

Leadership Strategies and Initiatives for Combating Medicaid Fraud and Abuse

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Abstract

This study explored how health-care leaders in Arizona characterized limitations to the mitigation of Medicaid fraud and abuse. Emergent themes included the need for the application of modern technologies to combat Medicaid fraud and abuse and the concentration of Medicaid fraud and abuse mitigation efforts at the state level.

Problem

Of the approximately \$2 trillion spent annually on health care in the U.S., 3-10% (\$60B-\$200B) is estimated to be lost to inappropriate expenditures (Morris, 2009).

The **general business problem** is the need for reforms to ensure the integrity and financial viability of the federally funded health care system.

The **specific business problem** is the invisible nature of health care fraud and the business opportunity inherent in the commitment of fraud, both of which limit the effectiveness of efforts to detect and control fraud in the Medicaid program.

Purpose

A **qualitative case study** was conducted to explore how health-care leaders describe limitations to the detection of Medicaid fraud and abuse and characterize strategies necessary for counteracting the financial incentives motivating the commitment of Medicaid fraud and abuse.

Research Question

How do health care leaders in the state of Arizona describe factors contributing to the invisible nature of Medicaid fraud and abuse and necessary strategies for counteracting the business opportunities posed by the commitment of Medicaid fraud and abuse?

Relevant Literature

Conceptual Framework

- **Institutional choice analytic framework** (Collier, 2002; Onuf, 1997; Ostrom, 2011)

Relevant Scholarship

- **Invisible nature and business opportunities inherent in health care fraud and abuse** (Sparrow, 2008)
- **Consequences of health care fraud and abuse** (Chernew, Hirth, & Cutler, 2009; Orszag & Emanuel, 2010; Rosenbaum, Lopez, & Stiffler, 2009; Sullivan, 2009)
- **Responses to health care fraud and abuse** (Krause, 2006; Schindler, 2009; Sutton, 2011).

Procedures

Conducted **semistructured interviews with 10 health care leaders in the state of Arizona**

Purposeful and snowball sampling

Interviewees included Medicaid administrators (3), state legislators (3), antifraud technology specialist (1), health care professionals (2), law enforcement official (1)

Gathering of information from **8 publicly available documents**

State auditor assessments, Medicaid program integrity plan, legislative and congressional testimony, health care safety net panel video

Data Analysis

Deductive and inductive (open) coding of collected data

Categorization of codes by research subquestion and conceptual framework to identify themes

Co-occurrence analyses to explore relationships between codes

Limitations

Use of purposeful sampling – potential for restriction in diversity of opinions and perspectives offered.

Qualitative case study – findings potentially not transferable to other geographic settings, Medicare, or private insurance programs.

Conclusions

Changes needed in focus of strategies to mitigate Medicaid fraud and abuse

- Shift from federal to state control
- Use of biometrics and predictive modeling

Unintended consequences of health care reform efforts might exacerbate the problem of Medicaid fraud and abuse

- Pay-for-performance
- Electronic health records (EHRs)
- ACOs, Anti-Kickback Statute, and Stark Law

Financial and political interests disincentivize health-care leaders from taking action against Medicaid fraud and abuse

Social Change Implications

Implementation of identified strategies and initiatives might:

- **Increase the efficacy of health-care leaders** and support their efforts to combat Medicaid fraud and abuse
- **Lead to reductions in the amount of fraud and abuse in Medicaid**
- **Bolster the financial and structural integrity of the Medicaid program**
- Create opportunities for health care leaders to reinvest savings from Medicaid fraud and abuse mitigation efforts in **improved care for Medicaid recipients**

Findings

Feedback model created from findings to illustrate the causal relationships between the demand, delivery, and health care outcome elements of the Medicaid system and depict the influence of Medicaid fraud and abuse on outcomes within the system.

