Urgent Care at the Crossroads: Eight Critical Issues Affecting Urgent Care in 2015

Alan A. Ayers, MBA, MAcc is Practice Management Content Advisor and serves on the Board of Directors of the Urgent Care Association of America, is Practice Management Editor of *The Journal of Urgent Care Medicine,* and is Vice President of Concentra Urgent Care.

The rapid growth of urgent care over the past ten years has been fueled by patient demand for convenient, accessible, and affordable medical treatment. In the face of a growing primary care physician shortage and emergency room overcrowding resulting in long waits to see a doctor, that patients can be seen right away, in their neighborhood, and on their own time has created a new generation of health care consumers who see urgent care as their preferred "medical home." And with few barriers to opening new centers, physician entrepreneurs, private investors and hospital systems have pounced on the opportunity by creating and refining their own consumer-centric delivery models.

The challenge is that unlike oncology, pathology, orthopedics, and other medical "specialties," urgent care is "general medicine" that does not meet an ongoing, specific, unique medical need but is instead a delivery model based current consumer preferences. Thus, the urgent care "industry" may be vulnerable if consumer needs and underlying market forces start to change. Follows are some structural changes already affecting urgent care centers across the country:

- **Over-saturation of urgent care centers in the suburbs of major cities while rural and urban areas remain under-served.** Urgent care centers are generally considered "doctor's offices" without any licensure or regulatory process in most states to limit the number of locations. This lack of specific regulation combined with a relatively low cost to build out and equip a new center means entry barriers are few. Because urgent care is a volume-driven business, profitability requires sufficient employment or residential density to support a center. As a consumer driven phenomenon, urgent care's growth trajectory has resembled that of "retail" with entrepreneurs staking out the most desirable demographics. As a result, we're seeing some "over-saturation" of urgent care centers in the high-density, affluent suburbs of major cities. When more centers open in a community than the population density can support, odds increase that some of the new entrants will fail.

  Meanwhile, many rural and urban areas remain without urgent care access. One reason is that Medicaid in many states has not recognized the urgent care operating model—treating it like a primary care medical home with reimbursement that doesn't cover an urgent care center's operating costs or with requirements like pre-authorization, 24-hour on-call access, or hospital admitting privileges that are not consistent with the practicalities of a walk-in, episodic model. And while we have seen some urgent care operators succeed in secondary communities, they often do so by adapting their clinical staffing, reducing their operating hours, or expanding their scope of services beyond episodic walk-in.

- **Blurred lines and consumer confusion between urgent care, walk-in family practice, retail clinics and freestanding EDs.** In the past, urgent care has been described as "a lower-cost alternative to the emergency room," or "after-hours/overflow for primary care," but when evaluating competition in a given community, an urgent care operator must consider each and every venue that is available to treat a patient's medical need. Increasingly, large pediatric and family practice groups have extended hours to evenings and weekends, leaving some appointments open each hour for walk-ins. Retail health clinics such as those in Walgreens, CVS, Target and Walmart have extended their scope of services beyond basic vaccinations and first aid to include work-related physicals and management of chronic disease. Freestanding emergency departments promote zero wait for the cost of a hospital ED co-pay. Not only has all of this new competitive activity bombarded consumers with messaging on where to go should a medical need arise, it has also resulting in confusion among consumers, payers and regulators as to what exactly constitutes and differentiates "urgent care" from other, unscheduled walk-in models of care. With more "hybrid" models evolving—ranging from urgent care centers staffed only by physician assistants to urgent care centers with advanced imaging and observation capabilities—confusion as to when and why to use urgent care will only increase.

- **Existing centers struggling for profitability and private equity investors having difficulty scaling the operating model.** Being a "volume driven" business means that an urgent care center must achieve a minimum number of visits to cover its costs, with each incremental visit contributing to the center's bottom line. When an investor opens

one or multiple centers in a short time span, the expectation is those centers will generate "red ink" until break even volume is attained. Until a center "breaks even" its operating losses are absorbed by "working capital" provided by the center's investors. Exhausting working capital is the number one reason for urgent care center failure. When a center does not hit this break even volume on schedule, it must either secure more capital, reduce its costs by reducing its hours or staffing, or it must expand its services to drive revenue from services other than walk-in urgent care.

The time for urgent care centers to break even is becoming longer with increased competition, greater difficulty in finding "prime" locations, and with higher clinic operating costs. In addition, we're seeing that private equity is having difficulty scaling its investments because the urgent care operating model is location based with centralized billing and administrative functions accounting for a relatively small share of a center's overhead. Given that private equity is conventionally attracted to high margins and fast growth (i.e. computer software) or turnaround stories, there are signs that lackluster profitability from urgent care investments is precipitating the cash out of some private equity activity in recent years with hospitals as the most likely buyers.

- **Hospitals operating urgent care centers as "loss leaders" to drive downstream referrals.** Many hospital systems see urgent care as a way to "capture" new patients, many of whom will require diagnostic studies, specialist consults, surgeries, and physical rehab offered by the health system. While independent and private equity owned urgent care centers must turn a profit at the actual walk-in clinic, hospitals can justify investment in urgent care based on the center's "downstream revenues." In addition to deep pockets and a low cost of funding, hospital systems have other advantages including the "brand halo" of the hospital's reputation, charity care and community benefit programs leading to tax-exempt status, integration of electronic medical records across services, and "captive" primary care groups who will refer patients to the urgent care center. With a quarter to one-third of urgent care centers operated by hospitals, there is room for health systems to grow their urgent care footprint but with a different financial model, non-profit hospitals benefitting from "downstream revenues" perhaps can endure in competitive environments longer than entrepreneurs who must make a profit to survive.

- **Cheaper, more convenient options including telemedicine from home, employer worksites, primary care at home, etc.** Urgent care may cost less and have shorter wait times than the hospital emergency room but it's not always the "cheapest" or "most convenient" alternative for patients and payers. This year, KentuckyOne Health launched "Anywhere Visits" in which a patient anywhere in the Commonwealth can have a one-on-one consultation with a nurse practitioner using telephone and webcam for $35. There are similar subscription-based services, such as Teledoc, which are being bundled with insurance benefits. While telemedicine is a potential source of referrals to urgent care for patients requiring an in-person evaluation, more likely is that patients will skip urgent care altogether if they can resolve their medical issues from home. This means that urgent care centers will have to focus on treating higher acuity patients and that a center's differentiation is its ability to perform minor procedures.

  Self-insured employers, rather than paying for network medical utilization administered by a third-party, are now directly paying for more of their employee's health care through clinics located at their worksites. And for consumers more sensitive to time than cost, concierge medicine, at home consultations and even freestanding emergency rooms promote their time-saving benefits. As the pace of competition accelerates, urgent care must continue to evolve its value proposition beyond "time and cost savings."

- **Case rate which dis-incentivizes the needed higher acuity visits that enable urgent care as "ER diversion" in favor of low-acuity, low-touch, episodic which can be treated for lower cost elsewhere.** Fee-for-service is a reimbursement scheme that pays providers for each of their billable activities. Critics claim fee-for-service has an inherent conflict of interest because a provider can increase his/her pay by performing more procedures, x-rays, lab tests, etc. By contrast, "case rate" (a.k.a. "flat fee" or "global rate") reimburses a clinic the same amount for all visits, realizing that the clinic will make more under case rate for low acuity visits but will make less for higher acuity visits and procedures. Case rates should be set according to an "average" visit mix so as not to disadvantage a clinic versus fee-for-service. Increasingly payers, particularly national payers, are offering only case rate contracts for urgent care. The issue is that, over time, urgent care centers become incentivized to control costs by skipping lab tests, not staffing an x-ray technician during slow hours, or by referring more complex and time-consuming cases to

the emergency room. Followed to its end conclusion, this type of behavior puts urgent care more on par with "retail clinics" than "alternative to the emergency room" in its competitive positioning. Yet, urgent care has higher operating costs than other low acuity venues. Case rate can effectively lead an urgent care to fall in the acuity of patients treated whereas with increased competition for low-touch visits, urgent care really should be looking to increase its capabilities to serve higher acuity patients and better differentiate from competitors.

- **Difficulty in recruiting and staffing centers with providers.** In urgent care, the "physician" is the "product" and clearly a center cannot see patients if there is no provider present. While a shortage of primary care physicians may be driving some patients to urgent care, the challenge is that the same primary care physicians are needed to staff the urgent care center. In the short-term, higher reimbursement and greater scheduling flexibility make urgent care appealing for physicians considering leaving primary care. By contrast, emergency physicians typically find higher pay and better benefits at the hospital.

  Ultimately, the story is increasing patient needs pressuring fewer available provider resources. We're already seeing urgent care centers in some states struggle with physician recruiting and retention. Operating hours end up being set not by consumer demand, but by what the urgent care operator can staff with clinicians. Other centers deal with providers who lack good patient manner and turn off patients long-term. A shortage of physicians can drive up wages, lead to increased use of locums which can affect patient care delivery, coding and labor costs, and lead to increased use of mid-level providers which then changes the scope and acuity of the urgent care practice. Difficulty in recruiting and retaining providers has also been a factor limiting private equity's ability to scale their urgent care investments.

- **Independent operators with fee for service operating models getting shut of out ACOs/skinny networks under "Obamacare." Lack of experience with capitated or risk models in urgent care.** One of the defining features of the Affordable Care Act is creation of Accountable Care Organizations in which physicians, hospitals, and health plans share financial and medical responsibility for providing coordinated care for patients with the intention of controlling costs. ACOs tie in to managed care in which patients are directed by a third party to the most appropriate in-network option for their medical need. In the past, urgent care centers contracted with insurance plans as fee-for-service providers could rely upon a steady flow of in-network patients with dependable urgent care reimbursement. But as health plans integrate with hospitals and physician groups and reimbursement takes a "whole patient" approach, we're hearing of instances in which independent urgent care centers are being completely dropped from networks who want to steer patients to after-hours options within the ACO. Patient behavior is to not pay for services they believe insurance should cover so when an urgent care center goes out-of-network, its patients typically migrate to centers that accept their benefits. Independent urgent care centers with a fee-for-service financial model also have difficulty pricing their services when reimbursement is a set capitation per patient or based on taking risks related to medical utilization and outcomes.

  One of the hopes of the Affordable Care Act has been that a greater number of insured consumers would result in greater overall utilization of urgent care. But in addition to employer-provided plans raising employee out-of-pocket responsibility, many of the insurance options in the online Health Insurance Marketplace are high-deductible, narrow-network plans which mean many of the "newly insured" will be paying for urgent care themselves. For these "newly insured patients," urgent care centers are seeing higher accounts receivable balances and write-offs if they don't have the right processes in place to assess and collect patient financial responsibility at the time of service. And last, many of the newly insured under "Obamacare" are on Medicaid, which for reasons provided excludes many urgent care centers.

Conclusion

As Bob Dylan put it, "the times they are a changing." In the face of rapid change, the risk of "staying the current course" is that urgent care becomes undifferentiated from competitors, its value proposition is undermined by cheaper and more effective options, or that urgent care gets shut out of integrated and coordinated systems of care. The ability of urgent care to continue to grow, provide a financial return to investors, and meet the medical needs of patients will

depend on whether the industry's constituents recognize what's taking place in their operating environments, understand the impact on their delivery models, and devise plans to adapt and evolve.