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

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Objectives

At the conclusion of this session, participants should be able to:

- Evaluate the impact upon their local operations of eight critical issues affecting the urgent care industry;
- Develop a strategy for connectivity with the emerging health care ecosystem;
- Assess the service offerings and technology platforms of successful urgent care providers;
- Differentiate their centers amidst increasing urgent care and non-urgent care competition; and
- Revise the center’s business plan, strategy and culture to enable future growth and profitability.

Urgent Care: The Brand

Consumers generally view all urgent care centers as "equal." Few centers have established differentiated brands.

Urgent Care Business Drivers

Patient Demand

- On-demand access
- Neighborhood convenience
- Walk-in, after-hours, short wait times
- Retail customer service orientation
- Increasing co-pays, deductibles and co-insurance

Physician Shortage

- Shortage of physicians in primary care specialties
- Many patients lack a PCP relationship
- Low reimbursement and heavy case loads in PCP offices
- Long waits in the ED or to get a PCP appt.

Investment Dollars

- Retail and technology have “matured” as investment themes
- Aging, obese and increasingly ill population
- Greater numbers of insured w/out-of-pocket responsibility
- Few entry barriers for new centers

“Urgent Care” is a Place; Not a Condition

- Urgent care does not meet an ongoing, specific medical need
  - Compare to Oncology, Immunology, Orthopedics, etc.
- No unique or differentiated clinical body of knowledge
  - Borrows from family practice, emergency medicine, and occupational/preventive…among others.
- Not structurally “locked in” by regulation and institutions
- A treatment venue based on consumer convenience
  - Retail in orientation and subject to consumer preferences
  - Model can be at risk if consumer or payer behaviors change

Issue #1 Over-Saturation of Key Markets

- Urgent care is a volume driven business.
  - Revenue = Reimbursement Times # of Visits
- Attaining high volumes requires high population density.
- Populations who use urgent care tend to skew up-market:
  - Premium placed on time
  - Visits covered by private insurance
  - Marketing target has been “soccer mom”
- Like any retail business, urgent care investors are attracted to the fast-growing and affluent suburbs of major urban areas.
  - Dallas, Houston, Phoenix, Baltimore/Washington, etc.
- Urban and rural areas remain “underserved” because they cannot support the business model.

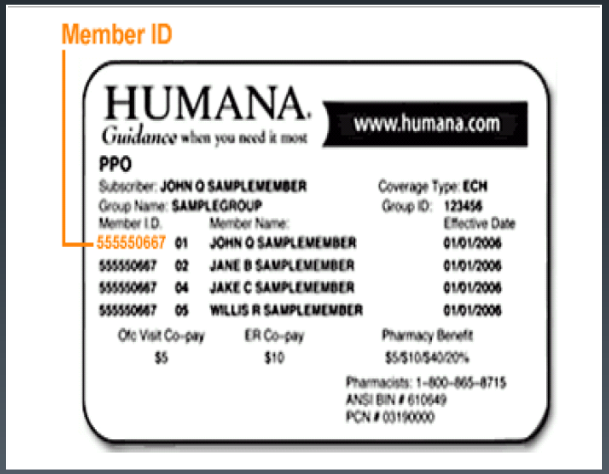
Consumer Urgent Care Demographics

Married Couple with Children Present

College Graduate Age 35-54

Owner-occupied Single Family Housing

Growing Suburbs of Major Metro Areas



Employer-Provided Health Insurance

Household Income $50,000 to $100,000

Medicaid and Urgent Care

- Coverage of “uninsured” has entailed an expansion of state Medicaid programs.
- Some Managed Medicaid payers have embraced urgent care as a cost-saving mechanism and include Managed Medicaid with their HMO, PPO, POS, etc. contracts.
- “Straight” Medicaid tends to be based on a Primary Care Medical Home Model:
  - Pre-authorization for urgent care visits;
  - 24-hour after-hours coverage;
  - Hospital admitting privileges;
  - Other requirements inconsistent with an episodic, walk-in model.
- Medicaid reimbursement is often too low to cover urgent care operating costs.
- Result is no on-demand option provided Medicaid populations except for the emergency room.

Competition: Any Option Available to a Consumer

Charleston, SC Population: 127,000 (664,000 in MSA)
Number of Urgent Care Centers: 44

Issue #2 Blurred Lines Between Walk-in Providers

- Urgent care is a “lower cost alternative to the emergency room” and “overflow/after-hours for primary care.” So is…
  - Family Medicine Group Practice w/Extended Hours and Walk-in Appts.
  - After-hours Pediatrics w/Moonlighting Docs in a Retail Setting
  - Nurse Practitioner Clinic inside a Food/Drug/Mass Retailer
  - Freestanding Emergency Room Center
  - Hybrid models:
    - Urgent care center staffed only by mid-levels
    - Urgent care center open 24 hours with advanced diagnostics and observation capabilities
    - Occupational medicine center with incremental urgent care
- Urgent care’s value proposition gets confused and diminished by so many competing options, some of which are more convenient and cost less than urgent care.

Issue #3 Existing Centers Struggling for Profitability

- "Volume-driven" means:
  - A minimum number of visits are required to cover the center's variable operating costs
  - Each incremental visit contributes to the bottom line
- Organic growth occurs through signage, advertising, word-of-mouth, and repeat business from loyal patients
- Centers sustain operating losses until break-even volumes are attained
- Operating losses are absorbed by the center's working capital
- Exhausting working capital prior to break-even is the top reason why urgent care centers fail

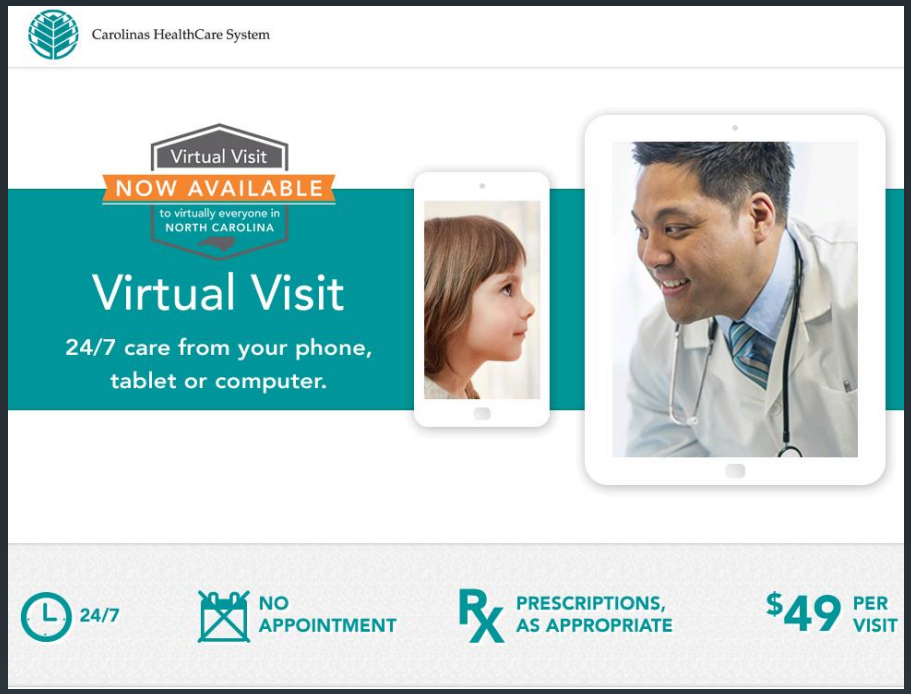
Issues w/Private Equity Investment

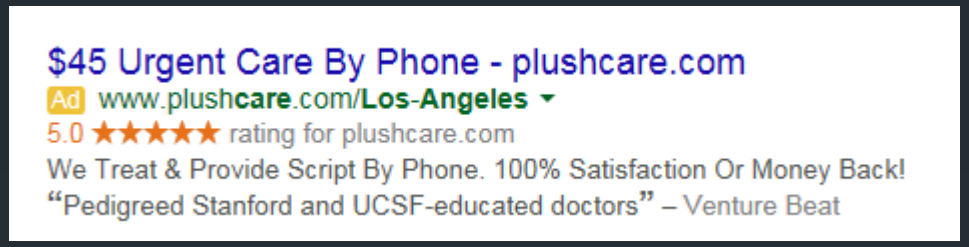
- Private equity is historically attracted to fast growth and high margins (computer software, high technology, fashion) and turn-around stories (leveraged buy-outs).
- Timeline to break-even in urgent care, when multiplied by numerous centers in a rapid expansion, can spell accelerating red ink.
- It's taking longer for de novo centers to achieve break-even volumes from organic growth:
  - Increased number of competitors w/their own loyal patients
  - Difficulty in finding "prime" real estate
  - Increased operating costs, especially for providers
- Overall difficulty in scaling the operating model:
  - Location-based business dependent upon a local doctor in the center
  - Centralized administrative and billing functions are a small percent of total operating costs
  - Time and resources to achieve critical marketing mass
- When private equity cashes out, hospitals will be the most likely buyers.

Issue #4: Hospital Urgent Care as a Loss Leader

- One quarter to one-third of urgent care centers operated by hospitals today provides plenty of room to grow.
- Entrepreneurial urgent care operators must turn a profit at the point of service whereas hospitals can justify urgent care as a means of “capturing” new patients for “downstream” revenues:
  - Imaging, specialist consults, surgeries, physical rehab
  - Seamless integration via shared electronic medical record
  - Referral network of “captive” PCP providers
- Hospital “brand halo” resonates “quality” with consumers.
- Hospitals can endure competitive environments longer than independents:
  - Deep pockets, low cost of funding, tax-exempt status, payer leverage
  - Provider bench/recruiting capability

Issue #5: Telemedicine from Home





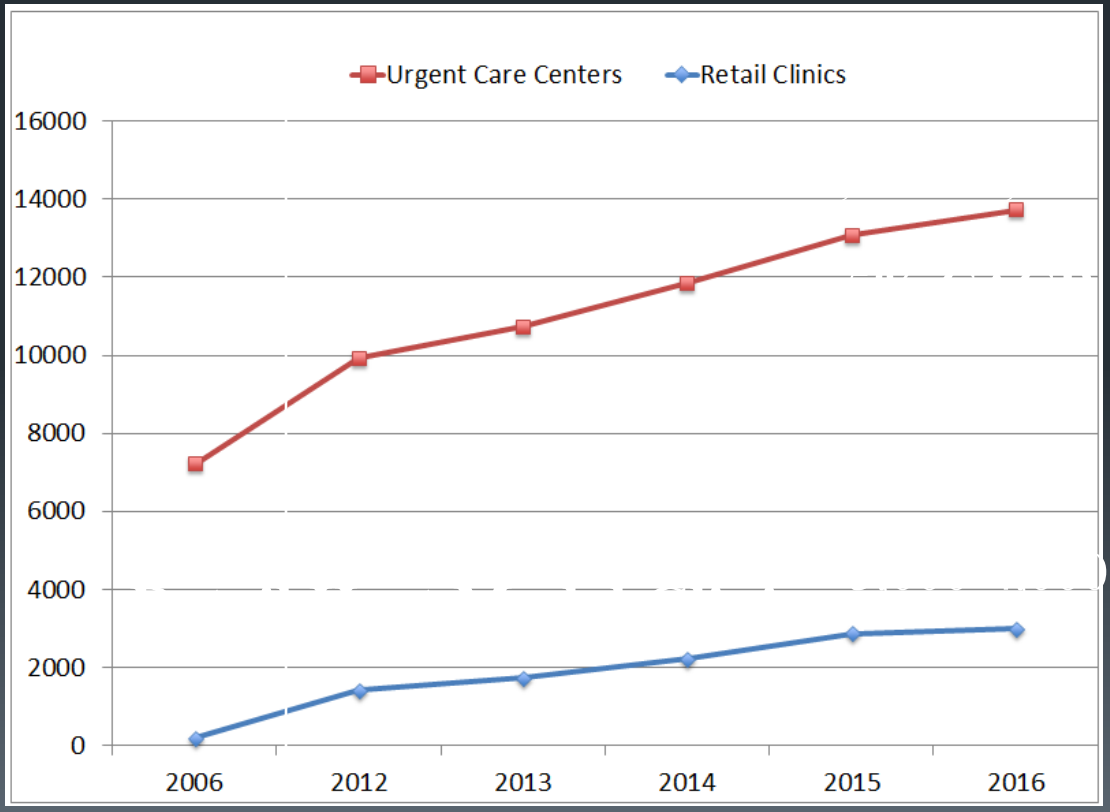
- Cheaper and more convenient than urgent care?
- Issue of trading high NRV urgent care visits for low NRV telemedicine consults.
- State restrictions on ability to prescribe to a patient via telemedicine, if no previously established relationship (Texas).

Issue #6: Case Rate

- Fee-for-service “conflict of interest” is increasing reimbursement by providing more reimbursable services, including “defensive medicine.”
- Case rate provides a flat fee per urgent care visit, generally $115-165:
  - E/M code must be billed
  - Includes all services, supplies, medications/vaccinations, lab and x-ray
  - Center makes more money on low-acuity visits and less on more complex visits
- Behavior to maximize profits under case rate:
  - Staff with mid-level providers
  - Use diagnostic services sparingly (don’t staff RT during slow periods)
  - Refer complicated/time-consuming cases to the emergency room
- True “ED Diversion” requires a higher acuity of care (stat labs, observation, advanced imaging, IV hydration, etc.).
- Case rate incentivizes a lower acuity of care, leading to little differentiation from retail clinics (despite urgent care’s higher operating costs).

Issue #7: Difficulty Recruiting and Retaining Doctors

Urgent care benefits from the shortage of primary care providers but it's also dependent on the same primary care workforce to staff centers.



Issue #8: Closed/Skinny Networks and ACOs

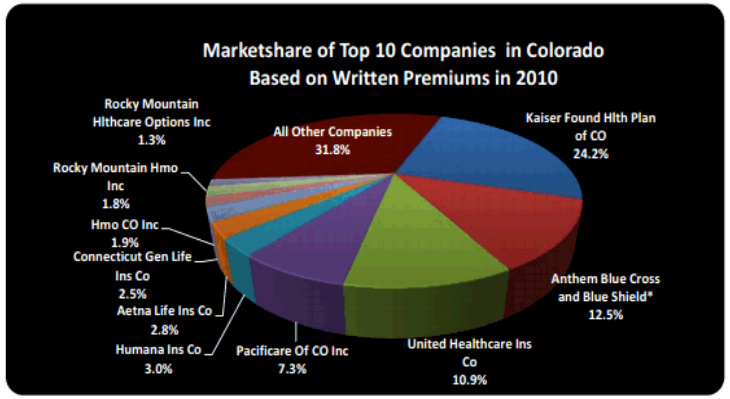


Figure 9: Marketshare of Top 10 Companies in Colorado Based on Written Premiums in 2010

Company	2010 Written Premiums	2010 % of Market Share
Kaiser Found Health Plan of CO	2,404,286	24.2%
Anthem Blue Cross and Blue Shield*	1,240,068	12.5%
UnitedHealthcare Ins Co	1,084,157	10.9%
Pacificare Of CO Inc.	727,762	7.3%
Humana Ins Co	299,981	3.0%
Aetna Life Ins Co	274,023	2.8%
Connecticut Gen Life Ins Co	249,833	2.5%
HMO CO Inc.	187,936	1.9%
Rocky Mountain HMO Inc	177,882	1.8%
Rocky Mountain Healthcare Options Inc.	130,364	1.3%
All Other Companies	3,148,830	31.8%
Total	9,925,122	100.0%

Table 18: Market Share of the Top 10 Health Carriers in Colorado[12]

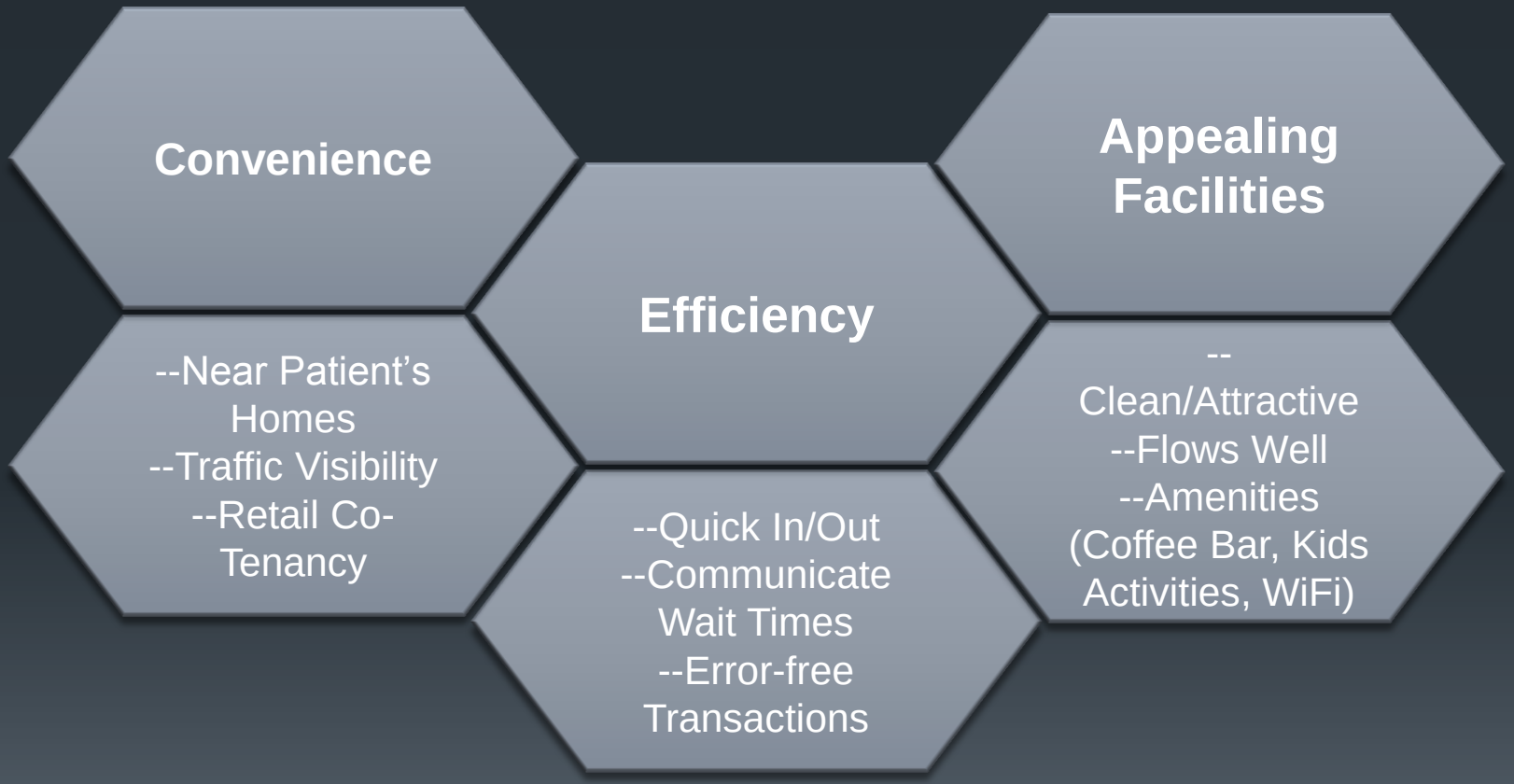
The New Insurance Marketplace

- Fee-for-service urgent care lacks experience with capitated/risk-/value-based reimbursement methods.
- Accountable Care Organizations control costs by limiting access to network providers and directing care within a primary care medical home model.
- High-deductible plans result in high write-offs for urgent care centers lacking front office processes to verify and collect patient financial responsibility at time of service.

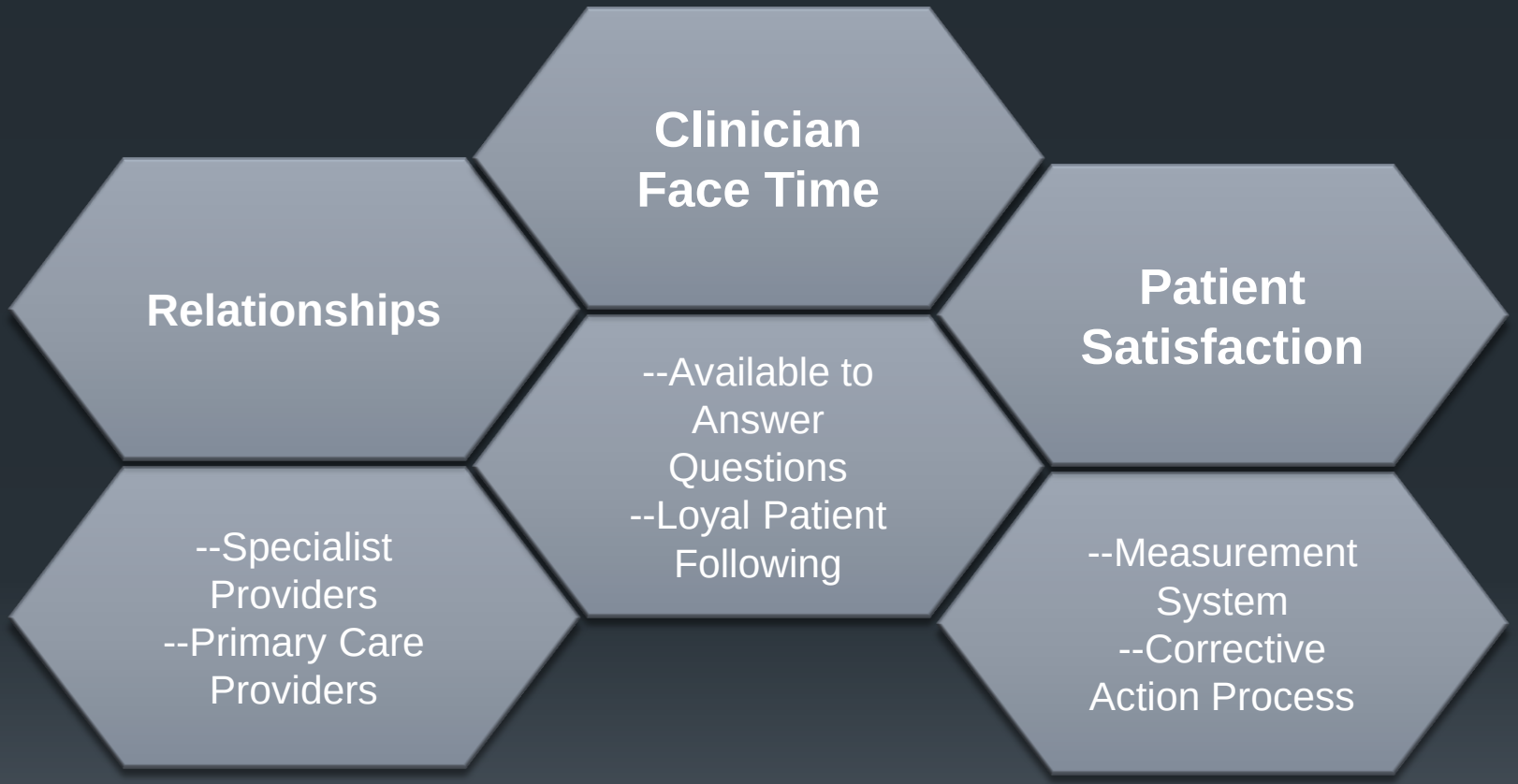
Urgent Care Industry Today	Future of Urgent Care
• Stand-alone entrepreneurs; some regional platforms	• Integrated with payers, accountable care organizations, health systems and multi-specialty groups
• Fee for Service Evolving to Case Rate	• Capitation, Outcomes Based Payment
• NO BRAND DIFFERENTIATION	• BRAND LOYALTY BASED ON POSITIVE PATIENT EXPERIENCE
• Walk-in location-based service	• Multi-channel including at home, at the employer and via telemedicine

Urgent Care Industry Today	Future of Urgent Care
• Sole physician with support staff	• Teams of physicians, mid-levels, nurses and technicians
• General practitioner	• Generalists and specialists or specialized urgent care facility
• Episodic one-touch limited focus on cold/flu, allergies, minor infections and minor injuries, referring out for follow-up	• Expanded capabilities to follow a case from intake to resolution; access point to the tertiary health care system
• Defensive of the business model	• Evolving and changing in response to consumer needs and open to a range of operating models

Characteristics of Successful Urgent Care Operations



Characteristics of Successful Urgent Care Operations, cont'd.

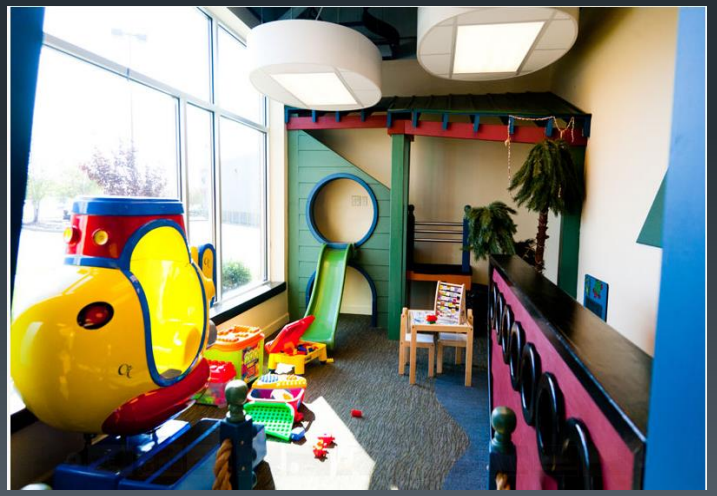


Identifying Best in Class Examples

PatientFirst: Primary/urgent care integration.

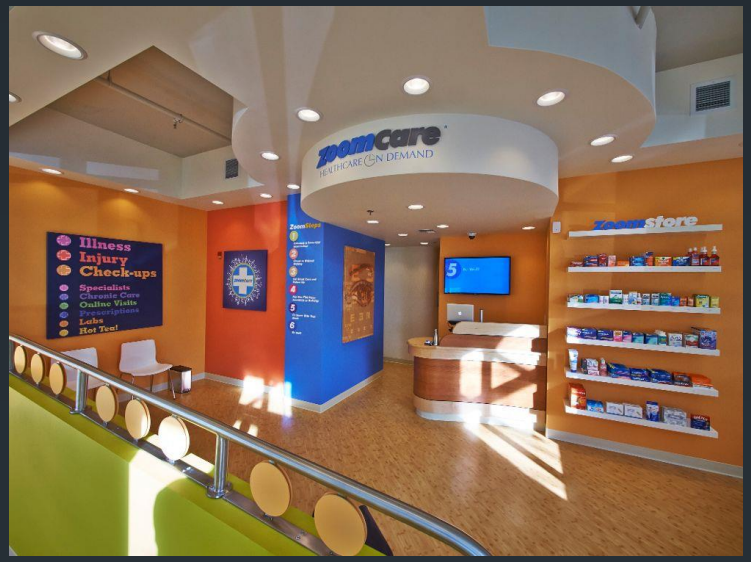
CareNow: Web Check-in, Mobile App

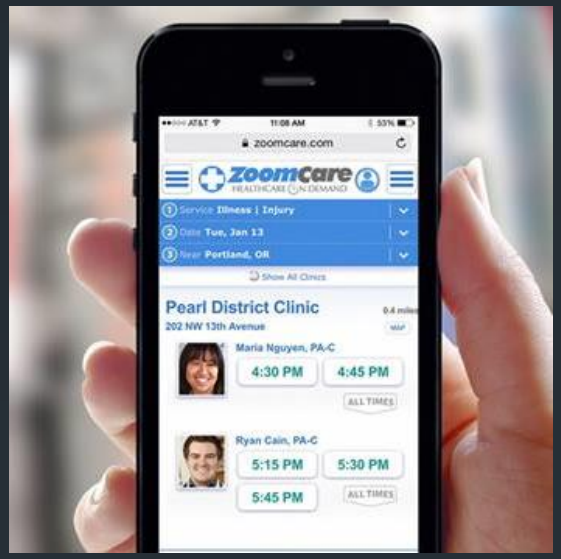
HealthCARE Express: Community engagement/grassroots marketing.



Physicians Quality Care: Waiting room experience (Play Areas, Movie Theater).

Identifying Best in Class Examples, cont'd.





ZoomCare:

- **High visibility retail locations with dense market footprint**
- **Extended hours as late as 12:00 am**
- **Virtual visits (Telemedicine from Home) via Skype**
- **Online scheduling, provider bios and extensive patient portal capabilities**
- **Posted/transparent pricing**
- **In-center dispensing/retail sales**
- **Zoom Health Insurance covering clinic visits plus network access for higher acuity care.**
- **Integration of medical specialists, primary care, pediatrics, chronic condition management, mental/behavorial health, physical therapy and naturopathy services.**
- **Nurse practitioner/physician assistant staffing for walk-in urgent care**
- **Community engagement ("Free Nights")**
- **Hospital concierge program**

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