Fraud Detection in Healthcare from Capgemini and Palantir

Capgemini and Palantir partner to uncover fraud in healthcare organizations and insurers

Demand for healthcare is growing around the world, driven by demographic changes, rising standards of living and improvements in governmental healthcare provision. Sadly, fraud and abuse in the healthcare sector are also increasing. The National Healthcare Anti-Fraud Association estimates 3% of all healthcare spending in the United States is lost to healthcare fraud while the European Healthcare Fraud & Corruption Network (EHFCN) estimates European Union countries lose about €56 billion to healthcare fraud in Europe each year. International and national governments recommend that public and private institutions develop and implement anti-fraud policies since insurance fraud affects more than just insurance companies and healthcare institutions. Patients,

governments, and taxpayers all incur the burden of insurance fraud.

A significant amount of fraud and abuse within the healthcare sector occurs in the reimbursement processes generally and through insurance claims more specifically. Fraudulent or abusive claims are difficult to detect among the millions of legitimate claims received every day, and even a claim which includes errors might be considered legitimate. Moreover, criminals are always devising new tactics making it even more difficult to detect these bogus claims. Fraudsters exploit the fact that fraud and abuse detection capabilities and

resourcing suffer from a lack of funding. This lack of funding has led to fraud detection system capabilities that do not interrogate the full range of data available, and detection criteria that are rarely managed systematically. Additionally, fraud detection staff and investigators spend more time gathering and substantiating data than in the pursuit of offenders.

The challenge is complicated further in health insurance operations where claims are paper-based, and where data sources include both structured and unstructured types. The multiple data sources make the process of detecting and investigating fraud a challenging and time-consuming task. Claim fraud places a heavy burden on resources, with the result that precious time, money and effort are being diverted into retrieving money that never should have been lost. Some private and most governmental programs (such as Medicaid and Medicare in the US) have payment policies whereby providers are reimbursed promptly, but when fraud is detected post-payment, a pay-and-chase scenario is the result. This reactive approach makes payment recovery even more difficult.

New tools for uncovering fraud

To improve the efficiency of fraud detection in the healthcare sector, Palantir provides a powerful data analysis platform to identify fraudulent claims and other abuses within reimbursement operations. With an attractive and intuitive user interface, it has been designed to address the challenges of data assurance, collaboration, security, and data integration from the outset. Capgemini is successfully integrating this platform into healthcare and insurance organizations in a way which delivers quantifiable benefits to commercial and public sector insurers.

Capgemini provides tailor-made add-ons that shape the Palantir platform

according to specific customer needs. For example, it may sometimes be necessary to integrate existing data infrastructure with Palantir, or adapt and enhance the analytical capabilities already in Palantir to suit particular market needs. Moreover, Capgemini has extensive knowledge and experience in the healthcare sector with regard to:
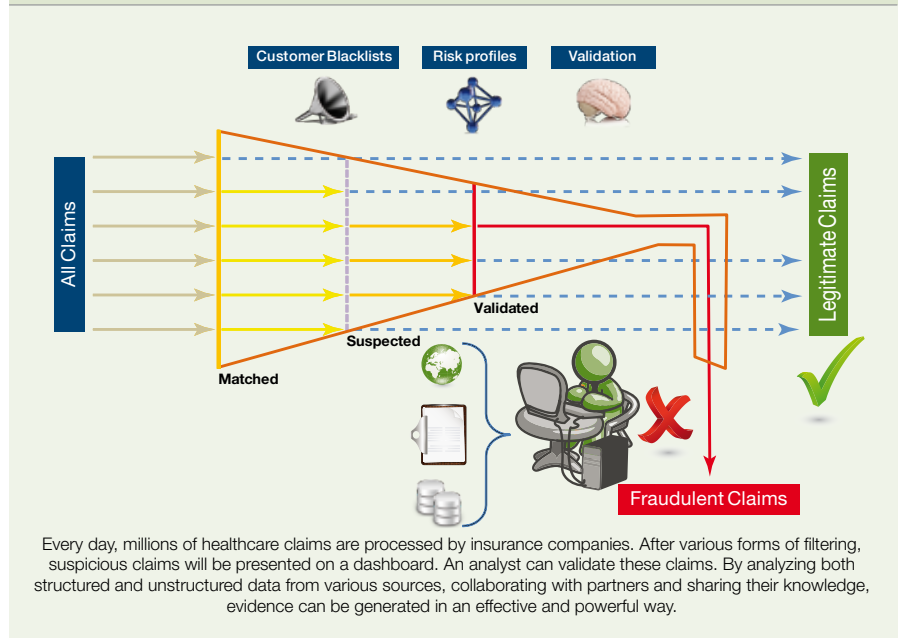
- Claims Operations
- Medicaid Fraud & Abuse Detection
- Business Analysis and Transformation
- Solution Architecture Development
- Business Information Management
- Health Information Exchanges
- Solution Implementation and Configuration
- Health IT Hosting and Application Management
- Business Process Outsourcing

Beyond the healthcare domain, Capgemini has successfully deployed Palantir technology in other fields such as European Border Control Agencies, Intelligence agencies and National Crime Squads, in order to disrupt criminal networks and investigate high-risk individuals and their networks.

How the fraud and abuse investigation process works

The automation of the claim validation process in standardized workflows is one of the efficiency paths that many organizations are following in the healthcare sector. Meanwhile, a lot of manual work still needs to be done by analysts, especially when these claims are submitted on paper, to investigate the validity of a suspect claim against multiple data sources. In this initial phase of the claims workflow, the Palantir platform can be used to substantially reduce the time and effort necessary to gather and analyse data. It is able to do this work within a few seconds, enabling the analyst to be more efficient, make decisions more quickly, handle more claims in the same time and make better decisions. Analysts detect new fraud and abuse patterns during the

Identifying Fraudulent Claims with Palantir

Customer Blacklists   Risk profiles   Validation

All Claims

Legitimate Claims

Matched

Suspected

Validated

Fraudulent Claims

Every day, millions of healthcare claims are processed by insurance companies. After various forms of filtering, suspicious claims will be presented on a dashboard. An analyst can validate these claims. By analyzing both structured and unstructured data from various sources, collaborating with partners and sharing their knowledge, evidence can be generated in an effective and powerful way.

investigation of claims or people. These patterns can then be included in the automated fraud/abuse detection filters, thus maximizing detection without increasing investigation efforts.

Way forward
Capgemini and Palantir provide a strong and intuitive fraud and abuse investigation solution that provides or augments existing detection solutions. The result is a comprehensive and closed loop approach to combating the increasing burden of claim fraud and

abuse, utilizing existing investigation staff. If you are interested and would like to know more about the solution, Capgemini offers live demonstrations tailored to your business environment.

To find out how Capgemini and Palantir can support your strategy to counter fraud and abuse, please contact:
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Further information
www.capgemini.com/health
www.palantir.com/government/health

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