Discussion board part 2

Business

DISCUSSION BOARD PART 2 This paper is a precursor to one of the overarching problems in the healthcare industry. The paper addresses the issue of Medicaid fraud by pinning down the core problem bringing about the fraud in the first place and then seeks ways in which by using quantitative, qualitative, and mixed method approaches, the problem can actually be studied, understood and addressed appropriately. To gain clarity of objective, the issue is addressed from different world views and more importantly, aligns the world view with the research methodologies.

Introduction

Medicaid fraud is one of the overarching problems in the healthcare industry resulting in losses of billions of dollars each year. It is actually claimed, “ Medicare fraud costs the U. S. government approximately $80 billion a year” (Stefanacci, 2010, p. 1). The federal government as well as healthcare legislative bodies in the healthcare industry find it extremely difficult to address this problem adequately since the healthcare industry relies heavily on health and billing records to track Medicaid fraud (Krause, 2010). More notably, tracking of fraud becomes difficult since reimbursement formulas are not appropriate. Additionally, technological advancement especially in information systems has not been fully utilized to address the issue. However, hope in addressing this issue is still overwhelming as research that is more rigorous and fruitful continues to find interest in policy implementers.

Phenomenon for Research

Healthcare industry is continually benefiting from technological advancement. However, integrating technology and information systems that are more reliable to address Medicaid fraud has not yielded a lot since

the specific problem has not yet been addressed. Therefore, the main point of concern for this research is to find the most appropriate and appealing use of technology and information systems to solve the menace of Medicaid fraud.

Problem Statement

Whereas it is a basic and constitutional human right to have access to affordable and appropriate healthcare, Medicaid programs are heavily compromised by Medicaid fraud. More specifically, approaches to address the issue of Medicaid fraud are yet to yield meaningful results since they rely heavily on traditional methods of health records. The problem becomes even more complicated when reimbursement formulas have not been harmonized and information systems have not yet been fully optimized to address this problem.

Statement in a Worldview

From a perfectionist point of view, healthcare industry needs a near-perfect system of tracking Medicaid fraud for there to be meaningful results. Fraud in healthcare industry affects all taxpayers. Considering the amount of money involved, overall economy is also affected. More notably, Medicaid fraud compromises the utilitarian aspect of a harmonious society, which is one of the core prerequisites for existence of a society. The problem affects the moral standards of the society in general and poses a serious ethical issue hence the need to have mechanisms in place to address this problem.

Alignment of Research Methods

The magnitude of this problem demands a proper alignment of research methods with the problem at hand. The three methods which include qualitative, quantitative and mixed method approach can be used to

research on this problem from different perspectives. Whereas quantitative method can be of utmost importance when dealing with statistics, qualitative method can also be integrated to capture more fluid information. However, a synergistic application of both methods would yield even better research findings.

References

Krause, J. H. (2010). Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road. American Journal Of Law & Medicine, 36(2/3), 343-369.

Stefanacci, R. G. (2010). Medicare Provider? ... Then Read This. Journal of the American Geriatrics Society. pp. 1591-1592. doi: 10. 1111/j. 1532-5415. 2010. 02976. x.