New York HPA Health Plan Association

Fighting Fraud, Waste and Abuse

Health plans prioritize the integrity of New York's Medicaid program through strong protocols to prevent and vigorously combat fraud, waste, and abuse (FWA), employing a multi-pronged approach to detect and address fraudulent activity and improper billing practices.

Examples of Fraud, Waste & Abuse

Health plans work hard to protect members and taxpayers from activities that can result in excessive costs to the Medicaid program, which can include:

Upcoding and Overbilling in which a provider consistently submits claims for more complex procedures than performed or bill at higher reimbursement rates.

Billing for Services Not Rendered including procedures or visits that never occurred or exploiting billing codes to maximize payments.

Unnecessary Tests and Procedures from ordering excessive diagnostic tests or services that fail to meet recognized standards of care to inflate costs.

Measures Health Plans Undertake to Address Fraud, Waste & Abuse

All plans have special investigative units that focus on preventing, detecting and correcting fraudulent and abusive billing activities. These efforts can include:

Audits and Investigations through multi-disciplinary teams who conduct compliance reviews to identify improper payments and fraudulent activity.

Claims Editing Systems and other technologies to spot errors, missing data, incorrect codes, and incomplete patient details to prevent paying inappropriate claims.

Prior Authorization to limit the use of certain codes to ensure services are appropriate, prevent payment of duplicate claims, and confirm individuals are eligible for service.

Network Verification that includes comprehensive screening and monitoring of providers, including license and accreditation checks, ownership and control disclosures, and site visits.

Pre-Pay Pending of Claims when suspicious billing activity, upcoding or unnecessary services are detected.

Comparative Data Monitoring and other analytic tools to scan for known fraud patterns, recognize outlier billing or unusually high volumes of services, or other anomalies between patient records and submitted claims.

Provider Training to ensure that providers are completing annual FWA and General Compliance training so that they are adhering to applicable state and federal requirements.

Confidential Hotlines that enable members and providers to report suspected cases of FWA.

State & Federal Requirements

Health plans must comply with extensive state and federal reporting requirements designed to detect, and prevent fraud, waste, and abuse in Medicaid. This includes:

Special Investigation Units of trained investigators with expertise in law enforcement, coding, clinical policy, and claims administration, and ongoing FWA training to remain current on evolving fraud schemes.

Mandatory Reporting of Suspected FWA to the Office of the Medicaid Inspector General (OMIG) within 10 business days of identification.

Referring Suspected Cases of Fraud to state and federal agencies, as well as to law enforcement, and working with the relevant government entities when they choose to pursue civil or criminal prosecutions.

Extensive State Reporting that includes program integrity annual assessment reports to OMIG, quarterly provider reports to the Department of Health (DOH) and OMIG, twice monthly encounter data reporting, and monthly provider investigative reports to DOH that include information on overpayments. Additionally, health plans must report to the appropriate professional disciplinary agency within 30 days any provider terminations due to fraud, disciplinary measures or potential harm to patients, and immediately report suspected criminal activity to OMIG and the Attorney General.

These efforts reflect plans' commitment to accountability, transparency, prudent stewardship of taxpayers' dollars, and safeguarding access to health services for New Yorkers who rely on the Medicaid program.