelerated by patient frustration over the extended wait time to get an appointment with a physician and the high cost of seeking non-emergent care at hospital emergency rooms. While still fragmented, the UC industry has seen rapid consolidation over the past few years. According to the Urgent Care Association of America, 53% of all urgent care companies operate one site and only 20% operate more than four. However, as of 2013 nearly 33% of UC’s were owned by corporations up from 13.5% in 2009, and physician ownership had declined over this same time from 50% in 2009 to only 27% in 2013. It is expected that consolidation will continue as financial investors see continued opportunity and health systems and payors seek partnership and alignment strategies to fill the gap between appointment-based practitioners and the ER as well as support the development of accountable care organizations focusing on population health management, continuity of care, and bundled payments.

This article will briefly outline the various business models currently being deployed in the urgent care sector along with some thoughts on the risks and opportunities in each sector. Historically, urgent care was founded as more cost-effective, convenient alternative to the emergency room for non-emergent, episodic injury and illnesses. Models have evolved but the pure-play urgent care provider is still the predominant operating model in the industry.

### A. Pure-play Model.

The pure-play UC model is the standard model where providers serve as the intermediary between an emergency room and physician office in a moderate-to-highly populated area. Pure-play operators believe this model has several benefits over others. For starters, operators have been able to streamline the clinical model to a hyper-efficient model that boasts wait times well under one hour from check-in to check-out. In addition, given narrow focus on episodic cases solely, operators have been able to use staffing models more reliant on mid-level providers, which generally create higher operating margins. This model and focus is easily replicable through a de novo or acquisition strategy. Finally, there is great diversity of the players using this model such as payors, hospitals, institutional organizations and regional chains.

However, this model has seen significant challenges from newer models that are evolving as well as increased competition. With the rapid expansion of the industry, many operators have found it difficult to solely focus on pure urgent care needs and remain profitable. Acquisition targets are getting more expensive along with the cost of operating assets. Further, even the most experienced operators face challenges with de novo businesses and chain-building projects given the diversity

of practices. Ancillary to growth, some states have begun to take a strong interest in figuring out how to increase regulation of the UC industry. Additionally, other healthcare providers, such as hospitals, feeling regulatory pressures look to expand into low-cost places of care delivery and compete with urgent care in saturated markets.

Despite the challenges, many still believe the pure-play urgent care has its place and can continue to thrive particularly in larger, metro markets, where proximity and convenience are the driving forces in care decision-making.

## **B. Rural Model.**

The rural UC model is similar to the pure-play UC model except that the clinics are in rural, sparsely-populated areas.

The advantages of the rural UC model are that the UC operator can become integrated into a community and be known as the leading provider of quality care. The country continues to face access to care issues in rural areas, and so there is a real demand for rural urgent care services. Rather than facing hospitals as competitors, UC operators will have the opportunity to collaborate with them as extensions of the hospitals' reach to service their patient populations. Additionally, there is currently a lot of green space for UC operators to claim.

The disadvantages of the rural UC model include the difficulty to develop a uniform regional brand if geography makes integration difficult. Specifically, common management and shared employee arrangements would not work if clinics were 50+ miles apart.

As long as health care is scarce in rural communities, there will be a great need for the rural UC model. It remains to be seen whether UC operators can effectively build a large regional chain based on this model.

## **C. Hybrid Model.**

The hybrid UC model involves a medical practice that accepts scheduled patients and walk-in patients. These practices could be storefront practices or the standard doctor's offices.

The hybrid UC model allows primary care physicians to build their practices in a flexible manner where the physicians can offer convenience to their current patients, while providing an attractive option for securing new patients. The hybrid UC model is often overlooked, but may become the preferred model for primary care physicians looking for an option other than joining a hospital system in the next five to ten years.

The risks to the hybrid UC model include the larger overhead required to staff the office to handle both scheduled and walk-in patients. Physicians may need to work longer hours and there would likely be additional physicians needed to provide practice support and call coverage.

Overall, the hybrid model may offer struggling primary care practices an option to diversify and others to reject further integration with a hospital or larger physician group.

## **D. Pediatric Model.**

The pediatric model follows the pure-play model, but focuses on care of pediatric patients.

The pediatric model is highly specialized and can draw patients in any market, whether or not such market is already saturated with other UC providers. UC operators can also cater to all aspects of the business from the providers available to the office space to distinguish itself from other providers. It will also provide a quick outlet for the often injury-prone children whose parents clog local hospitals' ERs. Parents in today's society will spend tremendous amounts of money on their children whether it's for day care or medical care.

The risks of this model would be that certain markets may not have a large enough pediatric population to support such specialized care. There also has regulatory scrutiny in other pediatric care areas such as the pediatric dental space that may carry over into medical care.

While the pediatric model remains untested in many markets, these providers should find opportunities in most metropolitan and suburban areas.

## **E. Onsite Model.**

The onsite model involves healthcare providers and mobile or fixed clinics onsite at large employers and organizations.

These large institutions will have the benefit of immediate care for their employees, while the UC providers will be able to capture a significant numbers of patients. Providers and operators may also develop mobile units that could lower overhead and provide more convenient care to address changing needs of the host institution. Finally, the onsite model will provide employers attractive low-cost healthcare options that not only allow them to control the initial point of access to healthcare, but also may have a hand in directing the sites of future treatment for such employees.

The risks of utilizing this model will be that the UC providers and operators will be concentrated with a smaller number of large employers that could be susceptible to market shifts and business pressures.

As employers and other large organizations look to cut costs, we expect to see an increase in the utilization of this model to provide cost-effective care to their employees and other dependents.

## **Conclusion.**

The pure-play model will continue to be the dominant model in the UC marketplace, while physicians increasingly will look to the hybrid model in light of ACA implementation, reimbursement concerns and market concentration. Further, it is doubtful that the pure-play model will be unseated by the other three models since each of these target specific populations that would not necessarily compete with the pure-play model in a metropolitan or suburban area. If you have any questions regarding how to structure one of these models, please do not hesitate to reach out to one of the authors.