Primary Care Cures

Episode #35 – Michael Berg

Ron Barshop: Most problems in healthcare are fixed already. Primary care is already cured on the fringes. Reversing burnout, physician shortages, bad business models, forced buy outs, factory medicine, high deductible insurance that squeezes the docs and is totally inaccessible to most of the employees, the big squeeze is always on for docs. It's the acceleration of costs 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: Fee-for-service versus value-based care is a binary choice. Here's what I don't get about value-based care. When only six to 16 percent of patients are compliant with their meds, and half don't make it to their specialist referral, what exactly is the PCP supposed to do? They are supposed to dance the tango by themselves? This is why I'm not hanging onto fee-based service model.

Ron Barshop: It's why most doctors aren't hanging onto fee-based service model is they can't answer what do you do to get a patient to comply? A world-class pediatrician I had dinner with recently told me the reason he chose children. During his residency, he saw an adult who had just been hospitalized for hypertension, and he had a very serious sodium intake problem and was told that something simple as a pretzel could kill him in a few months. And he walks in right after the diagnosis and sees the guy eating a jar full of pickles, a month's worth of his prescriptive diet times 10. He said, "That's the day I chose pediatrics, at that moment."

Ron Barshop: The value-based care issue is what do you do about pickle eaters? What do you do about smokers that know it's bad for them? What do you do about people that are non-compliant? I don't have an answer, and I would love any answers that you as a listener have. Primary care at its very best is a human connection. It takes two.

Ron Barshop: There's a carrot and stick initiative from the smartest guys in the room with value-based care is my opinion right now, but I'm definitely looking for any answers, and it appears a noble charge at windmills, but again, penalizes PCPs for something they can't control, reality versus ivory tower

thinking. It really gets down to this primary care is a bad model, and that's our guest today. We're going to address this primary care model that has so many flaws but a big fix called ancillaries.

Ron Barshop: How do you tilt the bad model in your favor? Well, direct primary care is one answer and ancillaries is the other. Today, I'd like you to meet Michael Berg, who's the president and co-founder of Ancillary Medical Solutions based out of California, but they're nationwide. 13 years he's been in the medical sector, 10 in ancillaries, and he's an expert in ancillaries, so we're going to really tap his brain today. And he publishes the comprehensive medical ancillary catalog and has 50 plus verticals he has knowledge over, so welcome to the show, Michael Berg.

Michael Berg: Thank you for having me. It's a pleasure to be here.

Ron Barshop: What I learned and the reason I got excited about ancillaries when I was just getting started was I met a doctor in the middle of nowhere who was drawing patients from 400 miles around. He showed me his tax return. He was netting $2 million that he was reporting on his taxes as a family practice doctor.

Ron Barshop: And his secret sauce was he ran a practice that was lead-generated, we'll call it in our parlance, and then his main business really was ancillaries. He had 120 patients a day, but most of them were going back to his 10 or 12 different ancillaries he had in the back of the office. And they were so happy that they had one place to go to get all of these workups done, and they didn't have to go see a specialist, which I just reported half of them won't go anyway.

Ron Barshop: What got you into ancillaries? Because that's what got me into ancillaries is seeing something wonderful like that could really change family practice care forever.

Michael Berg: I actually started as a drug rep just like you guys. I was a drug rep for Merck, and I remember being in an office once, and I heard a sales rep walk in and start talking to the front desk person about medical ancillaries.

Michael Berg: And at that point, I had to Google what a medical ancillary was. I really had no idea what it was, but as soon as I started doing some research, I was intrigued because while I was pushing certain medications, a lot of the feedback that I was getting from physicians is that, "This is all well and good, Mike, but I have bigger problems than which cholesterol medication I'm going to give this patient or that patient."

Michael Berg: And the more you got to know physicians, especially the independent physicians, the more I saw the need for something like medical ancillaries.

And so I wanted to be part of the solution and really help those doctors that I had forged relationships with. I was looking for a way to help them with their biggest problem, which was maintaining their independence.

Ron Barshop: You're in California. Of course, you have a nationwide overview. What are you seeing, with this direction towards corporatization of care, is the salvation for independence if not ancillaries?

Michael Berg: Absolutely. I don't know if you guys saw Medical Economics had published a issue last month - I think it was the May issue - and it was solely dedicated to the rise of medical ancillaries and had several articles in there about medical ancillaries. And I don't remember the exact statistics, but I think it's up to about 91 percent, I want to say, of independent primary care practices that have at least one medical ancillary that they've enrolled in.

Michael Berg: When I got started in this business, that number was in the teens, so this has definitely reached critical mass. This is something that providers know about, and just like you brought up that example of the rural doctor, we're seeing that with a lot of independent practices that are now thriving by just providing more services at the point of care and taking advantage of these different programs that the marketplace has supplied to them.

Ron Barshop: You and I have both been at this for a decade, and my experience in the early days was the specialists really were very angry with the PCPs for taking away their cookie jar. These workups are really quite profitable, and they're terrific cash generators and don't take a lot of specialty expertise, and [MA 00:06:28] can run most of these. There was a little bit of a little head throb vein working when the specialists would talk to you.

Ron Barshop: But that's changed because what's happened, instead of 50 percent compliance, when I've got a workup, I'm more likely to go get that diabetes treatment. When I have a workup, I'm more likely to do that weight management program or quit smoking or whatever the specialist they're sending me to, even a podiatrist. I'm more likely to go if I have a workup that says, "Here's exactly what's going on that my PCP ran for me." Do you find that to be true?

Michael Berg: I do, yeah. And we got the same sort of pushback in the beginning, especially from the specialists and even some primary care doctors that were worried about upsetting their specialists that they're referring their patients to. But what we found is that for a lot of medical ancillaries, they are screening tools in a lot of cases, which have obviously some opportunities to build codes and to generate some revenue at the point of care.

Michael Berg: But that patient who has severe cardiovascular issues, who needs intervention, is still going to be referred to the cardiologist, but what these tools allow doctors to do is to screen and track patients better, in most cases, and basically have that specialist focus in on the patients who really need their care. And it helps actually filter out some of the patients who could be treated by their primary care physician.

Ron Barshop: It's a bell curve. Let's call a 10 percent of the doctors pure Hippocratic oath and, "Profits are terrible. You shouldn't be going for profits." 10 percent of the doctors are, "Show me the money, honey," and the 80 percent in the middle is some degree of inflection between those two extremes.

Ron Barshop: When I meet a doctor who says, "I don't want to do anything that takes away from what a specialist should be doing," what is your reaction? I feel sorry for them.

Michael Berg: Well, the ancillary market place is pretty vast, so in my experience, what we tend to do is to focus in on exactly what the goals of their practice would be. And if they are worried about taking patients away from their specialists, there are other ways to employ medical ancillaries that may not cannibalize their relationship with their providers. Oh God, there's got to be 100 plus opportunities right now in the medical ancillary space.

Michael Berg: If you don't want to bring in allergy testing because, "My brother-in-law's the allergist. I send everything over to him," or, "I just have a great relationship going with my allergist. I don't want to start supplying immunotherapy at the point of care because of that," well, that's fine, but there are several other disease states. There are several other conditions that could be treated at the point of care.

Michael Berg: And so that's pretty much how we handle it. We just tend to go with whatever the practice is comfortable with and respect those relationships that they have. But as I said, in a lot of cases with the medical ancillaries, what they're helping do is just provide additional services at the point of care so that the patients who end up with that specialist are the patients who really need that specialist.

Michael Berg: We see the opposite problem happen too where the specialists are now performing some of the functions that primary care used to do. Chronic care management is an example. I just had this come up where a physician was telling me she was kind of upset with her rheumatologist that she's referring a lot of her patients to, and she says, "I put in this chronic care management program, but I found out the rheumatologist is already signing up my patients for chronic care management," so it cuts both ways.

Ron Barshop: A lot of PCPs are worried about sending somebody out to a specialist and never seeing them again. That's a very real fear. I've done my own analysis, Mike, and I found there's about 20 different categories of ancillaries that make sense.

Ron Barshop: I don't want to go through all 20 of those right now, but what should a doctor be looking for in terms of just a foundational model for what makes sense with adding ancillaries? There's, for example, models where they come in, and they'll just do a day trip, and you'll schedule appointments, and they'll see all your patients for that day.

Ron Barshop: There's people that are embedded. They'll have a full time staff person there, and there's every color and flavor in between. What are you seeing are the most successful models that are working for PCPs if they hire an outside ancillary services firm to help them out?

Michael Berg: Well, there's really no one-size-fits-all solution. As you brought up, there are a lot of different models out there. What we try to do is custom fit solutions for each practice. The factors that need to be taken into consideration are obviously your location, because there are some restrictions in certain States with certain ancillaries.

Michael Berg: You have to take into consideration your population, your patient population. Are you heavy with Medicare? Are you heavy with state Medicaid? A lot of programs don't work with state Medicaids, but there are some programs that thrive with state Medicaid. Same with Medicare. Some are PPO only. Some practices do a lot of work comp and personal injury, and there is a select, niche group of ancillaries that are for those markets. That's the first thing we do.

Michael Berg: And then we also look at the size of the practice and try to give realistic expectations because some of those models that you had just highlighted there where maybe you have somebody who's coming in periodically to perform a service, or you're putting a full time technician in the office to maybe run a specific device or perform a certain tests, those require a certain volume of patients, and you have to make the determination of whether you have the right sort of patients where you're going to be able to fulfill the minimum requirements, the quotas that these companies will put on you.

Michael Berg: Because that's the flip side of it. You can bring in a program that looks great, but in order to justify having a technician working there at the practice basically full-time, that's going to require X amount of patients. And if you don't get there, then you're going to face the other problem of facing pressure from the ancillary vendor to supply more patients, which a provider may or may not have the capability of doing.

Ron Barshop: Look, you and I've met professionals in the ancillary business, and we've met amateurs. And there's three models I've seen for revenue sharing, and maybe you think can think of a fourth one.

Ron Barshop: But the first model is going to be, "You're going to pay a professional fee, and I'll get the global fee or vice versa." A second model would be, "I'm just going to rent space from you and pay you every which way I can that's legal with [inaudible 00:13:10] kickback." And a third model that I see actually the most of is what I call a fee-splitting model, which isn't legal and isn't acceptable.

Ron Barshop: Do you agree that there's a lot of people out there that are playing games with what is acceptable? And the doctors, some of them don't know the difference.

Michael Berg: Yeah. I would agree 100 percent, yeah. Fee-splitting, taking a percentage of the bill, that is not legal, so any company who's pushing that on you, I would be suspect of a company like that. However, maybe five years ago I ran into those sorts of firms that were employing some sort of model like that. I see that less and less, so the models where it's just straight rental income, it's not tied to patient production, that's 100 percent legal.

Michael Berg: And that's an easy way to get out of the insurance pay paradigm. Put the onus on the ancillary vendor. I'll give you an example just because I did a webinar last night with one of our companies that advertises with us called Physician Hearing Network. And they do onsite audiology, so they pay the physician a set fee. I think it's for two days per week.

Michael Berg: They will tie up an exam room, but they do their own billing. They see the physician's patients, but they get a guaranteed rental income of I think it's around $1,700 per month or so, so it's fair market value. That's a compliant legal ... You're not going to get rich, but it is a way to add some additional revenue to your practice and add some additional services for your patients, so that would be an example of a clean compliant model.

Michael Berg: Whereas you mentioned, I have seen some of these models in the past where it's, "Doc, I'm going to bring in this machine, and we're going to a 50/50 split on the billing." If you hear that, you should be very suspect of someone who brings you an opportunity that looks like that.

Ron Barshop: Excellent. What are your two or three favorite models you see out there right now? I know you've got a diabetes model that I'd love to hear more about, but what do doctors seem to be responding to the most right now?

Michael Berg: Probably turnkey models are where we can bring in maybe a new modality into a practice. Over the last year, there's an osteoarthritis treatment

protocol that's been very successful, very popular with primary care physicians. And again, this kind of ties into what we had spoke about earlier about not cannibalizing your relationship with your specialist.

Michael Berg: I don't know how much you know about viscosupplementation, but these codes are now available for primary care doctors. And the reason is is because primary care doctors have a vested interest in avoiding surgery, and they have about a 70 percent success rate, give or take, depending on the study. It is very effective at at least delaying surgery if not avoiding it altogether, so this is a big cost savings.

Michael Berg: The orthopedic surgeons, on the other hand, their incentive structure is to cut people open and do surgeries. That's where they make their money, so in this model, we can basically bring in a full osteoarthritis treatment protocol, including a fluoroscope and onsite training from a physician, physician-to-physician training, and basically walk a practice through performing viscosupplementation.

Michael Berg: Now, there's good revenue in it for a practice. It's also there's a lot of patients that suffer from osteoarthritis, but some of the patients are not going to respond to it. They could be bone-on-bone. It's just not going to do any good, and those patients will still get sent to the orthopedic surgeon to get their surgeries, but that would be an example of a program that's had a lot of success because it's something that affects a lot of patients.

Michael Berg: It's a turnkey model, so it's really buttoned up. There's nothing for the practice to figure out. They will come into the practice and basically do full training for two days, and by the time the company leaves, that practice is pretty well-versed on how to perform these procedures, establish medical necessity properly, do the documentation, and, of course, patient intake and billing and coding.

Michael Berg: Now, the other program that is extremely popular right now is the Diabetes Diagnostic and Treatment Protocol. Same sort of model, but this focuses on diabetic patients, and this is done in coordination with the CDC program called the Diabetes Lifestyle Change Program. CMS also has their own program called DPP, the Diabetes Prevention Program. They operate off the same set of guidelines, but these programs are supported because they have proven results. The patients who go through the Diabetes Lifestyle Change Program have shown to have a 58 percent reduction in type two diabetes.

Michael Berg: Those who do get diabetes delay the onset by four years on average. Now, CMS pays roughly $17,000 per year to treat one diabetic patient, so you can do the quick math in your head as to what the incentive structure would be for CMS to promote a program like this. If you can delay the

onset by four years, that's about a $70,000 savings to the healthcare system.

Michael Berg: They make programs like this available for physicians with no co-pay to the patients. These generate thousands and thousands of dollars for the practice and meets several quality measures toward your MIPS Composite Score. We like programs like this because this really kind of goes with the flow. There are programs that exist out there that maybe I hate to say exploit a loophole, but they do.

Michael Berg: There are programs we've seen in the past where maybe it's ... I don't know how familiar physicians would be of the compounding space, but we've seen this in the compound pharmacy space in the past where pharmacies figured out, "Hey, if we just combine these three different NDCs, we can get a $12,000 reimbursement on this prescription."

Michael Berg: Well, that's a loophole. That's not a program that's built to last. That's meant for opportunistic people who are looking to get rich. For physicians and practices who are looking for a program that is built to last, you need to look at where the incentive structures lie, and CMS is incentivizing doctors through the MIPS Composite Scoring.

Michael Berg: And I'm sure all the physicians who listen to your podcast are at least vaguely familiar with your MIPS Composite Score, but this affects your total reimbursements. It's a zero sum game, so you can bet the corporate guys are paying attention to this, but you look at the programs that are built to last, these are the ones that have quality measures.

Michael Berg: These are the ones that offer lots of codes for doctors to bill because ultimately, it leads to a cost savings down the road and leads to a better quality of care and reduces instance of patient getting diabetes, improves just the overall quality of care. Those are the types of programs that are built to last.

Ron Barshop: All right. I've got a hard stop at just a few minutes, so I'm just going to ask two more questions of you, Mike. The first question is do you have any strong feelings one way or another towards cash pay versus insurance-based? In other words, are you presenting solutions for JUVÉDERM and BOTOX and eyelash extensions?

Michael Berg: Of course. Of course. A lot of physicians have diversified either partially or completely away from the insurance pay paradigm and for good reason. I totally get it. I hear the complaints from doctors all the time, and I understand the stresses that they go through and the claw-backs or the push-backs on not getting a co-pay because you didn't properly establish medical necessity in the notes back and forth.

Michael Berg: And a good portion of they and their staff's time is spent fighting with insurance companies, and it drives everybody crazy. I understand that. However, the bulk of the medical industry is still an insurance pay model, so if you want to fish in the deeper ocean here, you have to stick with the insurance pay model. For a lot of physicians, they don't have a choice, so what we try to do is advise doctors within that paradigm, like I mentioned with the osteoarthritis or diabetes protocol, "Here are some things that you can do that basically go with the flow."

Michael Berg: Now, the cash pay models though, there are a lot of practices that we talk to who, five years ago, they might've been just sticking their toe in the water with some cash pay services. There's a lot of great regenerative medicine products that are out in the market. The marketplace is just absolutely flooded with them, and these programs go anywhere from good to great.

Michael Berg: I mean, they all work. That's the thing. These regenerative products, they all seem to work on some level, and there's a huge market out there for patients, especially as the baby boomers get older. They'll pay for things like regrowing hair, for looking younger, for feeling younger. Whether it's bioidentical hormone replacement, PRP, amniotic-derived fluid, STEM cells, all those sorts of products, there's a big growing market.

Michael Berg: I know that that market is expected to grow by five X by the year 2030, so especially if you're a doctor who's maybe in the front nine of your career, not a bad thing to diversify and have at least a portion of your payers be cash payers. We've also seen doctors who switched to concierge models altogether, and if you have the right sort of location and the right sort of patients, that can be a successful model also. And I know several doctors who are doing concierge models, and their quality of life has improved dramatically from just getting completely out of that insurance pay paradigm. The answer to your question is both models work.

Ron Barshop: All right. I have two more questions. The books you're recommending people read to learn more about this area, is there any magazines, books, reading cues they should get on to find out more?

Michael Berg: Well, I read Medical Economics, and I follow them. That's probably number one, because I know a lot of physicians read Medical Economics so they can stay on top of the latest trends. We also publish our own blog, and we do a vlog also, I just published one last night actually, on five reasons that doctors should pay attention to their MIPS Score.

Michael Berg: We just did an analysis of looking at some Google analytics to see which programs doctors are seeking out, so I did one last week on nine trending

ancillaries for 2019 that kind of dovetail with the Medical Economics article. And other than that, that's pretty much it.

Ron Barshop: Great. And my last question is if you could fly a giant banner over America, what would your message be to Americans?

Michael Berg: Well, my message would be targeted at doctors because this is my market. This is my career. I've been in this space now for more than half of my career, and this is where I plan on retiring.

Michael Berg: And when I went from pharmaceuticals and transitioned into the ancillary side, I really felt like this was my calling, and so I created this whole company based on this. And this is what I think about morning, noon, and night, and so my sole focus is on helping independent medical practices maintain their independence and provide the maximum amount of services that they can provide to their patients.

Ron Barshop: And I think that maintaining independence is critical for healthcare in general because the problem when people either have to be forced to sell or are encouraged to sell because they just can't seem to manage, burnout increases dramatically; medical errors increase dramatically; the outcomes don't improve; and the care cost goes up, so the referral patterns change from a different place of service to a more expensive place of service within a system.

Ron Barshop: And so there's no advantage cost-wise, there's no advantage outcome-wise to going to work for the man, and any perceived independence you have working for the man or peace of mind is replaced by other worries and other pressures. Is that true?

Michael Berg: 100 percent.

Ron Barshop: There you go.

Michael Berg: Couldn't have said it any better.

Ron Barshop: I'm not sure that doctors realize that when they're selling, that they're not just relieving pressure. They're just trading pressure.

Ron Barshop: Well, I want to thank you for your time, and we'll do this again. You have an interesting overview that most don't have, and we will make this happen again.

Michael Berg: Thank you. It's a pleasure being with you.

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 us a review. It helps our [megafund 00:26:00] more than you know. Until next episode.