Detect and prevent Medicaid fraud and improper payments to improve your state budget

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."

- Wei Shin Wang, Chief of the Bureau of Fraud Science and Technology, Illinois Department of Healthcare and Family Services Office of Inspector General

Challenges

- **Multiple data silos and formats**. It's difficult to incorporate all data sources into a usable format.
- **Limited investigator resources**. Investigators need tools that prioritize alerts and cases and automatically assimilate all data necessary to review and investigate a case in a way that uses their time wisely.
- **Complexity in finding critical cases**. Without a single platform, you can't find basic overbilling schemes or sophisticated fraud rings, reduce false positive alerts, and identify improper claims before they are paid.

The Issue

Medicaid spending grew 3.9 percent to $565.5 billion in 2016, or 17 percent of total US National Health Expenditure. Under current law, national health spending is projected to grow at an average rate of 5.5 percent per year for 2017-26 and to reach $5.7 trillion by 2026. This growth trend in Medicaid spending is due to an increasing projected share of aged and disabled enrollees.

Fraud and improper payments, estimated to be 3 to 10 percent of all Medicaid spending, can seriously affect one of the largest, and fastest-growing, expenditure items in US state budgets. With a financial incentive for managed care organizations to combat fraud and improper payments, the savings won't be realized without cost containment in both 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**. Seamlessly integrate any enterprise data source, 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.
- **Find more fraud, waste and abuse faster**. Techniques such as anomaly detection, predictive modeling and social network analytics contribute to the SAS 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 crime 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. Users can define and monitor program performance via a dashboard of KPIs.

The SAS® Difference

SAS has more than 40 years of experience helping the largest financial institutions, insurance companies and government organizations in the world address their complex fraud and financial crime challenges.

- Other systems rely almost exclusively on claims data and the limited provider and recipient data obtained during enrollment. With SAS, you can automatically incorporate enterprise data resources into the analysis and investigation of Medicaid fraud and abuse. By incorporating external data, you can increase detection rates, decrease false positive alerts and allow investigators seamless access to all enterprise data – substantially improving their overall efficiency and effectiveness.
- Many existing fraud detection systems are query-based and rely on users to know what questions to ask of the data. The SAS solution automates the process with advanced analytics to push alerts out to investigators. SAS even prioritizes leads so investigators know which ones have the highest probability for 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.

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 Department of Healthcare and Family Services Office of Inspector General

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

The Office of the Inspector General used SAS 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 applying 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.

SAS machine learning allows the solution to evolve as fraud schemes evolve; artificial intelligence helps predict those changes to find potential fraud faster.

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** with 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?
- **Prioritize alerts for your investigators each day** and equip them with tools 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 is used by all 50 US state governments and currently supports over 600 government departments, ministries, offices and agencies around the world to solve their most complex problems with reliability and accuracy.
- SAS helps customers at more than 83,000 sites improve performance and deliver value by making better decisions faster – including 100 percent of US government cabinet departments and agencies.
- SAS is rated as THE leader in Chartis' *RiskTech Quadrant® for Enterprise Fraud Technology Solutions* (August 2017).

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

To contact your local SAS office, please visit: sas.com/offices

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