› Solution Brief

Business Impact

With this modeling approach, our accuracy is much, much higher. … We've also decreased the time to create a model from weeks to just a few hours.

– Weishin Wang, Assistant Bureau Chief
State of Illinois, Inspector General's Department of Healthcare and Family Services

Challenges

- **Multiple data silos and formats**. It's difficult to incorporate all data sources into a usable format.
- **Quickly finding the needle in a haystack**. You need one platform to find everything from basic overbilling schemes to complex and sophisticated fraud rings, reduce false-positive alerts, and identify improper claims before they are paid to avoid the cost and risk of trying to recover funds.
- **Limited investigator resources**. It's important to provide investigators with tools that prioritize alerts and cases and automatically assimilate all data necessary to review and investigate a case, making the best use of their time.

Detect and Prevent Medicaid Fraud and Improper Payments to Improve Your State Budget

Estimated between 3 and 10 percent of all Medicaid spending, fraud and improper payments can seriously affect one of the largest, and fastest-growing, expenditure items in US state budgets. And with the passage of the ACA, Medicaid enrollment rates are expected to increase up to 30 percent. This massive increase in recipients will cause expenditures to exceed $1 trillion, and collectively states will share nearly $76 billion of the total costs to administer the program – only exacerbating losses due to fraud and improper payments.

To control costs, many states are moving toward managed care delivery models that provide some level of cost certainty. Although creating a financial incentive for managed care organizations to combat fraud and improper payments, states will see the promised savings significantly reduced unless payment accuracy is ensured in both the traditional fee-for-service and managed care models. With a sound method to tackle fraud, states can recover previously lost funds, prevent future improper payments and significantly influence growing Medicaid expenditures.

Our Approach

By consolidating data from both internal and external sources on providers and beneficiaries – coupled with advanced analytics – SAS delivers a comprehensive solution to thwart the efforts of today's sophisticated schemes and methods.

- **Enhance information credibility**. SAS® seamlessly integrates any enterprise data source, regardless of format (including unstructured text like notes in claims files), and applies 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.
- **Find more fraud, waste and abuse faster**. Techniques such as anomaly detection, predictive modeling and social network analytics contribute to the SAS hybrid analytics scoring engine. These methods produce a comprehensive risk score for each claim, provider, beneficiary or network in real time – from basic overbilling schemes to large organized criminal fraud rings.
- **Improve investigator efficiency**. SAS generates alerts prioritized by severity and value and routes them to a web-based interface for investigators' review and disposition. They can drill into and visualize detailed data, perform interactive queries and generate reports, and then use outcomes to improve future detection. Program performance can be defined and monitored via a dashboard of KPIs.

sas
THE POWER TO KNOW.

The SAS® Difference

SAS has more than 38 years of helping customers in both the private and public sectors address fraud and financial crimes. Several of the largest financial institutions, insurance companies and government organizations in the world rely on SAS to help address their most complex fraud and financial crimes challenges.

- Other systems rely almost exclusively on claims data and the limited provider and recipient data obtained during enrollment. Only SAS allows you to automatically incorporate enterprise data resources into the analysis and investigation of Medicaid fraud and abuse. By incorporating external data, SAS can increase detection rates, decrease false-positive alerts and allow investigators seamless access to all enterprise data – substantially improving the overall efficiency and effectiveness of investigative staff.
- Although other vendors claim they're using the same techniques as SAS, SAS is the world leader in advanced analytics and has the knowledge and experience to support you in mastering Medicaid fraud detection and prevention.
- Many existing fraud detection systems are query-based and rely on the end user to know what questions to ask of the data. The SAS solution automates the process with advanced analytics to push alerts out to investigators. The SAS solution even prioritizes leads so that investigators know which ones have the highest probability of being substantial fraud or abuse.
- The SAS Advanced Analytics Lab for State and Local Government develops innovative analytical processes and techniques by applying SAS solutions to solve the most complex problems facing state and local governments. The lab's team of data scientists, technical architects and quality assurance analysts is comprised of more than 400 high-level SAS experts holding minimum education levels of a master's degree in a quantitative field, with most members holding doctorates, and all having between 10 and 30 years of experience.

SAS addresses all aspects of the Medicaid program, including: eligibility and enrollment, managed care oversight, post-payment detection and recovery of improper payments, and pre-payment identification and prevention of improper claims.

Case Study:
Illinois Inspector General's Department of Healthcare and Family Services

Situation

The State of Illinois needed a solution that used historical and social network data to uncover fraudulent provider Medicaid claims and claims overpayment at the transaction or patient level, while uncovering fraud perpetrated by members of criminal networks.

Solution

SAS was used to transform the Medicaid program to identify overpayments and prevent further improper payments to health care providers. A fraud platform based on SAS uses historical data on previous fraud and abuse cases to develop well-honed fraud predictors. By utilizing the insights from known fraud cases, the system can spot provider collusion and identify undiscovered fraudulent providers and criminal networks – avoiding significant fraud-related financial losses each year.

Results

- Identified overpayments and prevented further improper payments.
- Uncovered criminal network fraud.
- Avoided significant fraud-related financial losses.
- Decreased time to create models from weeks to a few hours.
- Boosted reporting efficiency.

What if you could …

- Accurately identify fraudulent behavior utilizing all available data sources, regardless of type, format, agency or source, to ensure a complete and accurate picture of a recipient or provider?
- Investigate fraudulent activity and stop a payment before it is made versus spending money, time and resources to recoup previously paid fraudulent claims?
- Equip your staff with a prioritized set of alerts each day, and have investigative tools that allowed them to easily review all relevant claim, provider and beneficiary information from a single user interface?

You can. SAS gives you THE POWER TO KNOW®.

SAS Facts

- SAS helps customers at more than 70,000 sites improve performance and deliver value by making better decisions faster.
- SAS is used by all 50 US state governments to solve their most complex problems with reliability and accuracy.
- SAS is a Leader in the "Forrester Wave™: Agile Business Intelligence Platforms, Q3 2014."

Learn more about SAS software and services at: sas.com/medicaid.

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