

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



## Business Impact

The Centers for Medicare & Medicaid Services (CMS) reports that improper payments totaled \$98.72 billion – that's over 21% of total payments and more than a \$10 billion increase year over year.

– CMS.gov

## The Issue

The problem of fraud in government assistance programs exploded in 2020 and has continued to grow over the life of the COVID-19 public health emergency. In 2021, improper Medicaid spending hit a record high. According to the Centers for Medicare & Medicaid Services (CMS), improper payments grew from \$57.36 billion in 2019 to \$98.72 billion in 2021, a 72% increase. Changes to Medicare and Medicaid rules due to COVID-19 certainly have made things worse.

## 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.
- **Finding fraud schemes faster.** 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.
- **Recovering payments.** The traditional pay-and-chase approach to fraud has become an increasingly difficult way for states to recover fraudulent expenditures.

Fraud and improper payments are conservatively estimated to be from 3% to 10% of all Medicaid spending, and can seriously affect one of the largest, fastest-growing expenditures 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 internal and external sources on providers and beneficiaries – coupled with advanced analytics – SAS delivers a comprehensive solution to thwart 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.

**Prepayment focus.** SAS' hybrid approach combines anomaly detection, rules and predictive modeling to identify fraud, waste and abuse earlier than traditional methods by applying:

- Predictive modeling rules. SAS implements a library of rules embedded in its program integrity solution to ensure known schemes are detected.
- Unsupervised learning. Proactively predict where fraudulent activities are anticipated to occur.
- Machine-learning models. The SAS solution includes industry best practice predictive modeling templates, hyperparameter autotuning and embedded model interpretability – all accessed through an intuitive interface, enabling faster, better modeling results.

With SAS, data scientists can always work in their preferred programming language. They can access SAS algorithms via open-source programming interfaces to R, Python, Java and Lua from applications such as Jupyter Notebook. Data scientists with varied programming skills can all contribute, taking advantage of their existing personal knowledge.

SAS helps large health insurance providers and payers, pharmacy benefit managers, financial institutions and government organizations 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 prepayment identification and prevention of improper claims.

## Prime Therapeutics: A pharmacy benefits manager for large health care organizations.

### Situation

Estimates from the National Health Care Anti-Fraud Association show fraud costs health care organizations \$70 billion to \$230 billion each year. With a commitment to making health care more effective by helping people get the medicine they need to feel better and live well, Prime Therapeutics works with health plan owners and clients to support complete member health. Part of Prime Therapeutics' mandate is to reduce the total cost of health care with a business unit dedicated to preventing fraud, waste and abuse.

### Solution

SAS provided a fraud detection and investigation solution on SAS Cloud. This advanced analytics platform allows Prime Therapeutics to consolidate data from pharmacies, drug claims and medical services. By applying SAS artificial intelligence and machine-learning capabilities to this comprehensive data set, Prime Therapeutics can now detect and prevent fraud regardless of the source.

Now it can identify members who use deception to get prescriptions, whether through insurance fraud, collusion with a pharmacy or prescriber or identity theft. The solution can also find prescribers who falsely diagnose patients, receive kickbacks for certain medications or submit duplicate claims.

### Results

Prime Therapeutics increased the speed and accuracy of investigations, and it recovered more than \$355 million in fraudulent payments and cost avoidance the first 18 months.

- **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 push 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?

## SAS Facts

- SAS is used by all 50 US state governments and currently supports more than 700 government departments, ministries, offices and agencies around the world to solve their most complex problems with reliability and accuracy.
- SAS helps customers improve performance and deliver value by making better decisions faster – including 100% of US government cabinet departments and agencies.
- As a premier member of NHCAA and NAMPI, SAS subject matter experts often present the newest in fraud, waste and abuse models and algorithms at various conferences across the United States.

Learn more about SAS software and services at [sas.com/medicaid](https://sas.com/medicaid).

