AMPLIFY

Amplify Your Leverage: Using Data to Reshape Payer Contracts and Market Entry

Tammy Mallow, CEO Mallow Consulting

Speaker

- Tammy Mallow
- CEO, Mallow Consulting, LLC
- Mallow.consulting@gmail.com
- 417-353-9069

Game Plan for Today

- Discuss policy and importance of advocacy
- Discuss how we can use data and technology to more effectively negotiate payer rates and terms.
- Talk about alternatives to additional revenue – without payers.
- Leave you with ideas on how to navigate the whole process.

Advocacy

Master Policy Tracker: POP / Parity + Site-Neutral Reimbursement	
Workbook Purpose	Tracks current policy and advocacy activity tied to (1) payer-owned/provider-owned parity issues and (2) site-neutral / hospital-owned outpatient reimbursement issues.
How to Use	• POP / Parity Tracker: insurer-provider ownership, downcoding, and related reimbursement policy. • Site-Neutral Tracker: hospital-owned vs independent outpatient payment, facility fee limits, and model legislation. • Distortion Framework: simple map for presentations and payer strategy. • Talking Points: paste-ready advocacy and negotiation language.

Policy is Reshaping Reimbursement

⚖️ **Site-Neutral Payment Policies**
Same service → same reimbursement
Reduces hospital vs independent rate gaps
Impacts system pricing advantage & UC competitiveness

🏛️ **POP (Provider-Owned Practice) Legislation**
Addresses different payment for affiliated vs independent providers
Pushes **transparency + payment parity**

📉 **Payment Parity / Transparency Movement**
Scrutiny on higher system rates for same services
Driven by **employers, legislators, and CMS data**

But First…

Give Yourself a Raise

- How many are confident your RCM team is collecting 100% of what is owed to you?
- If not – you need to get there.
- Negotiating with a payer is much harder than giving your self a raise.

Standing Still = Moving Backwards – The Cost of Not Negotiating

2.8+ Million Dollar Reimbursement Shortfall

*Had reimbursement kept pace with CPI, My Urgent Care would have received an additional $2,869,270 in revenue.

This shortfall represents a direct loss in resources that could have been reinvested into access, staffing, and patient care.

Year	CPI Value	$ Difference	Volume	Loss
2017	$133	($3)	1,200	$(3,276.00)
2018	$136	($6)	1,350	$(7,992.00)
2019	$138	($8)	2,098	$(17,560.26)
2020	$140	($10)	3,261	$(32,707.83)
2021	$147	($17)	5,068	$(84,179.48)
2022	$158	($28)	7,876	$(223,205.84)
2023	$165	($35)	12,240	$(426,319.20)
2024	$170	($40)	19,023	$(762,822.30)
2025	$174	($44)	29,565	$(1,311,207.75)
Total				$(2,869,270.66)

CPI Inflation Calculator : U.S. Bureau of Labor Statistics

Small Changes = Big Impact

Small Rate Changes = Big Impact

No Volume Growth Required

+3% rate increase → ~$115K/year
+5% rate increase → ~$192K/year

👉 *Same patients. Same operations. Just better rates.*

This Is a 6-Figure Decision

Most providers focus on volume…

But rate optimization alone drives meaningful growth

💡 Many urgent cares are 10–30% below market and don't realize it

Example Only – Impact will vary based on practice dynamics and resource costs.

ROI of Renegotiation

Typical investment: ~$10K

Annual impact: $100K–$200K+

👉 ROI: ~10–15x

Payback Period

~$464/day impact from improvement

Break-even: ~3 weeks

The Takeaway

3–5% sounds small…
until it becomes **a six-figure decision**.

Total Volume per Day	270			**Payer Visits per Day**	81
Payer Share of Visits	0.3			**Current Daily Revenue**	$10,530.00
Current Rate per Visit	$130.00			Current Annual Revenue	$3,843,450.00

Increase %	New Rate	Payer Visits/Day	Annual Revenue	Incremental Annual Revenue
0%	$130.00	81	$3,843,450.00	$0.00
1%	$131.30	81	$3,881,884.50	$38,434.50
2%	$132.60	81	$3,920,319.00	$76,869.00
3%	$133.90	81	$3,958,753.50	$115,303.50
4%	$135.20	81	$3,997,188.00	$153,738.00
5%	$136.50	81	$4,035,622.50	$192,172.50
6%	$137.80	81	$4,074,057.00	$230,607.00
7%	$139.10	81	$4,112,491.50	$269,041.50
8%	$140.40	81	$4,150,926.00	$307,476.00
9%	$141.70	81	$4,189,360.50	$345,910.50
10%	$143.00	81	$4,227,795.00	$384,345.00
11%	$144.30	81	$4,266,229.50	$422,779.50
12%	$145.60	81	$4,304,664.00	$461,214.00
13%	$146.90	81	$4,343,098.50	$499,648.50
14%	$148.20	81	$4,381,533.00	$538,083.00
15%	$149.50	81	$4,419,967.50	$576,517.50

One Payer

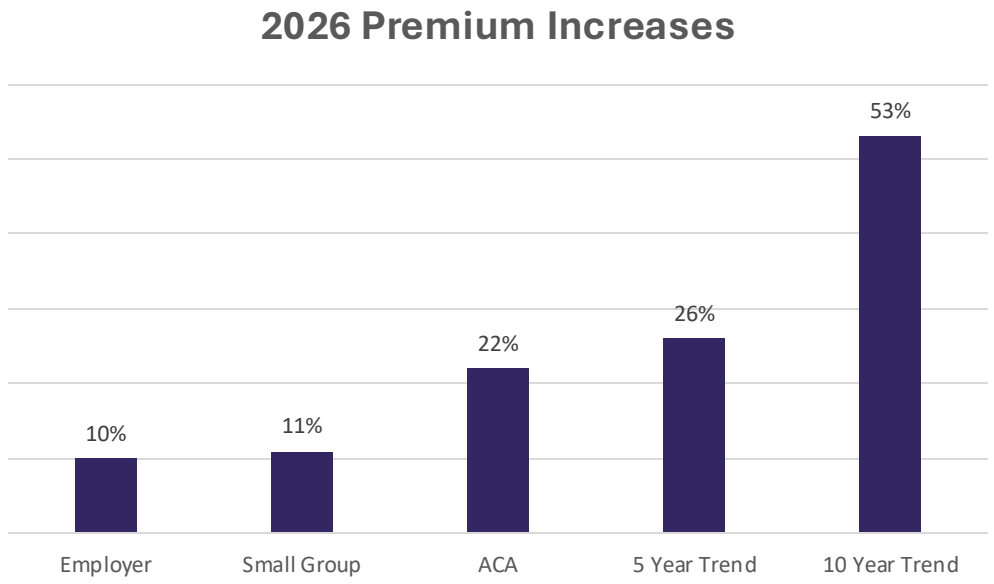
Payer Negotiations Have Changed

- More data than ever before
- Less “human touch”
- Payers report they are leveling the playing field*
- Tighter margins, higher stakes

We’re operating in a system where premiums are rising, but reimbursement is not keeping pace—and negotiations are getting harder, not easier.

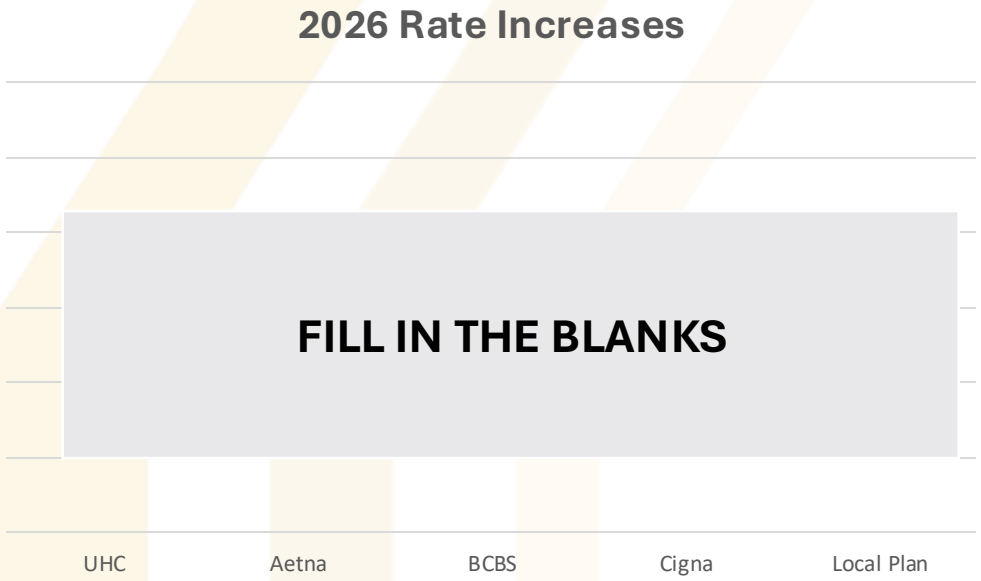
The Disconnect

Double digit increases in premiums



[2025 Employer Health Benefits Survey | KFF]
[Employers prepare for the highest health benefit cost increase in 15 years]
[How much and why premiums are going up for small businesses in 2026 - Peterson-KFF Health System Tracker]
[Why Group Health Insurance Costs Keep Rising Faster Than Inflation]

Single or zero digit increases in rates



The story being told in the market doesn't match what we're seeing in contracts.

Preparedness

Outreach and Preparation 30-45 Days

- Gathering internal and external information
- LOI/Rep assignment

Payer Review Period: 30-45 Days

- Payer running analysis

Counter and Conclusion: 45 – 90 Days

- Ongoing negotiations to obtaining final amendment

Execution and Effective Date: 30 – 60 Days

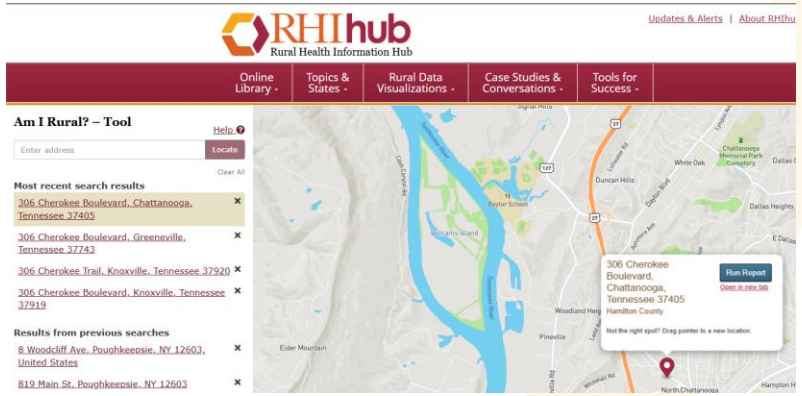
- Effective date assigned and executed version completed

Tools

Am I Rural – Price Transparency – Covered Lives – Barrier to Access

Am I Rural

- Being rural or in an underserved area can be a big value add to payers.
- Supports Network Adequacy & Health Equity
  Reduces Avoidable Costs
- Enhances Member Experience & Community Commitment
- Demonstrates payer investment in local care access, improving satisfaction and reinforcing trust in the community.



Program Eligibility

The information provided by this service addresses only the rural aspect of a program's requirements. Your *Am I Rural?* report is not a guarantee of your rural status. Please check with the program contacts directly to verify your eligibility for specific federal programs.

Program	Rural?	
CMS - Rural Health Clinics (RHC) Program	**NO**	CMS interim guidance considers a location to meet the rural location requirement for the RHC program if it is outside of an urbanized area in the 2010 Census Bureau data OR if it is outside of an urban area in the 2020 Census Bureau data. • This location is in a 2010 Urbanized Area (Chattanooga, TN--GA Urbanized Area) AND is in a 2020 Urban Area

Shortage Designations

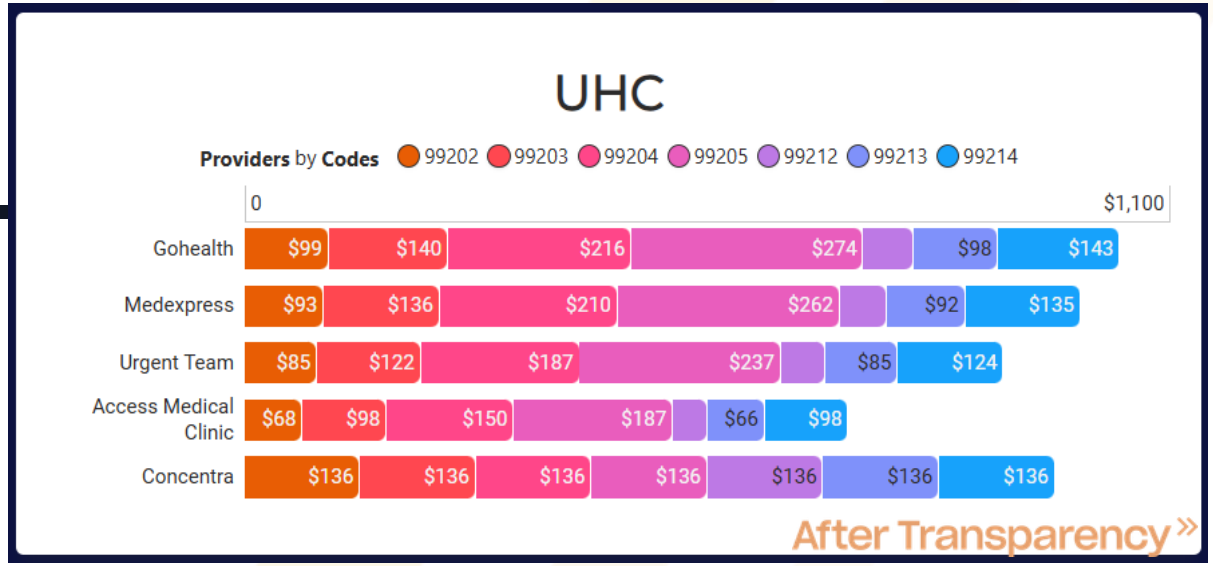
Area Type		Details
Primary Care Health Professional Shortage Area (HPSA)	**YES**	**Name**: LI-Hamilton County **ID**: 1477617961 **Type**: HPSA Population **Population**: Low Income Population HPSA **Score**: 9 **Date of Designation**: November 30, 2016 **Last Update**: September 10, 2021
Dental Care HPSA	**YES**	**Name**: LI-Hamilton County **ID**: 6474681975 **Type**: HPSA Population **Population**: Low Income Population HPSA **Score**: 15 **Date of Designation**: March 22, 2022 **Last Update**: March 22, 2022
Mental Health HPSA	**YES**	**Name**: LI-Hamilton County **ID**: 7479596450 **Type**: HPSA Population **Population**: Low Income Population HPSA **Score**: 16 **Date of Designation**: April 5, 2022 **Last Update**: April 5, 2022
Medically Underserved Area/Population	**YES**	**Name**: Hamilton Service Area **ID**: 03244 **Type**: Medically Underserved Area **Score**: 56.4300003 **Date of Designation**: June 3, 1982 **Last Update**: May 4, 1994

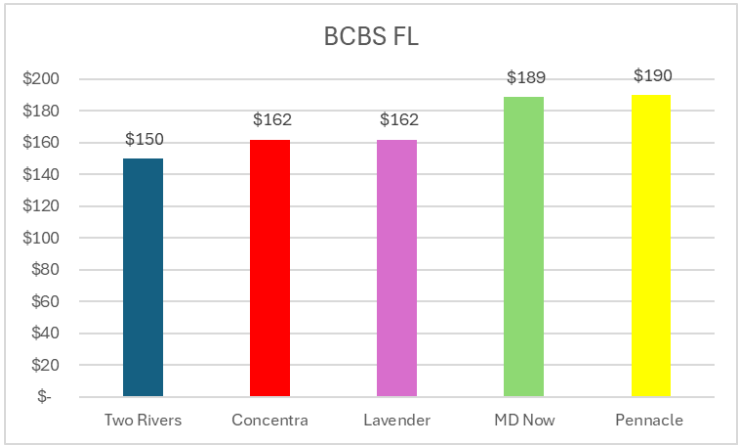
Price Transparency

Payers publish rates?

Your comp can see your rates?

Used the data?





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- Competitor-specific rates
- Validates accuracy
- Strengthens negotiation credibility
- Eliminates “data challenge” from payer

	My Clinic	Your Clinic	Their Clinic	Her Clinic	His Clinic	HS Clinic
Global						
36415	**$3**	$3	$5	$3	$2	$3
80053	**$6**	$6	$8	$6	$4	$6
85025	**$5**	$5	$10	$5	$4	$5
87502	**$53**	$53	$53	$53	$49	$53
87651	**$19**	$19	$19	$19	$15	$19
99202	**$65**	$147	$68	$65	$62	$150
	$111	$193	$115	$111	$105	$193
	$150	$264	$155	$150	$148	$269
	$217	$335	$220	$217	$198	$342
	$22	$66	$24	$22	$21	$67
	$43	$93	$44	$43	$42	$95
	$71	$145	$72	$71	$70	$148
99214	**$104**	$190	$105	$104	$102	$194
99215	**$139**	$238	$141	$139	$137	$243

Green : Greater
Yellow: Equal
Red : Less

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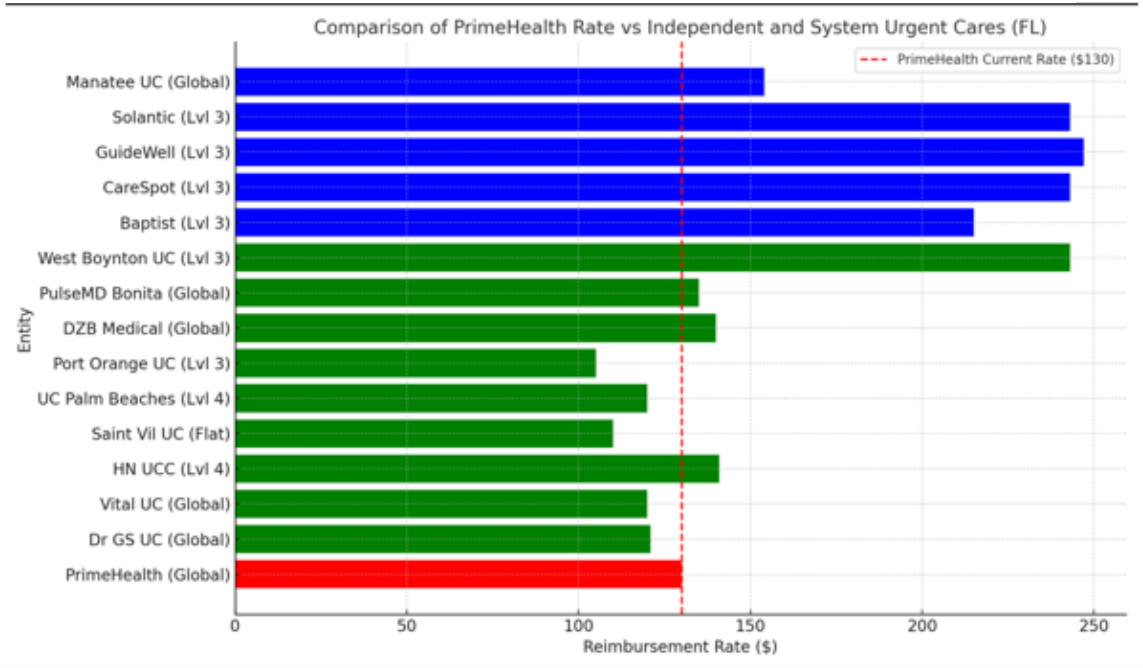
Price Transparency

Market Positioning Example



trek health

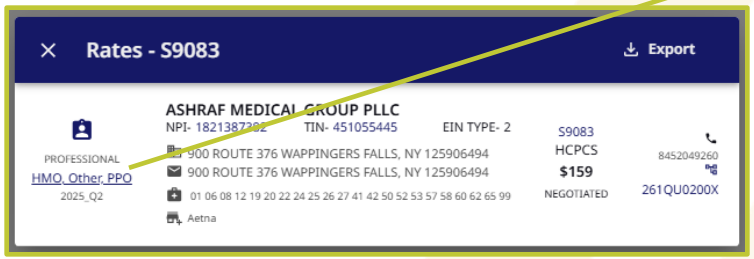
Key Findings (Global & Tiered Daily Only)

- PrimeHealth (global): $130
  - Below the independent average
  - Far below system-affiliated peers.
- Independent peers:
  - Average ≈ $137
  - Median ≈ $121
  - ~55% are paid > $130 on some or all levels
- System-affiliated peers:
  - Typical Level-3 equivalents ≈ $215–$247
  - Median ≈ $243 → ~+87% vs. $130

Price Transparency

Employer list?

Rate change?



Billing Code	Rate Change (%)	Rate Change ($)	Previous Avg Rate 2024_Q4	Current Avg Rate 2025_Q2
S9083	↓-3.25%	↓$-5	$159	$154
Onpoint Medical Group, Llc	↑27.42%	↑$34	$90	$124
Pahs Onpoint Urgent Care Llc	↑4.28%	↑$14	$313	$327
Healthone Carenow Urgent Care, Llc	↑3.43%	↑$7	$197	$204
Denver Health and Hospital Authority	↑1.4%	↑$2	$141	$143
Advanced Urgent Care Llc	0%	$0	$165	$165
Afterours Inc	0%	$0	$148	$148
Children's Hospital Colorado	0%	$0	$310	$310
Colorado Complete Urgent Care Physicians Llc	0%	$0	$140	$140
Colorado Urgent Care Pllc	0%	$0	$90	$90
Denver Urgent Care	0%	$0	$157	$157
Front Range Urgent Care, Inc.	0%	$0	$90	$90
Horizon Laboratory Llc	0%	$0	$90	$90
Injury Care of Colorado Llc	0%	$0	$90	$90
Lone Tree Acute Care Center Pc	0%	$0	$136	$136
Northern Colorado Community Urgent Care, Pc	0%	$0	$180	$180
Onpoint Medical Group, Llc	0%	$0	$90	$90
Peaks Urgent Care Pc	0%	$0	$225	$225
Pediatrix Urgent Care of Colorado, Pllc	0%	$0	$133	$133
Urgent Care of Colorado Pc	0%	$0	$140	$140
Banner Urgent Care Colorado	↓-1.74%	↓$-2	$117	$115
Catholic Health Initiatives Colorado	↓-37.2%	↓$-61	$225	$164
Denver Health and Hospital Authority	↓-42.67%	↓$-64	$214	
Boulder Community Health	↓-42.86%	↓$-54	$180	

trek health

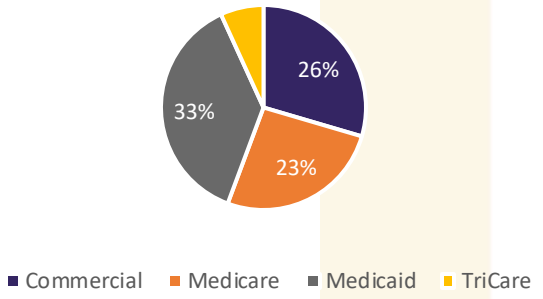
Employers with Aetna HMO

- (G.P.)
- 1 FLIPT LLCAetna Choice POS II
- 1 FLIPT LLCHSA Aetna Choice POS II
- 1 TRICK PONY LLCAetna Choice POS II
- 1 TRICK PONY LLCHSA Aetna Choice POS II
- 100 BLACK MEN OF AMERICA INCAetna Choice POS II
- 100 BLACK MEN OF ATLANTA INCAetna Choice POS II
- 110% INC DBA GREAT AMERICAN FLOORSHSA Aetna Choice POS II
- 1130 CONSULTING LLCAetna Choice POS II
- 116 INDUSTRIES LLCAetna Choice POS II
- 120 LOMBARD STREET DBA BISTRO ROMANOAetna Choice POS II
- 1295 TOWBIN LLCAetna Choice POS II
- 1295 TOWBIN LLCHSA Aetna Choice POS II
- 1636 COUNTRY CLUB INC DBA HOT SHOTS BAR AND GRILLAetna Choice POS II
- 1647 LLC DBA ENGINEER UPAetna Choice POS II
- 1647 LLC DBA ENGINEER UPHSA Aetna Choice POS II
- 19 JACKSON ST INCAetna Choice POS II
- 1MICRO
- 1ST DENTAL CARE LLCAetna Choice POS II
- 1ST DENTAL CARE LLCOpen Access POS II
- 2 GUYS & A PIE PIZZERIA DBA 2 GUYS AND PIE PIZZERIAAetna Choice POS II
- 2 THIRTY NINE INC DBA PLANET SUBAetna Choice POS II

Payer Market Data – Covered Lives

Payer	COM			MCR			Medicaid			TriCare			Market
	# Lives	% MS	NRV	# Lives	% MS	NRV	# Lives	% MS	NRV	# Lives	% MS	NRV	Share
BCBS South Carolina	637,035	15%	$ 135.00				173,247	4%	$ 101.00				19%
Palmetto				596,856	14%	$ 127.00							14%
SC Medicaid FFS							483,895	11%	$ 93.00				11%
Humana				179,390	4%	$ 129.00				243,587	6%	$ 138.00	10%
Select Health of SC							380,458	9%	$ 99.00				9%
UHC	111,245	3%	$ 142.00	108,575	3%	$ 136.00							5%
Absolute Total Care							204,898	5%	$ 95.00				5%
Cigna	239,539	6%	$ 130.00										6%
Molina							164,547	4%	$ 97.00				4%
Aetna	94,034	2%	$ 138.00	81,202	2%	$ 122.00							4%
Total Covered Lives	1,081,853			966,023			1,407,045			243,587			88%
% of Total Covered Lives	26%			23%			33%			6%			

Payer Type Distribution



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After Transparency
MMIT

The Negotiation

Leadership Interview

Operational + Strategic Questions:

- What issues exist with this payer today?
- Do you have access to contracts/FS?
- Do you have a strong reporting tool?
- What are your goals? (increase, restructure, access)
- Are you willing to walk away?

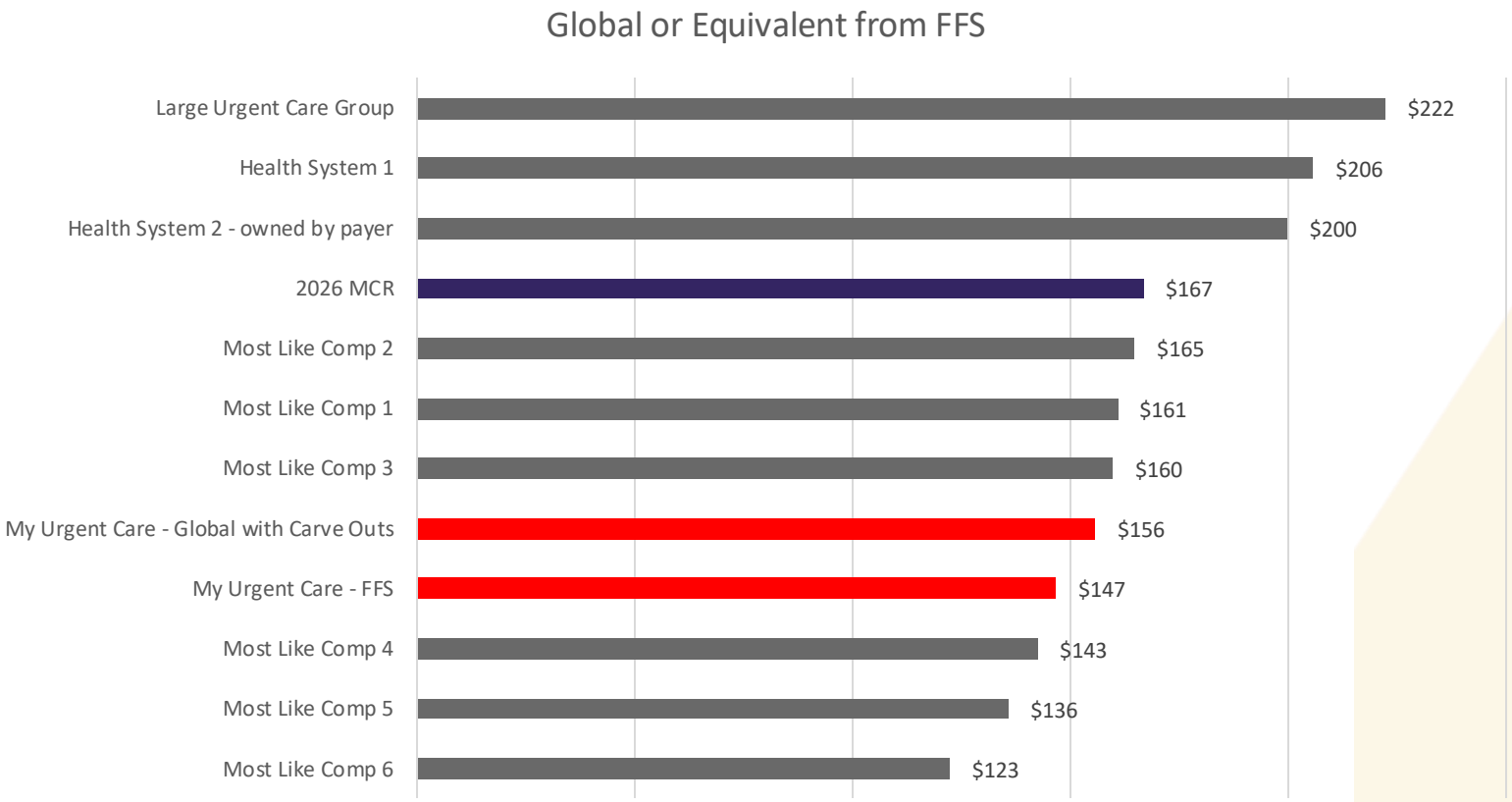
Positioning Questions:

- What differentiates you in the market?
- Any prior history with this payer?
- Do you have an existing rep?

Market Context:

- Who are your competitors?
  - Health systems vs independents
  - Any payer-owned urgent care centers?
  - Have any competitors gone out of the market or stopped taking this payer?

Run the Data and Level the Field



Price Transparency Data (After Transparency) + Modeled Assumptions

- Converted FFS to Global
  - Discuss importance of big picture – end NRV vs “weeds” of rates
- Assumptions Used in Modeling
  - E/M Distribution: ~3.8
  - Average Ancillary Revenue per Visit: $35
- Current performance:
  - $156 Global/$147 FFS
- Comps: 95% – 130% MCR

Payer Selection Grid – Contract Review

Payer	NRV	Global or FFS	Term Notice	Rate Comps NRV	% Covered Lives	Rate Variance from Competitor	% Change/Comps	Last Neg	Other	Employee Benefit Provider	Large Employer Benefit Provider	Am I Rural
Source	*Internal*	*Contract/FS*	*Contract*	*Price Transparency*	*Data*	*Price Transparency*	*Price Transparency*	*Internal or Vendor*				
Additional Information	*Net Revenue Per Visit*		*When can I request negotiation*	*Using FS or Global - compare NRV based on E/M & Ancillary*		*What is the difference in my NRV and my competitor?*				*Is this payer MY employee benefit provider as an employer*	*How many large employers have this as employee benefit provider*	*Often an advantage to a payer*
UHC	$ 150	Global	Next Year	$177	23%	18%	5%	N/A			3	Y
Aetna	$ 120	Global	Now	$159	18%	32%	15%	N/A	Local large comp went OON	Yes	2	Y
Cigna	$ 133	FFS	6 Months	$153	8%	22%	8%	3 years			2	Y
Anthem	$ 145	FFS	9 Months	$145	38%	0%	12%	N/A			5	Y
					87%							

Timely Selection Process

Choose a payer within the required timeframe and understand history.

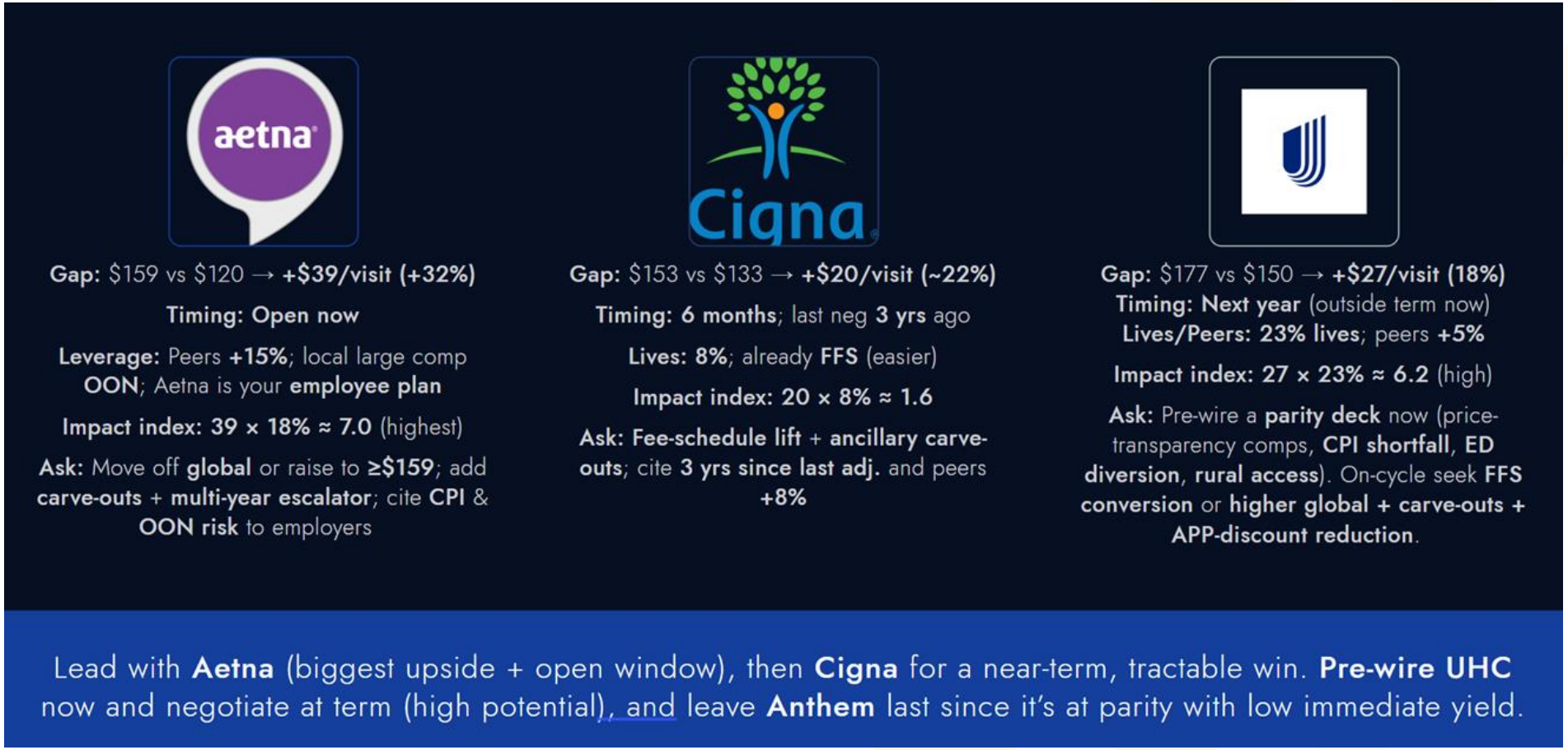
Evaluate Payer Priority

Focus on payers with larger market share and lower reimbursement rates compared to your competitors.

Assess Success Factors

Consider strong relationships, market exits, practice growth, rural service areas, and employer influence for better negotiation outcomes.

Decisions


aetna
Gap: $159 vs $120 → +$39/visit (+32%)
Timing: Open now
Leverage: Peers +15%; local large comp OON; Aetna is your employee plan
Impact index: 39 × 18% ≈ 7.0 (highest)
Ask: Move off global or raise to ≥$159; add carve-outs + multi-year escalator; cite CPI & OON risk to employers
Cigna
Gap: $153 vs $133 → +$20/visit (~22%)
Timing: 6 months; last neg 3 yrs ago
Lives: 8%; already FFS (easier)
Impact index: 20 × 8% ≈ 1.6
Ask: Fee-schedule lift + ancillary carve-outs; cite 3 yrs since last adj. and peers +8%
Gap: $177 vs $150 → +$27/visit (18%)
Timing: Next year (outside term now)
Lives/Peers: 23% lives; peers +5%
Impact index: 27 × 23% ≈ 6.2 (high)
Ask: Pre-wire a parity deck now (price-transparency comps, CPI shortfall, ED diversion, rural access). On-cycle seek FFS conversion or higher global + carve-outs + APP-discount reduction.
Lead with Aetna (biggest upside + open window), then Cigna for a near-term, tractable win. Pre-wire UHC now and negotiate at term (high potential), and leave Anthem last since it's at parity with low immediate yield.

Engage Early (But Don’t Negotiate Yet)

Secure the Right Contact

- If there is an existing/past rep
  - Re-engage
  - Reference prior discussions
- If no rep: Contact Provider Relations
  - Determine process
    - Letter of Intent
    - Portal submission
    - Pre-proposal request
- Go by the rules (initially)
  - Documentation – proof you met timeframe
  - Push back/delays – find an alternative
    - Rep from previous project
    - Local or state government official

Justification

- Timing
  - Contract terms
  - No negotiation/rate changes 3+ years
  - Adding new services, location, etc
- Cost
  - CPI
  - Labor Costs
  - Payer premium increases
  - Rate Data access
- Sustainability
  - Acquisition pressures
  - Health System ownership pressures

Important:

- Do this **early** to avoid delays
- Do NOT send rates yet

Speed matters—but structure matters more.

Leadership Strategy Session

Discuss:

- Internal performance & external benchmarks
- Where do you *want* to be vs where markets says you are?

Common Reaction:

- *"We should be at or above our competitors"*
- *"We should be paid the same as HS"*
- *"This payor should make up for lost time"*

Payers are not going to knock on your door to negotiate (up).

Payer Perspective:

- Providers should initiate negotiations
- Cannot "true you up" in one cycle
- Do not treat HS as direct comps

Reframe

- Negotiation is not retroactive correction
- It is forward-looking progression
- Include "what if" in proposal
  - But focus on realistic comps

Turn Data into a Story the Payer Understands

Initial Proposal:

📄 Deliverables

- Executive summary
- Supporting analysis
- Clear rate proposal

🎯 Tone

- Data-driven
- Collaborative
- Non-adversarial
- Yet letting them know this is critical for sustainability

⚠️ Avoid

- Overloading with raw data
- Emotional arguments
- Unstructured requests

🎯 Your Goal

Not just to show:

❌ "We want higher rates"

But to demonstrate:

✅ "Here is the gap—and why it matters"

Set realistic target for rates

Example:

Cigna offer:

From $156 global to FS @ 88% MCR ($147)

Setting our Target:

- Current: $156 per visit
- Offer: $147 per visit (–5.8%)
- Target: $180 per visit (+15.4% vs current)
- **+22.4% improvement vs payer offer**

Control first impressions.

Demonstrate Impact on Members

Reach & Access

•18 locations by 2025, serving payer members since 2016

•Strong presence in rural and underserved areas

Services & Scope

•Urgent, Primary, Telehealth, Behavioral

•Radiology, Labs, Workplace Health, Travel Medicine

Quality & Accountability

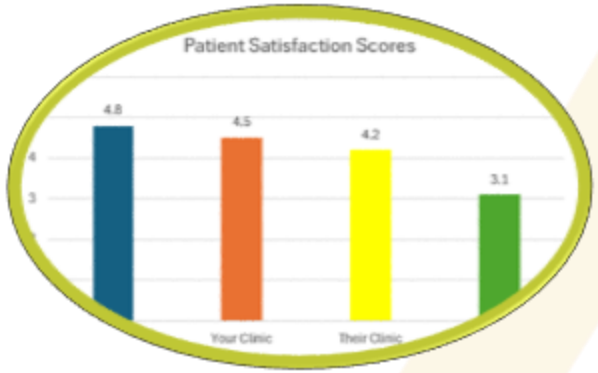
•Active Quality Improvement Programs

•Strong provider education and oversight

Affordability & Access

•Proven growth from 1 to 18 sites

•Lower ED transfers than national average



Illustrative example.

Presentation Phases

Step 1: State Intent

•Email introduction + intent to negotiate.

•Emphasize sustainability and investment.

•Share key data (rate gaps, locs, volume).

•Define next steps and expected timeline.

Step 2: Present & Engage

•Deliver 2–3page summary or deck.

•Highlight rates

•Patient satisfaction

•Rate proposal

•Include alternatives if applicable

- Ancillary carve-outs
- Tiered rate structure
- Removal differentials
- Facility-based credentialing
- Change in POS
- Additional services
- COLA

•Request meeting to review

Step 3: Escalate

•Reengage with new data

•Show OON/Closed/Sold Impact

•Employer testimonials

•Request leadership level

•Demand payer benchmark & inequity justification

•CPI

•Premiums vs Payer Rates

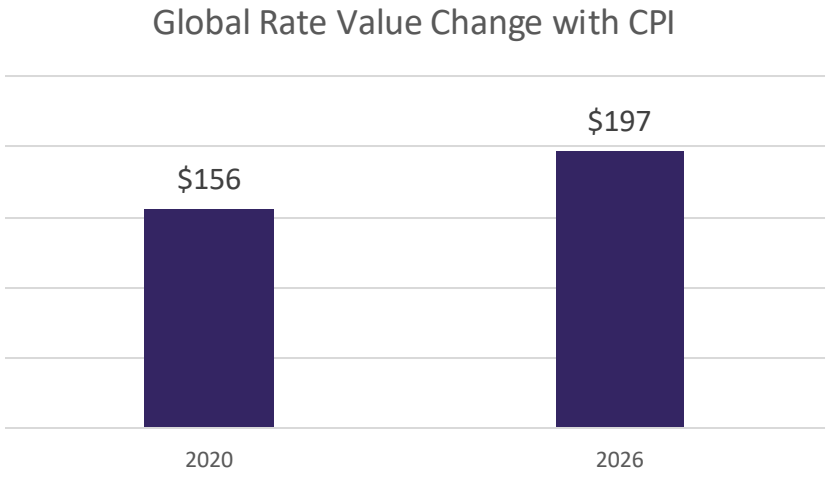
📊 Premium Inflation vs Provider Reimbursement

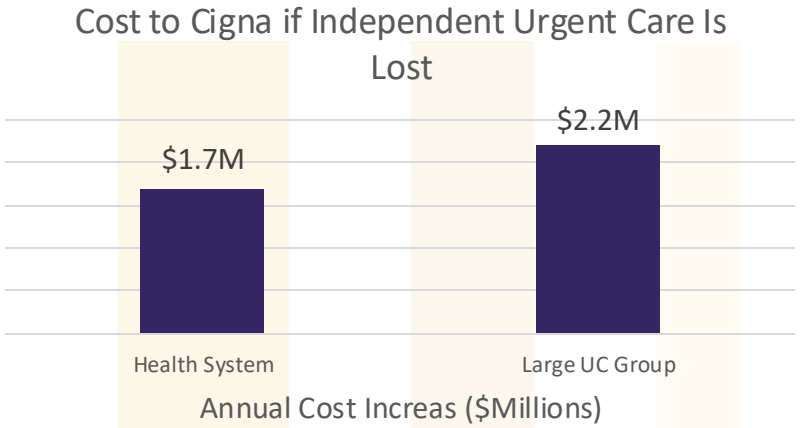
Category	2026 Trend
Employer Premiums	+10–15%
Small Group Market	~+11–12%
ACA / Individual	~+18%+
Cigna (example filings)	~30–40%+
Provider Reimbursement	**~0–3% (or flat)**

👉 And Cigna-specific filings show:

- ~34% (AZ)
- ~40% (GA)
- Source: Cigna Health & Life Insurance Company (CHLIC)

To: Cigna Healthcare
Re: Network Status and Reimbursement – My Urgent Care
Dear Cigna Healthcare Network Management Team,
On behalf of the City of Anywhere, USA, we are writing regarding the status and sustainability of My Urgent Care within the Cigna network.
As a municipality, we provide health benefits to a large and diverse employee population, including first responders, public works staff, administrative personnel, and their families. Access to convenient, high-quality, and cost-effective care is critical to both our workforce and our ability to manage healthcare expenditures responsibly.
My Urgent Care has been a key access point for our employees, offering extended hours, timely care, and an appropriate alternative to higher-cost emergency department utilization. We have seen firsthand the value they provide in maintaining workforce productivity and controlling overall healthcare costs.
We understand that there are ongoing discussions regarding reimbursement and contract structure. We are concerned that the current reimbursement levels being offered may not be sustainable for this provider. Any disruption to their participation in the Cigna network would negatively impact our employees' access to care and could result in increased reliance on higher-cost settings.
From an employer perspective, maintaining strong, local urgent care access is essential. The potential loss of My Urgent Care from the network would not only affect employee satisfaction and access but could also increase our overall healthcare costs.
We respectfully request that Cigna work collaboratively with My Urgent Care to ensure a sustainable reimbursement structure that supports continued network participation. Preserving access to high-value, community-based care providers is in the best interest of employers, members, and the broader healthcare system.
We value our relationship with Cigna and appreciate your attention to this matter. We would welcome the opportunity to discuss further if helpful.





Success Stories

Despite Market Pressure, Payer Resistance, and Policy Shifts…

We're Seeing:

- +3%–19% reimbursement improvements
- $100K–$500K+ annual revenue increases for small to mid size groups
- $5–$20+ per visit gains
- Immediate recovery of missed or mispaid revenue

Source: Aggregated client results based on claims analysis, contract modeling, and payer negotiation outcomes (de-identified).

Price Transparency Use Cases

Market Entry & Expansion

- Evaluate reimbursement by region to guide site selection
- Identify payer dominance and regional rate gaps

Service Line Development

- Target high-margin services (labs, imaging, procedures)
- Focus growth where reimbursement is strongest

Employer Strategy

- Demonstrate employer overpayment at hospitals
- Support direct-to-employer or membership models

Sales Strategy

- Identification of revenue positive targets
- Improve sales revenue

- **Proforma & M&A Analysis**
  - Model revenue using real market rates
  - Assess acquisition targets based on true reimbursement
- **Revenue Cycle & Denials**
  - Compare contracted vs paid amounts for shortfalls
  - Flag systematic underpayments or payer variances
- **Network Access & Adequacy**
  - Expose payer coverage gaps vs competitors
  - Use data to strengthen “must-have” network positioning

Market Entry Decisions

Smarter Investment Decisions Combine

Rates + Competitors + Covered Lives + Access

Results:

- ✓ Clear “go / no-go” markets
- ✓ Stronger proformas
- ✓ Faster path to in-network viability

Who:

- 💰 Operators / Owners
- 🏢 Employers (Self-Insured)
- 📈 Investors / Private Equity
- 🏥 Health Systems (Expansion Strategy)

Identify High Value Markets

- Analyze payer specific rates by geography

Define True Competitive Set

- Identify in network comps by payer
- Health system vs independents
- Benchmark against actual rates, not assumptions

Layer in Demand

- Overlay Zip level covered lives by payer
- Identify high density commercially insured populations
- Consider employer concentration
- Select site with rev opportunity, not just population

Assess Access to Barriers

- Closed or narrow networks
- Low rates
- CIN/IPA influence
- Networks are saturate = high barrier to entry

Don’t ask where you can open… ask where you should.

Revenue Driven Sales Strategy

Who:

- 💰 RCM Companies
- 📊 Revenue Capture SW Providers
- 🎯 Sales Optimization Companies
- 🖨️ Equipment and Testing Vendors
- 🧪 Lab, POCUS, Radiology, DME
- 📈 Investors

Identify Revenue Rich Targets

- Analyze payer specific rates by geography

Align to Reimbursement Structure

- Product that ties to % of client revenue target ↑ $ markets
- Vendors of testing & equipment target FFS vs Global
- Benchmark against actual rates, not assumptions

Redefine Ideal Customer Profile

- Same volume ≠ same revenue

Focus Sales on Strategy

Improve Sales ROI for Company & Clients

Smart business decisions drive sustainability & expands patient access.

Reducing Payer Reliance: Direct to Employer Models

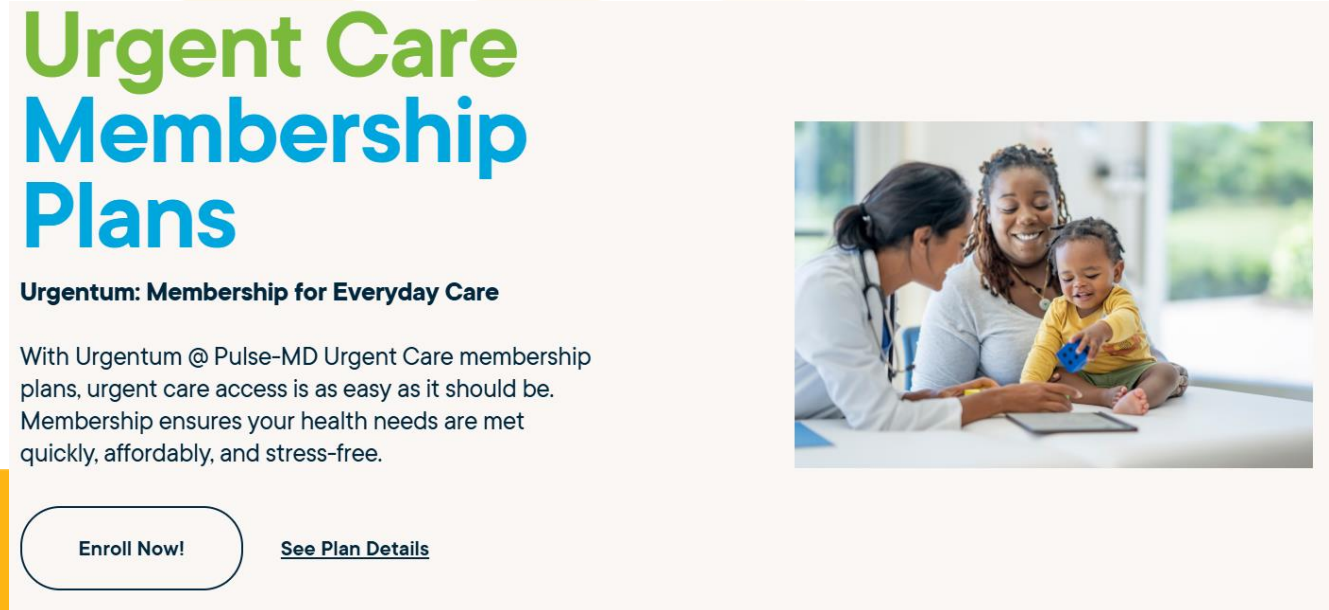
The Opportunity for Urgent Care

- Position as:
  - **Front door of care**
  - **ED diversion solution**
  - **Low-cost, high-access alternative**
- Align with employer priorities:
  - Cost savings
  - Access & convenience
  - Workforce productivity

urgentumcare membership for everyday care @ PulseMD Urgent Care est. 2011

Why This Matters

- Employers are shifting to self-funded models and seeking cost control, predictability, and direct partnerships.
- Urgent care delivers with lower costs, reduced ED use, and accessible, scalable care.



Models

Membership & Direct Contract Models

💼 Employer-Sponsored Memberships

- Per employee/per month (PEPM) pricing
- Covers:
  - Visits
  - Basic labs/testing
- Predictable cost for employer
- No claim friction

🤝 Direct-to-Employer Agreements

- Contract directly with **self-funded employers / TPAs**
- Options:
  - Bundled visit rates
  - Episodic care pricing
- Bypasses traditional payer structure

🧩 Hybrid Models

- Membership + fee-for-service carve-outs
- Integrates with:
  - Employer health plans
  - Narrow network strategies

Feedback Requested – Scan the QR

Thank You...

Tammy Mallow, CEO
Mallow Consulting, LLC
Mallow.consulting@gmail.com
417 353 906