Primary Care Cures
Episode 142: Bill Wulf

Ron Barshop:

Welcome to the only show dedicated to a new way of delivering healthcare. This new model has no name, but let's go ahead and call it direct contracting or digital first care. The new way centers on opting out of the games bigs play with their rigged dice, their crooked game board and their purchased referees. And if you're looking for a future where everyone wins, that's the doc, the consumer, the employer, and with assured amazing outcomes and measurably lower costs that are ranging up to 60%, you're in the right place. I'm Ron Barshop, your host. I'm glad you're here. Welcome to the new healthcare economy.

Ron Barshop:

So, imagine an aquarium that can support one or two small fish per gallon, and imagine your aquarium is leaking 10% every year, yet you're adding fish every month, and that's what's happening in primary care today because we can only support a certain number of patients in a panel, and we're losing doctors because the average age of a primary care physician today is 58 years old. So, a third of them will be aging out. Now, many of them don't have to quit working. They can still do locums work. They can still work till they're 70 or 75, because 70 is the new 60, but more and more chronic patients are getting added every day. In fact, 10,000 Medicare patients daily are added to Medicare, and half of them have at least two chronic conditions. So, this is what I'm talking about, where the fish are going to overwhelm the water, and it's already happening because you're seeing wait times are getting longer, especially in cities like Boston and under-physician staffed cities, but you're also seeing longer waits for specialists and you're longer waits for well visits and sick visits.

Ron Barshop:

So, it's just a growing problem that is not going to get better. So, if you just had to look at exactly what's going on, we're about 2000 PCPs shy every year of what we need to have to just tread water. But remember, we're not treading water. We need to add to take care of this giant silver tsunami of demographics. So, worst case scenario, we're talking maybe 100 million underserved. If we have 54,000 to 150,000 doctors shy in the next 10 years, that's 100 million underserved. That's a third of our nation. That's a lot of people. So, normally prices will rise when you have shortages like this to deal with an imbalance, but the CMS just announced they're cutting primary care and other physician fees, so it's going the opposite direction. It's going the wrong direction. And 90% of healthcare is priced by these federal controls.

Ron Barshop:

10% of us are buying with cash, or using direct contracting, but with these great and mighty lobbies that hospitals and big system zone and quiet backroom deals, the bigs have federally

financed the independent PCP buyouts at a record pace of almost 2000 a month during the pandemic, thanks to the 175 billion in so-called Marshall Plan Funds, which had no strings attached. So, what changes overnight after the buyout of an independent? Well, the hospital can charge two X to four X for the exact same services, nothing different. That's as well as the tests and procedures, and they're likely also to be referring to X, to imaging and to labs that are owned by hospitals. So, those costs go up and they have a carve-out first, anti-kickback so that they can refer back to the hospital and actually get rewarded. That has happens in Independent. You get yourself in trouble.

Ron Barshop:

That's called stark anti-kickback. It's not a level playing field. So, the costs only rise with these buyouts and consumers have to wait longer, and consumers have to wait longer to see a family practitioner, an internal medicine doc, a pediatric doc, or an OB/GYN And if it's weeks now, count on months for well visits as these shortages literally grow daily. So, we'll be paying double for not one ounce of better care, and in big systems, the burnout increases also, and so do medical errors, which is the third leading cause of death in America. So, there's more pressure to send patients upstream or downstream, as you might say, into the hospitals and ERs and those physicians, once they sell out, they don't like it, but that's the game they got to play. Now ,the AMA we would think is going to protect PCPs, but they've turned into this motorless, rudderless, leaderless boat drifting off the falls, representing only 10% of the docs today, because half of their members are students and residents that have to pay the 20 bucks.

Ron Barshop:

If you look at their 2020 annual report, they have not stated their membership since 2011, it turns out, because they earn most of their revenues off of this CPT coding. So, here's to the rescue, hopefully, Primary Care of America, which is really the first coalition started by large independent physicians to sort of fight back and think this thing through. What is the right strategy? It is comprised as founding members, of a lot of people that have been on this show. So, the key partners right now are [all a day 00:04:21] Inc and the American Academy of Family Physicians, the American College of Physicians, Catalyst Health Network. Y'all have met Chris Crowe twice. You've met Gordon Chen of ChenMed, Elation. Everside Health, you met [war ed die all 00:04:34] MD VIP One Medical, a public company and Village MD you've met Clide Fields.

Ron Barshop:

Today's guest is on the board of Agilon Health, which he founded and they're banded together to support independent PCPs, and their great strength is primary care is the only medical care with measurably better outcomes over time for independence, lower costs, longer life, improved health span, and importantly, and this is the big one is patients attributable to a doc. What that means is that the weight of the millions of patients behind these founders are representative. You can get your patients, in other words, to potentially call Congress and put some heat on them because you literally have millions of patients that are behind you. Specialists do not have attributable patients. It's episodic or transactional. The primary care does, especially the independents. So, Bravo.

Ron Barshop:

Today we welcome [inaudible 00:05:29] a co-founder of Primary Care for American, Dr. Bill Wulf. He's currently practicing with the Central Ohio Primary Care and as its leader, but he also is on the board, as I said, of Agilon Health. So, COPC, Central Ohio Primary Care is an independently physician-owned organization and has grown to over 430 physicians in 80 locations throughout Central Ohio, and we welcome Bill Wulf to the show.

Bill Wulf:

Thank you, Ron. Your introduction even made me sad with the dire condition we're in looking forward, with up to 100 million Americans underserved. So, thank you for having me.

Ron Barshop:

Thank you for joining us. So, ,the million dollar question I have right now, because we're at sort of a precious point in Congress is there's a three and a half of trillion dollar infrastructure package being finally negotiated and voted on in the Senate and in Congress, that is basically, hopefully going to have something in it for primary care. I think the ask, when I look at the websites is 14,000 new GME-funded residencies. Is that in the bill?

Bill Wulf:

Yeah, and I surely can't speak to what will be in the final bill or what they're negotiating, but we can only hope that primary care is addressed by Congress. I think CMMI is trying very hard to address primary care and move physicians to value, which we of course, support strongly. But I do hope Congress gets behind that with significant funding for primary care.

Ron Barshop:

You know, and I don't like to thump hospitals, but it's just so easy to, but they are primarily on the fee for serve business. The fee for services, really what value-based care sort of abhors, because it's all the volume-centric and it's based on how much activity you have, not on patient outcomes. Whereas, value-based care is very rewarded for precisely the opposite.

Bill Wulf:

I can, if you'll you'll allow me, I'll take you all the way back to 2010 with our organization. COPC was, we were founded in 1996. 33 of us got together to form COPC, and we did so for lots of reasons. One of them was to, we thought we could provide higher quality. So ,if we fast forward to 2010, I was our Medical Director at that time, prior to becoming CEO. For one of the first times, we actually had good data around our physician's performance, individual physician's performance. When I looked at, when I looked for our quality physicians, and so what's a quality physician, a high-quality physician? That's a physician that has most of their diabetics in control, most of their hypertensives in control, has excellent cancer screening percentages. They're identifying breast cancer in Stage One because all of their women get mammograms.

Bill Wulf:

They have no one with colon cancer, because everybody's had a colonoscopy. When we could finally identify our highest quality physicians, when I bumped that up against their salary in a fee for service world, our highest performing physicians made the least money. All you had to do was look at their, if you looked at their schedule, you found out why. They saw patients in

extended blocks of time. So, our highest performing physician only saw patients in a half-hour block, and in a fee for service world, quite frankly, in 2009, she made $52,000 as a primary care physician, but was entirely happy with her performance. She could go home at night and feel good about what she had done that day. And, it was, became so obvious to us that we had to, we had to move our physicians into contract structures that paid them for things that didn't happen to their patients.

Bill Wulf:

So, we went out to the payers and said, "We need a per-member, per-month payment upfront, and when we create value, when we create programs that help our physicians and patients create value, we need to share in the savings. Fortunately, payers were willing to do that, but it is so obvious that the fee for service system is broken. You cannot do primary care fast. You have to take your time. You have to take your time with the right patients, and the fee for service system is entirely broken, and you've addressed that already. So, I hope that demonstrates what we were up against and why we started down the path to value.

Ron Barshop:

So, these, this band of brothers, if you will, is now a value- based, centric group. What do you hope you'll accomplish in the next year or two or three, as you start getting the wheels turning, because you just announced literally last month.

Bill Wulf:

Correct. Correct. What we hope to do, number one, is attract other physician organizations to this organization, and encourage physicians to move into the value movement. I would also tell you and what, when you introduced me, and thank you for that kind introduction, I am also the board chair for America's Physician Group, an organization that is not just primary care-centric, but is also deep into the value movement. We, as an organization at APG, represent 345 physician groups, 190,000 physicians who are caring for 45 million patients. It is just crucial that we move primary care from volume to value. I know that's a buzzword, but quite frankly, we've got to move physicians to risk. We at Agilon Health, as a founding member of Primary Care for America, that's what we do. We move physicians into risk-based contracting. Right now, for just seniors, both for Medicare Advantage, and we as Agilon are in direct contracting.

Ron Barshop:

Well, so let's talk about that. If you, ideally, you could go after hospital populations in rural areas because those are attributable to the hospital as its primary care, if you will.

Bill Wulf:

Absolutely. I would love for system-based primary care physicians to move into this organization and quite frankly, systems should be doing that. They should be in value contracting. You mentioned it upfront. A primary care physician employed by a system is generally paid more than they are generating. They do not live in a revenue-minus expense world. So, a system is quite typically overpaying a physician for their services and they can overpay them, because as you mentioned, there is downstream revenue that, that physician generates for a system. But, if we can get that physician into value-based contracting, we can

offset some of that cost the system is paying to support that primary care physician. So, every physician in America could be in, every primary care physician, whether employed by a system or independent, could be in value- based contracting and, and be focused on creating value.

Bill Wulf:

I would point to, and so let me give you another example of what value looks like. For our organization, COPC and also for many of the Agilon organizations, if you're a COPC patient today, and you show up in the four busiest emergency rooms in Columbus, Ohio, the first person to see you is a COPC-employed nurse, not providing clinical services. But that nurse goes up to Betty Smith, our patient in the ER, and says, "Betty, I'm a nurse with COPC. I'm going to help manage your emergency room stay." And, our goal is to hopefully send home people that don't need to be admitted. ER, docs aren't bad people. They just need to disposition that patient, and quite frankly, if the ER doc isn't convinced that that patient is going to get adequate follow up tomorrow, they're going to put the patient in observation.

Bill Wulf:

But if we, a nurse goes over to the ER doc and says, "I'm with Betty Smith in Bay 12. I think we can get her home. I can get an appointment for her tomorrow. I have her medical record. I'm communicating securely with her primary care physician. I think we can get her home." That satisfies the ER doc. If we can send that patient home, we do. So, the patient leaves the emergency room with an appointment. If that patient's admitted, they're admitted to one of our hospitalists in those four hospitals. The following day, a transition nurse sits at the bedside and says, "Betty, I think you're going home Thursday. I have an appointment for you Tuesday."

Bill Wulf:

So, our patients don't leave an admission without an appointment. That nurse then calls Betty Smith the day after discharge and says, "Betty, how are you doing? Did you change your prescriptions? Did you, do you have everything you need? Do you need food? Are there any needs we can meet for you to prevent a readmission?" If Betty needs something, we will send at our expense, without charge, a social worker, a nurse, or a doctor. We have three physicians, all they do are home visits after discharge, if necessary. We will do anything to prevent a readmission to the hospital. A Medicare admission is $11,000. What would you do today to save $11,000? You'd send a nurse, a social worker and/or a doctor to the house. So, that's what value-based contracting does, and that's what we want for primary care physicians across America, and quite frankly, that's what we want for patients.

Ron Barshop:

I'm going to assume that Optimum, the largest primary care group in America is value-based, because they're also an insurance company. I'm going to assume Kaiser Permanente, because they're a systematic system wide insurance/hospital/primary care group.

Bill Wulf:

Kaiser's a superstar at this. You're right.

Ron Barshop:

Yeah. Geisinger, I'm going to say they've got to be value-based as well for the same, and Intermountain, they have to be for the same reason.

Bill Wulf:

Absolutely. All great organizations.

Ron Barshop:

But, then you've got companies like HCA. Why would they care to join this when they are again, procedure-focused, volume- focused?

Bill Wulf:

Well, quite frankly, I just don't think ... they are volume- focused, but if you're a hospital, you don't necessarily make much money on a Medicare medical admission. In fact, you might, it might be breakeven. Admitting a Medicare patient with a simple pneumonia that could be treated as an outpatient, admitting a Medicare patient overnight for a quick observation stay, I just don't think they've gotten to the point that this is their focus. There are people that need to be in the hospital, and what hospitals want and need to survive are procedures. So, I do think eventually systems get to this point. I just don't think it's their current focus.

Ron Barshop:

Okay. So, it's a matter of time? It's inevitable, you think?

Bill Wulf:

Well, I hope it's a matter of time, and I hope it's inevitable, because this is, that's what patients deserve.

Ron Barshop:

All right. So, CMS has come out with a lot of studies that show that value-based care is not saving hardly more than a 10th of a percent over fee for service, which kind of shocked me to see that. I know there's different risk models like the ChenMed is the full risk model, where they go at full risk and they're not ... and they tell me that only two to 5% of primary care physicians are at full risk. Most are at a partial risk schedule, capitation schedule. Do you see full risk as an answer or is it just too scary for most to step into?

Bill Wulf:

Yeah. I think full risk is surely part of the answer. I think full risk changes behaviors and creates the value necessary to change behavior. So, I do think, and we at Agilon move our physicians to full risk and physicians oftentimes need a partner to move to full risk. Quite frankly, we chose Agilon as our partner, taking full risk on a large population. When we moved to full on our Medicare Advantage lives, we had 22,000 patients. That's a $220 million book of business. Even COPC, as one of the largest primary care organizations in the country couldn't take downside risk on those patients. So, we like many groups, needed a partner to move to risk. So, I do think finding the right partner is important. I think that, but I do think full risk is the answer.

Bill Wulf:

People need to move to a prepaid, full risk arrangement for their lives, and it just takes time. It takes time to get there, and we've gone from 22,000 to 35,000 in Medicare Advantage, and we've got another 35,000 in direct contracting. COPC, we were like many of the Agilon organizations and many of the organizations in Primary Care for America, we were in CPC Plus, a CMMI program, and have moved to direct contracting. I think, and you referenced how many of these programs haven't worked. Remember, these, many of them are pilots. CMMI has a pilot program. They roll it out. So, some of these programs are working and will work. The problem with CPC Plus was it wasn't full risk, and again, the value created in that program didn't necessarily change behaviors, but that's what we have to get to.

Ron Barshop:

Let's talk about the physician shortage. I have seen, the last two or three years, there are six states that are now allowing foreign medical graduates to skip residency and go straight to practicing in that state with full licensure as long as they're under an American doc for three years. We have at least 15,000 pediatricians that are foreign medical graduates that can't get slotted, because there's only 7,000 slots. I have, I think there's even more internal medicine foreign medical graduates who are earning ridiculously low wages because they're not yet a white coat here. Do you think that that might be a solution for solving the primary care shortage, is accelerating the F and G residency rate?

Bill Wulf:

Yeah. I must admit I haven't thought much about that. So, this would be all off the top of my head, but I do think if we can prove adequate training at, in their, in the environment they trained in and place them under another physician or an organization that can track performance, I do think that would be a reasonable approach, and really, it may just be expanding primary care training. Maybe it's a shorter training period here in America, but it would be expanding training, which of course would take the support of Washington and CMS. But, I do think there are physicians that we should include as primary care physicians with some level of training after we've proven that their initial training was adequate. So, I do think that's an approach. The other thing is we need, we do need more slots, and there are, are slots that aren't filled by American-trained physicians in primary care. The solution to that is making primary care a more attractive alternative, and I think that's what we're doing with risk-based contracting.

Ron Barshop:

What, let's talk about that for a second. What is the comp, is there a comp diff differential between traditional fee for service and value-based for, let's call it an internal medicine doc or family practice doc?

Bill Wulf:

Oh, absolutely. There's a comp, a difference, and I'll tell you where, what occurs. What, in a fee for service world, a physician can essentially set their salary. If you, as an independent physician, I can say, I want to make X and whatever fraction of X one patient represents, that just turns into how many patients I have to see in a day. So, and doctors did that for generations. As a primary care physician, you could be as busy as you wanted to be and make what you needed to make.

The problem is, along came the electronic medical record, which is undoubtedly a better record. It's just harder, and it's more complicated, and there's more clerical work for the physician involved. So, the electronic record, though, a better record, and can absolutely assist us in taking better care of patients.

Bill Wulf:

I just say a simple thing about that. Show me a wall of 20,000 medical record charts, and tell me which diabetics aren't in control. You can't do it, and put 20,000 patients in electronic record, and you can tell me in a minute, who's not in control. So, it is a better record. It's just harder. So, the electronic record became the impediment to seeing 30 or 35 patients a day in a fee for servers world. So, but at 35 people a day, you cannot, I just don't think you can be providing quality. So, along comes value-based contracting, where we as physicians in primary care, we should be seeing the patients that need to be seen, not those that necessarily want to be seen, and so we can identify who should be seen in a day.

Bill Wulf:

Again, another example, in 10 years ago, our physicians would start the day with a full schedule and, and squeeze as many people as they could in, in a day, in the fee for service world. Now, unfortunately, Betty Smith was home in stage two heart failure on Tuesday, and couldn't get an appointment until Thursday, and Wednesday she's in the hospital. So, if what we do now is, our primary care physicians, our adult primary care physicians see somewhere between 16 and 18 people a day, not 25 to 30. And they start the day with open spots, because we're now seeing the patients that need to be seen, not just the patients that want to be seen.

Ron Barshop:

We had start off the question about comp. And I think we got into this other quality discussion. Is comp up 10, 20, 30%. What is it looking like in value-based versus the high volume centric?

Bill Wulf:

I would tell you that compensation is up 30 to 40%, and 30 to 40% of our physician's compensation, 30% of our physician's compensation is shared savings and value-based earnings, and physician satisfaction is significantly up. Our net promoter score for our physicians is 84 to 87, the last couple of years. My gosh, that's above Southwest Airlines than apple. Our physicians are more satisfied with their practice, with their experience, with the care they're able to deliver. The bottom line is, we are providing high-quality, high-value care to our patients.

Ron Barshop:

If you're saying 16 versus 25 or 27, that's got to have an impact on burnout. Now, have their been any studies to show that that less volume is going to help the doctor get through their week?

Bill Wulf:

I can't tell you that we've done it, but I know there are studies that show that. [inaudible 00:25:58] and again, high volume means you're working harder at night to complete charts. You have more charts to finish. It's very difficult to get all your charting done in the electronic record while you're seeing patients. Now, some doctors have become very good at it, and we're dabbling

into remote scribes. We use dictation, direct dictation into the HR. I mean, we are, we're working hard to help our physicians, and improve physician wellbeing. Burnout is real. We have physicians that are still burning out. It is real. I, but I do think we are, we are delaying burnout. We still have to address the difficulty of the electronic record and we're doing that, but we're delaying it with fewer patients and improved income.

Ron Barshop:

So, this new coalition to kind of close this discussion out, if you could say you had a really good three-year run when we talk three years from now, what would that look like?

Bill Wulf:

I think we would to triple our membership, and I think we would see a significant increase in the number of physicians in America that are in value-based contracting. Initially, it starts with a per-member, per-month payment that helps you develop programs that create value. You then get shared savings, and then you move into full risk contracting. I think America's physician groups is pushing for that. I think Primary Care for America is pushing for that. It's, when we as physicians have seen the change that value based-contracting makes in a physician's life and in patient's care, we just have to, we have to spread the word and we have to get as many physicians in the right contracting model as possible.

Ron Barshop:

Okay. So, we're going to set a target here. So, if we have 200,000 PCPs that are currently VVC, what percentage right now are in value-based of the 200,000? Do you have any sense of that?

Bill Wulf:

I would say, and again, I'd be guessing. I don't know, but I think it's probably less than 25%.

Ron Barshop:

Okay. So, maybe in three years we might get that up to what, 35, 45, 50%?

Bill Wulf:

Boy, I think we're at the precipice of moving to 50% in three years. I mean, this has to be the solution. Yeah. The other thing we haven't addressed is this helps eliminate waste. There is so much waste in the system that if we just, as physicians, go after waste, we create savings, and we eliminate some harm to patients.

Ron Barshop:

Right. Well, Bill, thank you for your time. How do people reach to out to you if they want to join this coalition?

Bill Wulf:

Yeah. Go to the website, the Primary Care for America website.

Ron Barshop:

All right, and if you could fly a banner over America with one important message for all to read, what would that be?

Bill Wulf:

Value-based contracting leads to higher quality and lower cost.

Ron Barshop:

Thank you for your time, Bill.

Bill Wulf:

Thank you, Ron.

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 podcast and subscribing and leave us a review. It helps our megaphone more than you know. Until next episode.