Running in the Never-ending Race against Healthcare Fraud (Strategic Focus)

Description: As healthcare reform takes center stage in the US, fraud is being recognized as a larger and more complex issue than most realized. This report surveys the current healthcare fraud market and examines both near- and long-term changes that will impact technology solutions and healthcare payers.

Scope

- Provides an overview of market trends
- Highlights priorities for solution development
- Analyzes the pricing models of fraud solutions

Highlights of this title

In healthcare fraud prevention, public sector leads the charge
Retrospective, prospective and real-time solutions should be used in tandem
Collaboration between public and private payers is key

Key reasons to purchase this title

- Understand how the Obama administration is impacting healthcare fraud
- Identify the near and mid-term threats to fraud detection

Contents:

Overview
Catalyst
Summary

Key Messages
In healthcare fraud prevention, public sector leads the charge
Retrospective, prospective and real-time solutions should be used in tandem
Collaboration between public and private payers is key

Market Opportunity
Detecting healthcare fraud is a never-ending Red Queens race
Both private and public payers are now shining a spotlight on healthcare fraud
In an economic recession, payers are unable to pass higher costs onto patients
Government led initiatives against fraud impact the private sector as well
As providers move to EHRs and ICD-10, opportunities for fraud will likely increase
Yet tackling healthcare fraud is still a sensitive subject that is not taken seriously
Within a payer organization, fraud is a politically difficult topic to broach
Payers do not want to alienate their provider networks
While committing healthcare fraud may be a laughing matter, fighting fraud is not

Technology Evolution
Old and new tools are being used to fight fraud
Healthcare fraud detection is slowly moving closer to real time
Retrospective analysis of claims data will continue to play a role in catching fraud
The use of prospective analysis is growing and the benefits are clear
Regional health information organizations may increase collaboration between payers
On-demand solutions are the easiest and most cost effective
Educating doctors on good billing practices is a must
Looking to the future, EHRs will change billing processes and, in turn, fraud detection
Customer Impact: Recommendations to Healthcare Payers
Be open to increased collaboration with other payers
Incorporate patient inquiries as a part of the fraud detection process
If financially possible, consider using more than one solution
Go to Market: Recommendations to Technology Vendors
IT vendors need to start focusing on medical identity solutions as well
Vendors must take market education to a new level, the C-level
It goes without saying, but technology companies should continue developing new tools

APPENDIX
Abbreviations
Methodology
Further reading
Ask the analyst
Disclaimer

List of Figures
Figure 1: The number of stakeholders involved in the claims process makes it vulnerable to fraud
Figure 2: Potential for fraud centers around the provider
Figure 3: On the surface, claims processing seems to be straightforward
Figure 4: A comparison of real-time, prospective and retrospective analysis
Figure 5: Claim submission process will be streamlined in the future due to EHRs

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