New York State Comptroller
THOMAS P. DiNAPOLI

Department of Health

Medicaid Program – Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care (Follow-Up)

July 2026 | Report 2026-F-1
Prepared by the Division of State Government Accountability

Contents

Authority

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health (DOH) to implement the recommendations contained in our initial audit report, *Medicaid Program – Improper Medicaid Payments to Hospitals for Outpatient Services Billed as Inpatient Services for Recipients Enrolled in Managed Care* (Report 2023-S-23).

Background, Objective, and Scope

DOH administers New York's Medicaid program. Most of the State's Medicaid recipients receive their medical services through Medicaid managed care organizations (MCOs). When managed care enrollees receive inpatient care or outpatient care from hospitals, MCOs reimburse the hospitals. DOH also pays hospitals Graduate Medical Education (GME) payments related to inpatient care to help cover the expenses associated with training resident physicians.

A recipient's status in a hospital—inpatient versus outpatient—affects Medicaid's reimbursement for services provided. Inpatient care generally requires recipients to stay overnight in the hospital and to be monitored by the health care team throughout treatment and recovery. Generally, outpatient services are medical procedures that can be performed on the same day and are less expensive than inpatient treatment because they are less involved and do not require a patient's continued presence in a facility.

The objective of our initial audit, issued on August 28, 2024, was to determine whether Medicaid made improper payments to hospitals for outpatient services that were erroneously billed as inpatient services for recipients enrolled in managed care. The audit covered the period from July 2019 through June 2023. The audit focused on inpatient claims with patient stays of less than 24 hours ("short-stay") to identify high-risk claims that may have been incorrectly classified as inpatient instead of outpatient. The audit found that DOH did not conduct reviews of short-stay inpatient encounters or provide guidance to MCOs and hospitals to assist them in determining whether a short-stay claim should be billed as inpatient or outpatient, which may have contributed to billing misclassifications. We identified a risk population of 61,171 short-stay admissions totaling over $684 million, for which providers reported both an inpatient encounter and a GME claim. Almost $144.1 million of the $684 million was for patient stays of 10 or fewer hours, which we determined to be higher risk. We reviewed a sample of 33 admissions totaling $773,492 and determined that 13 admissions, totaling $151,508, were billed improperly, either as inpatient rather than outpatient or for other reasons.

The objective of our follow-up was to assess the extent of implementation, as of April 3, 2026, of the four recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

DOH officials made little progress in addressing the problems we identified in the initial audit report, and additional actions are still needed. In particular, officials did not develop an ongoing process to identify and review the appropriateness of high-risk, short-stay inpatient claims, and most of the admissions we identified in the initial audit have not been reviewed for appropriateness. Of the initial report's four audit recommendations, one was implemented and three were not implemented.

Follow-Up Observations

Recommendation 1 – Develop and provide guidance to hospitals and MCOs to assist them in determining if a service should be billed as an inpatient or outpatient claim, including when patients leave the hospital against medical advice.

Status – Implemented

Agency Action – In January 2025, DOH issued guidance to hospitals and MCOs to assist them in determining when a service should be billed as inpatient, including when patients leave the hospital against medical advice.

Recommendation 2 – Review the 13 reported admissions with payments totaling $151,508 that were inappropriately billed and recover overpayments, as appropriate.

Status – Not Implemented

Agency Action – The initial audit identified 13 admissions totaling $151,508 that were overpaid because they were inappropriately classified as inpatient rather than outpatient, or for other reasons. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of DOH. New York State statute allows OMIG to audit providers' claims and recover overpayments up to 6 years after the date when the service or supplies were furnished or billed, whichever is later.

At the time of our follow-up, providers had voided or adjusted claims totaling $58,225 for four admissions. However, OMIG was unable to provide evidence that these voids resulted from its actions or documentation showing that it reviewed any of the 13 admissions. We note that OMIG has already lost the opportunity to recover $6,623 in payments due to lookback provisions. We encourage DOH and OMIG to promptly review the remaining admissions to prevent further loss of recoveries.

Recommendation 3 – Develop a risk-based approach to review the remaining 61,138 reported admissions identified in this audit that have inpatient encounter and GME payments totaling $683.8 million, giving particular focus to shorter patient stays (e.g., patient stays of 10 or fewer hours), to identify improper payments and make recoveries, as appropriate.

Status – Not Implemented

Agency Action – During the initial audit, we provided DOH with 61,138 short-stay admissions totaling approximately $683.8 million for review. These admissions involved patients discharged

within 24 hours of admission, indicating a high risk that the services were outpatient rather than inpatient. In response to our initial audit, OMIG stated that it analyzed the identified admissions and determined that 12,397, totaling approximately $119 million, were at low risk of being inappropriately classified as inpatient. This determination was based on the reported Diagnostic-Related Group (DRG) codes, which had an average length of stay of at least 3 days. However, this approach was flawed because claims should be considered at higher risk for improper payment when the DRG has an average length of stay of at least 3 days but the recipient is discharged in less than 24 hours. Additionally, upon request, OMIG was unable to provide further detail to support its determination.

At the time of our follow-up, providers had voided or adjusted claims totaling $14.6 million for 1,217 admissions. However, OMIG was unable to provide evidence that these recoveries resulted from its actions. Further, we found that OMIG had recovered only $76,972 for three admissions. As a result, no action was taken to review the remaining $669.1 million ($683.8 million - $14.6 million - $76,972) for 59,918 admissions. We note that OMIG may have already lost the opportunity to review 10,744 admissions totaling $104.7 million due to lookback provisions. We encourage DOH and OMIG to take prompt action on the remaining admissions to prevent further loss of recoveries.

Recommendation 4 – Develop an ongoing process to identify and review the appropriateness of high-risk, short-stay inpatient claims, such as the ones identified in this audit.

Status – Not Implemented

Agency Action – Although OMIG officials stated they met to discuss developing a process to identify and review the appropriateness of high-risk, short-stay inpatient claims, they were unable to provide evidence of these discussions. Since our initial audit, for the period from July 2023 through December 2025, we identified an additional risk population of 36,986 short-stay inpatient admissions for which providers were reimbursed over $419.6 million. Of this amount, approximately $90.4 million was for stays of 10 or fewer hours. We encourage DOH to develop an ongoing process to identify and review these claims for potential Medicaid cost recoveries.

Reporting Requirements

DOH officials are requested, but not required, to provide information about any actions planned to address the unresolved issues discussed in this follow-up within 30 days of the report's issuance. We thank the management and staff of DOH for the courtesies and cooperation extended to our auditors during this follow-up.

Contact

Office of the New York State Comptroller
110 State Street
Albany, New York 12236

(518) 474-4044

www.osc.ny.gov

Prepared by the Division of State Government Accountability

July 16, 2026

Executive Team

Andrea C. Miller – Executive Deputy Comptroller
Tina Kim – Deputy Comptroller
Stephen C. Lynch – Assistant Comptroller

Contributors

Christopher Morris – Audit Director
Thomas Sunkel, CPA – Audit Manager
Daniel Rossi – Audit Supervisor
Kimberly Geary – Examiner-in-Charge
Mahnoor Ali – Senior Examiner
Anna Williams – Staff Examiner