



# UPDATES FROM BARATZ & ASSOCIATES, P. A. FOR THE HEALTHCARE INDUSTRY

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## SUPPORT FOR HEALTHCARE REFORM, WHAT DO YOU THINK?

A June 1, 2009 article and subsequent June 23, 2009 follow-up published in The New Yorker by Atul Gawande highlighted some alarming examples of physician provision of medical services which adds fuel to the growing pressure to institute significant healthcare reform. As stated in his article, President Obama has said “the greatest threat to America’s fiscal health is not Social Security, it’s not the investments that we’ve made to rescue our economy during this crisis. By a wide margin, the biggest threat to our nation’s balance sheet is the sky rocketing cost of healthcare. It’s not even close.” Mr. Gawande’s article discusses the town of McAllen in Hidalgo County, Texas “which has the lowest household income in the country, but it’s a border town, and a thriving foreign-trade zone has kept the unemployment rate below 10%.” The other distinction that this town has is that it is one of the most expensive healthcare markets in the country behind only Miami, based on 2006 data. According to the article “Medicare spent \$15,000 per enrollee in McAllen, almost twice the national average. The income per capita is \$12,000. In other words, Medicare spends \$3,000 more per person here than the average person earns.” How could this be? According to the analysis, McAllen had similar healthcare technology and service capability as other less costly communities. The population did not indicate significantly unhealthier inhabitants and it did not stand out over other communities for its quality of care, when analyzing various available national publicly available data. The article also noted that a tough new Texas malpractice law, capping pain-and-suffering awards at \$250,000, negated the

argument that maybe McAllen was more litigious. As Mr. Gawande pressed a group of McAllen doctors for their thoughts on the high cost issue, a general surgeon in the group stated “come on, we all know these arguments are bullshit. There is overutilization here, pure and simple.” He also added that doctors were “racking up charges with extra tests, services and procedures. The way to practice medicine has changed completely. Before, it was about how to do a good job. Now it is about how much will you benefit?” Corroborating analysis by Mr. Gawande indicated that “patients in McAllen got more of pretty much everything”. Other observations from the article included:

- A local physician-owned hospital had much higher utilization than other area hospitals.
- Clinical protocols differ dramatically amongst different communities nationwide.
- Different doctors have different viewpoints on how to run the business side of their practice.
- Some regional areas and health systems are surfacing as leaders in the provision high quality, low cost medical services such as the Mayo Clinic Minnesota, Grand Junction Colorado, Geisinger Health System Pennsylvania, Marshfield Clinic Wisconsin, Intermountain Healthcare Utah, Kaiser Permanente California, all not-for-profit institutions.



The article seems to conclude that at the end of the day the key issue is not the payor methodology (public, private, single payer, etc.) but more “whether we are going to reward the leaders who are trying to build a new generation of Mayos and Grand Junctions. If we don’t, McAllen won’t be an outlier. It will be our future.”

Included is the link to the full text of both articles by Mr. Gawande for your review.

My conclusion is that little of what Mr. Gawande presents is not already out and available in the public domain. In other words, many people in the industry (providers, insurers, regulators, etc.) know about these issues and understand that they will have to be addressed.

## CONSEQUENCES

Data analysis and regional profiling seems to be a logical step to attack cost saving and cost recovery methods by various regulatory agencies. A part of educating the healthcare industry will come from enforcement and recovery actions. On June 25, 2009 Daniel R. Levinson, Inspector General, Department of Health and Human Services, testified before the Subcommittee and the Home Energy and Commerce Committee on Healthcare Reform, and included in his remarks was: “Collaboration and innovation are essential in the fight against fraud. On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new initiative to marshal significant resources across the Government to prevent health care waste, fraud, and abuse; crack down on fraud perpetrators; and enhance existing partnerships between HHS and DOJ to reduce fraud and recover

taxpayer dollars. To further this effort, the Secretary and Attorney General created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) joint task force consisting of senior level leadership from both departments. These Strike Forces use advanced data analysis techniques to identify criminals operating as health care providers and detect emerging or migrating fraud schemes.”

This program is already getting results with the recent indictment of 53 people, including physicians, healthcare executives, medical assistants and Medicare beneficiaries involved in several schemes to submit more than \$50 million in false Medicare claims in Detroit, including conspiracy to defraud the Medicare program, criminal false claims, and violations of the anti-kickback statute.

## WHAT TO DO?

Diligent, consistent compliance and ongoing education of the healthcare providers in your area is key to making sure that appropriate provision and billing of medical services is performed. Be ahead of the curve.

[http://www.newyorker.com/reporting/2009/06/01/090601fa\\_fact\\_gawande](http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande)

<http://www.newyorker.com/online/blogs/newsdesk/2009/06/atul-gawande-the-cost-conundrum-redux.html>

<http://www.usdoj.gov/opa/pr/2009/june/09-ag-623.html>

NOTE: FOR ADDITIONAL INFORMATION AND RESOURCES MAKE SURE YOU CHECK OUT OUR NEW WEBSITE: <http://www.baratzcpa.com>

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