HEALTHCARE.

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

THE CHALLENGE

Healthcare fraud, waste and abuse represent a significant and growing problem in the United States. In 2011 alone, $2.27 trillion was spent on healthcare, of which the FBI estimates 3-10% was fraudulent. This translates to a staggering $70 to $240 billion lost to fraud per year.

In fiscal year 2013, the Medicaid program covered about 71.7 million individuals at a cost of $431.1 billion, of which CMS estimated $14.4 billion (5.8%) were improper payments. Yet the average state Medicaid recovery rate is only 0.09% with the range among states ranging from less than 0.01% to a little over 1%.

Most recently, a May 2014 GAO report revealed that the states surveyed had not begun to closely examine program integrity in Medicaid managed care. The report goes on to say that CMS is unable to ensure that MCO's are taking appropriate actions to identify, prevent and discourage improper payments.

WHY LOOKING AT YOUR MANAGED CARE DATA IS IMPORTANT

When CMS introduced the National Correct Coding Initiative (NCCI) in 1996 it was into a fee-for-service world. In the complex programs today a member is almost never involved in just FFS or MCO claims. States need a more holistic view of member history.

Our NetReveal® solution is able to take NCCI edits and apply them across all data including both FFS and MCO. It also takes the edits, analytics and alerts a step further and uses them to deliver a unique insight into the quality of care, wasteful spending, and fraudulent networks.

"We are pleased that NetReveal® will provide early detection of fraudulent billing practices and further protect these health care services for those who truly need it."

ATTORNEY GENERAL MARTHA COAKLEY, COMMONWEALTH OF MASSACHUSETTS

KEY FEATURES

- Enrollment Risk Assessment – Ability to risk score providers and members as they enroll into your system
- Off-the-Shelf Solution – Single platform with modules developed for a wide variety of detection capabilities that can be tuned to your program and policies
- Pre-Payment – Real-time direct integration with your claims from MMIS system in a post adjudicated format to stop claims before they are paid
- Post-Payment – Automatically build and rank providers recipients, claims and networks in order of risk and identify organized and collusive schemes to prioritize recoveries
- Mutliple Data Sources – Ability to fuse all claims and program data as well as third-party data held by an organization – to include but not limited to MCO, FFS, Pharmacy, Public Sources and Exclusion Lists
- SaaS or Hosted – Our solution can be hosted in your environment or as Software as a Service (SaaS) to give you the degree of flexibility you need
- Transparent Analytics – Detailed information on how and why risk gets scored

Applied Intelligence

BAE SYSTEMS
INSPIRED WORK

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Fraud - Upcoding, or the practice of submitting an inaccurate procedure to increase reimbursement, is a well-known problem in fee-for-service (FFS) programs, but it also plays a large role in a managed care (MCO) environment. By upcoding, managed care organizations are able to increase their utilization which ultimately leads to higher capitation payments. NetReveal uses a unique blend of outlier, predictive, and peer group analytics to identify providers that are consistently upcoding across both FFS and MCO programs.

Waste - Do you know where your members are receiving their care? Take the example of a member who visits the emergency department daily. This member is part of a MCO, but you can see from their MCO claim history that they have not been receiving the care they need. As a result there are hundreds of FFS emergency department claims for this member every year. NetReveal is able to identify these members and providers so that states can take action to improve quality of care, and reduce wasteful spending.

Abuse - Substance abuse is a national problem, and nowhere is the problem more acute than in pregnant members. NetReveal is able to apply cutting edge predictive analytics to determine pregnant mothers who are at risk of substance abuse. This allows agencies to intervene early and greatly increases outcomes for these children. Additionally NetReveal is able to identify the providers who are persistently contributing to abuse with their prescription practices.

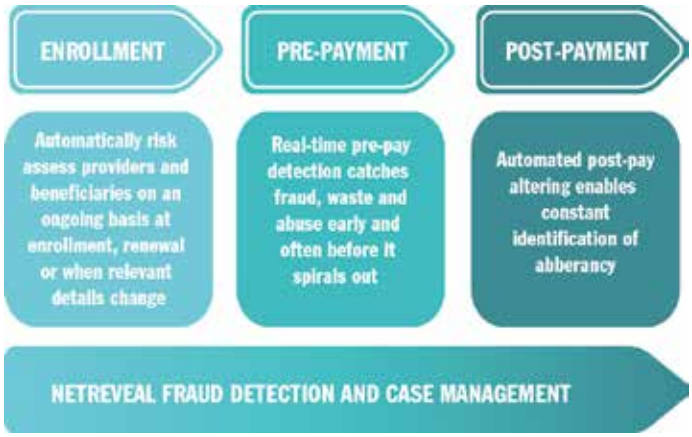

Figure 1: NetReveal's advanced analytics risk assess all providers, recipients, and claims at the points of enrollment, pre- and post-payment.

SOLUTION APPROACH

Our NetReveal solution unlocks the intelligence in your data to prevent fraud, waste and abuse by automatically linking disparate information together to make sense of behavioral interactions between providers, recipients and claims. This reduces the time spent on manual investigation of relationships among these players.

Our solution features:

- Advanced and proven detection capabilities
- Analytics, algorithms and predictive modeling combined with social network analysis to discover hidden relationships including suspicious billing or referral patterns
- Integration of data from disparate sources so that claims data is given historical context and is no longer viewed in isolation
- Seamless, real-time integration with Medicaid Management Information System (MMIS)
- Detection at multiple points, enabling you to intervene earlier
- User configurable models that can be tuned to your program and policies
- Identification of providers that will benefit from education programs, enabling you to save money on waste and abuse
- User friendly interface, enabling users to adapt thresholds, modify or add scores to ensure detection scenarios stay relevant to evolving fraud methodologies

SOLUTION BENEFITS

- Single solution to build a full picture of care so that you can take action when required to improve quality of care, and reduce wasteful spending
- Prioritize high risk cases and reduce false positives
- Ongoing risk assessment of every claim, provider and recipient at enrollment, pre-pay and post-pay
- Reduce time spent on investigations and facilitate collaboration
- Faster payment — low risk providers and claims may be processed more quickly

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