Payment integrity: Predict fraud and detect loss to improve your medical loss ratio

Business Impact

The US Office of Management and Budget estimates that improper payments made under the Medicaid program totaled $29.12 billion in FY 2015. This figure represents a 9.78 percent improper payment rate.

Source: *Fiscal Year 2015 Agency Financial Report*, US Department of Health and Human Services

Challenges

- Transforming from a compliance and reporting structure that uses an ineffective pay-and-chase approach.
- Integrating business processes to share siloed data.
- Predicting costs without risk profiles on so many new insureds.
- Creating outcome-based analytics that shows quality of care, episodes of care or provider effectiveness.
- Responding to the dynamics of local markets and containing core operating costs.

The Issue

Waste and abuse of health care claims and eligibility continue to plague government and private organizations. Mitigating health care fraud requires a holistic payment integrity approach that includes benefit plan definition, member enrollment, claims adjustment and customer service. By gaining a comprehensive view of these processes and the valuable data they generate, your organization can achieve payment accuracy and control.

Data management and analytics solutions can integrate and analyze large amounts of disparate data to provide insight into fraud patterns and payment anomalies. From this comparative and behavioral view, you can predict and detect loss in all its forms. This means you can use your data to rid your health care organization of administrative waste, payment error and systemic inefficiencies.

Our Approach

With an advanced analytics platform, you can quickly detect patterns and anomalies and improve payment decisions. SAS is the only vendor to combine three disciplines – behavioral analytics, claim analytics and clinical targeting – into a comprehensive payment integrity solution available through multiple deployment options (including cloud for a fast implementation), so you can:

- **Identify gaps in payment integrity across the enterprise.** Examine the payment process in a holistic way, including data about relevant internal processes captured during service operations. Use many of the same analytics techniques for fraud (anomaly detection, trend analysis, regression and predictive techniques, and link analysis) to uncover hidden insights.
- **Uncover all types of known fraud schemes.** SAS® employs hybrid analytics for a more comprehensive detection mechanism to uncover fraud. Using a number of methods concurrently – such as active pattern, link and fraud scheme analysis – helps you find the most complex and best hidden schemes. Machine learning delivers additional insight from data to constantly improve where and how improper payments are detected.
- **Reduce losses while increasing recoveries.** Near-real-time daily batch scoring catches fraud quickly. Find loss padding in similar claims. Identify repeat offenders and uncover insider or collusive fraud by integrating staff data and audit records and applying risk- and value-based scoring models to prioritize output for investigators.
- **Visually discover data on executive dashboards to create enterprisewide results.** Tap into the data from payment integrity, operations, compliance, subrogation, investigations and finance for a far-reaching impact beyond just fraud, waste and abuse.

The SAS® Difference

With our unified technology platform, SAS can help solve your most complex problems across medical cost management; risk adjustment; fraud, waste, abuse and error; outcome-based analytics; and value-based payments. Using an advanced analytics infrastructure, SAS helps you identify, investigate and make higher-value referrals to regulators and law enforcement. We provide:

- **Coverage of multiple disciplines.** SAS is the only vendor to offer multiple disciplines that cover relevant functions for multiple areas in your payer organization, including coding/policy, clinical targeting and behavioral analytics.
- **A single enterprise technology platform.** Our end-to-end process includes data preparation, model life cycles, what-if scenario tuning, forecasting and reporting over multiple data sources, such as health plan and third-party data.
- **Consolidation of more contextual information.** To surround the services and claims transaction data, SAS consolidates your view of information – from provider contracts and company policies to comparative behavior and performance data – as well as external data that helps assess risk and differentiate behavior.
- **Analytics results.** Comprehensive data integration and analysis that allows not only reporting, but also true analysis that offers insight to payers on their members and providers to improve care, policy and member health.
- **Continuous monitoring.** Fraud models and rules can be executed on a continuous basis instead of running queries on an ad hoc basis for detection.
- **Visual investigation for the intelligent analyst.** SAS marries advanced analytics with dynamic and interactive visual workspaces, so intelligence analysts can quickly gain a complete view of people, relationships, networks, patterns, events, trends and anomalies across all available data. Analysts can easily grasp reasons for events or alerts and act on deep analytical insights thanks to these intuitive visuals and search.

Case Study: A Commercial Health Plan

Situation

As a US top-five health plan, this company covered 6 million lives and processed 70 million claims per year. It hosted 15 terabytes of raw data and claims using seven different data sources, cleansing it to help with false positives.

To meet government contract mandates, the company wanted to be in a position to detect fraud and waste as early as possible in the claim payment life cycle. However, the existing rules-based approach wasn't producing the anticipated leads.

Solution

The company uses SAS Fraud Framework for Health Care to analyze finalized claims data from all lines of business. Seven disparate data sets were normalized to provide an end-to-end look at provider activity. This data integration with data management built a foundation for business analytics and reporting.

Results

With a new single source of truth for consistent and effective decision making, the organization gained a return on investment within eight months, with more than $5 million in savings on overpayment, waste and abuse.

When your investigations combine clinical, legal, claims process and law enforcement skills with data visualization, advanced analytics and machine learning, you ensure that those who intentionally perpetrate fraud without regard for patient safety and financial well-being are brought to justice.

What if You Could...

- Prototype new scenarios and bring the data closer to the analyst to help provide insights into suspicious behaviors and abnormal trends?
- Easily integrate critical information with workflow and knowledge management to share important insights across departments and the enterprise?
- Identify drivers to better understand and ensure if utilization is appropriate?
- Anticipate and manage medical care expenses, and provide a benefit to move to less expensive care services?

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

SAS Facts

- All 15 major US federal departments and all 50 US state governments rely on SAS to solve their most complex problems with reliability and accuracy.
- SAS clients include nearly every US state department of health, CDC, FDA, CMS, NIH, ONC, health insurance payers, pharmaceutical companies, health care providers and more.
- SAS is a Leader in The Forrester Wave™: Enterprise Fraud Management, Q1 2016. The report gave SAS among the highest scores in the current offering category, with the highest scores among all vendors in the strategy and market presence categories.
- For 40 years, SAS has provided advanced analytics support for both public and private health care initiatives across the globe.
- Our software is installed at more than 80,000 business, government and university sites.

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