Primary Care Cures

Episode 67: Tom Banning

Ron Barshop:

You know, most problems in healthcare are fixed already. Primary care is already cured on the fringes, reversing burnout, physician shortages, bad business models, forced buyouts, factory medicine, high deductible insurance that squeezes the docs and it's totally inaccessible to most of the employees. The big squeeze is always on for docs. It's the acceleration of cost and the deceleration of reimbursements. I want you to meet those on this show that are making a difference with us Ron Barshop CEO of Beacon Clinics, that's me.

Ron Barshop:

So according to health affairs, we spend about 11,200 per person in America last year, which is double our nearest competitor nation wise, which would be Switzerland, which is double most of the other care nations. So we are way, way ahead on spending and we have the lowest outcomes, but that's old news. But here's what new news with the COVID environment. Hospitals last year treated 22 million people, which is about 7% of our population and nationally, that represents about a third of the overall federal spend for healthcare. So without going into a bunch of numbers, what we're talking about is we spend about $3700 per hospital patient per year in America. The bail out that was just received by hospitals is $10,000 per patient per year.

Ron Barshop:

So let me just repeat that, the bailout is three times the size of the patient revenues that the patient revenues that the hospitals are getting in normal times. In other words, they've got a three year supply of revenue based on this bailout. Hat tip to the American Hospital Association lobbyists. Now primary care by comparison I should say is really 190 people versus those 22 million people and that's about 60% of us in America and the spend there is not roughly 3000, but it's about a sixth of that and the bailout package for primary care, zero. If you want to look at the PPP plan, yes, there is some revenue that's coming. There's grant revenue for some of the doctor's offices, but 60% of primary care offices are estimated to be broke and destroyed by the end of June.

Ron Barshop:

So we don't have a bailout for primary care, which keeps the whole backbone of the body going, which is the machine that keeps everything running. We do have a bailout for the hospitals and a second one coming. So today, and this is all coming from the Robert Graham center and from our guest today, who I'm really excited to introduce you too. Tom Banning is the CEO and EVP for the Texas Academy of Family Physicians. For 13 of his 20 years on board with them, he's been directing strategic and legislative strategy, grassroots political action, CME membership and communication activities. They're the largest specialty society in Texas with over 8000 members. That's almost as many members as AMA and I'm joking, but they are very strong because they have a strong advocate in Tom Banning. And in Tex, represents one of the largest

family physician models of all of the associations in the country. So Tom, welcome to the show. We're so glad to have you onboard.

Tom Banning:

Great. Thank you for having me. I appreciate you giving me the time.

Ron Barshop:

TAFP is associated with the American Association of Family Practice. Are you sort of a state version of that? How are you associated with the national boards?

Tom Banning:

Yeah, the American Academy of Family Physicians is our national parent organization. We're just in aligned or integrated state chapter. So every state has an academy of family medicine and I just happen to represent the one in the best state, which is Texas.

Ron Barshop:

So when Texas does secede, you will be the equivalent of the AAFP? Is that correct?

Tom Banning:

Yeah. I think and I hope that talk of our secession or seceding has subsided. Certainly the COVID-19 pandemic has put into very clear perspective, we some of our state limitations are-

Ron Barshop:

Let's talk a little bit about this powerlessness of physicians versus the powerfulness of the bigs, and I call them the bigs because medical devices, hospitals, insurance companies, the PBMs, you can throw in the brokers, their lobby combined taking out physicians entirely, the next four in line would not even be bought by the largest that's in the lobbying of the big four, the big five. What happened to physicians along the way where they didn't get that same capital to spend?

Tom Banning:

Well I think I would disagree to an extent. I think the physicians have capital, but their capital is not dollar bills in their pocket. Their capital is with their patients. Physicians are by and large, they go into medicine as a calling. They want to care for people. They have a relationship with patients and that's where they spend their time. That's where they put their political capital. That's where they put their personal capital. Their financial capital is to pay off medical school debt, to take care of their families, take care of their communities and politics to a lot of folks and physicians in particular are really turned off by politics just generally. They think it's just an ugly game and it's dirty and based on what you might see on the news, it's certainly an understandable feeling that they're expressing.

Tom Banning:

Unfortunately, how that manifests itself is... I don't want to say lack of a voice, but not as strong as a voice as people that expend vast amounts of money and higher hoards of lobbyists to represent them in the halls of Congress. So while physicians are busy taking care of their

patients, taking care of their communities, they're not investing the same amount of time, the same amount of money and resources into the political process and the groups that you have mentioned.

Ron Barshop:

So the ACA in 2009, 11 years ago was a banquet for a lot of the bigs. A lot of them won big, the doctors got nothing. This latest martial plan we'll call it, the two trillion dollar bailout, the doctors essentially got nothing other than PPP. Am I wrong? Did I miss something there?

Tom Banning:

No, we have got a system where everything up to this point has really revolved around the hospitals, that's why we got our finances so out of whack. When you design systems, when you design payment methodologies, you're going to get the outcomes you've designed and thus far we have designed payment methodologies, care models around the hospitals, which are the highest cost areas. So again, no surprise that costs are going up, but they're also the highest vectors for spreading COVID-19 and that's playing itself out or showing itself through studies that were done in Italy and some in the northwest U.S. where the disease was first expressing itself here in this country. That's how the politicians have responded is by throwing a ton of money at the hospitals.

Tom Banning:

Let me say there's not question that the hospitals are hemorrhaging money right now. They built a business model around emergency room use and elective procedures. With both the Trump administration's directive as well as many state governors directives to limit elective surgeries, it's really hampered those revenue streams that the hospitals had built their businesses around. We also represent... we got a lot of family doctors that do emergency medicine and I've talked to them often. Actually, our current president is an ER doctor in Star County along the valley and he was telling me how the ER rooms have essentially dried up. That only people with true emergencies are coming in because people are heeding the warnings about where to get care.

Tom Banning:

But back to the question that you posed, the government, the federal government has really put all of its efforts into subsidizing or keeping open the hospitals. That attention has really not been given to the physicians despite our best efforts in telling them what's happening in the field. Most primary care practices have seen their patient volume go down 50 to 70%, which is crushing to the bottom line and the ability to pay your bills and keep the doors open. Even for doctors that have moved significantly to providing telemedicine services to their patients. You still see a drop in revenue in the range of 25 to 30% because the physicians are not able to provide those other ancillary services that occur at an in person visit; labs, vaccinations, immunizations, things of that nature.

Tom Banning:

So what you're starting to see is furloughing of staff. Significant cuts in salaries for the existing staff as well as the physician practices and sadly, we're seeing practices just close their doors that aren't able to make a model work that can keep their doors open, and that's devastating for not

only the practice, but for the patients that that physician was serving. Just because we're dealing with COVID doesn't mean people aren't still getting sick. People are still having heart attacks, people still have chronic diseases that need to be managed. We're seeing a lot more mental health issues arise because of stress, of job loss, where the economy is, being around your family for far too long in some instances. We are losing the critical frontline primary care physician to the economics of our broken fee for service system.

Ron Barshop:

So fee for service, I'm calling it walking dead, the model is no longer. You're working on an initiative right now to change that model to more of a revenue value unit model. Can you talk a little bit about where you think fee for service should be evolving to and who pays for this?

Tom Banning:

Sure. So fee for service as you know is just a volume game. A patient has to come in, physically be seen, maybe you could do it via telemedicine, but it's a transactional system. What we're talking about is moving for primary care payment to more a prospective or relational payment model. In other words, pay a physician a monthly fee or lump sum, a per member per month unit of payment for caring for that patient's needs. So you unburden the primary care doctor from a lot of the administrative crap frankly, that is driving them nuts under fee for service to document that what they're doing is truly a billable event.

Tom Banning:

So we're just saying okay, let's assume as a percentage [inaudible 00:12:07] premium that we could come up with a number that would make sense financially for physicians, financially for the system for that physician to provide your typical primary care services, care management, disease management, be accessible and provide that continuity without being forced to rely on that transactional nature of having folks physically come into the office to see you.

Ron Barshop:

You're describing value based capitated pay and you're also describing direct primary care. I mean, that's exactly what you're talking about right now.

Tom Banning:

That's correct and if you think about it from a budgeting standpoint, the CFOs of companies have already determined what they're going to spend on a premium for insurance, whether you're self insured or you're buying a fully insured product. What we're saying is look, for primary care services, this is a budgetable item. Let's either take it out of the premium all together and buy directly that primary care service, or make it a percentage of premium that should, and it certainly has expressed much higher downstream savings for reduced specialty utilization, reduced VR utilization, reduced hospitalization.

Ron Barshop:

Can I play with some numbers with you? If you look at the average premiums for corporations that are self insured there, for an individual, not family, they're 15,000 they're putting in individuals adding another 5000 premium themselves, so 20,000 and let's say 5% of all that 20 is

going into primary care. What we just talked about at the top of the show, we're talking about $1000 per member or 80 bucks per member per month. Is that about the range we're talking about or thinking about for a share of that 20,000, 5%?

Tom Banning:

You know, we're actually working with some insurance modeling groups right now and using both direct primary care as a way to look at it. We're also using Medicare Advantage as a model to look at, and some of the more advanced capitation, but I don't want to get stuck on a number.

Ron Barshop:

Sure, I understand that. Yeah.

Tom Banning:

Because it depends on your patient population. You could risk adjust upwards or downwards, it also depends on the services or bundle of services you're willing to offer. But I think generally the range that you're looking at would be within the ball park.

Ron Barshop:

Yeah. I mean, DPCs are charging the biggest that I know if in the country that has been on my show is Clint Flanagan in Colorado has 60 locations. Clint is charging $79 for the first member, 59 bucks for the spouse and less for the kids. So he's averaging about 70 bucks on average per member, per month not including the kids. He's doing all right. He's doing just fine. There's others that are less. In Topeka, Kansas Bear Brothers that are really a progenitor of all this, their goal is closer to 50 bucks, but that's Topeka, Kansas and it's a healthier population.

Ron Barshop:

Then I Had Gordon Chin on the show last week and Gordon has a Medicare population he's getting ready to launch here in Texas. Gordon has... and I didn't talk to him specifics, but I know he's doing very well with only 400 patients per white coat. So he doesn't need a lot of patients with the Medicare reimbursement to do very well. Frankly, when patients are coming in the clinic and they're not having to staff the clinics fully, this is a golden era for that type of a model.

Tom Banning:

That's exactly right. I mean, you've got groups like Iora or Oak Street that have proven the model works. It more than pays for itself. My personal doctor Chris Larsen is a direct primary care physician here in Austin. He's worked a deal with Rudy's Barbecue, there's been some stuff that they have published where they saw I believe it was between 20 and 30% reduction in total health care cost just by moving their employees into this model that gives them better care, more accessible care at a lower cost. So I think that... I hate that it took a pandemic of this magnitude to focus people's attention on just how broken our fee for service system is and models that are better, but that's just the reality of how things work and I think there's a lot of attention that's going to be paid to this model going forward.

Ron Barshop:

So Chris Crow in Dallas and North Texas, Oklahoma, Clive Fields in Houston and Point South of Dallas have... well actually all over the country have this value based model that looks like it's really ahead of the game right now. That model seems to be doing very well in these times, even if you're not with Medicare patients, but with working class people. Is that model still solid with those two big ACOs and others like them?

Tom Banning:

Yeah, and it's not to mix metaphors, it's not rocket surgery here. What they have done, they've built fantastic networks that are highly sophisticated from a tech standpoint and they wrap a ton of care management and patient navigation around their patients. They help them make decisions again, that's not a reimbursable event, but they help them, they navigate them through a very costly system. If there's savings on the back side, then they get to split it and both groups have been phenomenal in their ability to bend the cost curve, to improve quality and it's based around some pretty simple care management strategies that honestly, that's what managed care was designed to do for the [inaudible 00:18:15] is the big health plans got out of managing care and simply started managing money.

Tom Banning:

So almost what's old is new again and that's some of the success to their model, but they also have some pretty good tech around them to help empower their physicians to perform at such a high level.

Ron Barshop:

Yes. I think you and I are going to have a disagreement about what is the top of the food chain in your... we had tacos in Dallas when we met at the Health Rosetta event and you thought that this value based model was really the bomb, and I thought direct primary care was the bomb, and I'd like to prosecute my case with you if I may. May I try that with you? You... there's probably nobody in the state I respect more than you to have this debate with, so it's not even a debate. It's just a matter of opinion, but my concern about value based care nationwide is that it's a set up, and it's a set up for a takeover of primary care. Everybody knows that the bigs have design on owning the network. Their customer's not the employer, not the tax payer, not the federal government, it's the networks, that's who they're trying to please.

Ron Barshop:

If they have more control of their networks, they have more control of what comes into their system and therefore, they've got really the source of the Nile, the mouth of the Mississippi however you want to look at it. I'm concerned that if capitation goes the way that MRIs went, that every other vertical you and I can name has gone, it just steadily gets hammered year after year after year until basically it's not affordable anymore. So if we want to say hey, the bigs are noble and they're trying to do the right thing by America, we're going to say, "They're never going to lower it so much that Clive and Chris Crow can't make a good living for their physicians to survive."

Ron Barshop:

But if we take a little bit of a conspiracy theory, a grassy knoll theory, we're going to say they're going to hammer reimbursement rates, or capitation rates until it's worth nothing and then they can just take those over. Am I completely smoking dope here?

Tom Banning:

No. I actually think that you're exactly right and it's a big concern that we have had in the conversations that I'm having with physicians about getting a cap rate, or a prospective payment rate that is simply too low and doesn't capture the services that a primary care physician is providing. All of the other care management strategies that they're utilizing and put in place. Now, this is going to be a hard thing for physicians to appreciate or understand, but I don't think we can avoid it and that is when we get on the other side of this pandemic, the world is going to look a lot different and we are not going to go back to the way in which healthcare has been delivered in the past. We are not going to go back to the way that we've been paying for it.

Tom Banning:

I think what you are likely to see are organized regional systems of care that are going to essentially consolidate or aggregate physicians, and that's going to occur either through the hospital, through private equity groups or physicians coming together to lead within their communities. So groups like Catalyst in Dallas or Village M.D. down in Houston. I think it's going to be incredibly tough if not impossible for solo or small group practices to continue doing what they have done, in the way in which they have done it.

Tom Banning:

In other words, they're going to have to align with like minded colleagues to help pay for the technology that's going to be required to help pay the care of management services that are going to be needed and required, and really just to do a lot of the business of medicine, and how do they choose to align is really going to define what the future looks like. But I think that as the groups get more sophisticated and certainly as they get larger, that should be a good counter balance to the desire or ability to squeeze even further the calf rate or the prospective payment rate. I think the doctors, certainly the more thoughtful and aggressive physicians really understand that their business model, what they can do and the savings that could be accrued if giving the opportunity and responsibility with some upside savings.

Tom Banning:

So I don't believe that they're scared to go down that path. I don't think that they're scared to renegotiate or look at the rates going forward, but I we are absolutely concerned that people are going to come and have a much different idea of what a rate should be that's "fair and adequate."

Ron Barshop:

The kindness of strangers model, you're Scarlet O'Hare and you're hoping the strangers are going to give you a fair rate every year, and the strangers aren't going to want you alive and their network is my feeling.

Tom Banning:

That's a fair issue, but if you think about just from a workforce standpoint, we've already got a big shortage of primary care physicians, because our medical schools have not been producing the workforce that we need. This pandemic is going to force a lot of retirements, or people that just can't make it any longer, which is going to create a greater strain on that workforce. So they may think that they can do something without... the bigs could do something without primary care, but I think they're going to be struggling to find enough as it is. So again, that creates a different environment.

Ron Barshop:

What I like about direct primary care... going back to taco days is that you don't have any stranger dictating what you're going to charge per member, per month. You get to charge your own rate and there's certainly market forces at work here, but direct primary care is... if you put the two ACOs we've talked about in Houston and Dallas together, they're still not even a tenth of Kaiser Permanente, which isn't even half the size of Optum's primary care group. So you're talking about a dot on the elephant's rear end, you know? That's value based care that's organized, because they can only work with five million dollar practices on up. They're trying to figure out how to go downstream and work with these smaller PCPs.

Ron Barshop:

So what you have in the ACOs is just they're aggregating larger and larger groups, and they've run out of independent larger groups, because they're all bought. There's literally towns in Texas, you can go to Temple, Texas not find a single independent family practitioner, or any other PCP. You can go the same thing to a dozen other smaller towns that are... I call them satellites, the metros, and there's literally no family practitioners that are independent anymore. They're just literally sopped up by these systems.

Tom Banning:

Yeah, and that's a failure of our healthcare system. Let me be clear, I like direct primary care. I am on the National Board of the Direct Primary Care Coalition. I go to a direct primary care physician. I think the challenge with DPC as it exists today is it's really difficult to scale and it is... if you limit the number of patients that you see in a DPC model, you are going to have difficulty caring for an entire community. The other issue is there's a tax advantage to employers providing health benefits that do not accrue at a direct primary care, and until that tax provision is changed. It's going to restrict the ability Of DPC to grow.

Ron Barshop:

Are you talking about the HSA? Or something else I don't know about?

Tom Banning:

Yeah, the HSA. The use of HSAs to... and in pretax dollars to be used to pay for direct primary care.

Ron Barshop:

Okay. So here's what I'm going to do with you. I'm going to set a time with you and before we hang up the phone today, and I'm going to show you a way around every problem you just stated. I think we've come up with a model that solves everything you just created as a non problem.

Tom Banning:

Great. I'd love to see it.

Ron Barshop:

I want to stay in touch with you, because as everything's changing so rapidly and you have this interesting macro view over the universe, how does TAFP rate among all the association of family physicians around the country? Are y'all the third largest or fourth largest?

Tom Banning:

We are the second largest in membership behind California but we are quickly catching them.

Ron Barshop:

Well they deserve to be in second place, they're not Texas.

Tom Banning:

That's very true.

Ron Barshop:

That's something you should be proud of. That's way to go Tom. So let's wrap up, what is the most important thing if [inaudible 00:27:22] family physician that you should be focusing on right now to shift gears and support the efforts you're using to get this more to a capitation model as opposed to fee for service, what can they do to join the movement if you will?

Tom Banning:

Well they can certainly go to our website; TAFP.org. They can go to the Health Rosetta website and read about the primary care martial plan. We've got an opportunity to provide feedback in our comment section, or they can reach out to me directly. My email address is tbanning@tafp.org or my cell phone... never stops ringing, so they can call me at 512-497-0048 if they want to share their thoughts. And I think they need to be open to change.

Ron Barshop:

If that martial plan, 50-50 chance a success? 10-90, what are you looking at as the odds of that even coming through?

Tom Banning:

We've had a lot of good conversations with both employers, insurers, and government. I think that there is a... again, a recognition that our fee for service system is failing primary care. We have spent over a decade talking about value base care and moving to a different model, and this is a real opportunity to significantly and fundamentally move the needle and change the

paradigm. I'm not a gambler, but I would say changing anything in healthcare is really hard, but I'd give it a 50... better than 50-50 chance.

Ron Barshop:

And who pays for it? Is it the insurance companies are going to check in with this value based model for everybody, or is it the employers are going to have to jump in? I mean, the employers aren't organized.

Tom Banning:

Well, the employers actually are pretty organized through groups like the National Alliance for Healthcare Purchasers. Some of the larger companies that are part of the Pacific Business Group on Health and some of the Dallas or the Texas Business Group on Health. The employers really have the opportunity to drive this, especially the self insurer employers that could just say, "We're going to take what we were spending in premium, take X percent and just carve it out for primary care and then use the insurers to pay for... or use the insurers and their TPAs to really provide insurance for what's insurable." Those conversations are ongoing.

Ron Barshop:

Well there's so much more to talk about, but no more time. What is the banner that you would fly over I'll call it Texas right now if you had to get a message out to all the Texas physicians?

Tom Banning:

Hang in there. We're going to get through this. It might be painful now. It is going to be painful and it is going to be ugly, but on the other side of this, the opportunities for primary care have never been better.

Ron Barshop:

Well Tom, thank you very much and I look forward to our next conversation.

Tom Banning:

Sounds great.

Ron Barshop:

Thank you for listening. You want to shake things up? There's two things you can do for us. One, go to primarycarecures.com for show notes and links to our guests and number two, help us spotlight what's working in primary care by listening on iTunes or wherever you get your podcasts and subscribing and leave a review. It helps our megaphone more than you know. Until next episode.