NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
Health Home (Adults)
Revised 04/01/2026

(For Service Dates 01/09/2014 through 08/21/2025)

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should retain or hire an attorney, or contact a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

Public Health Emergency (PHE)

During the PHE, services provided and billed in accordance with COVID-19 PHE guidance issued by the NYS Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS) pertaining to Health Home services will not be subject to disallowance, provided all other programmatic and billing requirements not altered or waived by the PHE guidance were met.

This includes the following guidance:

Agency	Guidance Title	Date Issued	Date(s) Revised
DOH	COVID-19 Guidance for Health Homes	03/14/20	
DOH	Health Home Frequently Asked Questions During COVID-19 State of Emergency	03/26/20	04/09/20
CMS	Appendix K: Emergency Preparedness Response NY.0238.R06.01	04/07/20	
DOH	Lifting of Member Disenrollment Restrictions - COVID-19	07/24/20	
DOH	Verbal Consent Guidance	10/26/20	11/25/20
DOH	NYS COVID-19 State Disaster Emergency, Executive Order No. 202	06/25/21	
DOH	Changes to Plan of Care (POC) Flexibilities and In-Person Requirements for Health Home Participants	02/21/23	

The Federal Government announced that the PHE expired at the end of the day on May 11, 2023. On the date the PHE ended, the flexibilities afforded providers regarding minimum billing standards and documentation requirements also ended, unless otherwise specified by DOH through formal regulatory waivers.

1.	**Missing Member Record**
OMIG Audit Criteria	If the member's record is not available for review, the claims for the dates of service associated with the recipient record will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.2 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section IX

2.	**No Documentation of Service**
OMIG Audit Criteria	The service must be documented in the member's record and must include the date the service was performed. If there is no service documentation, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2 Sections 4, 9.1, and 9.2 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections I, III, and IX

3.	**Service Documentation Does Not Meet Required Standards**
OMIG Audit Criteria	If the member's record does not document that one of the core Health Home services was provided, the claim will be disallowed. Health Home core services are defined as: • Comprehensive Care Management • Care Coordination and Health Promotion • Comprehensive Transitional Care • Enrollee and Family Support • Referral to Community and Social Supports • Use of Health Information Technology (HIT) to Link Services Note: Health Home Plus (HH+) members have additional requirements.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Sections 4 and 9.1 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections I, III, and IX

4.	**Incorrect Rate Code Billed**
OMIG Audit Criteria	If an incorrect rate code was billed, the difference between the correct and incorrect rate codes will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) and (i) 18 NYCRR § 518.1(c) **For Services 05/01/18 and After:** Billing and Documentation Guidance for Health Home Adult Rates with Clinical and Functional Adjustments **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section III **For Services 12/01/16 through 04/30/18:** Billing and Documentation Standards for Health Home: High, Medium, and Low (HML) Rates with Clinical and Functional Adjustments

5.	**Incorrect Billing During Inpatient Stay**
OMIG Audit Criteria	Billing for Health Home services that do not meet the guidance for billing during inpatient stays will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) **For Services 10/01/17 and After:** Continuity of Care and Re-engagement for Enrolled Health Home Members **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections III and VI

6.	Excessive Outreach and Engagement Billing
OMIG Audit Criteria	**For Services 07/01/20 and After:** All payments for conducting Outreach services are eliminated. **For Services 10/01/17 through 6/30/20:** Outreach services will not exceed two consecutive months. The second month must be a face-to-face contact. Outreach cannot be billed more than four months in a rolling twelve-month period **For Services 01/09/14 through 09/30/17:** The outreach and engagement rate codes may only be billed for three consecutive months, a lapse of three months must occur before outreach and engagement can be billed again. Claims billed in excess of the allowable amount will be disallowed. Note: This finding only applies to sampled claims in which outreach and engagement rate codes were billed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 518.1(c) **For Services 07/01/20 and After:** Elimination of Health Home Billing for Outreach **For Services 10/01/17 through 06/30/20:** Interim Guidance Addressing Outreach Modifications Modifications to Health Home Outreach: Guidance and Preliminary Timeline **For Services 01/09/14 through 07/10/19** Health Homes Provider Manual, Version 2014-1, Sections III and VI

7.	**Failure to Document Outreach and Engagement**
OMIG Audit Criteria	Active, ongoing, and progressive engagement with the member must be documented in the care management record. Claims for outreach and engagement that fail to document active, ongoing and progressive engagement with the member will be disallowed. This finding only applies to sample claims in which outreach and engagement rate codes were billed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/01/20 and After:** Elimination of Health Home Billing for Outreach **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.1 **For Services 10/01/17 through 06/30/20:** Interim Guidance Addressing Outreach Modifications Modifications to Health Home Outreach: Guidance and Preliminary Timeline **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section IX

8.	**Duplicate Billing for Service**
OMIG Audit Criteria	Claims submitted for services that are duplicative will be disallowed.
Regulatory References	18 NYCRR § 504.3(e) 18 NYCRR § 518.1(c)

9.	**Missing Care Plan**
OMIG Audit Criteria	Health Home service providers are required to develop a care plan. The care manager will be responsible for overall management and coordination of the member's care plan. If the care plan is not made available, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 08/01/19 and After:** Health Home Plan of Care Policy **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 7.3 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections I, VIII, and IX

10.	Care Plan Does Not Meet Required Standards
OMIG Audit Criteria	Health Home service providers are required to develop a care plan. The care manager will be responsible for overall management and coordination of the member's care plan. If the care plan does not contain the required elements, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 08/01/19 and After:** Health Home Plan of Care Policy **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 7.3 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections I, VIII, and IX

11.	Missing Comprehensive Assessment
OMIG Audit Criteria	If the care management record does not contain an initial comprehensive assessment, and if applicable, an annual reassessment has not been completed or reassessed as a result of a significant change in the member's health/behavioral health or social needs status, the claim will be disallowed. If the comprehensive assessment is not made available, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.2 **For Services 09/20/17 and After:** Health Home Comprehensive Assessment Policy (Adult and Children) **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section IX **For Services 06/01/17 through 09/19/17:** Health Home Comprehensive Assessment Policy (Adult)

12.	Comprehensive Assessment Does Not Meet Required Standards
OMIG Audit Criteria	If the care management record does not contain an initial comprehensive assessment, and if applicable, an annual reassessment has not been completed or reassessed as a result of a significant change in the member's health/behavioral health or social needs status the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(a) and (i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.2 **For Services 09/20/17 and After:** Health Home Comprehensive Assessment Policy (Adult and Children) **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section IX **For Services 06/01/17 through 09/19/17:** Health Home Comprehensive Assessment Policy (Adult)

13.	No Face-to-Face Encounter
OMIG Audit Criteria	If the care management record is missing a face-to-face contact at the initial assessment or development of the initial care plan, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.1 **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section IX

14.	Missing FACT-GP© and Health Home Functional Assessment Questionnaire
OMIG Audit Criteria	**For Services Prior to 01/01/17:** FACT-GP© is required at the initial assessment, annually, and at disenrollment. Compliance is evaluated based on the date the assessment was required to be completed and submitted. If the record did not contain the required FACT-GP© and the Health Home Functional Assessment Questionnaire in accordance with timing requirements, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) **For Services 01/09/14 through 12/31/16:** Health Homes Provider Manual, Version 2014-1, Sections IV and IX

15.	Failure to Obtain Member's Signed Consent
OMIG Audit Criteria	The provider must obtain a signed Health Home Patient Information Sharing Consent Form (DOH-5055) prior to sharing protected health information. Members who continually refuse to sign the consent form should be disenrolled. If consent was not obtained the claim will be disallowed. Note: Effective 08/01/18, enrollment cannot occur or continue without signed consent.
Regulatory References	18 NYCRR § 504.3(i) **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 9.2 **For Services 08/01/18 and After:** Access to/Sharing of Personal Health Information (PHI) and the Use of Health Home Consents **For Services 10/01/17 and After:** Interim Guidance Addressing Outreach Modifications **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Sections VI and IX

16.	Failure to Document Health Home Eligibility
OMIG Audit Criteria	Individuals served in a Health Home must have at least two (2) chronic conditions or a single qualifying condition as defined in Section 1945(h)(2) of the Social Security Act. If the record does not contain verification of diagnosis of the chronic or qualifying condition(s), or proof of HARP enrollment prior to the date of service, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) **For Services 10/31/23 and After:** Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program **For Services 06/06/22 and After:** NYS DOH Medicaid Update, May 2022, Vol. 38, No. 6 **For Services 09/01/20 and After:** Eligibility Requirements: Identifying Potential Members for Health Home Services Appropriateness Criteria **For Services 07/11/19 and After:** Health Homes Provider Manual, Versions 2019-1 through 2019-2 Sections 3.1, 3.2, and 9.2 **For Services 09/23/14 and After:** Eligibility Requirements: Identifying Potential Members for Health Home Services **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section I

17.	**Failure to Provide Continuity of Care**
OMIG Audit Criteria	As soon as a member is determined to be disengaged from care management services, efforts to locate and re-engage the member must be intensified beyond *Standard* CM activities. If the provider fails to intensify search efforts, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) **For Services 07/21/19 and After:** Health Homes Provider Manual, Version 2019-2, Section 4.5 **For Services 07/11/19 through 07/20/19:** Health Homes Provider Manual, Version 2019-1, Section 4.4 **For Services 10/01/17 and After:** Continuity of Care and Re-engagement for Enrolled Health Home Members **For Services 01/09/14 through 07/10/19:** Health Homes Provider Manual, Version 2014-1, Section III

18.	**Failure to Complete Required Background Checks for Health Home Care Managers That Serve Members Under the Age of 21**
OMIG Audit Criteria	The claim will be disallowed when the provider failed to complete the required background check for health home care managers.
Regulatory References	**For Services 04/01/18 and After:** Background Check Requirements for Health Homes and Care Managers Health Homes Provider Manual, Versions 2019-1 through 2019-2, Section 2.9

19.	**Services Ordered / Prescribed / Referred / Attended by Excluded Individual**
OMIG Audit Criteria	Claims for services ordered, prescribed, referred, or attended by an individual excluded from the New York State Medicaid program when the services were ordered, prescribed, referred, or attended will be disallowed.
Regulatory References	18 NYCRR § 504.7(d)(1) 18 NYCRR § 513.1(d),(e), and (g) 18 NYCRR § 515.1(b)(6) and (10) 18 NYCRR § 515.5(a)-(c) and (e) NYS DOH Medicaid Update, Special Edition December 2013, Vol. 29, No. 13 NYS DOH Medicaid Update, April 2010, Vol. 26, No. 6