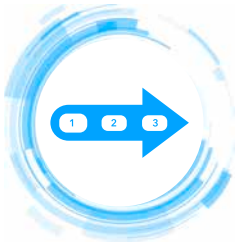
Medicaid and Medicare fraud

Strengthen your state budget by quickly detecting and preventing fraud and improper payments

Use all data sources to accurately identify fraudulent behavior

Investigate fraudulent activity rapidly and stop payment before it is made



Prioritize push alerts for your investigators

The Issue

The problem of fraud in government assistance programs exploded in 2020 because of the COVID-19 public health emergency. As organizations face ever-increasing and innovative fraud schemes, they must be able to rapidly detect and adapt to new threats. **According to the Centers for Medicare & Medicaid Services (CMS), the Medicaid improper payment rate was 15.62% or $80.57 billion in 2022**. Changes to Medicare and Medicaid rules due to COVID-19 have only made things worse.

Fraud and improper payments are conservatively estimated to be from 3% to 10% of all Medicaid spending – a significant portion of one of the largest, fastest-growing expenditures in US state budgets. Lacking a financial incentive for managed care organizations to combat fraud and improper payments, containing costs for traditional fee-for-service and managed care models is the only way to realize savings. By adopting a sound method to tackle fraud, states can also recover previously lost funds, prevent future improper payments, and significantly influence growing Medicaid and Medicare expenditures.

The Challenge

Multiple data silos and formats. It's difficult to combine all data sources into a usable format. SAS® collects and integrates diverse data from systems and program silos, then applies advanced analytics and visualizations to detect more suspicious activity and fraud.

Limited investigator resources. Small teams of investigators struggle to quickly identify fraud schemes and review cases efficiently. SAS streamlines the process by combining data into a single platform for analysis, then accurately scoring and prioritizing alerts and routing them to investigators. Advanced case management tools help investigators triage and effectively investigate high caseloads.

Ineffective payment recovery. The traditional pay-and-chase approach to fraud makes it hard for states to recover fraudulent expenditures. SAS incorporates multiple techniques – like automated business rules, multivariate anomaly detection, predictive modeling, text mining and network link analysis – to uncover fraud and improper payments before they occur. This enables agencies to preemptively review providers before claims are paid.

Our Approach

A comprehensive solution from SAS can thwart sophisticated fraud schemes, target payment integrity issues and help contain costs. We provide software and services to help you:

- **Enhance interoperability and information credibility.** Seamlessly integrate any enterprise data source across systems, regardless of format (e.g., notes in claims files) and apply embedded data quality techniques to improve accuracy. This creates a holistic view of a recipient or provider to better detect anomalies or discrepancies across government programs or systems.
- **Prevent improper payments and reduce waste.** SAS' hybrid analytics approach combines anomaly detection, rules and predictive modeling to identify fraud, waste and abuse earlier than traditional methods by applying:
  - **Business rules.** A library of rules ensures that known schemes are detected.
  - **Unsupervised learning.** This technique proactively predicts where fraudulent activities are likely to occur.
  - **Network analytics.** SAS recognizes underlying entity relationships – which helps uncover schemes (e.g., kickbacks) that cannot be detected by analyzing the billing patterns of individuals alone.
- **Benefit from flexible analytics for all skill levels.** With SAS, all types of users can get insights from the data – from business analysts to data scientists or machine learning engineers.

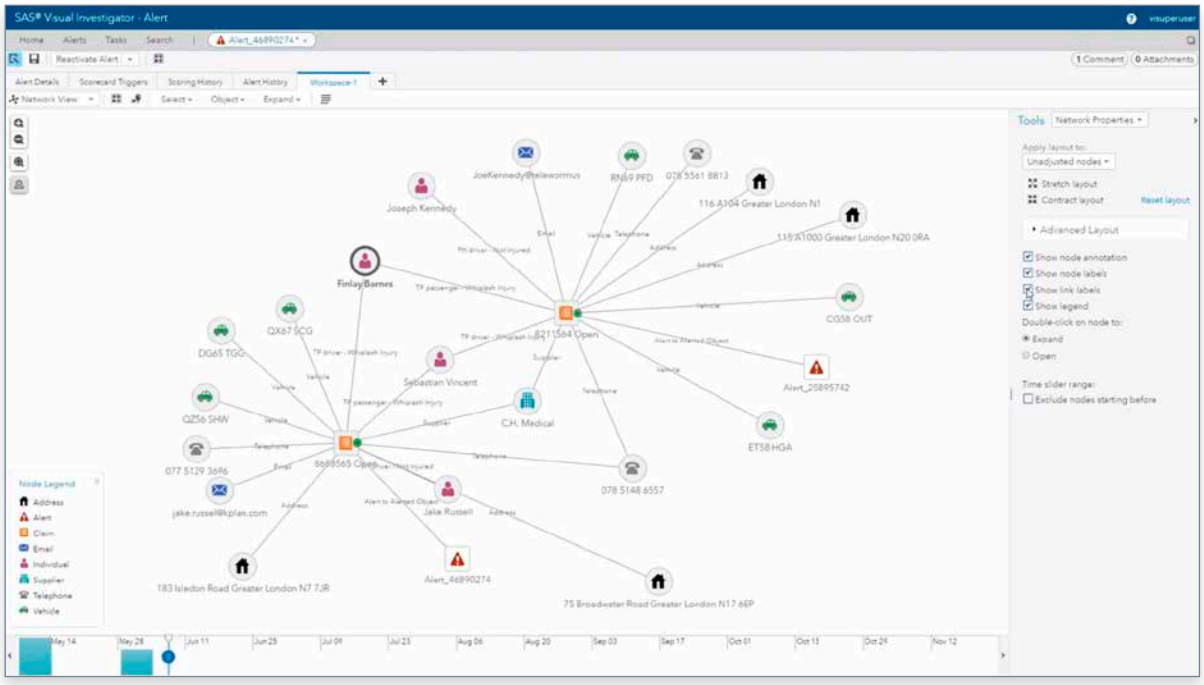
The SAS® Difference

Other solutions rely almost exclusively on claims data and limited provider and recipient data obtained during enrollment. With SAS, you can:

- **Get faster, better insights with a consolidated view of all types of data.** With a proven analytics platform from SAS, you can easily incorporate external data into investigations – helping you increase detection rates, decrease false positive alerts and make trustworthy decisions.
- **Spot suspicious activity and fraud quickly.** Many fraud detection systems are query-based and assume users will know what questions to ask of the data. SAS automates this process, using advanced analytics to push prioritized alerts to investigators so they can focus on what matters most.
- **Stay ahead with a flexible, unified platform.** Our cloud-native solution is explainable, repeatable and fast – and works with virtually all programming languages, including open source.

SAS helps large health insurance providers and payers, pharmacy benefit managers and government organizations address complex challenges across all aspects of government assistance programs. This ranges from eligibility and enrollment to managed care oversight, post-payment detection and recovery of improper payments, and prepayment identification and prevention of improper claims.

GAIN A CONSOLIDATED VIEW OF FRAUD RISK



Build social networks and gain a holistic view of fraud risk and discrepancies across Medicaid and Medicare programs.

Learn more about SAS Payment Integrity for Health Care.