Health Care Newsmakers: Steve McCoy, Vice President/General Counsel, Patient First

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Physician Practice Payment Reimbursement Reform and Strategies: An interview with Steve McCoy, Vice President/General Counsel, Patient First

Please tell us a little bit about Patient First and your responsibilities there.

Patient First provides primary and urgent care medical services at 73 medical centers located in Virginia, Maryland, Pennsylvania and New Jersey. Patient First centers are open on a non-appointment basis from 8 a.m. to 10 p.m. 365 days a year, including weekends and holidays. In addition to physician services, our on-site services include moderate complexity clinical laboratory tests, digital x-rays, and dispensing from a formulary of over 100 commonly-prescribed drugs. We employ 600 physicians and physician extenders, with a physician on site and seeing patients at each location during all hours of operation, as well as hundreds of nurses, lab and x-ray technicians, medical assistants and clerical staff. We focus on helping patients return to their lives and work as soon as possible.

As general counsel, I'm responsible for oversight of Patient First's legal and regulatory compliance; contract review and management; federal and state legislative review, advocacy, and relations; privacy and security initiatives; and litigation and risk management. Like most of my colleagues at Patient First, I wear a lot of hats but I'm fortunate to have good help, both internal and external.

With all the discussion lately about trying to manage the cost of healthcare, what are the most important recent changes in reimbursement methodology and strategies which Patient First has seen in the market?

The ongoing transition away from fee-for-service toward value-based reimbursement is probably the most important ongoing trend for all providers, not just physician medical practices like ours. That's particularly true as government and commercial payers begin to move toward mandatory risk-sharing. We've participated in both the CMS EHR Incentive Program and Physician Quality Reporting System for the past several years, and are in our first reporting period under MACRA's Merit-Based Incentive Payment System (MIPS) that replaces those initiatives now. I would expect the ongoing development both of MIPS measures and categories (including the introduction of cost measures into MIPS scoring) and of Alternative Payment Models to have substantial impact on our organization going forward.

Have those Medicare initiatives transferred over to the commercial insurance market?

Yes, commercial payers are steadily integrating value-based reimbursement into their reimbursement models and moving toward risk-sharing models. We've been involved with commercial value-based reimbursement since 2011 and have seen a number of variations on both primary and urgent care incentive programs in our markets, with payers focused initially on cost and utilization but transitioning over time to clinical outcomes evaluation and measurement.

What benefits have those new physician reimbursement protocols and strategies brought to your company and the public?

The benefit to the public of a properly-constructed program to identify and reward value-based care is obvious: if we can reduce costs and improve outcomes, everyone wins. The challenge, of course, is selecting and pacing program initiatives and rewards to maintain provider engagement and help all of the participants (patient, payer, provider) succeed.

The focus on value-based care provides an ongoing opportunity for us to talk about the value that Patient First brings to the patient, health care provider, and payer communities. Our medical center physicians and extenders routinely treat almost two-thirds of the diagnoses that are treated in hospital emergency rooms, at a fraction of the cost. We also believe that the patient experience is substantially improved when a laceration or other urgent but non-emergent trauma is treated in an urgent care center rather than a hospital emergency department, and that our hospital colleagues benefit when their over-stressed emergency departments are not tasked with treatment of patients who do not require true ED-level care.

One predictable but nevertheless welcome benefit of the shift away from fee-for-service is the ongoing conversation about coordination of care across the continuum and appropriate location of care that we are having with hospitals, payers and other community providers. Again, if we can "right-size" care, the patient, provider, employer and insurance communities all stand to benefit.

What risks and concerns have those initiatives required large physician practices like Patient First to face?

Any transition in reimbursement from a long-established model to a somewhat theoretical replacement will cause concern. The challenge to Patient First is similar to that facing other providers: finding a way to manage the transition in a manner that allows us both to succeed now and to be ready for the future.

Another challenge that is somewhat peculiar to Patient First is the need to integrate our sizeable, multi-state physician, extender and clinical staff into value-based care initiatives without interfering with their ability to treat patients efficiently and well. Meaningful Use, MIPS and commercial incentive programs are hard enough to understand and implement when you are trying to do so from an office desk; actually doing it in the treatment room is more difficult.

Finally, we see a real need for some degree of standardization among these programs. As one of my colleagues likes to say, "across government and commercial payers, if you've seen one program, you've seen one program." For example, every payer's choice of clinical quality, cost and utilization metrics is different. We recognize that innovation in care delivery is a trial and error process by necessity (and likely by design), but for these programs to succeed, the provider community needs a degree of consensus and consistency.

We know Medicare and the commercial insurance market have spent the last decade actively wrestling with physician payment reform measures. What are a few opportunities and concerns which you see going forward?

The opportunity is to create some true alignment of medical care among the provider and payer communities. As an intermediate-level provider, we have worked with local hospitals and physician practices in our markets since 1983 to coordinate care and transition patients appropriately among various settings and to share information efficiently. As payment models incentivize and reward care management across the spectrum of settings, I'd like to think that some measure of competition will yield to coordination of care among health care providers.

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