

Maternal Infant Health Program **OPERATIONS GUIDE**

**Division of Family and Community Health
Bureau of Family, Maternal and Child Health
Michigan Department of Community Health**

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1.0 INTRODUCTION TO MIHP

Purpose of the *MIHP Operations Guide*

The *MIHP Operations Guide* is designed to be a comprehensive, online reference source for MIHP providers on how to implement the MIHP Chapter in the *Medicaid Provider Manual*. It should not be construed as a substitute for the *Medicaid Provider Manual*, which is the official MIHP policy reference source.

Although the *MIHP Operations Guide* was conceptualized as a one-stop place for providers to go to seek answers to their MIHP questions, it is not intended to replace technical assistance offered by MDCH MIHP consultants. MDCH anticipates that the primary users of the *MIHP Operations Guide* will be the following groups:

- Potential and new MIHP providers who need detailed program information for start-up purposes
- Newly-hired staff who need an orientation to MIHP
- MIHP staff who need to look up requirements, protocols or up-to-date forms
- Persons interested in learning how Michigan implements MIHP

How to Use the *MIHP Operations Guide*

The authoritative source for the Maternal Infant Health Program (MIHP) is The *Medicaid Provider Manual*. The *Medicaid Provider Manual* includes all of the Medicaid polices that pertain to the MIHP, along with policies that pertain to other Michigan Medicaid programs. To review the MIHP chapter in the *Medicaid Provider Manual* in its entirety, go to [Medicaid Provider Manual](#) and click on "Maternal Infant Health Program" in the bookmarks column on the left.

The *MIHP Operations Guide* details how to implement the MIHP policies in the *Medicaid Provider Manual*. MIHP providers should be very familiar with both documents. The entire MIHP policy is incorporated within the *MIHP Operations Guide*, but it is presented in sections that are dispersed throughout the *Operations Guide* in **boldface** type. Wherever a policy section is inserted, a link back to the *Medicaid Provider Manual* is given, along with the section number and heading in parenthesis. In a few places, excerpts from other chapters of the *Medicaid Provider Manual* that are relevant for MIHP providers are also inserted in **boldface** type.

To locate information about a particular topic in the *MIHP Operations Guide*, start with the Table of Contents. If you can't find what you're looking for, please contact one of the MDCH MIHP consultants identified in the following section.

The *MIHP Operations Guide* is only available electronically. It is updated quarterly, at which time MIHP providers will receive an email notice that changes have been made. Providers are strongly encouraged to make it a practice to refer to the electronic *Guide*. If you do print out a particular section for ease of use, it is your responsibility to ensure that you are always working from the most recent version incorporating all updates.

The Michigan Department of Community Health (MDCH) wants to make the *MIHP Operations Guide* as user-friendly as possible. Please forward your questions or comments about the *Guide* to one of the consultants listed below.

MDCH MIHP Consultant Contact Information

MDCH welcomes your questions about the MIHP. For additional information, contact either of the individuals listed below:

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MIHP Web Site

MDCH maintains an MIHP web site at www.michigan.gov/mihp. The site includes a brief overview of the program, brochures, information on locating MIHPs across the state, information on becoming an MIHP provider, MIHP documents and links, MIHP trainings, news, resources and other items of interest to MIHP providers and the public.

MIHP on Twitter

MDCH also communicates through Twitter at <https://twitter.com/MyMIHP>. This site offers real-time information on research related to pregnancy and infancy, product safety recalls, and other issues affecting the population served by MIHP.

MIHP Coordinator and Transportation Directory

A document titled, *MIHP Coordinator and Transportation Directory*, includes updated contact information for each MIHP provider, as well as information about the transportation services offered by each provider. The *Directory* is posted on the MIHP web site at www.michigan.gov/mihp.

MIHP Overview

Origins

Medicaid pays for roughly 40% of all births in Michigan (50,068 of 125,172 births in FY07). In order to qualify for Medicaid, families must meet program criteria, including low-income level status. It has been well-established that low socioeconomic status is a major risk factor for infant mortality and morbidity. In an effort to reduce infant mortality and morbidity among pregnant and infant Medicaid beneficiaries, the Michigan Department of Community Health (MDCH) initiated the Maternal Support Services (MSS) Program in 1987 and the Infant Support Services (ISS) Program a few years thereafter. MSS was designed to address the psychosocial issues and logistical barriers (e.g., lack of transportation) that prevented many pregnant Medicaid beneficiaries from obtaining or benefitting from prenatal care. ISS was designed to promote health and development throughout infancy.

MSS/ISS services were essentially home-based, delivered by a qualified team that included a registered nurse, a licensed social worker, a dietitian, and an infant mental health specialist (if available). MSS/ISS providers were given broad leeway in determining how services were delivered, resulting in a great deal of variation across providers. Data-reporting requirements were minimal.

MSS/ISS providers could bill for the initial assessment and 9 service visits during pregnancy, and for an initial assessment and 9 home visits during infancy. An additional 9 visits could be provided during infancy when requested in writing by the medical care provider. Up to 36 visits could be provided when the infant was drug/alcohol exposed. Women were nearly twice as likely to participate in MSS as they were to participate in ISS.

Redesign

In 2004, MDCH undertook an effort to study and redesign MSS and ISS in order to improve program outcomes. As a result, MSS and ISS were consolidated and renamed the Maternal Infant Health Program (MIHP). The most significant redesign outcome, however, was MDCH's decision to convert MIHP to a population management model.

A population management model is population-based, meaning that the health of the entire target population is addressed in addition to the health of individuals within the population. For example, in MSS/ISS, pregnant women and infants were screened to determine if they were program-eligible; in MIHP, all pregnant and infant Medicaid beneficiaries are program-eligible. MIHP providers strive to identify as many eligible women and infants as possible and to "touch" each one. At a minimum, this involves administering a risk identification tool and providing the beneficiary with an educational packet and a phone number, in case help is needed later in the pregnancy or infancy. Other key features of a population management model are: care coordination; a strong focus on outcomes; systematic risk screening; use of specified, evidence-based interventions tied to level of risk; comprehensive data collection; development of a centralized database/registry; and use of data to drive program decisions in order to improve program quality.

The MIHP population management approach requires providers to focus on the following tasks:

1. Engage all Medicaid-eligible pregnant women and infants in MIHP.
2. Identify risk factors for all Medicaid-eligible women and infants in order to determine service intensity levels, using standardized *MIHP Risk Identifier* tools that generate stratified (no, low, moderate, high and unknown) risk profiles.
3. Develop *Plans of Care* based on *Risk Identifier* results, beneficiary priorities, and professional judgment.
4. Deliver prescribed, evidence-based interventions, targeting identified risks and beneficiary priorities.
5. Measure specified outcomes.

For quality assurance purposes, MDCH consultants conduct onsite program certification reviews and ongoing program monitoring of MIHP providers, as they did with MSS/ISS providers.

Administration by MDCH

MIHP is jointly managed by two administrations within the Michigan Department of Community Health. One is the Medical Services Administration/Bureau of Policy and Actuarial Services and Bureau of Medicaid Program Operations and Quality Assurance, and the other is the Public Health Administration/Bureau of Family, Maternal and Child Health/Division of Family and Community Health.

The Medical Services Administration (MSA) is responsible for promulgating Medicaid policies, assisting providers to implement Medicaid policies, entering into and monitoring contracts with Medicaid Health Plans, making payments to Medicaid providers, etc. The Bureau of Family, Maternal and Child Health, /Division of Family and Community Health is responsible for developing MIHP procedures, certifying and monitoring providers, and providing technical assistance to providers.

Goal of MIHP

The goal of MIHP is to support Medicaid beneficiaries in order to promote healthy pregnancies, positive birth outcomes, and infant health and development. MIHP services are intended to supplement medical (prenatal and infant) care. MIHP provides care coordination and intervention services, focusing on the mother-infant dyad. Care coordination services are provided by a registered nurse and licensed social worker, one of whom is designated as the Care Coordinator. Intervention services are provided by a registered nurse, a licensed social worker, registered dietitian (with a physician order), and an infant mental health specialist, depending on the beneficiary's particular needs.

During the pregnancy, the MIHP professional staff assists the woman to circumvent barriers to obtaining prenatal care (e.g., lack of transportation) and to make changes that increase the likelihood that her infant will be healthy at birth (e.g., decrease use of tobacco, alcohol or drugs; seek treatment for depression; improve management of a chronic disease; etc.). Staff provides education on topics related to the woman's own particular needs, offers guidance and encouragement as she endeavors to make changes, and facilitates referrals to other services and supports, as needed.

After the birth of the infant, the MIHP staff continues to support the mother and begins to monitor the infant's health, safety and development. The staff ensures that the infant has a medical care provider, encourages the mother to take the infant to see the provider for regular well-child visits (and when medical attention is indicated), and helps the mother to follow through with the provider's recommendations. The staff also assists the mother to address any safety risks (e.g., no car seat, environmental toxins, not using safe sleep practices, etc.). In addition, the staff administers standardized tools to screen for potential developmental delays in the following domains: communication, gross motor, fine motor, problem solving, personal-social, and social-emotional. If screening results indicate a potential delay in any of these domains, the staff refers the infant to *Early On Michigan* for a comprehensive developmental evaluation. The staff also provides basic developmental guidance for the mother to assist her to promote her infant's health and development.

The MIHP provider **must** provide nursing and social work services. The provider also **must** provide nutrition counseling services **or** refer beneficiaries to other local agencies that offer the services of a registered dietitian. The provider **may** provide infant mental health services or refer beneficiaries to other local agencies that offer the services of an infant mental health specialist, if available.

MIHP - One of Multiple MDCH Initiatives to Reduce Infant Mortality

The ultimate, long-term goal of MIHP is to reduce infant mortality and morbidity in the Medicaid population. Although some progress has been made, infant mortality is proving to be a very complex problem that will likely require action on multiple fronts before rates are significantly affected. In recognition of the complexity of the problem, MDCH has several other approaches that, in addition to MIHP, are intended to help combat infant mortality. These initiatives include the Fetal-Infant Mortality Review Program, Michigan Maternal Mortality Surveillance, Plan First! and Family Planning Program.

MIHP Providers

There are about 75 MIHP providers operating in Michigan at any given time, each serving one or more counties of their choice. In FY 08, seventy-six counties had 0-4 MIHP providers; two counties had 5-

MIHP providers; and four counties had 10-18 MIHP providers. As one would expect, the urban, densely-populated counties have the greatest concentration of MIHP providers.

In January, 2010, 39% of MIHP providers were local public health departments. The other 61% were federally qualified health centers or private providers, such as hospitals, home health agencies and individually-owned businesses.

In order to become an MIHP provider, an agency must apply to MDCH and complete a multi-step process, ending in program certification.

MIHP Provider Coordination with Medicaid Health Plans

Pregnant and infant Medicaid beneficiaries are required to enroll in Medicaid Health Plans (MHPs). There are some exceptions to this policy, but most beneficiaries do become health plan members. Currently, there are 14 MHPs operating in Michigan.

MDCH contracts with MHPs to provide medical health care, mental health care for mild to moderate mental health concerns, transportation, and case management for Medicaid beneficiaries. Since MIHP providers work with pregnant MHP members to reduce psychosocial and logistical barriers to accessing and benefiting from medical care, it's clear that MIHP providers and MHPs must closely coordinate their activities.

Coordination is critical, takes considerable effort, and can be time-consuming, particularly in major urban areas with multiple MHPs and MIHP providers. To ensure that this coordination takes place, MDCH requires each MIHP provider and each MHP serving a common county or group of counties to enter into an *MIHP - MHP Care Coordination Agreement* signed by both parties. The *Care Coordination Agreement* covers services provided by the MHP, services provided by the MIHP provider, medical coordination, transportation, quality improvement, grievances and appeals, and dispute resolution.

MIHP Provider Coordination with Medical Care Providers

In addition to coordinating with the MHP that is responsible for overall management of the beneficiary's health care, the MIHP provider also must coordinate with the beneficiary's medical care provider. The medical care provider may be a physician, certified nurse midwife, pediatric nurse practitioner, family nurse practitioner, or physician assistant. Since the MIHP provider and medical care provider are both striving to ensure that the beneficiary has the best possible care, it's important that they communicate regularly. Medicaid policy specifies points at which the MIHP provider must inform the medical care provider about the beneficiary's status.

MIHP Assumptions

MIHP, which is designed to promote healthy pregnancies, positive birth outcomes, and infant health and development, provides care coordination for pregnant and infant Medicaid beneficiaries. MIHP also provides educational interventions targeting the psychosocial, nutritional, and health risks specific to each pregnant woman and infant. MIHP providers supplement medical (prenatal and infant) care, assisting medical care providers to improve the beneficiary's health and well-being by identifying and addressing psychosocial, nutritional and health education needs.

MDCH developed the following assumptions for the MIHP redesign:

1. The MIHP will be co-managed by Medicaid and the Division of Family and Community Health in participatory planning with key stakeholders, including the women who participate in the program.

2. Resources are limited, and MIHP cannot address all issues for all beneficiaries.
3. Systems of care vary among communities.
4. The MIHP focuses on motivating beneficiaries and coordinating services.
5. The MIHP is based on a population management model.
6. The MIHP has a registry that is used for population management purposes, including tracking, reporting, and outcomes measurement.
7. Risks are determined systematically and periodically.
8. Interventions are prioritized to address (1) identified risks, (2) anticipated service-intensity levels, and (3) specified domains/areas. They are based on evidence or best-practices. Plans of care are tailored to individual beneficiaries based on readiness for change in addition to identified risks.
9. Interventions are delivered by providers operating within the program policy and professional scope.
10. Payment is Fee-For-Service (FFS) by "visit".
11. Providers must meet program expectations, including implementation of outreach strategies.
12. Providers require ongoing training and oversight.
13. The MIHP is evaluated annually and is outcome based.

MIHP Service Process

MIHP is a home-visiting program, providing care coordination and intervention services for pregnant and infant Medicaid beneficiaries. MIHP providers make use of available community resources and provide health education and support to address the beneficiary's identified risks. Once a potential beneficiary has agreed to a face-to-face meeting and signed an *Authorization and Consent to Release Protected Health Information*, the MIHP provider uses a standardized, system-wide service process, involving the following components:

1. Administration of the *Maternal or Infant Risk Identifier*.
2. Assisting the beneficiary to identify her individual needs, goals, and resources.
3. Facilitating the development of an individualized *Plan of Care*, incorporating the beneficiary's stated needs, goals, and resources.
4. Assisting the beneficiary to locate resources.
5. Facilitating connections with providers of services and supports; advocating on behalf of the beneficiary to obtain services, if needed.
6. Providing educational and other services as indicated in the *Plan of Care*.
7. Coordinating implementation of the *Plan of Care*; ensuring that services are rendered, monitoring beneficiary's use of services, and coordinating services when multiple providers are involved.
8. Assisting the beneficiary with problematic situations and needs, as they arise.
9. Using Motivational Interviewing and coaching the beneficiary toward self-empowerment and self-management.
10. Maintaining communication with the beneficiary to evaluate whether the *Plan of Care* is effective in meeting the beneficiary's goals.
11. Modifying the *Plan of Care*, as needed.
12. Communicating with medical care provider and Medicaid Health Plan.
13. Determining if specified, desired service outcomes are achieved.

2.0 MEDICAID PROVIDER RESOURCES

Medicaid providers must be familiar with numerous Medicaid policies, procedures, and forms, including those pertaining to covered services and billing, all of which are subject to change over time. Providers are responsible for implementing changes in policies and procedures as of the dates they become

effective. The following resources are intended to assist providers in their ongoing efforts to keep current on the Medicaid program:

Medicaid Policy Manual Web Site

The *Medicaid Provider Manual* includes all of the Medicaid polices that pertain to the MIHP, along with policies that pertain to other Michigan Medicaid programs. To review the MIHP chapter in the *Medicaid Provider Manual* in its entirety, go to [Medicaid Provider Manual](#) and click on "Maternal Infant Health Program" in the bookmarks column on the left.

Medicaid Provider Web Site

MDCH maintains a web site for Medicaid providers titled *Medicaid* at www.michigan.gov/medicaidproviders. It provides direct links to information on a variety of topics including: Hot Topics, Provider Enrollment, Eligibility Verification System, Policy and Forms (including Michigan Medicaid Approved Policy Bulletins), Draft Policy Bulletins for Public Comment, Billing and Reimbursement, and Communications and Training.

Michigan Medicaid Policy Bulletins

Michigan Medicaid Approved Policy Bulletins and Michigan Medicaid Proposed Policies are available at [Policy Bulletins Quarterly Update](#).

Billing and Reimbursement

Information about Medicaid provider billing and reimbursement, including electronic billing, explanation codes, National Provider Identifier (NPI) Registry, provider specific information, and fraud and abuse reporting requirements, is available at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-151698--,00.html

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be found at [Billing and Reimbursement](#). This web site, titled *MIHP Databases*, provides billing codes and fee screens back to 2003.

Billing Training

Communications and training information for billing agents, including the *Community Health Automated Medicaid Processing System (CHAMPS) Enrollment Guide*, is available at [Billing Agent Communications and Training](#).

Medicaid Provider Helplines

Providers with questions about Medicaid billing may call one of the toll-free numbers below:

CHAMPS Enrollment Helpline	1-888-643-2408
Michigan Medicaid Provider Support	1-800-292-2550

MIHP Medicaid Provider Forms

MIHP providers must use standardized forms developed by MDCH. The forms are available at the MIHP website at www.michigan.gov/mihp.

3.0 MIHP GOAL AND PARTNERS

This chapter (of the Medicaid Provider Manual) applies to certified Maternal Infant Health Program (MIHP) providers servicing Medicaid and Maternity Outpatient Medical Services (MOMS) beneficiaries. The purpose of MIHP is to reduce infant mortality and morbidity. This is an objective of both the State of Michigan and the Federal government who fund this program. The goal of the MIHP is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development.

Accordingly, MIHP services are intended to help pregnant Medicaid beneficiaries who are most likely to experience serious psychosocial or nutritional issues. Services are intended to supplement regular prenatal/infant care and to assist the following providers in managing the beneficiary's health and well-being:

- **Physicians (MD, DO)**
- **Certified Nurse Midwives (CNM)**
- **Pediatric Nurse Practitioners (PNP)**
- **Family Nurse Practitioners (FNP)**
- **Medicaid Health Plans (MHP)**
- **Physician Assistants (PA-C)**

(Section 1 General Information, MIHP Chapter, [Medicaid Provider Manual](#))

All pregnant and infant Medicaid and Maternity Outpatient Medical Services (MOMS) beneficiaries are eligible for MIHP, except for infants in foster care with non-relatives, unless family unification is in process. Beneficiaries at highest risk for pregnancy complications, poor birth outcomes, and delays in infant growth/development are offered MIHP services to address these concerns; beneficiaries at lower risk for these negative outcomes are offered services that correspond to their needs.

As MIHP services are intended to supplement medical (prenatal and infant) care, MIHP providers closely coordinate their efforts with medical care providers and with Medicaid Health Plans (MHPs), since most pregnant and infant beneficiaries are MHP members.

Medicaid Health Plans Description

Medicaid Health Plans (MHPs) are managed care organizations that provide or arrange for the delivery of comprehensive health services to Medicaid enrollees in exchange for a fixed prepaid sum or per-member-per-month prepaid payment without regard to the frequency, extent or kind of health care services. An MHP must have a certificate of authority from the State as a Health Maintenance Organization (HMO). Pregnant and infant Medicaid beneficiaries are required to enroll in MHPs, with a few defined exceptions.

MDCH contracts with MHPs to provide medical health care, out-patient mental health care for mild or moderate mental health concerns, transportation, and case management for Medicaid beneficiaries. (Mental health care for individuals with serious mental illness is carved out from the MHPs and provided by Community Mental Health Services Programs.)

MHPs may provide incentives to their members to encourage them to use prenatal and pediatric care. Once an MIHP beneficiary is enrolled in an MHP, the MIHP provider may encourage the beneficiary to take advantage of the incentives that may be offered by her MHP for following through with prenatal care visits, the postpartum visit, and well-child visits.

Accessing Information about Medicaid Health Plans

Currently, there are 14 MHPs operating in Michigan. A list of MHPs and the counties where they operate, a list of MHPs by county, MHP contact info, MHP enrollment data, and a sample MHP contract are available at: http://www.michigan.gov/mdch/0,1607,7-132-2943_4860_5047---,00.html

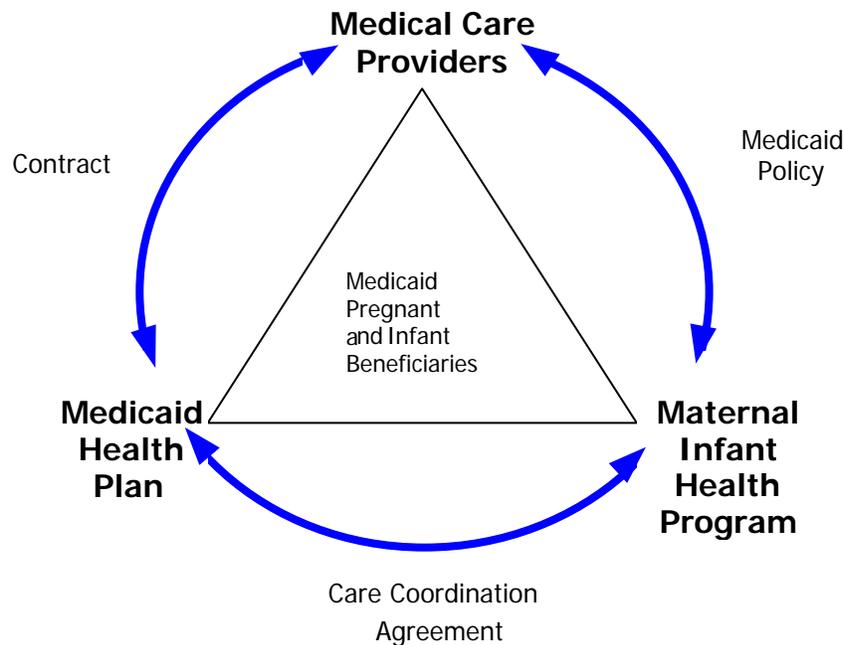
A list titled *Michigan Counties with MIHP Providers, WIC Agencies and Medicaid Health Plans* is available at the MIHP web site at www.michigan.gov/mihp.

A list titled, *Medicaid Health Plans: MIHP Contact Person*, may be accessed at www.michigan.gov/mihp.

A document titled *Medicaid Health Plan Transportation Grid*, gives information about the transportation services provided by each MHP. It is available at www.michigan.gov/mihp.

MIHP Providers, Medicaid Health Plans, and Medical Care Providers: Partners in Providing Coordinated Care for MIHP Beneficiaries

The MIHP provider, Medicaid Health Plan (MHP), and medical care provider are active partners in assuring that MIHP beneficiaries are systematically identified and provided with quality, coordinated care.



To ensure that coordination takes place between the MIHP provider and the MHP, MDCH requires an *MIHP and MHP Care Coordination Agreement* between them.

MHPs must refer pregnant enrollees to an MIHP provider. To define the responsibilities and relationship between the MIHP providers and the MHP, a Care Coordination Agreement (CCA) must be reviewed and signed by both providers. The CCA provides guidance by delineating the communication expectations between the two agencies. Each MIHP provider is required to have a signed CCA with each MHP in their service area. (Refer to the Forms Appendix of the Medicaid Provider Manual for a copy of a Care Coordination Agreement.)

(Section 1.4 Medicaid Health Plans (MHP), MIHP Chapter, [Medicaid Provider Manual](#))

The CCA defines the relationship, responsibilities, and communication expected between a particular MIHP provider and a particular MHP serving the same geographic area. It includes language stating that the MHP will refer pregnant members to the MIHP provider; that the MHP and MIHP provider will coordinate transportation for mutually-served beneficiaries, as both are required to arrange health-related transportation for beneficiaries; and that the MHP and MIHP provider will exchange appropriate information about mutually-served beneficiaries. For example, it is expected that the MIHP will notify each MHP at least monthly regarding beneficiaries of the MHP who have been enrolled in or discharged by the MIHP provider during the previous month. The CCA, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available at [Medicaid Provider Manual](#) in the Forms Appendix.

The MIHP provider and the MHP are encouraged to meet together to develop a working relationship, learn about the services and incentives each provides, and thoroughly discuss the provisions in the CAA. The MIHP provider and the MHP may not delete language from the CCA template, but they may add language, if both are agreeable.

To ensure that coordination takes place between the MIHP provider and the medical care provider, MDCH requires the MIHP provider to share specified beneficiary information with the medical care provider, to use standardized forms to communicate this information, and to meet specified timeframes in communicating this information, as described below:

When an MIHP case is opened without the medical care provider's involvement, the MIHP provider must notify the medical care provider within 14 calendar days. When an MIHP case is opened for a pregnant woman with no medical care provider, the MIHP must assist the woman in finding a medical care provider.

The MIHP provider must keep the medical care provider informed of services provided as directed by the medical care provider or when a significant change occurs. The initial assessment visit is the first visit when the Risk Identifier is completed. The communication identifying risks must be sent to the medical care provider within 14 calendar days after the initial assessment visit is completed. The discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and forwarded to the medical care provider when the MIHP case is closed.

(Section 2.16 Communications with the Medical Care Provider, MIHP Chapter, [Medicaid Provider Manual](#))

The MIHP provider uses standardized forms to share beneficiary information at intake, whenever there's a change in status requiring modification of the *MIHP Plan of Care*, and at service closure. The forms provide space for the medical care provider to identify issues that he or she would like the MIHP provider to address with the beneficiary. At the request of the medical care provider, the MIHP provider forwards a copy of the beneficiary's *Plan of Care*, which identifies all of the MIHP interventions being implemented by the MIHP team.

Specific guidelines for coordinating services with MHPs and medical care providers are provided in the Chapter 8 of this *Guide*, under *MIHP Care Coordination and Intervention Services: Pregnancy and Infancy*. [\(link\)](#)

4.0 BASIC DESCRIPTION OF MIHP SERVICES

MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Community Health (MDCH). MIHP services are provided by a licensed social worker and a registered nurse. An infant mental health specialist with an endorsement may be included. A registered dietitian may also provide services with a physician order.

Program services include social work, nutrition counseling, nursing services (including health education and nutrition education), and beneficiary advocacy services. MIHP services include:

- Psychosocial and nutritional assessment;
- Plan of care development;
- Professional intervention services;
- Maternal and infant health and nutrition education;
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments;
- Referral to community services (e.g., mental health, substance abuse);
- Coordination with other medical care providers and MHPs;
- Family Planning education and referral; and
- Coordinating or providing childbirth or parenting education classes.

(Section 1.1 Program Services, MIHP Chapter, [Medicaid Provider Manual](#))

Types of MIHP Services

MIHP provides two types of services for maternal/infant dyads: care coordination and interventions. Care coordination services are provided by a registered nurse or a licensed social worker. Intervention services are provided by a registered nurse, a licensed social worker, a registered dietitian, or an infant mental health specialist.

MIHP Care Coordination Services

Care coordination services include: risk identification, care plan development, care plan implementation, care plan implementation monitoring, documentation of care plan implementation, coordination with the MHP, and coordination with the medical care provider. The registered nurse or the licensed social worker is designated as the Care Coordinator for each beneficiary.

The Care Coordinator promotes access to health care and community services (especially for beneficiaries with multiple, complex issues) and is responsible for coordinating and monitoring all care provided to the beneficiary, including referrals and follow-up. The Care Coordinator advocates for the beneficiary as necessary, but ensures that she is involved in her own care plan development and service arrangements to the greatest possible extent, as the provider ultimately aims to empower the beneficiary to successfully navigate the health care system herself.

Detailed information about MIHP care coordination services is provided in Chapter 8 of this *Guide*. [\(link\)](#).

MIHP Intervention Services

In addition to coordinating the beneficiary's care, the MIHP provider delivers or arranges for the delivery of a range of interventions. These interventions fall under the following five categories:

1. Health education
2. Nutrition education
3. Social work
4. Nutrition counseling
5. Infant mental health services

MIHP-reimbursable activities under each of these intervention categories are specified in the grid below:

Intervention Category & Discipline	MIHP-Reimbursable Activities
<p>Health Education Registered Nurse or Licensed Social Worker</p>	<p>Communication of information to improve knowledge of maternal and infant health and to foster the motivation, skills and confidence (self-efficacy) necessary for beneficiaries to take action to improve individual risk factors and risk behaviors, and to use the health care system.</p> <p>Covers:</p> <ul style="list-style-type: none"> • One-on-one/dyad visits • Group sessions (childbirth and parenting education only)
<p>Nutrition Education Registered Nurse or Licensed Social Worker</p>	<p>Communication of basic, general information about nutrition during pregnancy and infancy for beneficiaries who do not have significant nutrition risks or health concerns that are affected by diet.</p> <p>Covers:</p> <ul style="list-style-type: none"> • One-on-one/dyad visits only
<p>Social Work Licensed Social Worker or Registered Nurse</p>	<p>Provision of psychosocial support, problem-solving assistance, and facilitation of referrals for beneficiaries with risks in the mental health, alcohol abuse, substance abuse, or domestic violence domains. Does NOT include clinical social work practice (i.e., assessment, diagnoses and psychotherapy). Also includes assisting any beneficiary with basic needs.</p> <p>Covers:</p> <ul style="list-style-type: none"> • One-on-one/dyad visits only
<p>Nutrition Counseling Registered Dietitian</p> <p>(NOTE: Requires physician order.)</p>	<p>Provision of medically-necessary, individualized counseling for health problems that are affected by diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, etc.; infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.).</p> <p>Covers:</p> <ul style="list-style-type: none"> • One-on-one/dyad visits only

<p>Infant Mental Health (IMH) Services IMH Specialist</p>	<p>Provision of home-based, parent-infant intervention where the parent's condition and life circumstances or characteristics of the infant threaten parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. The IMH specialist may:</p> <ol style="list-style-type: none"> 1. Assess need for infant mental health services, using recommended objective tools that measure: infant social-emotional development (Ages and Stages Questionnaires: Social/Emotional, Devereux Infant-Toddler Assessment); parent-infant attachment (Massie/Campbell Scale of Mother Infant Attachment During Stress); and parental depression (Edinburgh Postnatal Depression Scale). 2. If assessed need is low-moderate, provide brief, direct parent-infant intervention and/or referral to other parenting support program. 3. If assessed need is high, encourage beneficiary to accept referral to Community Mental Health Services Program (CMHSP) or other mental health provider for clinical infant mental health services; facilitate referral; support beneficiary to follow through with treatment. If beneficiary refuses referral, provide support with goal of getting her to accept treatment, and provide brief, direct parent-infant intervention. <p>Covers:</p> <ul style="list-style-type: none"> • One-on-one/dyad visits only
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A physician order must be obtained before a registered dietitian may visit with the beneficiary. The physician order must be included in the beneficiary record. If community resources are available, such as a hospital dietitian, the MIHP may coordinate with the physician to refer the beneficiary to the hospital dietitian. The MIHP also may coordinate nutrition services with the MHP. As in other areas, when nutrition counseling is needed, the documentation must indicate how services were provided.

(Section 1.2 Staff Credentials, MIHP Chapter, [Medicaid Provider Manual](#))

The MIHP provider must directly provide health education, nutrition education, and social work services. However, the provider may choose to directly provide nutrition counseling and infant mental health services (i.e., have a registered dietitian and infant mental health specialist on staff), to contract for these services, or to refer beneficiaries to other local agencies that offer these services.

If the MIHP provider opts to directly provide nutritional counseling and infant mental health services, the provider may choose to hire or contract with qualified professionals and bill Medicaid for these services. In order to bill for a visit made by the registered dietitian (RD), the RD must: 1) have a physician's order, 2) be on the MIHP roster, and 3) document the visit in the beneficiary's chart on a progress note. If the provider opts to refer beneficiaries to other agencies that offer these services, the MIHP provider cannot bill for services provided by these other agencies.

Nutrition counseling may be available from a local hospital, local health department, community health center, etc. that is able to accept outside referrals. The MIHP must provide nutrition counseling or make arrangements necessary for nutrition counseling. The record must clearly identify the entity that is providing nutrition counseling services.

Infant mental health services (referred to as Medicaid home-based services for infants and toddlers, in this case) are available through Community Mental Health Services Programs (CMHSPS) for families who need intensive parent-infant intervention. However, some beneficiaries who need infant mental health services may not meet CMHSP criteria for intensive home-based services. If infant mental health services are not available through other agencies in the local area for these beneficiaries, the MIHP provider is encouraged to provide infant mental health services directly, if possible.

The MIHP professionals with the most relevant expertise should provide the interventions for a particular beneficiary, based on her unique needs and goals. This means that some beneficiaries require the involvement of just one discipline, while others require the involvement of two to four disciplines. MIHP interventions are detailed in Chapter 8 of this *Guide* [\(link\)](#).

Duration of MIHP Services

MIHP serves the mother-infant dyad, ideally from early in the pregnancy, through the postpartum period (immediately after the birth of a child and extending about six weeks), and throughout infancy to the extent of maximizing authorized visits to meet *Plan of Care* objectives. However, the mother and infant are not always eligible for Medicaid at the same time, so a distinction is made between maternal and infant services for billing purposes, as described below:

MIHP serves the maternal /infant dyad.

(Section 2.1 Maternal Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

Maternal Services: Pregnant Medicaid beneficiaries qualify for MIHP services at any time during the pregnancy. After delivery, a new Maternal MIHP case cannot be opened. For purposes of closing a case, services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls.

Some services to postpartum women and infants are available through Medicaid-enrolled home health agencies. If the home health agency is also enrolled as an MIHP provider, services for the mother and infant must be provided as an MIHP service rather than a home health agency benefit.

Infant Services: MIHP services for an infant begin after the infant's birth and hospital discharge. Infant services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family. It is expected that a minimum, 90% of Infant Risk Identifier visits and 80% of professional visits will be provided in the home.

Both Maternal and Infant Services: MIHP services for women and infants focus on the family, encompass essentially the same services, and are generally provided to the same individual (pregnant woman/mother). In some situations, MIHP services for the mother and infant may need to be blended because the beneficiaries meet the qualifying criteria for both services at the same point in time. In these situations, providers must bill for services under either the mother's Medicaid ID number or the infant's Medicaid ID number, but not under both when one professional intervention, although a "blended one", is provided.

It is the responsibility of the MIHP provider to target services to Medicaid beneficiaries most in need of this assistance.

(Section 1.3 Duration of Services, MIHP Chapter, [Medicaid Provider Manual](#))

When an infant being served by MIHP reaches 12 months of age, the provider should continue to serve the infant until all allowable MIHP visits have been used or the infant's *Plan of Care* goals have been achieved, whichever comes first.

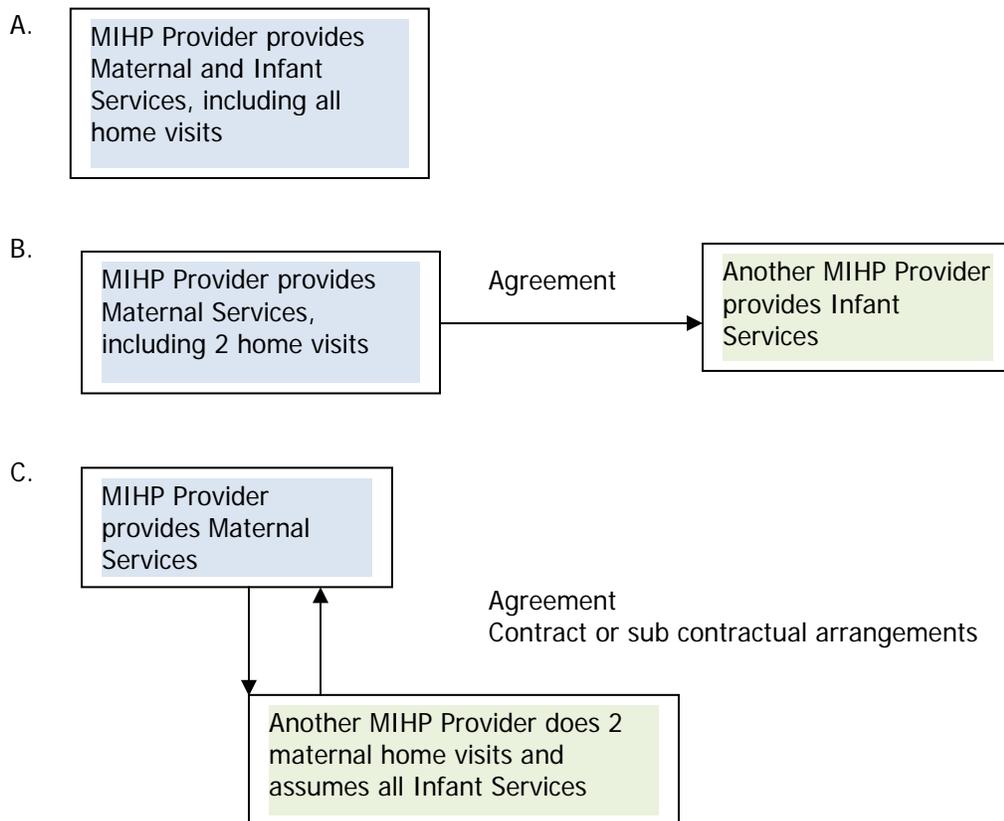
The *Infant Risk Identifier* visit must be billed under the infant's Medicaid ID number.

All providers are required to serve the mother-infant dyad in one of three ways. The options include the following:

1. Provide all maternal and infant services directly.
2. Provide all maternal services, including the two required home visits, and after the baby is born, transfer the dyad to a second certified MIHP provider, per a written agreement.
3. Jointly provide maternal services with a second certified MIHP provider who would conduct the two required home visits, and after the baby is born, transfer the dyad to the second provider, per a written agreement, contract, or subcontract.

These options are diagrammed below:

Mother – Infant Dyad Service Options



5.0 REIMBURSEMENT FOR MIHP SERVICES

Billing MDCH through the Community Health Automated Medicaid Processing System (CHAMPS)

The MIHP provider submits bills directly to MDCH, although if the beneficiary also has commercial insurance, the provider needs to coordinate benefits with the other insurer, as stated below:

Although most beneficiaries are in MHPs, all services provided by MIHP providers should be billed directly to MDCH. For beneficiaries with other commercial insurance, refer to the Commercial Health Insurance section in the Coordination of Benefits chapter of this manual.

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

Bills must be submitted to MDCH electronically, using the Community Health Automated Medicaid Processing System (CHAMPS). This requires the MIHP provider to complete the CHAMPS enrollment process. One step in this process is to obtain a National Provider Identifier (NPI) as a facility, agency or organization, not as an individual, as specified below:

To receive reimbursement, the MIHP billing National Provider Identifier (NPI) must be a facility, agency, or organization. A MIHP specialty must be indicated when enrolling as a MIHP provider through the CHAMPS system.

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

Communications and training information for billing agents, including the *Community Health Automated Medicaid Processing System (CHAMPS) Enrollment Guide*, is available at [Billing Agent Communications and Training](#).

Information on CHAMPS enrollment and procedures, including electronic billing, explanation codes, National Provider Identifier (NPI) Registry, provider specific information, and fraud and abuse reporting requirements, is also available at http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-151698--,00.html.

MIHP providers who have questions about Medicaid billing may call one of the toll-free numbers below for assistance:

- CHAMPS Enrollment Helpline 1-888-643-2408
- Michigan Medicaid Provider Support 1-800-292-2550

Medicaid Fee-for-Service Reimbursement

Although most pregnant and infant Medicaid beneficiaries are enrolled in MHPs, MIHP services are reimbursed on a fee-for-service basis by MDCH. This means that the provider is paid a specified fee for each individual MIHP service rendered to the beneficiary (i.e., each assessment visit, professional visit, professional visit - substance exposed infant, childbirth or parenting education course, or transportation service). Providers must use particular procedure codes when billing for MIHP services, as referenced below:

The MIHP provider must bill only the procedure codes listed in the MDCH Maternal Infant Health Program fee screens located on the MDCH website. (Refer to the Directory Appendix for website information.)

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

MIHP billing codes and fee screens (reimbursement rates for various covered services) may be found at [Billing and Reimbursement](#). This web site, titled *MIHP Databases*, provides billing codes and fee screens back to 2003.

Missed appointments are not billable. If a provider travels to visit a beneficiary as scheduled and finds that the beneficiary is not at home, or if the beneficiary misses an appointment for another MIHP service (e.g., transportation) arranged by the provider, the provider may not bill Medicaid. Also, the provider may not bill the beneficiary for MIHP services, as noted below:

Services scheduled but not provided to the beneficiary are not billable. This includes all MIHP services. The beneficiary must not be billed for visits provided beyond the established limit.

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

Reimbursement for Different Types of MIHP Services

The general types of MIHP reimbursable services are as follows:

1. Assessment (using *Maternal or Infant Risk Identifier*) in home or office
2. Professional visit in home or office
3. Professional visit - drug-exposed infant
4. Childbirth and parenting education classes
5. Transportation

MIHP services are described in detail in Chapter 8 of this *Guide*. [\(link\)](#) Reimbursement rates vary by type of service. Special considerations with respect to each of the five service categories are discussed below.

1. *Assessment*

Assessment involves the administration of the *MIHP Maternal Risk Identifier* or the *MIHP Infant Risk Identifier*. These are standardized tools that are used to determine a beneficiary's risk level in multiple domains and overall. Results are used to create the beneficiary's *Plan of Care (POC)*. (*POC* development is not a separately billable MIHP service.) Providers must enter *Risk Identifier* data into the MIHP electronic database. Reimbursement considerations with respect to the *Risk Identifier* are as follows:

The initial assessment visit and up to nine professional visits per woman per pregnancy are billable. The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit/contact the beneficiary within 14 calendar days for the pregnant woman.

(Section 2.1 Maternal Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

The initial assessment visit and up to nine professional visits per infant/family are billable. An additional nine infant visits may be provided when requested in writing by the medical care provider. The reason for and purpose of additional visits must be well documented in the medical record.

(Section 2.2 Infant Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

The assessment visit is the initial visit with the beneficiary. The appropriate Risk Identifier is a mandatory part of the initial assessment visit. The initial assessment visit is comprised of completing the Risk Identifier and writing the plan of care (POC) to identify needed services. It should be billed and paid using the appropriate place of service code.

(Section 2 Program Components, MIHP Chapter, [Medicaid Provider Manual](#))

The Risk Identifier is required to be completed and entered into the MIHP database before the service is billed. MIHP providers receive separate reimbursement for each Risk Identifier form completed and entered into the MIHP database even if it is determined the beneficiary does not need MIHP services. The Risk Identifier is billed and reimbursed based on place of service. PC H1000 is billed for office visits; PC H2000 is billed for home visits. PC T1023 further assessment will be end dated, and no longer used. As with all Medicaid services, documentation must support the services billed and paid.

Reimbursement is limited to one Risk Identifier per pregnant woman during her pregnancy and one Risk Identifier per infant or family if a multiple birth. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, an MIHP provider may do a Risk Identifier on a pregnant woman and receive reimbursement twice in the same year. In such instances, the provider must indicate "second pregnancy" in the remarks section of the claim when billing for the service.

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

The beneficiary must sign the *Authorization and Consent to Release Protected Health Information* before the *Risk Identifier* is administered. If she does not sign the *Authorization*, the provider does not administer the *Risk Identifier* or provide any MIHP services. If the beneficiary signs the *Authorization*, completes the *Risk Identifier*, and then declines MIHP services, the provider can still bill the full amount for the *Risk Identifier*, but only after her *Risk Identifier* data has been entered into the MIHP electronic database.

If a potential client declines MIHP services, there is no need to open a case and document that she was approached and declined to participate, as no billable service has been provided. If the potential client is an MHP member, notify the MHP that she has refused MIHP services, using the *MHP/MIHP Collaboration Form*.

To bill for assessment visits, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter. [\(link\)](#)

2. Professional Visits

Reimbursement considerations with respect to professional visits are as follows:

The Risk Identifier and POC must be completed before professional visits are initiated. Rarely on the same day as the initial visit, a problem will need to be addressed immediately. In these cases a professional visit can be made later the same day by a different professional discipline. This professional visit must last at least 30 minutes.

(Section 2 Program Components, MIHP Chapter, [Medicaid Provider Manual](#))

A professional visit is a face-to-face encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) for the specific purpose of implementing the beneficiary's plan of care. A registered dietitian may conduct a visit when ordered by a physician.

The professional visit is a one-on-one visit that must be scheduled to accommodate the beneficiary's situation and be appropriate to the beneficiary's level of understanding. Visits lasting less than 30 minutes, or provided in a group setting are not billable.

Occasionally more than one visit may be provided on the same date of service if a different discipline provides the second visit. The provider must keep in mind the beneficiary's ability to benefit from extended counseling/education when more than one visit is provided on the same date. Documentation must clearly state the need for the second visit on the same date of service. The two visits should be made at separately identifiable documented times. Medicaid reimbursement for a professional visit includes related care coordination and monitoring of activities. Visits provided beyond the established limit cannot be billed to the beneficiary.

All professional visit records must include the place of service, time the visit began and ended, risk factors discussed, and actions taken. Coordination of agency and community services and arranging transportation for the beneficiary are part of each professional visit. The MIHP provider must assure the beneficiary has been referred to WIC.

The MIHP must provide directly or arrange bilingual services and services for the visually impaired and/or hearing impaired when needed, so all beneficiaries may fully participate in the program.

MDCH does not reimburse for missed visits/appointments. A beneficiary may not be billed for a missed visit/appointment.

(Section 2.7 Professional Visits, MIHP Chapter, [Medicaid Provider Manual](#))

Only one infant per household may be enrolled in MIHP. In the event of multiple births or multiple infants in one home, the standard assessment visit and nine visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family. When there are multiple infants in the home all infants should be assessed at each visit. Regardless of the number of infants in the home, only one professional visit should be billed. With multiple births, it is not appropriate to bill visits under several infant ID numbers. All visits are considered blended visits.

(Section 2.3 Multiple Births, MIHP Chapter, [Medicaid Provider Manual](#))

Providers may visit only one beneficiary/dyad at a time.

As a rule, there should be only one visit per day, as the program intent is to provide care coordination throughout the pregnancy and/or infancy. Upon occasion, it may be appropriate for two professionals to visit a beneficiary on the same day. An example would be when the first professional identifies an urgent need for the second professional to see the beneficiary that same day. In this case, two separate visits may be billed, but there must be documentation in the case record explaining why this was necessary. Documentation must also include the begin and end times for both visits *and there cannot be any overlap in time*. If the MIHP provider sends out more than one professional on a home visit, it should last at least 30 minutes, and this can only be billed as a single visit. This includes situations in which two people go out together because of concern for staff safety.

The first 9 infant visits do not require a physician order; the second 9 infant visits do require a physician order. The order can be verbal or written. A verbal order must be documented in the record. The medical director can write a standing order for the second 9 infant visits for justified risk situations. A copy of the standing order must be placed in the record. The first 9 infant visits do not include the assessment visit, which is billed using a different code.

To bill for professional visits, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter. [\(link\)](#)

3. Professional Visits – Drug Exposed Infant

Reimbursement considerations with respect to professional visits – drug-exposed infant are as follows:

A drug-exposed infant is an infant born with the presence of an illegal drug(s) and/or alcohol in his circulatory system, or living in an environment where substance abuse or alcohol is a danger or is suspected. Due to the complex nature of these cases, additional visits may be required. A separate drug-exposed procedure code is assigned for additional visits. The beneficiary's record must contain documentation to support the use of the drug-exposed procedure code.

The initial assessment and up to nine professional visits for a drug-exposed infant are billable by the MIHP. Additional infant visits may be provided when requested in writing by the medical care provider. In these cases, the reason for and purpose of additional visits must be well documented in the beneficiary record.

The maximum of 36 visits and the initial assessment visit may be reimbursed for a drug-exposed infant. The provider must use the professional visit code for the first 18 visits; the drug-exposed procedure code may then be billed for up to an additional 18 visits.

(Section 2.8 Drug-Exposed Infant, MIHP Chapter, [Medicaid Provider Manual](#))

To use the professional visit - drug-exposed infant billing code, the provider must document that the infant was born with the presence of an illegal drug(s) and/or alcohol in his circulatory system, or that he is living in an environment where alcohol or substance abuse is a danger or suspected. Documentation that the infant was born with substances in his circulatory system can be obtained from the medical care provider. Documentation of suspected substance or alcohol abuse most often consists of professional observations made by the medical care provider or the MIHP provider.

Signs of suspected abuse may include the following: the mother is involved with Child Protective Services related to alcohol or substance abuse; the mother appeared to be high or intoxicated while pregnant; the mother shows signs of being high or intoxicated post delivery; the mother's breath smells of alcohol; the home smells of marijuana; there are street drugs or drug paraphernalia in the infant's home; others who live in the home show signs of intoxication, substance use, drug dealing; etc.

If the medical care provider or the MIHP provider documents suspected alcohol or substance use/abuse, the MIHP provider may use the professional visit – drug-exposed infant billing code. Signs observed by the MIHP provider must be documented in *MIHP Professional Visit Progress Note*. MIHP providers may use the drug-exposed infant visit billing code, even if the beneficiary denies using drugs or alcohol.

MIHP providers may be reimbursed for a maximum of 36 professional visits when a drug-exposed infant is involved. The first 9 infant visits do not require a physician order; the second 9 visits do require a physician order. After the first 18 visits, the MIHP provider switches to the professional visit drug-exposed infant billing code. The first 9 visits under the drug-exposed infant code do not require an order; the second 9 visits do require an order. (The first 9 visits under each code do not require an order.) The order can be verbal or written. A verbal order must be documented in the record.

A physician may write a standing order authorizing all 27 additional drug-exposed infant visits (after the first 9 visits). The order must specify that the additional visits are authorized in blocks of nine and that drug-exposed risk is still evident after each block of nine visits is completed. A copy of the standing order must be placed in the beneficiary record.

To bill for professional visit - drug-exposed infant, the provider must use a Place of Service Code. See *Reimbursement for Professional Visits Depends on Place of Service* later in this chapter. [\(link\)](#)

4. Childbirth and Parenting Education Classes

Reimbursement considerations with respect to childbirth education classes (during pregnancy) and parenting education classes (during infancy) are as follows:

Reimbursement for MIHP childbirth classes and/or parenting classes are for the complete course, regardless of the number of classes needed to complete the course. At a minimum, the course outline in the MIHP Operations Guide must be covered. Additional items may be added at the discretion of the provider. The pregnant woman or parent must attend at least one-half of the classes or cover at least one-half of the curriculum for the service to be billed. Dates of attendance must be documented in the beneficiary's record. If the class is offered in the community, but not all items on the outline are covered, the missed items should be covered during a professional visit, not billed separately as education.

- **MIHP childbirth education may be billed one time per beneficiary per pregnancy.**
- **MIHP parenting education may be billed one time per infant. In the case of twins or other multiple births, parenting education may be billed only once for the family.**

If the MIHP provider refers the beneficiary to a local hospital to provide the classes, the hospital must bill the appropriate MHP to receive payment. If the MIHP provider contracts with an outpatient hospital or community based organization for childbirth education, the contract must indicate which provider is to bill and receive payment. If the classes are available at no charge to the public from a community-based organization, the MIHP cannot bill the Medicaid Fee-For-Service program, or the beneficiary for the service.

(Section 3.1 Education Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

Childbirth education (CBE) and Parenting Education (PE) are provided to groups of people in a classroom setting and cover a variety of topics that are relevant for all beneficiaries (all first-time mothers in the case of CBE) regardless of risk level in any particular domain. There is a separate billing code for CBE/PE classes.

In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition), CBE may be provided in the beneficiary's home as a separately billable service. In this case, the beneficiary record must document the need for one-on-one CBE, where CBE was provided, and that at least ½ of the CBE curriculum was covered. The progress note can be used for documentation purposes.

Alternatively, CBE may be provided in the home and billed as a professional visit. This may be done when there are other extenuating circumstances (e.g., the beneficiary is too anxious or intimidated to participate in a group class).

Case records must document the need for one-on-one childbirth education and where services were provided.

5. Transportation

Reimbursement considerations related to transportation services are as follows:

Transportation services are to help beneficiaries keep their health care appointments. Transportation needs must be assessed. Transportation is provided only if no other means are available for the beneficiary to get to health care services.

MDCH covers beneficiary transportation for medical/health care, substance abuse treatment, WIC visits and for any MIHP services, including childbirth/parenting education classes. A mother's trip to visit her hospitalized infant is also covered. Transportation is available for an initial medical visit that will likely result in the enrollment in MIHP. Transportation is available for the pregnant woman when she is enrolled in the MIHP. Transportation is available for the infant and the primary caregiver to attend the infant's appointments when the infant is enrolled in the MIHP. Transportation services may be billed under the mother's Medicaid ID number for the pregnant woman and under the infant's Medicaid ID number for the infant.

Medicaid covers transportation services for all beneficiaries for obtaining medical care. Transportation is available through MIHP, MHPs, and the local Department of Human Services (DHS). MIHP providers should coordinate transportation services with the local DHS office which may have transportation resources available. The CCA between the MIHP and the MHP should specify how best to provide for transportation needs. The goal of providing transportation service is to get the beneficiary to the necessary medical related appointments.

MDCH reimburses the provider an administrative fee equal to six percent of the cost of the transportation. When billing for transportation, the six percent fee should be calculated and included in the amount charged.

The MIHP may also contract for transportation services. Transportation services should be billed for each date of service it was provided. The MIHP provider's Care Coordination Agreement with MHP should specify responsibility for meeting the transportation needs of enrolled beneficiaries. The MIHP provider must determine the most appropriate and cost effective method of transportation. MDCH reimburses transportation costs at the lesser of actual cost or the maximum/upper limit for:

- **Bus**
- **Mileage (volunteer/relative/beneficiary/other)**
- **Taxi: If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDCH reimburses a maximum of 20 trips per beneficiary through MIHP.**

The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify:

- **The name and address of the beneficiary;**
- **The date of service (DOS);**
- **The trip's destination (address, city) and starting point;**
- **The purpose of the trip;**
- **The number of tokens or miles required for the trip; and**
- **The amount that the beneficiary or transportation vendor was reimbursed.**

The MIHP provider must ensure the beneficiary kept the appointments for which transportation funds were provided. Medicaid does not pay for transportation not provided.

The MIHP provider may give transportation tokens or funds to the beneficiary or parent of an infant. In situations where funds are provided, it is recommended that the beneficiary sign a receipt and that the receipt be retained in the case records.

Beneficiaries in the Nurse Family Partnership (NFP), another MDCH program, do not need a risk identifier completed to receive transportation services. Transportation is the only MIHP service available to NFP beneficiaries.

(Section 2.10 Transportation, MIHP Chapter, [Medicaid Provider Manual](#))

A significant number of women participate in MIHP services for several months before their Medicaid applications are approved and they are enrolled in MHPs. This is feasible because they have enrolled in the Maternity Outpatient Medical Services (MOMS) Program and have been given a *Guarantee of Payment for Pregnancy Related Services Letter*. Additional information on the MOMS Program is provided in Chapter 7 of this *Guide*. ([link](#)).

As MIHP beneficiaries, these women are entitled to transportation services while their Medicaid applications are pending. Once their Medicaid applications are approved and they are enrolled in an MHP, they become eligible for transportation services through the MHP.

There are also women who are enrolled in an MHP before they are referred to MIHP. Throughout this period, the MHP provides transportation for them. When these women enroll in MIHP, they become eligible for transportation through MIHP.

When a woman becomes eligible for transportation from both the MHP and MIHP, a decision is made as to which of the parties will provide her with transportation. This decision must be made carefully, so that it best meets the beneficiary's needs. The following guidelines are used to make this decision:

1. MIHP bills FFS for all transportation reimbursement provided, including medical appointments, when the resources/plans they have established with a beneficiary are meeting the beneficiary's needs.
2. MHPs provide transportation (reimbursement and/or drivers) for members for currently covered transportation services when it is the best option.
3. For those beneficiaries that have unique transportation needs, the MIHP and MHP will collaborate and coordinate the transportation services to meet the beneficiary's needs.

In other words, if a woman was involved with MIHP before enrolling in an MHP and transportation arrangements are working well, the MIHP provider will continue to provide transportation to medical appointments. If a woman was in an MHP before participating in MIHP and the transportation arrangements are working well, the MHP will continue to provide transportation to medical appointments. If a woman has unique transportation needs, the MIHP provider and MHP will discuss the situation and coordinate transportation services to meet her particular needs.

A document titled, *Medicaid Health Plan Transportation Grid*, gives information about the transportation services provided by each MHP. It is available at www.michigan.gov/mihp.

MIHP providers must document transportation needs and arrangements in the beneficiary's record. Transportation documentation guidelines are included in the *MIHP Certification Tool*, Transportation Section at www.michigan.gov/mihp.

The Nurse-Family Partnership (NFP) is a prenatal, infant and early childhood home visiting program with similarities to MIHP. One difference between the two programs is that MIHP provides transportation while NFP does not. A few communities have both MIHP and NFP services available. Medicaid beneficiaries are not to participate in both programs simultaneously except for transportation services. MIHP can support NFP clients' transportation without administering either the *Maternal or Infant Risk Identifier* or developing a *Plan of Care*. This is the only exception to these expectations. NFP, MIHP and the MHP (if beneficiary is in an MHP) should collaborate to determine the most appropriate and beneficial arrangements to assure health care transportation for NFP clients, using the MIHP-MHP transportation guidelines. MIHP providers must obtain a signed *MIHP Authorization and Consent to Release Protected*

Health Information form from the NFP beneficiary before providing transportation services. The *Authorization* is being revised to accommodate NFP beneficiaries, but in the meantime, use the current form and revise the statement after the first check-off box to read as follows: "I do not wish to participate in the MIHP except for transportation." Providers must document transportation provided for NFP clients using the standard MIHP transportation forms.

Reimbursement for Professional Visits Depends on Place of Service

Reimbursement for professional visits depends on the place of service, reflecting the travel time and costs associated with visiting beneficiaries. Generally speaking, when a provider travels to the beneficiary's residence, the reimbursement rate is higher, and when the beneficiary travels to the provider's office or clinic, the reimbursement rate is lower. The specifics are provided below:

Reimbursement for a professional visit is based on the place of service. The place of service must be documented in each professional visit note and billed accordingly. Medicaid reimbursement for a professional visit includes related care coordination and monitoring of activities.

(Section 3 Reimbursement, MIHP Chapter, [Medicaid Provider Manual](#))

Reimbursement for professional visits is based on the place of service. An office visit and a home visit pay different amounts; therefore, the place of service must be documented in each professional visit note.

(Section 2.9 Place of Service, MIHP Chapter, [Medicaid Provider Manual](#))

Maternal Services

- **Professional visits may be provided in a clinic/office setting or in the beneficiary's home/place of residence, including homeless shelter, or a mutually agreed upon location.**
- **Professional visits may not be provided in the inpatient hospital setting.**
- **Efforts must be made to visit the beneficiary in the home. MDCH requires one visit be made to the beneficiary's home during the prenatal period to better understand the beneficiary's background.**
- **A second home visit must be made after the birth of the infant to observe bonding, infant care and nutrition and discuss family planning. This may be a blended visit, combined with the infant visit. It should only be billed under a single Medicaid identification number, either the mother's or the infant's, but not both.**

(Section 2.9.1 Maternal Services, MIHP Chapter, [Medicaid Provider Manual](#))

Infant Services

- **MIHP is a home-visiting program.**
- **The initial assessment visit, when the Infant Risk Identifier is completed must be completed in the home 90% of the time.**
- **On average, 80% of all professional interventions must be done in the beneficiary's home.**
- **If a home visit is not feasible, services may be provided any place other than an inpatient hospital setting.**
- **The infant and primary caregiver must be present at all visits.**

Typically, all visits are performed at the beneficiary's home or at the MIHP provider's office. On rare occasions when a visit cannot be completed in the beneficiary's home or in the provider's office, the provider may work with the beneficiary to identify a

mutually agreeable site to conduct a visit. These types of visits are referenced as visits occurring in the community setting.

For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in her home or in the MIHP office setting. This documentation must be completed for each visit occurring in the community setting. Visits occurring in buildings contiguous with the provider's office, in the provider's satellite office, or rooms arranged or rented for the purpose of seeing beneficiaries, are considered to be in an office setting rather than in a community setting. Visits should never be conducted in the MIHP provider's home.

(Section 2.9.2 Infant Services, MIHP Chapter, [Medicaid Provider Manual](#))

Once the beneficiary delivers her baby, she should be encouraged to see her obstetrician for her postpartum visit while her Medicaid coverage is still in effect. For many women, coverage ends 60 days after the baby's birth, but may end earlier.

After the infant is born, the provider must observe the infant during every visit with the primary caregiver. Most often, the primary caregiver is the infant's mother. However, if the mother is not functioning as the primary caregiver, the MIHP provider may visit with another individual who is serving as the infant's primary caregiver.

MIHP is a home visiting program and every effort should be made to provide visits in the home. On average, at least 80% of all professional infant interventions must be done in the beneficiary's home. This average applies to total agency caseload.

If the MIHP provider travels to the beneficiary's residence or to a community site requested by the beneficiary, the provider is paid more than the amount paid if the beneficiary traveled to the provider's office or clinic. When submitting a claim, the provider must use a Current Procedure Terminology (CPT) Code (see [Billing and Reimbursement](#)) and a Place of Service Code. Place of Service Codes used by MIHP providers are defined below:

Code 04 Homeless Shelter

A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

Code 11 Office

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

NOTE: The office code includes the following:

- a. The provider's office or clinic
- b. A building contiguous with the provider's office or clinic
- c. The provider's satellite office or clinic, including a community site arranged or rented by the provider (e.g., a school, a mobile home club house, etc.), where three or more beneficiaries are invited/scheduled to be seen on a given day

NOTE: If the provider's office and the WIC office are in the same building, and the provider visits the beneficiary at the WIC office, the provider bills this as an office visit.

Code 12 Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

NOTE: If a provider visits several beneficiaries who live in the same building (e.g., public housing) on the same day, the provider bills for separate home visits.

Code 15 Mobile Unit

A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.

NOTE: The Mobile Unit code includes what is referred to in the Medicaid policy above as a community visit. The community visit takes place at a community site when the beneficiary cannot be seen at her home or at the provider's office for good reason (e.g., beneficiary does not want family member to know she is in the MIHP). The community visit takes place at a location that is agreed to by the provider and a beneficiary, such as a restaurant or school. If the provider is doing outreach at another agency (e.g., DHS or WIC office) which is not adjacent to the provider's office, and the provider administers a *Risk Identifier* and enrolls a new MIHP beneficiary there, this is considered to be a community visit.

To clarify further:

1. If you see four women on the same day at same shelter, apartment building, etc., you would bill for four home visits because the shelter, apartment building, etc., is their place of residence.
2. If you see four women on the same day at the same restaurant, DHS, school, etc., you would bill for four office visits.
3. If you see one to three women on the same day at the same restaurant, DHS, school, etc., you would bill for one to three community visits.

When documenting a visit provided in a place other than a home or office, check the "Other" box on the *MIHP Professional Visit Progress Note*, and indicate where the visit took place. "Other" location visits should be billed using the Mobile Unit Place of Service Code 15. These visits are reimbursed at the home rate.

The Critical Importance of Documentation for Purposes of Medicaid Reimbursement

As reiterated throughout this entire discussion on MIHP reimbursement, Medicaid requires MIHP providers to carefully document the provision of services in the beneficiary's case record. MDCH provides standardized forms for this purpose. The forms and instructions for completing them are available at the MIHP web site at www.michigan.gov/mihp.

Documenting Begin and End Times for MIHP Professional Visits

Providers must ensure that the clinical record is sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for service provided must be signed and dated by the rendering health care professional. For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

(Section 13.7 Clinical Records, General Information for Providers Chapter, [Medicaid Provider Manual](#))

MIHP visits must be at least 30 minutes in length in order to be billable. MIHP providers must document begin and end times in the case record for every professional visit. The *MIHP Professional Visit Note* form provides a space to record this information.

6.0 BECOMING AN MIHP PROVIDER

Criteria for Becoming an MIHP Provider

Medicaid has specified a comprehensive set of criteria for becoming an MIHP provider. The criteria cover staffing, capacity to provide services geared to the mother/infant dyad, contractual arrangements, facilities, outreach, processing referrals, required services and service protocols, linkages to referral sources, the beneficiary records system, confidentiality, communication with medical care providers and MHPs, and other aspects of provider operations. These criteria are given below:

MDCH certifies MIHP providers. To become an MIHP provider, the criteria in the Michigan Medicaid Provider Manual and the MIHP Operations Guide must be met. Provider participation criteria includes, but is not limited to, required staffing and the capacity to provide services, including outreach and weekend and after-hours coverage. MIHP providers must follow all policies and procedures in the Medicaid Provider Manual in addition to the MIHP Operations Guide.

(Section 5 Operations and Certification, MIHP Chapter, [Medicaid Provider Manual](#))

Provider must meet the following participation criteria.

- **The provider must meet program requirements to qualify for enrollment in Medicaid.**
- **In cases where services are provided through a contract with another agency, the contract or letter of agreement must be on file for review by MDCH. It must specify the time period of the agreement, the names of the individuals providing services, and where the billing responsibility lies.**
- **The provider's physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements.**
- **The provider must have experience in the delivery of services to the target population and demonstrate understanding of the concept and delivery of maternal and infant services.**
- **The provider must demonstrate linkages to relevant services and health care organizations in the area to be served.**
- **The organization must demonstrate a capacity to conduct outreach activities to the target population and to medical providers in the geographic area to be served.**

(Section 5.1 Criteria, MIHP Chapter, [Medicaid Provider Manual](#))

Staffing Qualifications

MIHP staff will consist of registered nurses and licensed social workers with the following qualifications:

<p>Nursing</p>	<p>All nurses must possess current Michigan licensure as a registered nurse.</p> <ul style="list-style-type: none"> • Possess a Master's of Science in Nursing (MSN) or possess a Bachelor's of Science in Nursing (BSN), and at least one year of experience providing community health, pediatric and/or maternal/infant nursing services; or • Possess a nursing diploma or Associate Degree in Nursing (ADN), and at least two years of experience providing community health, pediatric and/or maternal/infant nursing services.
<p>Social Work</p>	<p>All social workers must possess current Michigan licensure as a licensed social worker.</p> <ul style="list-style-type: none"> • Possess a Master's of Social Work (MSW); or • Possess a Bachelor's of Social Work (BSW). <p>The above-degreed social workers must have at least one year of experience providing services to families.</p>

Other professionals who may provide services must have the following qualifications:

<p>Infant Mental Health Specialist</p>	<ul style="list-style-type: none"> • Licensure by the State of Michigan; • Psychologist, Master's social worker, or professional counselor and possess: <ul style="list-style-type: none"> ○ Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), level 2 or level 3. <p>At least one year of experience in an infant health program is also required.</p>
<p>Registered Dietitian</p>	<ul style="list-style-type: none"> • Possess a Master's in Public Health with emphasis in nutrition or Master's Degree in human nutrition; or • Possess a Bachelor's Degree and registration as a dietitian (RD); or • Possess a Bachelor's Degree and RD-eligible with examination pending in six months or less. <p>The above-degreed dietitian must have at least one year of experience providing community health, pediatric, and/or maternal/infant nutrition services. A physician order is needed before the dietitian may provide services.</p>

A physician order must be obtained before a registered dietitian may visit with the beneficiary. The physician order must be included in the beneficiary record. If community resources are available, such as a hospital dietitian, the MIHP may coordinate with the physician to refer the beneficiary to the hospital dietitian. The MIHP also may coordinate nutrition services with the MHP. As in other areas, when nutrition counseling is needed, the documentation must indicate how services were provided.

(Section 1.2 Staff Credentials, MIHP Chapter, [Medicaid Provider Manual](#))

Required staff for the MIHP program is comprised of registered nurses and licensed social workers. Optional staff may include a registered dietitian and/or infant mental health specialist. All staff must meet the qualifications as stated in Section 1.2.

(Section 5.2 Staffing, MIHP Chapter, [Medicaid Provider Manual](#))

Because dietitians are not licensed in Michigan, a physician's order must be obtained before they can work with an MIHP beneficiary. If the MIHP provider does not have a medical director, the provider must obtain a physician order from the beneficiary's medical care provider (e.g., physician, physician assistant, midwife, etc.) before arranging for nutrition counseling services by a registered dietitian.

If the MIHP provider does have a medical director, the medical director may issue a standing physician order to cover all MIHP beneficiaries needing the services of a registered dietitian (RD) because of health problems that are affected by diet (e.g., maternal gestational diabetes, obesity, anorexia, bulimia, lactose intolerance, etc.; infant digestive disorders, inappropriate weight gain, failure-to-thrive, etc.). The standing order can state that it applies to any MIHP beneficiary who has nutrition needs requiring the services of an RD. If a beneficiary is seen by an RD pursuant to a standing order, a copy of the standing order must be placed in the beneficiary's case record. Standing orders must be reviewed and reauthorized annually.

The MIHP provider may choose to provide nutrition counseling services directly or to refer the beneficiary elsewhere for these services (e.g., a local hospital, local health department, or community health center that has the capacity to provide high-risk nutrition counseling services and is able to accept outside referrals, etc.).

If a professional meets the staffing qualification requirements for more than one discipline (e.g., social work and infant mental health), she may provide both services for MIHP beneficiaries. However, only one billable visit is allowed per beneficiary per day. When providing both services for a given beneficiary, the professional would sign the appropriate *POC* signature lines for both disciplines.

Staffing Waiver Requests

MIHP providers must assure that professional staff persons are qualified to provide services. Providers must use the *MIHP Agency Personnel Roster* form at www.michigan.gov/mihp to document specific information about the qualifications of each person on the MIHP staff. Once an MIHP provider is certified, the *Personnel Roster* must be updated and submitted to MDCH at the end of any quarter in which staffing changes have occurred. Updated *Personnel Rosters* are due on March 31, June 30, September 30, and December 31.

Certain personnel requirements could possibly be waived when a provider is unable to find a fully qualified professional for a particular position. Although requirements for having a specified amount of maternal and child health experience could possibly be waived, education and licensing/registration requirements cannot.

A provider who is unable to find a staff person who fully meets staffing requirements must submit a waiver application in writing to MDCH, explaining why a waiver is being requested and how the provider

will assure that the appropriate in-service training will be provided for the individual in question. MDCH examines the validity of each waiver request and approves or disapproves accordingly.

Providers who wish to submit a waiver application should go to the MIHP web site at www.michigan.gov/mihp to obtain the following documents:

1. MIHP Professional Staff Requirements
2. MIHP Professional Staff Waiver Application
3. MIHP Recommended In-service Plan
4. MIHP Notice of Waiver Completion

Sex-Offender Registry Check

The MIHP provider may wish to check the Michigan State Police Sex-Offender Registry before making an offer of employment to an individual who will work directly with MIHP beneficiaries. The registry is available at <http://www.mipsor.state.mi.us>. The provider may also wish to do a criminal history check using the Michigan Department of State Police's internet criminal history access tool (ICHAT) at <http://apps.michigan.gov/ICHAT/Home.aspx>.

Required Identification Cards for MIHP Direct Service Staff

MIHP staff who work directly with beneficiaries in their homes or at other community locations must carry identification (ID) cards or badges with them at all times. This is to assure beneficiaries that staff are legitimately affiliated with the MIHP. An ID card or badge should include a picture of the staff person, the staff person's name, the name of the MIHP, and the name of the agency. A business card without a picture is not sufficient. The ID card or badge must be presented when meeting a beneficiary for the first time and whenever a beneficiary asks to see it.

Operations and Certification Requirements

Providers must demonstrate their ability to validate the need for, and delivery of, MIHP services appropriate to each beneficiary's individual need. The MIHP provider must:

- **Deliver services appropriate to the beneficiary's level of understanding.**
- **Schedule services to accommodate the beneficiary's situation.**
- **Complete appropriate Risk Identifier by a licensed social worker or registered nurse.**
- **Develop the plan of care by a licensed social worker and the registered nurse jointly.**
- **Complete the Risk Identifier based on a home visit as required for the infant and, if possible, for the pregnant woman, and develop a plan of care.**
- **Demonstrate a system for handling beneficiary grievances.**
- **Provide for weekend and after-hours emergencies.**
- **Provide directly or arrange for bilingual services, and services for the visually impaired and/or hearing impaired, as indicated.**
- **Maintain all physician orders in the medical record.**
- **Coordinate agency and community services for the beneficiary.**
- **Arrange transportation as needed for the beneficiary to keep health-related appointments.**
- **Respond to referrals promptly to identify the beneficiary's needs (within a maximum of 7 calendar days for the infant and 14 calendar days for the pregnant woman).**

- Respond to referrals received prior to the infant's discharge from the inpatient setting within 48 hours of hospital discharge.
- Notify the medical care provider of the beneficiary's enrollment within 14 days.
- Document and report disposition of the referral (i.e., initiation of services, inability to locate, or refusal of services) to the referring source.
- Provide ongoing communication with the beneficiary's medical care provider.
- Provide directly, the services of at least a registered nurse or licensed social worker. Infant mental health specialist and/or registered dietitian services may be provided through a subcontractor or services may be accessed in other ways.
- Not bill for services provided by community resources.
- Provide services in a clinic, an office, a home setting and/or community setting, as appropriate.
- Maintain a current list of local Public Health programs such as WIC Nutrition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Community Mental Health (CMH), Children's Special Health Care Services (CSHCS), and other agencies that may have appropriate services to offer the beneficiary, and agree to work cooperatively with these agencies.
- Have written protocols that comply with the reporting requirements mandated by the Michigan Child Protection Law (Act No. 238, Public Acts of 1975). Include protocols on coordination with the local DHS CPS unit that specify how the MIHP provider will make CPS referrals, initiate follow-up contacts with CPS, and participate in local CPS multidisciplinary team meetings involving infants served by the MIHP.
- Maintain an adequate and confidential beneficiary records system, including services provided under a subcontractor. (HIPAA standards must be met.)
- Have written internal protocols to include all aspects of the program.
- Be actively linked to or be a member of the local Part C/Early-On Interagency Coordination Council, and the Great Start Collaborative Council.
- Report all new MHP enrollees to the appropriate MHP on a monthly basis or as agreed to in the Care Coordination Agreement.
- Follow all the procedures as written in the MIHP Operations Guide. This Guide can be accessed at www.michigan.gov/mihp.
- Follow all Medicaid policies as published in the Michigan Medicaid Provider Manual, Medical Service Administration Bulletins and the MIHP Operations Guide. Refer to the Directory appendix.

(Section 5.3 Operations and Certification Requirements, MIHP Chapter, [Medicaid Provider Manual](#))

Issuance of Certification

Based upon satisfactory application, MDCH provides a provisional MIHP certification. After an agency is provisionally certified and providing services, MDCH conducts a provider site visit. The site visit must occur within six months of the provisional certification. The site visit is to observe how the program is being implemented and to assist in resolving any problems experienced in the implementation of the program. Based upon the site visit, MDCH grants the agency either a six-month certification, a three-year certification, or discontinues certification. For certified agencies, MDCH makes a formal certification visit every three years, with informal site visits at more frequent intervals.

If at any time after receiving certification the provider becomes deficient in any of the qualifying criteria, including staffing, the provider must notify the MDCH MIHP program immediately. MDCH then determines whether the agency may continue providing

services given the deficiency(ies). MDCH's decision is based on the evaluation of many factors, including the number of deficiencies, the specific deficiency(ies) involved, the availability of other providers in the area, impact on caseload, etc.

If at any time the MIHP provider fails to meet the program policies or certification requirements, Medicaid reimbursement can be jeopardized. The MIHP provider is subject to audit by Medicaid and if any discrepancy (ies) is found, appropriate follow-up action may be taken, such as recoupment of payments, holding reimbursement on claims, or termination of Medicaid enrollment. If a negative action is imposed, the MIHP provider is given an opportunity for appeal.

Agencies wishing to become a MIHP provider may contact the MDCH. (Refer to the Directory Appendix for contact information.)

(Section 5.4 Issuance of Certification, MIHP Chapter, [Medicaid Provider Manual](#))

MIHP Provider Application Process

A prospective MIHP provider must complete a multi-step application process in order to become certified. MDCH MIHP consultants function in an advisory role to guide the prospective provider through this process. MIHP providers are strongly encouraged to make use of the consultation services that are available in order to achieve and maintain certification.

Once MDCH approves a new provider application, the provider is granted a provisional certification, which allows the provider to operate during the start-up phase. About three months after the application is approved, an onsite consultation is provided. Approximately six months after the provisional certification is granted, the provider undergoes a certification review, ideally resulting in initial certification, which is good for three years.

The steps in the MIHP provider application process are as follows:

1. A prospective provider contacts MDCH Division of Family and Community Health to request an application to become an MIHP provider.
2. The prospective provider is sent an application packet which includes the following documents :
 - a. MIHP Application
 - b. MIHP Provider Directory
 - c. MIHP Chapter from the *Medicaid Provider Manual*
 - d. *Medicaid Provider Manual* Web Site Address
 - e. *MIHP Operations Guide* Web Site Address (*Operations Guide* includes required forms)
 - f. MIHP Web Site Address
 - g. Electronic Risk Identifier Information
 - h. NPI Federal Number Access
 - i. MIHP Collaboration Form
 - j. Medicaid CHAMPS Information
 - k. Medicaid Provider Enrollment Information
3. The prospective provider designates an individual to: serve as the point of contact for ongoing communications between the provider and the MDCH MIHP consultants; be responsible for overseeing the application process and program implementation; and assure that all the MIHP Medicaid policies and procedures are followed.
4. The prospective provider completes the application and returns it to MDCH MIHP.
5. If the prospective provider does not have a National Provider Identifier (NPI), they must obtain one by calling or applying online to the National Provider Enumeration System. Phone is 1-800-465-3203. URL is <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

6. After obtaining an NPI number, the prospective provider completes the online Medicaid enrollment process at www.michigan.gov/medicaidproviders. The prospective provider will need to scroll down to Hot Topics, click on CHAMPS, scroll down to New Providers, and follow the instructions from there.
7. The MIHP consultant receives the application packet from the prospective provider and within 45 days, reviews it for completeness and clarity.
8. If the application is not complete or additional clarification is required, the MIHP consultant will contact the prospective provider for additional information.
9. If the application is not approved after the additional information has been requested and received, the prospective provider is informed about the appeal process.
10. If the application is approved, provisional status is granted until the initial certification review is completed.
11. The initial consultation visit with the new provider takes place 3 months after the application is approved. The consultant reviews all forms and processes and provides consultation and technical assistance.

Initial Certification Review Process

MDCH conducts the initial certification review approximately six months after a new MIHP provider has begun to serve MIHP beneficiaries, and recertification reviews will continue every 18 months until the MIHP redesign is complete, for as long as the provider continues with the program. Certification and recertification reviews are intended to be quality improvement learning opportunities for MIHP staff, not just program monitoring sessions.

The initial certification review is a two-day, onsite examination of the provider's protocols and operations. The purpose is to ensure that the provider is in compliance with MIHP Medicaid policies as stated in the *Medicaid Provider Manual* and with the procedures as stated in the *MIHP Operations Guide*.

Two months prior to the initial certification review, the provider receives a letter describing how to prepare for the onsite visit. The provider also receives the *MIHP Certification Tool* and the *MIHP Certification Tool Index* (both available at www.michigan.gov/mihp), along with the *MIHP Policies for Initial Certification Review* and the *MIHP Certification Review Agenda*. The provider is encouraged to review their program prior to the initial certification review visit, so they are as prepared as possible for the onsite review.

During the review, the MIHP consultant completes the following tasks:

1. Interviews the MIHP coordinator and staff.
2. Examines the provider's written protocols for each policy noted in the *MIHP Certification Tool*.
3. Reviews open and closed charts to make certain that the provider is using the program forms correctly and has proper documentation.
4. Compares selected remittance advice and billing/beneficiary encounter slips or reports to service documentation.
5. Provides consultation on program issues, as needed.
6. Provides a summary of findings at the end of the review, identifying both provider strengths and any corrective actions that need to be taken.

Within 45 days after the review is completed, the provider receives a letter indicating if certification has been denied, approved, or approved pending submission of a corrective action plan. Once MDCH approves the corrective action plan, the provider receives a letter granting certification for 18 months, signifying that all fiscal requirements, policies and protocols are in place.

When the MIHP coordinator experiences exceptional difficulties in delivering services to a beneficiary or encounters significant barriers to implementing a particular policy or protocol, the coordinator is encouraged to contact an MIHP consultant to discuss the situation. The consultant will carefully evaluate all of the factors involved and assist the Coordinator to resolve the situation if at all possible so that the program is not cited with a deficiency.

Information on recertification reviews is provided in Chapter 9 of this *Guide* ([link](#)).

Required Computer Capacity to Use MIHP Electronic Database

MIHP providers are required to enter beneficiary *Risk Identifier* data into the MDCH MIHP electronic database. The database was established to improve information sharing among programs, where appropriate and with participant consent, and to improve MDCH's ability to monitor programs and evaluate program outcomes. At this time (2010), only the *Maternal Risk Identifier* is available in the electronic format.

Each provider must have a process for timely, efficient entry of *MIHP Maternal Risk Identifier* data into the database. Data entry can take place at the provider's office, at the beneficiary's home, or at another location where confidentiality is assured.

Internet access is the core requirement to use the database. Minimum hardware and software requirements are as follows:

Hardware

Computer or laptop with Windows XP or higher operating system (with the cessation of security updates for XP, there is movement towards using 07 in the future) and Internet connectivity (dial up or high speed). If you wish to use the system from remote locations, you'll need to investigate wireless connectivity in the form of an Internet Service Provider (ISP) - examples include SPRINT and Verizon. (Identification of these vendors is not to be taken as a recommendation or endorsement.) You will also need a laptop with Windows XP Operating system that meets the requirements of your chosen wireless ISP.

Software

Internet Explorer Version 5.5 or higher (preferred)
Netscape Version 6 or higher

Provider Authorization of MIHP Electronic Database Users

The MIHP provider must authorize staff members to use the electronic database or they will not be allowed to access it. The provider should acquire assurance of confidentiality from staff before authorization. The authorization process is as follows:

1. The MIHP coordinator emails the first and last name(s) of individual(s) who will be using the MIHP electronic database to MIHP@michigan.gov.
2. The MIHP provider receives an email message confirming the names of the authorized users.
3. If the MIHP coordinator wishes to remove a name from the list of authorized users, the coordinator notifies DFCH at MIHP@michigan.gov.

Registration of Individual Authorized Users through Michigan's Single Sign-On System

Once MDCH confirms that a particular individual has been authorized by the MIHP provider to use the database, the authorized individual must register through Michigan's Single Sign-On (SSO) System. Only individuals who are registered with SSO can access the database. The registration process is outlined below:

1. After being approved as an authorized user, the individual goes to the state's Single Sign-On (SSO) System web site at <https://sso.state.mi.us>.
2. The individual follows the instructions on the SSO web site to obtain a User ID and Password. (Note: If the individual has used the SSO System previously, he or she may use their current User ID and Password.)
3. The individual writes down and safeguards the User ID and Password.

Questions regarding this process should be directed to an MDCH MIHP consultant. Consultant contact information is provided in Chapter 1 of this *Guide*. [\(link\)](#).

Requirements for Transmission and Maintenance of MIHP Beneficiary Information

MIHP providers must follow the *MIHP Field Confidentiality Guidelines* developed by MDCH. The guidelines are available at www.michigan.gov/mihp. One of the key guidelines is that beneficiary information must be encrypted before it can be sent electronically. Using the beneficiary's name, even though no other identifying information is provided, is not acceptable in communications sent to medical care providers or MHPs. MIHP providers that wish to send communications electronically must use encryption software.

Required Infant Developmental Screening Tools

An important MIHP infant intervention is developmental monitoring. MIHP providers must purchase and use the following standardized screening tools from Brookes Publishing for this purpose:

1. Ages and Stages Questionnaires, 3rd Edition (ASQ-3)
Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asq/index.htm>
2. Ages and Stages Questionnaires: Social-Emotional (ASQ: SE)
Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

The ASQ-3 and the ASQ: SE are both available in English and Spanish.

Guidelines for Office in Provider Residence

MDCH has developed guidelines for providers that use their residence as an MIHP office. Providers that do this are required to follow these guidelines, which are available at www.michigan.gov/mihp.

7.0 MIHP MARKETING AND OUTREACH

Marketing the MIHP in the Community

Marketing the MIHP is an ongoing activity for MIHP providers. Marketing is the process of promoting awareness of MIHP in order to persuade referral sources to refer potential beneficiaries to the MIHP and to persuade potential beneficiaries to seek MIHP services.

Typical community marketing strategies include the following:

1. Conducting MIHP presentations at community agencies, churches, and other places where community members come into contact with pregnant, low-income women or infants.
2. Placing and maintaining posters and brochures or fliers in locations frequented by pregnant, low-income women (e.g., WIC agencies, local health departments, grocery stores, etc.).
3. Developing good relationships with entities that are in a position to refer a significant number of women to the MIHP (e.g., WIC agencies, MHPs, etc.).
4. Providing potential referral sources with an easy referral process.
5. Participating in local coalitions that work to improve maternal and child health or to coordinate services for identified children and families, such as:
 - a. Infant mortality reduction coalitions
 - b. Great Start Collaboratives (local groups building early childhood comprehensive systems focusing on Physical Health Care, Social-Emotional Health Care, Parenting Education and Family Support, Early Care and Education, and Basic Needs)
 - c. Fetal-Infant Mortality (FIMR) Teams
 - d. *Early On* Local Interagency Coordinating Councils

Two standardized MIHP brochures have been developed for MIHP providers to distribute statewide; one is for the general public and Medicaid beneficiaries and the other is for medical and social service providers. There is a blank section in each brochure where providers can insert their contact information. The beneficiary brochure is written at the 6th grade reading level. The brochures can be downloaded and printed from the MIHP web site: www.michigan.gov/mihp. Although they were designed in color, they also print out well in black and white.

MIHP providers must market their services to potential referral sources. It is recommended that providers do this regularly, because of staff turnover and the fact that health and human services workers are continually bombarded with information about many different programs and may “forget” about MIHP over time. Different providers market their services differently. For example, some conduct marketing activities on an ongoing basis; others do a week-long blitz once a year. Some providers advertise incentives for participating in the program, such as free diapers.

Marketing the MIHP to MHPs

MHPs are contractually required to refer their pregnant members to the MIHP. In most counties, there are several competing MIHP providers. In densely-populated, urban counties, there may be many MIHP providers. It's the MIHP provider's responsibility to ensure that every MHP operating in the same county as the provider is very familiar with the provider's MIHP. It is well worth the provider's time to develop good working relationships with each MHP so that the MHP will feel confident in referring its members to the provider's program. Working relationships are promoted by the requirement that there must be a Care Coordination Agreement (CCA) between each MHP and MIHP operating in the same county.

The CCA, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available at [Medicaid Provider Manual](#) in the Forms Appendix. A list titled, *Medicaid Health Plans: MIHP Contact Person*, may be accessed at www.michigan.gov/mihp.

Marketing the MIHP to Medical Care Providers

MIHP services are intended to supplement prenatal and infant medical care and to assist medical care providers to promote the beneficiary's health and well-being. A medical care provider may be a physician, certified nurse-midwife, pediatric nurse practitioner, family nurse practitioner or physician assistant. However, as a group, medical care providers have not been a primary source of referrals to MIHP, likely because many of them are not familiar with MIHP. MHPs do educate their network providers about MIHP and encourage them to make MIHP referrals, but MHPs do not contractually require their providers to refer to MIHP.

It's important for MIHP providers to market themselves to medical care providers so that the medical care providers will make MIHP referrals and understand how the MIHP provider will coordinate with them when they are serving the same beneficiary. (Medicaid policy requires the MIHP provider to coordinate with the beneficiary's medical care provider at specified points throughout the MIHP service process, from intake to case closure, using standardized forms.)

MIHP providers are advised to meet with staff at medical care provider offices (e.g., "lunch & learn" sessions) to discuss MIHP services, how to refer to MIHP, and how communications regarding mutual beneficiaries will occur. If meetings are not feasible, the provider could send brochures with a cover letter on how to refer.

MIHP providers are especially encouraged to market their services to medical care providers serving large numbers of low-income pregnant women and infants, such as Federally Qualified Health Centers, community health centers, etc. It is suggested that providers also market their services to staff at local birthing hospitals, as they are in a position to refer women and infants to MIHP at the time of discharge.

MDCH does not provide a standardized form for medical care providers to use to refer their patients to MIHP. MIHP providers may wish to develop their own form for this purpose.

MIHP Outreach through Partnerships

Outreach is another ongoing activity for MIHP providers. Outreach is the process of identifying a particular pregnant woman, mother of an infant, or primary caretaker of an infant, who may be eligible for MIHP and reaching out to her to explain the program and encourage her to participate.

Outreach is done in several ways. One method is face-to-face outreach at a community agency. This requires an agreement between the MIHP provider and the agency, allowing the provider to visit the agency to approach potential beneficiaries (e.g., in the waiting room), and then take them to a private space to talk.

Outreach also may be done by phone, mail, or home visit. These methods are used when a referral source supplies the MIHP provider with the names of potential MIHP beneficiaries, along with their phone numbers and/or addresses. Unfortunately, many phone numbers and addresses are not current, and the MIHP provider is unable to locate a fair number of referred individuals.

Generally speaking, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and MHPs generate the greatest number of MIHP referrals and are most likely to support MIHP provider outreach activities. MIHP providers should do everything possible to promote sound partnerships with WIC and MHPs.

Outreach through Partnerships with WIC

WIC is an absolutely critical partner in identifying potential MIHP beneficiaries. Most WIC programs are operated by LHDs, but some are operated by other community agencies. There are two different ways in which WIC can partner with an MIHP provider to identify potential MIHP beneficiaries:

1. A WIC agency may agree to allow an MIHP provider to conduct outreach activities on its premises during clinic hours.
2. A WIC agency may agree to fax or send written referrals to an MIHP provider.

It is easiest for WIC to partner with the MIHP provider when an LHD operates both the WIC and MIHP programs. However, private MIHP providers may also work out partnering agreements with LHDs that don't operate their own MIHPs or with LHDs that do operate their own MIHPs, but don't have the capacity to provide MIHP services for all of the women who come through their doors. Private providers may also work out partnering agreements with WIC agencies other than LHDs.

Outreach through Partnerships with LHDs Involving Programs Other than WIC

It may be possible for an MIHP provider to partner with the LHD to conduct outreach activities through LHD maternal-child health programs besides WIC. LHDs don't all offer the same maternal-child health programs, but may offer Medicaid outreach and enrollment, prenatal clinics, immunization clinics, and home visiting programs other than MIHP.

Outreach through Partnerships with MHPs

MHPs are required to refer their pregnant members to the MIHP. Some MHPs rotate referrals among all of the MIHP providers in a given county and others refer only to MIHP providers with whom they have established good working relationships. It is their choice.

The MIHP – MHP Collaboration Form has been developed for use by both MIHPs and MHPs to share information about referred individuals. MHPs use it to refer pregnant women to MIHP providers and MIHP providers use it to inform MHPs of members currently receiving MIHP services. The form and instructions for its use are available at www.michigan.gov/mihp.

Outreach through Partnerships with Federally Qualified Health Centers (FOHCs) and Large-volume Prenatal Clinics

FOHCs and large-volume prenatal clinics that do not operate their own MIHPs may also be willing to serve as MIHP outreach sites.

Locating MIHP Marketing Targets and Outreach Partners

MIHP providers need to be familiar with the particular entities in their respective service areas that frequently come into contact with low-income pregnant women and infants, as these entities are potential marketing targets and outreach partners.

Local United Way offices are a good source of information about community resources. The Michigan Association of United Ways web site at <http://www.uwmich.org/> provides links to the local offices. Also, resource and referral guides developed by local agencies may be available for the asking. Although every community is different, the following is a list of MIHP marketing targets and potential outreach partners common to most:

1. Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
MDCH WIC Program
[WIC](#)

MDCH WIC Agency List (by County)
http://www.michigan.gov/mdch/1,1607,7-132-2942_4910_4920-14165--.00.htm

To find local WIC agency: 1-800-26-BIRTH.
2. MHPs
A list titled *Michigan Counties with MIHP Providers, WIC Agencies and Medicaid Health Plans* is available at the MIHP web site at www.michigan.gov/mihp.

A list of MHPs by county is available at:
http://www.michigan.gov/mdch/0,1607,7-132-2943_4860_5047---.00.html

A list titled, *Medicaid Health Plans: MIHP Contact Person*, may be accessed at www.michigan.gov/mihp.
3. Medical Care Providers
Ask Local Health Department or refer to phone book or Internet to identify medical care providers. Develop relationships with key staff at obstetric offices, prenatal clinics (especially high-volume clinics serving Medicaid beneficiaries), newborn nurseries, pediatric clinics and offices, Federally Qualified Health Centers, hospitals (especially discharge planners), and childbirth education programs. Make sure that social workers affiliated with prenatal clinics and hospitals know to refer to your program. To identify Federally Qualified Health Centers in your locale, go to:
<http://www.wheretofindcare.com/FederallyQualifiedHealthCenters/Michigan-MI/City.aspx>
or
http://findahealthcenter.hrsa.gov/Search_HCC_byCounty.aspx.
4. Local Health Departments (LHDs)
Many LHDs are MIHP providers.
Local Public Health Department Locator
<http://www.malph.org/page.cfm/108/>
5. Department of Human Services County Offices
<http://www.michigan.gov/dhs/0,1607,7-124-5461---.00.html>
6. *Early On* Michigan
<http://www.1800earlyon.org/>
7. Great Start Collaboratives – Early Childhood Investment Corporation
<http://www.greatstartforkids.org/content/great-start-your-community>
8. Michigan Domestic Violence Resource Directory
http://www.michigan.gov/som/0,1607,7-192-29941_30586_240---.00.html
9. Community Mental Health Services Programs
Michigan Association of Community Mental Health Boards Members
<http://www.macmhb.org/BoardList.html>
10. Regional Substance Abuse Coordinating Agencies

http://www.michigan.gov/mdch/0,1607,7-132-2945_5102-14983--,00.html

11. Emergency food, shelter, utility programs
12. Grocery stores
13. Thrift stores (Goodwill, Salvation Army, Volunteers of American, etc.)
14. Laundromats
15. Places of worship

Medicaid Application and Maternity Outpatient Medical Services (MOMS) Program Enrollment

Many MIHP beneficiaries who are identified through outreach are not enrolled in Medicaid (and so are not in MHPs) when MIHP services are initiated. MIHP providers cannot be reimbursed for services provided to a woman until she has applied for Medicaid, been approved, and received a Medicaid ID number.

However, if the woman enrolls in the Maternity Outpatient Medical Services (MOMS) Program at the time she applies for Medicaid, she is given a *Guarantee of Payment for Pregnancy Related Services* letter, verifying presumptive Medicaid eligibility. This letter, which is valid for 45 days from the date of issue, assures Medicaid providers, including MIHP providers, medical care providers, and pharmacies, that MDCH will reimburse pregnancy-related services provided to the woman who holds this letter while her Medicaid application is pending, even if it is ultimately determined that she is not eligible for Medicaid. (NOTE: It may take longer than 45 days for the woman's Medicaid application to be approved or denied and each MIHP provider must decide whether or not to continue to serve pregnant women if the 45-day presumptive eligibility period ends before the Medicaid ID number is issued.)

Therefore, while MIHP providers are not paid for assisting women to apply for Medicaid and MOMS, it is clearly to their advantage to do what they can to facilitate the submission of these applications. They may do this by referring or assisting women to access Medicaid outreach efforts in the community. For example, local health departments (LHDs) perform Medicaid outreach and are authorized to issue *Guarantee of Payment for Pregnancy Related Services* letters. (See LHD Medicaid Outreach Activities section below.) MIHP providers may refer women to the LHD for this assistance, or may take it upon themselves to help women apply.

Medicaid applications are submitted to and processed by the Michigan Department of Human Services (DHS). If a Medicaid application is filed online, a statement is issued verifying the application date and presumptive eligibility. This statement is proof of the date that DHS received the application. The DHS standard of promptness to approve or deny a Medicaid application for a pregnant woman is 15 calendar days. The beneficiary's Medicaid ID number is issued at the time her application is approved.

For more information on MOMS, go to [Medicaid Provider Manual](#) and click on "Maternity Outpatient Medical Services" in the bookmarks column on the left. Medicaid and MOMS applications are submitted online at the MDCH On-Line Application Service web site at: <https://healthcare4mi.com/michild-web/>.

Mandatory Enrollment of Pregnant Women into Medicaid Health Plans

Most pregnant Medicaid beneficiaries are required to enroll in an MHP, although there are some voluntary populations that may choose to enroll in an MHP or to select fee-for-service coverage. Voluntary populations include women in the MOMS Program, migrants, Native Americans, Medicare/Medicaid

recipients, medically needy individuals (spend-down), and women residing in a county where there is only one MHP (except for all counties in the Upper Peninsula).

MDCH contracts with MAXIMUS, Inc. to enroll Medicaid beneficiaries in MHPs. This service is called Michigan Enrolls. After a pregnant woman's Medicaid application is approved, she receives a letter from Michigan Enrolls, asking her to select an MHP. Michigan Enrolls phone counselors (1-888-367-6557) are available to answer her general questions about Medicaid benefits (including MIHP), provide information on which doctors, pharmacies and hospitals are part of each MHP, and help her choose a plan. MIHP providers also may help a woman choose a MHP, if she needs assistance. If the woman does not select a MHP within 30 days, she is automatically assigned to one.

When the infant is born, the mother has of option of adding the infant to her MHP or to a different MHP. The mother must report the birth to the Department of Human Services in order to obtain the infant's Medicaid ID number, which providers must have in order to be able to submit Medicaid billings.

Local Health Department Medicaid Outreach Activities

Assisting MIHP beneficiaries to enroll in Medicaid is not a covered MIHP service. However, local health departments may conduct Medicaid outreach activities to assist Medicaid eligible individuals to access Medicaid-covered services. Medicaid outreach activities include informing families, parents and community members about the Medicaid program and assisting an individual or family to become enrolled. For more information, go to *Medicaid Provider Manual* at [Medicaid Provider Manual](#), click on "Local Health Departments" in the bookmarks column on the left, and then go to Section 3 of that chapter.

Replying to Referring Sources on the Disposition of Referrals

MIHP providers are required to document and report disposition of a referral (i.e., initiation of services, inability to locate, or refusal of services) to the referring source. The referring source may be a MHP, WIC office, medical care provider, community services agency, or other entity. Reporting the disposition of a referral assures the referring source that the beneficiary has not been lost in the system and is a basic professional courtesy. Providers who systematically report back to the referring source are seen as more efficient and reliable than those who do not.

MIHP providers must report all new MIHP enrollees who are MHP members to the appropriate MHP on a monthly basis. The *MHP/MIHP Collaboration* form is used for this purpose. It is available at www.michigan.gov/mihp.

There is no form for MIHP providers to use to report disposition of referrals to referring sources other than MHPs. However, it is suggested these reports be written rather than verbal.

MIHP Marketing and Outreach Development and Documentation

MIHP providers must demonstrate a capacity to conduct outreach activities to the target population and to medical care providers in the geographic areas to be served. MIHP providers must develop and maintain on file an outreach plan that includes coordination with local medical care providers, relevant agencies and community services, hospitals, and other providers offering services that MIHP beneficiaries may require. Outreach activities to the target population and contacts with medical care providers must be documented.

Conducting Outreach Activities Professionally and Fairly

While conducting outreach activities, the provider must be mindful that the needs and wants of the beneficiary come first. Some MIHP providers, especially if they are operating in counties with many other MIHP providers, may feel they are competing for MIHP referrals. A few may go so far as to engage in questionable outreach activities that are not in the best interest of beneficiaries. MDCH expects that all MIHP providers will conduct their outreach activities professionally and fairly. This includes properly using the MIHP electronic database, refraining from seeing beneficiaries who are already being seen by other MIHP providers, sharing information with other providers as appropriate, etc.

If an MIHP provider feels that another MIHP provider is consistently conducting outreach activities in an unprofessional or unfair manner, the provider is encouraged to contact an MDCH MIHP consultant, who will investigate the situation. If it is found that a provider is, in fact, operating unprofessionally or unfairly, the provider will be required to implement a corrective action plan, and this deficiency will be addressed in the provider's subsequent certification reviews.

8.0 MIHP SERVICE DELIVERY

Conducting Professional Visits to Deliver Care Coordination and Intervention Services

MIHP provides two types of services for the mother/infant dyad: care coordination and interventions. Care coordination services are much the same for all beneficiaries, but intervention services are tailored to each individual beneficiary subsequent to the risk identification process and as documented in the *Plan of Care*.

Care coordination services are provided by a registered nurse or a licensed social worker. Care coordination services include: risk identification, care plan development, care plan implementation, care plan implementation monitoring, documentation of care plan implementation, coordination with the MHP, and coordination with the medical care provider.

Intervention services are provided by a registered nurse, a licensed social worker, a registered dietitian or an infant mental health specialist. Intervention services fall under the following five categories: health education, nutrition education, social work, nutrition counseling, and infant mental health services.

MIHP services, except for transportation and childbirth and parenting education classes, are provided through one-on-one, face-to-face meetings with the individual beneficiary/dyad. These meetings are referred to as professional visits. Professional visits are conducted with individual beneficiaries/dyads, never with groups of beneficiaries. Professional visits must be one-on-one/dyad, face-to-face, and last for at least 30 minutes.

Medicaid has developed guidelines for conducting professional visits. These guidelines, except for those pertaining specifically to reimbursement, are given below:

A professional visit is a face-to-face encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) for the specific purpose of implementing the beneficiary's plan of care. A registered dietitian may conduct a visit when ordered by a physician.

The professional visit is a one-on-one visit that must be scheduled to accommodate the beneficiary's situation and be appropriate to the beneficiary's level of understanding.

All professional visit records must include the place of service, time the visit began and ended, risk factors discussed, and actions taken. Coordination of agency and community services and arranging transportation for the beneficiary are part of each professional visit. The MIHP provider must assure the beneficiary has been referred to WIC.

Family Planning options including Plan First! services and methods of family planning should be discussed at every MIHP maternal visit giving the woman time to consider her options.

The MIHP must provide directly or arrange bilingual services and services for the visually impaired and/or hearing impaired when needed, so all beneficiaries may fully participate in the program.

(Section 2.7 Professional Visits, MIHP Chapter, [Medicaid Provider Manual](#))

The way in which MIHP services are provided must be individualized to meet the needs of each beneficiary. Some beneficiaries may have limited reading skills or information processing difficulties, some may not speak English, some may require accommodations due to physical or emotional challenges, some may require evening or weekend appointments due to work or school schedules. MIHP providers must do everything possible to meet these needs.

MIHP staff persons who work directly with beneficiaries in their homes or at other community locations must carry identification (ID) cards or badges with them at all times. This is to assure beneficiaries that they are legitimately affiliated with the MIHP. An ID card or badge should include a picture of the staff person, the staff person's name, the name of the MIHP, and the name of the agency. A business card without a picture is not sufficient. The ID card or badge must be presented when meeting a beneficiary for the first time and whenever a beneficiary requests to see it.

Family planning should be discussed at every MIHP visit while the beneficiary is pregnant. Once the infant is born, family planning should be discussed, as appropriate.

Definitions of Case Management/Care Coordination

There are many definitions of case management and many other names for case management, including "care coordination." MDCH is choosing to use the terminology "care coordination." Definitions used by the Case Management Society of America, The National Academy of State Health Policy, and The Centers for Medicare and Medicaid (CMS) are given below:

Case Management Society of America

The Case Management Society of America defines case management as a collaborative process of assessing, planning, implementing, facilitating, coordinating, monitoring, and evaluating the options and services required to meet an individual's health and human service needs. It is characterized by advocacy, communication, and management of available resources, and promotes quality and cost-effective interventions and outcomes. Case management services are optimized if offered in a climate that allows direct communication among the case manager, the beneficiary, the payer, the primary care provider, and other service delivery professionals.

(Excerpted from <http://www.cmsa.org/PolicyMaker/ResourceKit/AboutCaseManagers/tabid/141/Default.aspx>)

National Academy for State Health Policy

"Case coordination" and "case management" are terms used to describe an array of activities that help to link families to services, avoid duplication of effort, and improve communication between

families and providers. While some sources make a distinction between the two terms, and some have advocated replacing the term case management with care coordination, the meaning of these terms varies, depending on the provider, program or payer. In practice today, the term care coordination and case management are used interchangeably without clear and distinct usage. For example, while most public health programs and pediatric primary care providers emphasize care coordination, Medicaid has traditionally paid only for services identified as case management. The federal Medicaid statute and implementing regulations do not contain a "care coordination services" category.

(Excerpted from *Improving Care Coordination, Case Management, and Linkages to Service for Young Children: Opportunities for States* (Apr 2009), National Academy for State Health Policy
<http://abcd.nashpforums.org/sites/abcd.nashpforums.org/files/Commonwealth.pdf>)

The Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services, US Department of Health and Human Services, define case management as "services that assist individuals eligible under the Medicaid State Plan in gaining access to needed medical, social, education and other services." Case management includes the following elements:

1. **Assessment** of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services, such as housing and transportation. Comprehensive assessment addresses all areas of need, the individual's strengths and preferences, and the individual's physical and social environments. Assessment activities are defined to include the following:
 - a. Taking beneficiary history.
 - b. Identifying the needs of the individual and completing related documentation.
 - c. Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.
2. **Development of a specific care plan** based on the information collected through the assessment described above. The care plan specifies the goals of providing case management to the eligible individual, and actions to address the medical, social, educational, and other services needed by the individual. This includes activities such as ensuring the individual's active participation, and working with the individual and others to develop goals and identify a course of action to respond to individual's assessed needs. While the assessment and care plan must be comprehensive and address all of the individual's needs, the individual may decline to receive services in a care plan to address those needs.
3. **Referral and related activities** to help an eligible individual obtain needed services, including activities that help link the individual with medical, social, education providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
4. **Monitoring and follow-up activities**, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring and follow-up activities may be with the individual, family members, providers, or other entities. These activities may be conducted as frequently as necessary to help determine such matters as whether:
 - a. Services are being furnished in accordance with the individual's care plan.
 - b. Services in the care plan are adequate to meet the needs of the individual.
 - c. There are changes in the needs or status of the individual, requiring adjustments to the care plan and service arrangements with providers.

(Excepted from *Federal Register*, Dec. 4, 2007, Vol. 72, No. 232, 68077-68093; 42 CFR Parts 431, 440, and 441)

MIHP Care Coordination Services

MIHP Care Coordinator

A specific registered nurse or licensed social worker will be identified as the care coordinator assigned to monitor and coordinate all MIHP care, referrals, and follow-up services for the beneficiary. The care coordinator must assure the family is appropriately followed and referred for needed services. The name of the care coordinator must be documented in the beneficiary's record. The care coordinator must refer all beneficiaries to the Women, Infants and Children Program (WIC) if they are not receiving WIC.

(Section 2.6 Care Coordinator, MIHP Chapter, [Medicaid Provider Manual](#))

After the registered nurse or licensed social worker administers the *Maternal Risk Identifier* or the *Infant Risk Identifier* and assists the beneficiary to identify her individual needs, goals, and resources, the beneficiary's *Plan of Care* is developed. This is done jointly by the registered nurse and the licensed social worker. At that time, either the registered nurse or the licensed social worker is designated as the beneficiary's Care Coordinator. The name of the Care Coordinator must be documented in the beneficiary's record. If there is a change in care coordinators during the beneficiary's participation in MIHP, this also must be documented in the record.

The Care Coordinator is responsible for overseeing all aspects of care coordination. This means that the Care Coordinator does the following:

1. Helps the beneficiary to locate resources; facilitates connections with providers of services and supports; advocates on behalf of the beneficiary to obtain services, if needed.
2. Facilitates implementation of the *Plan of Care (POC)*; coordinates services when multiple providers are involved.
3. Follows up with the beneficiary to determine if she has connected with, and is actually receiving services from, a particular referral source. If not, assists the beneficiary to address barriers. (NOTE: The Care Coordinator encourages the beneficiary to take as much responsibility as possible for arranging and accessing services for herself and her infant, in that learning to negotiate the health care system is an important goal for all MIHP beneficiaries. Of course, the Care Coordinator offers hands-on support in arranging services for beneficiaries who clearly need it, for example, women with developmental challenges or who are immobilized with depression.)
4. Assists the beneficiary with needs and problems as they arise.
5. Evaluates whether the *POC* is meeting the beneficiary's goals.
6. Modifies the *POC*, as needed.
7. Communicates with medical care provider and Medicaid Health Plan.
8. Uses Motivational Interviewing and promotes self-empowerment and self-management.
9. Determines if specified, desired service outcomes are achieved.

MIHP Psychosocial and Nutritional Assessment

Medicaid requires that a psychosocial and nutritional assessment is completed before the beneficiary's *POC* is developed and before she receives any type of MIHP service. The *Maternal and Infant Risk Identifiers* are the MIHP psychosocial and nutritional assessment tools.

The MIHP consists of many interventions in multiple domains designed to educate and inform the beneficiary, both as a pregnant woman and as the parent of an infant.

Domains include basic care, violence abuse, substance abuse, social behavior and health history. The Risk Identifiers are designed to determine if there is a high, medium, low, or no risk for each domain. Based on the Risk Identifier, and professional observation, the MIHP provider will determine interventions specific to each beneficiary. Refer to the MIHP Operations Guide for more information and interventions related to the domains.

The beneficiary must be assessed (Risk Identifier completed) for transportation needs, childbirth/parenting education classes, health education needs, and family planning services. The completion of the Risk Identifier must precede any professional visits. The Risk Identifier must be completed by the registered nurse or the licensed social worker.

If a MIHP prenatal case subsequently becomes an MIHP infant case, the Infant Risk Identifier must be completed to determine eligibility for the infant.

(Section 2.4 Psychosocial and Nutritional Assessment-Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

If the Risk Identifier does not indicate the need for MIHP services, then no follow-up services should be provided, however, the beneficiary should receive the informational packet. If a need is indicated, an appropriate POC must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s).

(Section 2 Program Components, MIHP Chapter, [Medicaid Provider Manual](#))

and

(Section 2.4 Psychosocial and Nutritional Assessment-Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

MIHP Risk Identification

A potential client must sign the *Authorization and Consent to Release Protected Health Information* before the *Risk Identifier* is administered. If a potential client declines to sign the *Authorization*, the *Risk Identifier* is not administered and no MIHP services are provided. The woman is given an MIHP brochure with program contact information, in case she changes her mind.

Maternal Risk Identifier

The Maternal Risk Identifier covers multiple domains, including basic care, drug and alcohol use, smoking, shelter, depression, transportation needs, and support systems. The Maternal Risk Identifier can be found in the MIHP Operations Guide at www.michigan.gov/mihp. It must be completed for each pregnant woman to determine the services needed through the MIHP. Either the licensed social worker or the registered nurse must work face-to-face with the beneficiary to complete the form. MIHP services will be provided based on the beneficiary's responses to the various questions on the Maternal Risk Identifier. The Maternal Risk Identifier must be completed to assure all appropriate services are identified.

The Maternal Risk Identifier results must be entered into the MIHP database. The MIHP database will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and licensed social worker, working together, will write a plan of care to determine appropriate interventions.

MIHP serves the maternal /infant dyad. When infant services are initiated, an Infant Risk Identifier must be completed.

(Section 2.1 Maternal Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

The *Maternal Risk Identifier* is the tool used to determine specific risks of pregnant women in the MIHP. It includes questions under the following domains: Basics/Demographics, Health History/Risks, Prenatal Care, Smoking, Alcohol, Drug Use, Stress, Depression and Mental Health, Social Support, Abuse /Violence, Basic Needs and Breastfeeding.

The professional staff must ask each question on the *Maternal Risk Identifier*. The staff may complete the *Maternal Risk Identifier* either by writing the beneficiary's responses on a hard copy or by electronically entering her responses while asking the questions.

During the first visit with the pregnant beneficiary, establishing rapport is imperative, as this will increase the likelihood that the beneficiary will want to stay in the program. Therefore, when soliciting a response, *Risk Identifier* questions should be asked in a caring and empathetic manner. The timing of asking sensitive questions, such as those pertaining to domestic violence or drug use, should be a consideration. If the beneficiary chooses not to respond to specific questions initially, the MIHP staff should ask the questions at a later visit and document the beneficiary's response in the progress note.

After a hard copy of the *Maternal Risk Identifier* is completed, the responses are entered in the MDCH MIHP database. All responses must be entered into the database in order to get a scoring results page. The scoring results page provides an overview of the beneficiary's risk domains and the level of risk (no, low, moderate or high) for each domain. Also noted on the scoring results page is "unknown" risk. "Unknown" is used when the potentially high risk questions regarding a specific domain are not answered by the beneficiary. These include specific questions regarding previous poor birth outcomes, alcohol or drug use, abuse/violence, stress/depression/mental health, and prenatal care/family planning. If a specific domain scores out as "unknown", treat this as an area of high risk for the beneficiary and provide the appropriate interventions. If an overall score is "unknown", treat the beneficiary as high risk overall and provide services accordingly.

Overall scores will be stratified as follows:

No:	If no domain has a high, moderate or low score and no unknown or refused responses were given
Low:	If no domain has a high or moderate score and no unknown or refused responses were given
Moderate:	If no domain has a high score and at least one domain has a moderate score and no unknown or refused responses were given
High:	If any domain has a high score
Unknown:	If no domain has a high score and at least one unknown or refused response was given to the high-risk questions

Once the risk level of each domain scores out and the overall level of risk is known, the MIHP staff can enter this information on the *MIHP Plan of Care* form.

All domains have "no risk" level interventions (*Plan of Care, Part 1*). In the *Plan of Care, Part 2*, most domains have moderate, high and emergency interventions. Some domains have low, moderate and emergency. This is because of the nature of the domain. Some domains do not lend themselves to a low, moderate, high categorization in the context of the MIHP service model, given limits on the number of visits and the amount of time per visit.

Infant Risk Identifier

The Infant Risk Identifier as found in the MIHP Operations Guide at www.michigan.gov/mihp must be completed for each infant entering the MIHP program to determine the services needed. Either the licensed social worker or the registered nurse must work face-to-face with the beneficiary and primary care giver to complete the form. The Infant Risk Identifier is made up of many domains including health and safety, feeding and nutrition, family support, child care and general growth and development. MIHP services will be provided based on the responses to the various questions on the Infant Risk Identifier.

The Risk Identifier must be entered into the MIHP database when available. The system will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and the licensed social worker, working together, must write a plan of care for each beneficiary.

The initial assessment visit and up to nine professional visits per infant/family are billable. An additional nine infant visits may be provided when requested in writing by the medical care provider. The reason for and purpose of additional visits must be well documented in the medical record.

The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the beneficiary within a maximum of 7 calendar days for the infant. For referrals received prior to the infant's discharge from the inpatient setting, the Risk Identifier should be conducted within 48 hours of hospital discharge.

(Section 2.2 Infant Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

The MIHP professional staff should administer the *Infant Risk Identifier* in that same way that they ask questions on the *Maternal Risk Identifier*. Questions should be asked in a caring and empathetic manner and the timing of asking sensitive questions should be a consideration. Establishing rapport with the infant beneficiary's parent is imperative. As it is with the maternal beneficiary, this will increase the likelihood that the infant beneficiary will stay in the program.

The *Infant Risk Identifier* will initially only be available in hard copy. It is divided into two sections: Postnatal Risk Screening-Infant Component and Postnatal Risk Screening-Maternal Component. The Postnatal Risk Screening-Infant Component asks questions about the infant's health, safety, feeding and nutritional status, and general development. The Postnatal Risk Screening-Maternal Component focuses on maternal risks that could potentially affect the health, safety and development of the infant. It also asks questions about family planning.

When the *Infant Risk Identifier* becomes available in electronic format, it will score out individual domain risks and an overall risk level in a manner similar to the *Maternal Risk Identifier*. Infancy is a dynamic time of change, physically, socially, emotionally and developmentally. An infant's status may change in a surprisingly short period of time and unless ongoing visits and developmental assessments are performed, early identification of concerns and necessary referral, support and treatment may not occur.

The *Risk Identifier* must be completed before the *Plan of Care (POC)*, *Parts 1-3*, are developed and before any professional visits can be provided. The *Risk Identifier* (but not the *POC*) must be completed before transportation services, childbirth education classes, and parenting education classes can be provided. (NOTE: This is a change from previous policy which allowed a beneficiary to obtain transportation services, childbirth education classes, and parenting education classes without an assessment/*Risk Identifier*). There's a single exception to the requirement that the *Risk Identifier* must

be completed before transportation services can be provided. The exception is for Nurse Family Partnership beneficiaries who receive transportation services through MIHP. Additional information on MIHP transportation provided to NFP beneficiaries is provided in Chapter 5 of this *Guide* ([link](#)).

Multiple Births

Only one infant per household may be enrolled in MIHP. In the event of multiple births or multiple infants in one home, the standard assessment visit and nine visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family. When there are multiple infants in the home all infants should be assessed at each visit. Regardless of the number of infants in the home, only one professional visit should be billed. With multiple births, it is not appropriate to bill visits under several infant ID numbers. All visits are considered blended visits.

(Section 2.3 Multiple Births, MIHP Chapter, [Medicaid Provider Manual](#))

In addition to the *Infant Risk Identifier*, developmental screening is required for all MIHP infant beneficiaries. Screening is administered as an intervention for all MIHP infants and as such will be included in the *Infant Plan of Care*. The *Ages and Stages Questionnaires-3 (ASQ-3)* and the *Ages and Stages Questionnaires: Social-Emotional (ASQ: SE)* must be used for this purpose. It may not be feasible to complete, score, and discuss the results of both of these tools and to provide anticipatory developmental guidance for two infants during the same visit. Therefore, in the case of multiple births, the MIHP provider may wish to conduct developmental screening for each infant in separate visits. As developmental screening is conducted periodically during infancy, the MIHP provider may need to request that the medical care provider authorize an additional 9 visits. Please remember that the MIHP provider can only bill under one infant's Medicaid ID number per family for the first 9 and any subsequent visits.

MIHP Plan of Care

The registered nurse and the licensed social worker together must develop a comprehensive POC to provide identified services to the beneficiary, and/or referrals to community agencies. The POC must indicate the specific domains at risk, the specific objectives, specific intervention(s) to be implemented, and the number of visits that are required for actualizing the plan. The POC must be updated whenever a significant change occurs. Documentation must support the changes made. The MIHP provider must determine how best to involve the registered nurse and the licensed social worker in implementing the POC based on the needs identified.

The POC must identify if a beneficiary would benefit from a visit with the registered dietitian based on the needs identified. If the services of a registered dietitian are needed, the necessary physician order must be obtained. The beneficiary may be referred to their MHP or local hospital for nutritional counseling.

The beneficiary's exit from the program is expected to occur when the objectives of the POC are complete, or when the MIHP provider determines that continued interventions are no longer needed.

(Section 2.5 Plan of Care, MIHP Chapter, [Medicaid Provider Manual](#))

The foundation of MIHP care coordination is the individualized *POC*, which is based on the beneficiary's risks as identified on the *Maternal Risk Identifier* or on the *Infant Risk Identifier*. Before the *POC* is drafted, the professional who administers the *Risk Identifier* talks with the beneficiary to get her input on her own problems, needs, goals, and objectives, so they can be clearly reflected in the *POC*.

The policy language states that the registered nurse and licensed social worker together must develop the *POC*. The registered dietitian and infant mental health specialist may provide input into the *POC* development process. A face-to-face conference is strongly recommended, but not required, for this purpose. Care conferencing by phone (documented in writing) is acceptable. It is also acceptable for one party to draft the *POC* and leave it for another party to review, comment on, and sign within a few days. This means that the *POC* can have different signature dates, but these dates must be within 5 business days of each other. The *POC* must be signed by the registered nurse and the licensed social worker before any professional visits are made. It is during the *POC* development process that the Care Coordinator is designated.

There is no requirement that the *POC* address a particular number of domains. The *POC* consists of all domains in which risks are identified by the *Risk Identifier* or by the registered nurse or licensed social worker, based on observations and information gathered during the initial interview. However, *POC* implementation is client-focused, meaning that the beneficiary selects the domains that are priorities for her and that she wishes to address. The beneficiary's record must state why interventions addressing the other risks are not being provided. The provider may encourage the beneficiary to address additional risks as time permits. As new risks are identified, the *POC* must be modified to incorporate them. There is no requirement that a particular number of disciplines must implement the interventions, as this will depend on the particular domains that the beneficiary has selected.

All pregnant beneficiaries who complete the *Risk Identifier* and consent to MIHP services will have a *POC*, even if no risks are identified. In this case, the *POC, Part 1* would be provided, which includes receipt of the MIHP Maternal Packet, provision of MIHP provider contact information, and a tentative date that the provider will visit the beneficiary again as she nears the end of her pregnancy to determine if any MIHP services are needed at that time. This is the only exception to the Medicaid policy that requires a minimum of two home visits for pregnant beneficiaries.

All infant beneficiaries whose primary caregivers consent to MIHP services also will have a *POC*. At a minimum, the *Infant Plan of Care* will include discussion of the Infant Packet materials and developmental monitoring. The provider will:

- a. Monitor general infant development (communication, gross motor, fine motor, problem-solving, and personal-social), using the *Ages and Stages Questionnaires-3 (ASQ-3)*.
- b. Monitor social-emotional infant development using the *Ages & Stages Questionnaires: Social/Emotional (ASQ: SE)*.

ASQ-3 and *ASQ: SE Age Administration Charts* are available at www.michigan.gov/mihp. The infant must be at least one month old before it's appropriate to administer the *ASQ-3* and at least three months old before it's appropriate to administer the *ASQ: SE*. Additional information on developmental screening is provided in Chapter 8 of this *Guide*. [\(link\)](#).

The Maternal Packet and Infant Packet materials are listed at www.michigan.gov/mihp. Some packet materials are provided by MDCH. Others must be ordered (at no charge) or printed from web sites. MIHP providers must pull the materials together into packets and give them to beneficiaries at assessment visits (when the *Maternal* or *Infant Risk Identifier* is administered).

The *POC* can be modified at any time to document a change in risk level in a given domain, based on professional judgment in light of new information obtained through interviews or observation. If the risk level determined by the *Risk Identifier* is different from the risk level determined by professional judgment, provide interventions based on the higher risk level. If risk level increases or decreases, note on progress note. Significant changes in the *POC* should be communicated to the medical care provider.

MIHP Care Coordination and Intervention Services: Pregnancy and Infancy

A more detailed description of MIHP care coordination and intervention services is provided below. It addresses service activities during the pregnancy and infancy phases. Although the overall process is essentially the same during both phases, there are some differences. For example, many of the required forms, while similar, do not contain the same information and questions. Also, the infancy phase, as noted previously, is a dynamic time of change, physically, socially, emotionally and developmentally. An infant's status may change in a surprisingly short period of time and unless ongoing visits and developmental assessments are performed, early identification of concerns and necessary referral, support and treatment may not occur. The Care Coordinator provides support as the infant's primary caregiver closely monitors the infant's health, safety and development. During the time that pregnant or infant beneficiaries are receiving MIHP services, all referrals should be made and all beneficiary questions should be answered.

MIHP providers strive to identify and enroll women in MIHP as early in their pregnancies as possible. Some women though, are not identified and enrolled in MIHP while they are pregnant. Their infants may be enrolled in MIHP after hospital discharge and at any time during infancy. After the birth of the infant, the MIHP provider works with the infant's primary caregiver. Most often, this is the infant's mother. However, if the mother is not the infant's primary caregiver, the MIHP provider may visit with another individual who is serving in this capacity.

The MIHP provider may deliver services to the dyad throughout implementation of the *MIHP Maternal Plan of Care* and until the objectives in the *MIHP Infant Plan of Care* are met, or until all available visits have been used. There are 9 visits available during the prenatal period and 9 visits available during infancy. In infancy though, after the first 9 visits are completed, an additional 9 visits may be provided in order to meet the *POC* objectives, if approved by the infant's medical care provider. A total of 36 visits may be provided for drug-exposed infants, if approved by the infant's medical care provider.

Below is an outline of tasks that are to be performed by the MIHP provider when a woman enrolls in MIHP while she is pregnant or after a baby is born, whether or not the mother participated in MIHP during her pregnancy. These tasks are classified under the following headings: Risk Identification, Care Plan Development, Care Plan Implementation, Care Plan Implementation Monitoring, Documentation, Coordination with Medicaid Health Plans, and Coordination with Medical Care Providers.

1. Risk Identification (Psychosocial and Nutritional Assessment)

- a. Upon receipt of a maternal referral to the MIHP, check the MIHP electronic database to see if the referred individual is involved with another MIHP provider. The *Infant Risk Identifier* is not currently available in electronic format. If the potential maternal or infant MIHP beneficiary was identified through outreach (e.g., at WIC office, DHS, OB clinic, pediatric clinic, etc.), determine if beneficiary is already involved with another MIHP provider (e.g., ask her, call MIHP office and ask someone to check the MIHP electronic database, etc.).
- b. Meet individually with the potential MIHP beneficiary or beneficiary's primary caregiver. Explain the *MIHP Authorization and Consent to Release Protected Health Information* form and obtain beneficiary's signature. The potential beneficiary, or the primary caregiver if the beneficiary is an infant, must sign this form before the provider can administer the *Risk Identifier* and enroll him/her in MIHP. If the potential beneficiary declines to sign the *Authorization*, she is not eligible to receive any MIHP services, including child birth education classes, parenting classes and transportation. Give her an MIHP brochure along with program contact information, in case she changes her mind.

- c. If the beneficiary signs the *Authorization*, administer either the *Maternal Risk Identifier* or the *Infant Risk Identifier*.
 - 1) The *Maternal Risk identifier* includes questions under the following headings: Basics/Demographics, Health History/Risks, Prenatal Care, Smoking, Alcohol, Drug Use, Stress, Depression and Mental Health, Social Support, Abuse/Violence, Basic Needs, and Breastfeeding.
 - 2) The *Infant Risk Identifier* is a comprehensive tool which consists of a maternal component and an infant component. The maternal component includes questions under the following headings: Family Social Support, Parenting and Child Care, Family Planning, Smoking, Alcohol, Drug Use, Stress, Depression and Mental Health, Abuse/Violence, Basic Needs, and Parenting. The infant component includes questions under the following headings: Identification/Demographic Info, Infant Health Status, Infant Health Care, Infant Safety, Infant Feeding and Nutrition, and General Infant Development.
- d. If the *Maternal Risk Identifier* indicates that the woman is at moderate, high or unknown risk overall, fully explain the MIHP to her. (NOTE: If the *Maternal Risk Identifier* indicates that the woman is at no risk overall, but based on your professional observation she is in need of MIHP services, document the need and encourage the woman to participate in services.) If the woman does not need MIHP services, give her the MIHP Maternal Packet and a number to call, should she need assistance later in her pregnancy. Also explain that you will contact her as she nears the end of her pregnancy to discuss preparedness for the infant and that after the infant is born, you will contact her to assess the infant for MIHP services.
- e. Give the beneficiary or the beneficiary's primary caregiver the Maternal Packet or the Infant Packet, as appropriate, at the assessment visit after completing the *Risk Identifier*, in case you do not see her again. As you make visits, review the packet materials with her, as needed. Of course there is the possibility that you will need to replace the packet or components that you find necessary. If the mother did not participate in MIHP during her pregnancy, there may be components of the Maternal Packet that you will want to give her, along with the Infant Packet.
- f. If the woman is not a Medicaid beneficiary, you may elect to help her apply for Medicaid and MOMS or to refer her to the local health department for assistance with this. Encourage her to select a Medicaid Health Plan (MHP) as soon as she receives notice that her Medicaid application has been approved (rather than wait an additional 30 days to be automatically assigned) and offer assistance with this, if needed.
- g. For infant beneficiaries, if the mother was a Medicaid beneficiary while she was pregnant (coverage continues for up to two months postpartum), encourage her to inform DHS of the baby's birth immediately, so that DHS can issue the infant a Medicaid ID number and enroll the infant in the MHP selected by the mother. If the mother is not a Medicaid beneficiary, you may elect to help her apply for Medicaid for her infant or to refer her to the local health department for assistance with this. Encourage the mother to enroll the infant in an MHP as soon as she receives notice that the infant's Medicaid application has been approved (rather than wait the 30 days to be automatically assigned). Be aware that it may take several months for DHS to issue the infant's Medicaid ID number and there's no presumptive eligibility letter for infants. However, if the mother was a Medicaid beneficiary, there's a probability that the infant will be eligible as well, and you can bill retroactively to birth, if the infant becomes eligible.
- h. Enter *Maternal Risk Identifier* data into the MIHP electronic database. Upon completion of data entry, a computer-scored profile is provided. The profile includes: 1) the beneficiary's risk factors, stratified into no, low, moderate, high or unknown risk levels, 2) a determination of overall risk level, and 3) an indication of the anticipated service intensity level.

- i. When the electronic *Infant Risk Identifier* becomes available, enter information from the *Infant Risk Identifier* into the electronic database. A similar computer-scored profile will be provided, including: 1) the dyad's risk factors, stratified into no, low, moderate, high or unknown risk-levels, 2) a determination of overall risk level, and 3) an indication of the anticipated service intensity level. Until the *Infant Risk Identifier* is converted to the electronic format, use professional judgment to determine the infant's risk level, based on observation and information provided by the beneficiary.
- j. For the pregnant beneficiary, complete the *Prenatal Communication/Notification of MIHP Enrollment Cover Letter Form A* and forward it to the medical care provider. For the infant beneficiary, complete *Infant Care Communication/Notification of MIHP Enrollment Cover Letter Form A* and forward it to the medical care provider.

2. Care Plan Development

Maternal Plan of Care and *Infant Plan of Care* development occurs in three parts.

a. **Part One**

Completion of the *Maternal Plan of Care, Part 1 Maternal Packet* or completion of the *Infant Plan of Care, Part 1, Infant Packet*, which includes:

- 1) Provision of the standardized maternal information packet which includes information about each of the maternal domains plus the additional risk categories of 2nd hand smoke exposure and interconception health
or
- 2) Provision of the standardized infant information packet to the primary caregiver of each infant beneficiary which addresses each of the infant domains and maternal considerations that may affect the infant's health, safety and general development.
- 3) Opportunity for the pregnant beneficiary or the infant beneficiary's primary caregiver to ask questions.
- 4) Preparation for further MIHP visits.
- 5) Provision of the MIHP Care Coordinator's contact information and information about how to contact the Care Coordinator if assistance is needed between scheduled appointments.
- 6) Plus:

Pregnant beneficiary	Infant beneficiary's primary caregiver
Advice on how to access community-based no and low cost food programs.	Referral to WIC.
Assistance with identifying at least one individual to call when needed.	Provision of information about parenting classes and support groups available in the community.
Assistance with identifying an emergency transportation plan.	Development of a plan to complete ASQ-3 and ASQ: SE Questionnaires corresponding to the infant's age. See <i>ASQ Age Administration Charts</i> at

b. Part Two

Completion of the *Maternal Plan of Care, Part 2 Interventions By Risk Level* or the *Infant Plan of Care, Part 2, Interventions By Risk Level* addressing the risks, problems, needs and goals that the pregnant woman or infant beneficiary's primary caregiver selects as priorities.

Plan of Care Part 2, Interventions by Risk Level documents are available for each of the following domains at www.michigan.gov/mihp:

Maternal

1. Family Planning
2. Prenatal Care
3. Basic Needs: Food/Nutrition
4. Basic Needs: Housing
5. Basic Needs: Transportation
6. Basic Needs: Social Support
7. Smoking
8. Secondhand Smoke Exposure
9. Alcohol
10. Drug Use
11. Stress/Depression and Mental Health
12. Abuse Violence
13. Chronic Disease: Asthma
14. Chronic Disease: Diabetes
15. Chronic Disease: Hypertension
16. Interconception Health

Infant

1. Infant Health
2. Infant Safety
3. Feeding and Nutrition
4. Family Support, Parenting and Child Care
5. General Development
6. Maternal Considerations

All domains have "no risk" level interventions (*Plan of Care, Part 1*). Most domains have moderate, high and emergency interventions. Some domains have low, moderate and emergency. This is because of the nature of the domain. Some do not lend themselves to a low, moderate, high categorization in the context of the MIHP service model, given limits on the number of visits and the amount of time per visit.

The *Plan of Care Part 2, Interventions by Risk Level* consists of several documents, each of which is designed to address an individual domain. These documents may be used alone or in combination to address all or some of the identified maternal or infant risks. The MIHP professional should use the specific *Plan of Care Part 2, Interventions by Risk Level* form for each domain with identified risk. The individual *Plan of Care Part 2, Interventions by Risk Level* forms should then be attached to the *Plan of Care Part 1* and the *Plan of Care Part 3, Signature Page for Interventions by Risk Level* to comprise a complete *POC* document.

The *Maternal Plan of Care, Part 2 Interventions by Risk Level* and the *Infant Plan of Care, Part 2, Interventions by Risk Level* form is divided into four columns: intervention level based on risk identifier; risk information; intervention; and expected outcome.

- 1) **Intervention level based on risk identifier.** This column is populated with the score for each domain (no, low, moderate, high) that is generated by the algorithm for the *Maternal Risk Identifier* or the *Infant Risk Identifier* (once it becomes electronic). It is the level of service intensity that can be anticipated based on the beneficiary's responses to specific questions on the *Risk Identifier*. (NOTE: There is also an emergency level of service intensity, which is based on observation and professional judgment rather than the algorithm.)
- 2) **Risk information.** This column has descriptions of the risks that are anticipated at each intervention level. Some of the risks are identified on the *Maternal Risk Identifier* or *Infant Risk Identifier*. Others are based on observation or additional beneficiary interview. Two optional tools are available for the MIHP professional to use to gather risk information that is not available on the *Risk Identifier*.
 - a) The first is the *Supplemental Maternal Risk Identifier Questions-Optional* form at www.michigan.gov/mihp. It asks additional maternal questions in the family planning, prenatal care, food, housing, and transportation domains. The *Supplemental Maternal Risk Identifier Questions* form is to be used with the *Maternal Risk Identifier*.
 - b) The second optional tool is the *Nutrition Questionnaire (optional)* at www.michigan.gov/mihp. It asks questions about the infant's nutritional status and about the primary caregiver's nutrition and intake. The *Nutrition Questionnaire* is to be used with the *Infant Risk Identifier*.

Risks in the risk information column that are based on professional observation or additional beneficiary interview with the *Supplemental Maternal Risk Identifier Questions* or *Nutrition Questionnaire* are marked on the *POC* with an asterisk and an associated checkbox.

- 3) **Intervention.** This column on the *Plan of Care, Part 2* holds the standardized interventions. Interventions are minimum expectations of service delivery and are developed based on best practices and available evidence. They are stratified by service intensity level. The service intensity levels are no risk, low risk, moderate risk, high risk and emergency.
- 4) **Expected outcome.** This column on the *Plan of Care, Part 2* holds the expected outcomes for the standardized interventions. As the individual outcomes are achieved, MIHP staff should check the appropriate box and provide the date that the outcome was achieved.

c. Part Three

The Plan of Care, Part 3, Signature Page for Interventions by Risk Level must be signed by the licensed social worker and registered nurse for each *POC, Part 2* completed. Signature affirms that both disciplines have been involved in the development of the *POC* and are responsible for implementation. An additional signature line is provided for other disciplines involved with *POC* development.

3. Care Plan Implementation

Care Plan Implementation spans the length of time the pregnant or infant beneficiary is in the MIHP. The *POC* should be discussed with each pregnant beneficiary or primary caregiver if the beneficiary is an infant. Discussion should occur around how the beneficiary's priority needs and goals have been incorporated. Other needs and goals identified by the registered nurse and licensed social worker should also be discussed. The beneficiary should be encouraged to work on these goals, along with the priority needs and goals she has set. Key aspects of *POC* implementation include:

- a. Refer beneficiary to other services and supports as specified in the *Plan of Care, Part 2, Interventions by Risk Level*. See *Referring MIHP Beneficiaries to Other Services and Supports: a Basic Guide to Identifying Community Resources at www.michigan.gov/mihp*.
- b. Implement interventions specified in *Plan of Care Part 2, Interventions by Risk Level*.
- c. Use Motivational Interviewing throughout *POC* implementation.
- d. Coach to promote self-empowerment and self-management throughout *POC* implementation.

4. Care Plan Implementation Monitoring

Care Plan Implementation Monitoring is ongoing and spans the length of time the pregnant woman or infant beneficiary is in the program. Monitoring includes discussion of beneficiary progress toward goals, identification of next steps to be taken to meet goals, and identification of barriers to achieving goals. Key aspects of care plan implementation monitoring include:

- a. Monitor *POC* implementation at each visit, including delivery of interventions provided by MIHP, as well as referrals to other services and supports.
- b. Modify *POC*, as needed. If significant changes in status occur, complete the *Prenatal Communication/Notification of Change in Risk Factors Cover Letter Form B* or the *Infant Communication/Notification of Change in Risk Factors Cover Letter Form B* and forward it to the medical care provider.

5. Documentation

Documentation of services provided in MIHP is required. Specific tools with instructions have been developed to assist in collecting required data elements and to assure that program services are appropriately recorded.

Use the *Professional Visit Progress Note* to document each visit, including type and location of visit, time in and out, sections of the *Maternal Plan of Care, Part 1 Maternal Packet* or *Infant Plan of Care, Part 1 Infant Packet* that were reviewed this visit. Check the box if the pregnant beneficiary is a first time mother. Interventions provided, referrals to other services and supports, beneficiary progress, and next steps should also be recorded. Check-off boxes must be used on this form in addition to the required narrative.

6. Coordination with Medicaid Health Plan

- a. Communicate with MHP as specified in *MIHP Provider – MHP Care Coordination Agreement (CCA)*. The *CCA*, titled *Sample 3 (Sample of Care Coordination Agreement)*, is available at [Medicaid Provider Manual](#) in the *Forms Appendix*. The signed *CCA* agreement with a particular MHP may include provisions not included in the *Care Coordination Agreement* template.

- b. Use the *MHP/MIHP Collaboration Form* and *MHP/MIHP Collaboration Form Instructions* to inform MHPs of members currently enrolled and receiving MIHP services. MHPs will use the same form to refer pregnant women to MIHP providers.
- c. Use the *Medicaid Health Plans Transportation Grid* at www.michigan.gov/mihp to contact MHPs to coordinate transportation for mutual beneficiaries. MHPs will use the *MIHP Coordinator and Transportation Directory* at www.michigan.gov/mihp to contact MIHP providers to coordinate transportation for mutual beneficiaries.

7. Coordination with Medical Care Provider

- a. Use the following forms to communicate with medical care provider:

Maternal

- 1) At MIHP service initiation:
Prenatal Communication/Notification of MIHP Enrollment Cover Letter Form A
- 2) When there's a change in beneficiary status:
Prenatal Communication/Notification of Change in Risk Factors Cover Letter Form B
- 3) At end of service or after birth of baby:
Maternal Summary for Medical Care Provider/Cover Letter Form C

Infant

- 1) At MIHP service initiation:
Infant Care Communication/Notification of MIHP Enrollment Cover Letter Form A
- 2) When there's a change in beneficiary status:
Infant Communication/Notification of Change in Risk Factors Cover Letter Form B
- 3) At end of service:
Infant Discharge Summary for Medical Care Provider/Cover Letter Form C

- b. Forward a copy of the *Maternal Plan of Care* or *Infant Plan of Care* to the medical provider upon request.

Participating in Care Coordination Facilitated by Other Programs on Behalf of MIHP Infant Beneficiaries

When the infant is also involved with other programs such as *Early On* or Children's Protective Services, the MIHP provider is encouraged to participate in care coordination meetings facilitated by the other programs in order to reduce duplication of services (not an MIHP reimbursable activity), as described below:

For the infant, MIHP providers are encouraged to participate in local Children's Protective Services (CPS) Interdisciplinary Team meetings, Part C/Early On Interagency Coordinating Council meetings, and in similar efforts to coordinate the infant's care. This assures the use of and coordination with other community resources to avoid duplication of services, identify gaps, and to assure ongoing support when the MIHP case is closed.

(Section 2.6 Care Coordinator, MIHP Chapter, [Medicaid Provider Manual](#))

Making Referrals to Child Protective Services

Monitoring the health and development of the infant is an important aspect of MIHP, and providers are required to observe the infant during every professional visit. When providers see signs of suspected

abuse or neglect, they are obligated by law to make a Child Protective Services (CPS) referral, as stated below:

When appropriate, MIHP referrals to CPS must be made.

(Section 2.6 Care Coordinator, MIHP Chapter, [Medicaid Provider Manual](#))

Because of the serious nature of MIHP cases, some beneficiaries need the assistance of the DHS CPS program. The MIHP provider must work cooperatively and continuously with the local CPS office. Contact persons for MIHP and CPS must be identified. Referral protocol and a working relationship must be developed and maintained. MIHP is a valuable resource for the CPS program. The MIHP provider must seek CPS assistance in a timely manner. MIHP and CPS work concurrently on at least some referred cases. CPS is not to be viewed as a resource of last resort for the agency to call when all else fails.

The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse/neglect to CPS. When and how the MIHP provider must refer can best be determined by discussions with the local CPS agency. MIHP activity does not replace the need for required CPS referrals.

(Section 2.15 Special Arrangements for Child Protective Services, MIHP Chapter, [Medicaid Provider Manual](#))

Information about how to report suspected child abuse or neglect to CPS is available at the Michigan Department of Human Services web site at http://www.michigan.gov/dhs/0,1607,7-124-5452_7119---.00.html. Families that become involved with CPS may become eligible to receive a wide variety of services intended to improve their ability to care for their children, such as parenting classes, counseling, substance abuse treatment, medical services, anger management education, and other services designed to meet the family's specific needs.

The MIHP provider should maintain a relationship with CPS in every county they serve. All MIHP staff must be familiar with the provider's CPS reporting protocol.

Building Trusting Relationships with MIHP Beneficiaries

Research confirms what MIHP providers know from experience: if the beneficiary doesn't trust the home visitor, it's unlikely that she will even continue with MIHP, much less act on the suggestions offered by the home visitor. Some research findings that emphasize the importance of trusting relationships in home visiting programs are given below:

The relationship the new parent has with the home visitor may prove more important than the quality of the curriculum used during home visits.

(Home Visiting Services for Adolescent Parents in Massachusetts, RWJF, July 2008)

Given the importance that mothers place on the development of interpersonal relationships, it is important for home visitors to continually assess the quality of their relationships with clients.

(Jack SM, DiCenso A & Lohfeld L (2005). A theory of maternal engagement with public health nurses and family visitors Journal of Advanced Nursing 49(2) 182-190)

Factors related to greater trust specific to patient-provider relationships in a population of low-income and minority women receiving perinatal care were:

- Effective communication
- Demonstration of caring
- Perceived competence

(Providing Health Care to Low-Income Women: A Matter of Trust, Family practice Vol. 21. No5@Oxford University Press, 2004)

Trusting relationships are the underpinning of MIHP. The beneficiary must trust the professional in order for learning and behavior change to occur. Trust is also the basis of Motivational Interviewing, a key approach in MIHP services.

MIHP provides comprehensive services for pregnant women and infants, drawing upon the expertise of professionals from four different disciplines. This breadth of expertise is a major strength of MIHP. However, it also means that when a beneficiary needs the expertise of more than one discipline, she must develop trusting relationships with two to four different MIHP staff. This poses a challenge, especially in light of the fact that the number of MIHP visits is limited.

MIHP providers are encouraged to do everything possible to promote the development of trusting relationships between MIHP professionals and a given beneficiary. This means limiting, to the greatest possible extent, the number of individuals of the same discipline who visit with the beneficiary. In other words, it is inappropriate for two or more licensed social workers or two or more registered nurses to visit the same woman unless there is no other choice (e.g., the first licensed social worker or registered nurse is ill, is on maternity leave, has changed jobs, etc.). In other words, it is not the intent of this program to send a different professional within a given discipline out on each visit; the intent is to promote same-staff consistency within disciplines so that trusting relationships can be developed.

Elements of Trusting Relationships

Much has been written about the importance of building trusting professional-client relationships in health, education and human services settings. Frequently cited elements of trusting relationships include the following:

- Mutual respect
- Empathy (ability to put oneself in another person's place using effective listening and to convey compassion vs. sympathy)
- Partnership
 - Shared power
 - Shared vision
 - Collaborative goal setting
 - Reciprocal communication
- Support
- Cultural sensitivity

Some professionals seem to be "naturals" at developing trusting relationships. However, educational activities to teach skills that promote trusting relationships are widely available for persons who are not "naturals" or who did not have much coursework in this area in their degree programs. Training on effective listening is paramount, as listening skills are particularly important in general and as a prerequisite to using Motivational Interviewing appropriately.

What Do Women Want from Home Visitors?

Developing a trusting relationship in an office or clinic setting is one thing; developing a trusting relationship in the sanctity of the client's home is another. Minnesota Healthy Beginnings, a universal home visiting program for expectant parents and families with new babies, was funded by the Minnesota Dept. of Health (MDH) from 1999-2003. MDH conducted focus groups to ascertain how Healthy Beginnings clients perceived home visiting. Here are some of the focus group findings, many of which pertain to the home visitor-client relationship:

What women want to know about home visits:

- Who is this person who makes the visits? Will I feel comfortable with her? What expertise does she have?
- Why is it better to have a home visit than to just call my doctor?
- Will it be worth getting dressed for?
- Why am I being called? Invited?
- What do other women who participated say about it?
- What should I expect during the home visit?
- Is it free? Is there a cost?

Why women hesitate to have home visitors:

- Fear of being judged.
- Not wanting to deal with a stranger.
- Feeling like they have to get ready for a visit and not wanting to get ready.
- Feeling like a home visit isn't "part of the package" or typical or normal.
- Feeling that if they get called for a home visit that they did something wrong.
- Not really understanding the purpose of the visit or how they can benefit.

Women want home visitors who:

- Make them feel comfortable.
- Are knowledgeable and experienced.
- Offer options for different ways to do things.

What a home visitor should do to help make women feel comfortable:

- Be down to earth, kind, gentle with the baby, and have a sense of humor.
- Don't expect them to do anything special to prepare (like cleaning).
- Tell them dads and siblings are welcome to participate.
- Offer options for things to do, ways to do things, things to talk about.
- Don't overwhelm them with too much information.
- Don't be judgmental.
- Refer to your own kids at times.
- Don't say you're a mandated reporter unless you have to.
- Don't write stuff down if you don't have to. If you do have to, let women know what you are writing down and why you are writing it down.
- Know when to leave.
- Reassure them. For example, tell them they are doing a good job; that they are a good mother or father; that the baby is doing great; or that they look good.
- Give them your number to call if they need help.

Basic Strategies for Building Trusting Relationships

MIHP professionals must be adept at forming trusting relationships as quickly as possible, given program limitations on the number of allowable visits. The focus group results reported by Minnesota Healthy Beginnings in the section above provide a springboard for formulating basic trust-building strategies, such as the following:

Initial contacts:

Beneficiaries may not be clear about why the home visitor is there and may not feel emotionally safe with the home visitor. Therefore, it's important to:

- Be friendly, relaxed, open, accepting, respectful and genuine.
- Tell the beneficiary about yourself and your experience providing support for pregnant women and infants.
- Clearly explain (repeatedly, if necessary) that MIHP is a benefit of Medicaid health insurance for all pregnant women and infants.
- Clearly explain how you see your role, how you see her role, and how you anticipate working together in partnership.
- Ask her about her expectations of MIHP and if what you have explained about roles and working together sounds acceptable to her.
- Try to identify any concerns or fears she may have related to home visiting and address them.
- Offer to explain the role of the home visitor to other family members if she would like.
- Find common ground and talk about it (e.g., "I had a December baby too," etc.).
- Watch and listen for positive attributes, behaviors, interactions, statements, etc., and comment about them to the beneficiary.
- "Be down to earth, kind, gentle with the baby (if applicable), and have a sense of humor."
- At the end of the visit, ask if she thought the visit went okay, and what you can do so that she is comfortable with you coming back again.

Throughout relationship:

- Be friendly, relaxed, open, accepting, respectful and genuine.
- Find common ground and talk about it (e.g., "I had a December baby too," etc.).
- "Be down to earth, kind, gentle with the baby (if applicable), and have a sense of humor."
- Never miss an opportunity to comment on a positive attribute, behavior, interaction, statement, etc.; one of the most important things you can do is serve as a mirror for the beneficiary's strengths.
- Focus on the beneficiary's strengths as you implement the interventions – keep a running list and refer to her strengths often, especially as you and she talk about the next steps she is going to take (e.g., "You're being so good to your baby by keeping all of your prenatal care appointments, but you said your OB doesn't always explain things; do you want to practice what to say to him if it happens again?") or "I know you're great at holding your baby when you feed her; do you think you can build on this and talk to her as you feed her – just describe what you see her doing or what you see as you look out the window? It doesn't really matter what you say – it's making eye contact with you and hearing your soft, loving voice as she eats that matters at this stage.")
- When the beneficiary says or does something that you think is particularly noteworthy, ask her if you can share that idea or practice with other women in the future.
- Whenever possible, present your suggestions as options with alternatives.
- If you say you're going to do something, do it. Follow through, follow through, follow through.
- If you are truly concerned about something the beneficiary is doing (or not doing) or about some aspect of her current situation, talk with her about it in a direct, but non-accusatory way, using an I message ("I'm concerned that...").
- Refrain from judgment.

- If you are having a hard time refraining from judgment or you are experiencing strong emotional reactions to working with the beneficiary, talk it out with your supervisor or another colleague. In the best of all worlds, all home visitors would have access to ongoing reflective supervision to work through concerns and increase self-awareness about how personal values, beliefs, and emotions affect interactions with clients.

Motivational Interviewing

Ideally, MIHP providers are skilled person/family-centered practitioners (person-centered when the beneficiary is an adult; family-centered when the beneficiary is a child). Person/family-centered practice is different from the traditional helping model in which the expert tells the client what to do and the client complies (or doesn't). In the person/family-centered model, the practitioner and the client operate as partners who work together and learn from each other, with the clear understanding that the client holds the ultimate decision-making power.

Client-centered practice is based on the six principles of partnership: everyone desires respect, everyone deserves to be heard, everyone has strengths, judgments can wait, partners share power, and partnership is a process (Appalachian Family Innovations, www.americanhumane.org/assets/docs/protecting-children/the-six-principles-of.pdf). Client-centered practitioners build strong partnerships, foster mutual respect and honesty, respect the client's culture, build on the client's strengths, promote individualized planning and flexible supports, and build the client's confidence.

Motivation Interviewing (MI) is a client-centered method used by MIHP providers as they talk with beneficiaries about setting and working toward meeting their behavior change goals. The goal of MI is to enhance the beneficiary's motivation to change behavior by helping her to see the difference between her stated goals and her current behavior, and exploring and resolving her ambivalence. This evidence-based approach is fundamentally collaborative and respectful, rather than confrontational and directive.

MI was developed in 1983 by clinical psychologists William R. Miller and Stephen Rollnick, to treat persons with alcohol problems. It has since been used and tested with a broad range of populations including: persons with other addictive behaviors (e.g., drugs and tobacco); persons with dual diagnoses (mental illness/substance abuse); persons with depression, anxiety, eating disorders, and risky sexual behaviors; homeless persons; adolescents treated in the ER for injuries related to carrying weapons, driving while drinking, not wearing seat belts or helmets, etc., and others. Increasingly, MI is being used in health care settings to address health-related lifestyle behaviors and to improve treatment adherence. Encouraging results have been reported on the use of MI with persons with chronic medical illnesses, including diabetes, obesity, hypertension, pain, and cardiovascular disease.

MI requires that practitioners become skilled at using four generic communications strategies. These strategies are as follows:

1. Expressing empathy (important for the client to feel understood and to develop the therapeutic alliance)
2. Supporting self-efficacy (focusing the client's effort to believe that change is possible, which is a significant motivator in being able to create change)
3. Rolling with resistance (not challenging resistance, but assisting client to identify solutions to her identified barriers to change)
4. Developing discrepancy (exploring with the client the difference between her identified goals and her current behavior)

(Excerpted from Harvard Pilgrim Health Care, January 2008)
https://www.harvardpilgrim.org/portal/page?_pageid=253.251590&_dad=portal&_schema=PORTAL

MI is not a "bag of tricks" to get someone to do something they don't want to do. Rather, MI is a "way of being" with people.

Empathy is fundamental in cultivating the MI spirit of collaboration in a health care setting. Empathy is the practitioner's sensitive ability and willingness to understand (and experience) the patient's thoughts, feelings, and struggles from the patient's point of view. Simple phrases, such as "So you are pretty frustrated with trying to lose weight," or "Many of my patients also have difficulty fitting exercise into their lives," can help build solid relationships with patients. Motivational enhancement strategies are less likely to be effective without the foundation of empathy.

The pillars of MI are referred to as OARS, which stands for open-ended questions; affirmations; reflective listening; and summaries. OARS strategies help engender the MI spirit of collaboration and build a solid foundation of practitioner-patient communication. The four OARS strategies are briefly described below:

1. Open-ended Questions

Open-ended questions can't be answered with a "yes" or "no." Rather, they invite patients to tell their stories. Practitioners who use open-ended questions receive less biased data from patients because open-ended questions allow patients to give spontaneous and unguided responses, which helps build rapport and trust. These responses enable practitioners to find out information they otherwise would not have thought to ask about, but that is nevertheless pertinent to the situation. Open ended questions usually begin with the phrase, "Tell me about... (How your exercise plan is going?)" or, "To what extent... (Have you been able to take your medication as we had discussed?)" vs. closed-ended questions, which usually begin with "Did you... (take your medications as prescribed?). Closed-ended questions focus on the practitioner's agenda and thus place the patient in a passive and less engaged role.

2. Affirmations

Statements of appreciation and understanding are important for building and maintaining rapport. Practitioners can affirm patients by acknowledging their efforts to make changes, no matter how large or small. Some examples are, "You took a big step by coming here today"; or, "That is great that you were able to quit smoking for 2 weeks"; or, "You've overcome a lot."

3. Reflective Listening

Reflective listening involves taking a guess at what the patient means and reflecting it back in a short statement. The purpose of reflective listening is to keep the patient thinking and talking about change. Reflective listening can be used (1) to understand the patient's perspectives and convey you are listening; (2) to emphasize the patient's positive statements about changing so she hears her positive statements about changing twice -- once from herself and once from the practitioner; and (3) to diffuse resistance. Several types of reflections are useful; all of these should be crafted as statements rather than as questions, which allows the patient to elaborate on her own ideas.

4. Summaries

A summary is longer than a reflection. Use summaries mid-consultation in order to transition to another topic, or to highlight both sides of the patient's ambivalence. Example: "You have several reasons for wanting to take your asthma medication consistently; you say that your mom will stop nagging you about it and you will be able to play basketball more consistently. On the other hand, you say the medications are a hassle to take, and they taste bad. Is that about right?" Use summaries at the end of the consultation to recap major points.

(Excerpted from Using Motivational Interviewing to Promote Patient Behavior Change and Enhance Health - Medscape Today Online Course <http://www.medscape.com/viewprogram/5757>)

Online MI training is available as follows:

- *Introduction to Motivational Interviewing*, developed by MDCH for MIHP providers at www.michigan.gov/mihp.
- *Using Motivational Interviewing to Promote Patient Behavior Change and Enhance Health* (Medscape Today Online Course approved for 1.2 contact hour(s) of continuing nursing education for RNs and NPs) <http://www.medscape.com/viewprogram/5757>

It is highly recommended that MIHP professionals are equipped with basic counseling skills, especially empathy skills, as these are fundamental to using the Motivational Interviewing approach.

Coaching to Promote Self-Empowerment and Self-Management

Helping the beneficiary learn how to address her own needs, as well as the needs of her infant, is one of the most important objectives of the MIHP. It's crucial that she gains the confidence and necessary skills to function as her own and her infant's "care coordinator," because her MIHP team is only available to assist her for a brief period of time.

To the greatest possible extent, the MIHP team strives to help the beneficiary develop the personal mindset and requisite tools to rely on herself to navigate complex health and human services systems. This includes teaching her how to:

- Seek out and acquire the information and resources she needs for herself and her baby
- Make her own appointments (physician, lab, WIC, etc.)
- Make her own transportation arrangements
- Make a list of the questions she has for her health care provider
- Talk with health care and human services providers without feeling intimidated; keep asking questions until she understands what actions she needs to take, when and how follow-up care will be provided, etc.
- Advocate for developmental screening for her child over time
- Access practical and emotional support
- Access emergency services

Of course, some MIHP beneficiaries are quite comfortable with and skilled at seeking and arranging for their own supports and services. Others, however, may need a great deal of coaching in this area. At the very minimum, all beneficiaries should be given clear information on calling 2-1-1, a multi-lingual, comprehensive information and referral service available 24/7/365 through the United Way (currently serving close to 80% of Michigan's population).

MIHP Intervention Services

The MIHP consists of many interventions in multiple domains designed to educate and inform the beneficiary, both as a pregnant woman and as the parent of an infant. Domains include basic care, violence abuse, substance abuse, social behavior and health history. The Risk Identifiers are designed to determine if there is a high, medium, low or no risk for each domain. Based on the Risk Identifier, and professional observation, the MIHP provider will determine interventions specific to each beneficiary. Refer to the MIHP Operations Guide for more information and interventions related to the domains.

(Section 2.4 Psychosocial and Nutritional Assessment-Risk Identifier, MIHP Chapter, [Medicaid Provider Manual](#))

Interventions by Risk Identifier Domain and Beneficiary Risk Level

MDCH has developed a standardized set of interventions for pregnant beneficiaries and a standardized set of interventions for infant beneficiaries. These are considered to be minimum interventions; providers can do more if they are in a position to do so. Separate interventions are provided for each domain covered in the *Maternal and Infant Risk Identifiers*.

Maternal interventions correspond with the domains covered in the *Maternal Risk Identifier*, which are as follows:

1. Family Planning
2. Prenatal Care
3. Basic Needs: Food/Nutrition
4. Basic Needs: Housing
5. Basic Needs: Transportation
6. Basic Needs: Social Support
7. Smoking
8. Secondhand Smoke Exposure
9. Alcohol
10. Drug Use
11. Stress/Depression and Mental Health
12. Abuse Violence
13. Chronic Disease: Asthma
14. Chronic Disease: Diabetes
15. Chronic Disease: Hypertension
16. Interconception Health

Infant interventions correspond with the domains covered in the *Infant Risk Identifier*, which are as follows:

1. Infant Health
2. Infant Safety
3. Feeding and Nutrition
4. Family Support, Parenting and Child Care
5. General Development
6. Maternal Considerations

The provider matches the intervention level to a particular beneficiary's risk level (no, low, medium, high, emergency) in a given *Risk Identifier* domain. For example, if the *Risk Identifier* indicates that a beneficiary is at high risk for depression, the provider would use the high-risk interventions listed under the Stress/Depression and Mental Health category.

In the *Maternal Risk Identifier*, there are several domains that score out "unknown" if the beneficiary does not answer certain questions. These include specific questions regarding previous poor birth outcomes, alcohol or drug use, abuse/violence, stress/depression/mental health, and prenatal care/family planning. When a domain scores out as "unknown", the provider uses the high-risk interventions for that domain.

MIHP providers are required to use the maternal and infant interventions developed by MDCH. However, it is expected that providers will use professional observation and judgment in implementing these interventions.

The maternal interventions have been incorporated within the *MIHP Maternal Plan of Care, Part 2* forms and infant interventions have been incorporated within the *Infant Plan of Care, Part 2* forms. This was done in order to streamline the *POC* development process. These forms are available at www.michigan.gov/mihp.

The MIHP interventions were derived from evidence-based, promising, and emerging practices identified in the literature; best-practices; and input given by various MIHP stakeholders, including Medicaid. Medicaid policy directly speaks to the following interventions: family planning, child birth education, parenting education, and immunizations, which are discussed below.

Family Planning

Appropriate family planning education and referrals must be made and documented.
(Section 2.6 Care Coordinator, MIHP Chapter, [Medicaid Provider Manual](#))

Family Planning options including Plan First! services and methods of family planning should be discussed at every MIHP maternal visit giving the woman time to consider her options.
(Section 2.7 Professional Visits, MIHP Chapter, [Medicaid Provider Manual](#))

Family planning interventions are crucial in the MIHP, as MDCH places a high priority on assisting women to avoid unintended pregnancies and to space pregnancies at least 18 months apart (short birth intervals are associated with adverse outcomes). Since some MIHP beneficiaries lose their Medicaid coverage by 60 days postpartum, MIHP providers are required to refer them to Plan First! before the expiration of their Medicaid eligibility.

Plan First! provides payment for family planning services, including contraception, for Michigan women 19 through 44 years of age, who are not currently Medicaid eligible, and whose family income is at or below 185% of the federal poverty level. A program description, including a brochure, is available at [Plan First!](#) For more detailed information, go to [Medicaid Provider Manual](#) and click on "Plan First!" in the bookmarks column on the left to get to the Plan First! Chapter.

Family planning should be discussed at every MIHP visit while the beneficiary is pregnant. The literature shows that discussing family planning with a woman during the first trimester and throughout her pregnancy is more effective than waiting until after she delivers. (Reference Guidelines for Prenatal Care, Sixth Edition 2007. American Academy of Pediatrics, American College of Obstetricians and Gynecologists). Once the infant is born, family planning should be discussed, as appropriate.

Childbirth Education Group Classes

Childbirth education is a series of group classes intended to help:

- **Understand the changes in the body during pregnancy;**
- **Understand the delivery process, including information regarding pre-term labor;**
- **Understand the postpartum period;**
- **Care for the infant (classes may include information on developing positive parenting skills);**
- **Interact with other pregnant women; and**

- **Build a support network.**

First-time mothers must be encouraged to complete the course.

The medical care provider or the MIHP provider may make a referral for childbirth education classes. MIHP providers may provide this service directly or have a contract with a local hospital's outpatient clinic. An outpatient hospital clinic that provides this service may bill Medicaid directly for FFS beneficiaries. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

MIHP childbirth education includes, but is not limited to the following topics:

- **Pregnancy,**
- **Labor and delivery,**
- **Infant care and feeding,**
- **Postpartum care, and**
- **Family planning.**

In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition), childbirth education may be provided in the beneficiary's home as a separately billable service. Case records must document the need for one-on-one childbirth education and where services were provided.

(Section 2.11 Childbirth Education, MIHP Chapter, [Medicaid Provider Manual](#))

Required content for MIHP-reimbursable childbirth education classes includes, but is not limited to, the following:

Pregnancy

- Health care during pregnancy
- Physical and emotional changes during pregnancy
- Nutrition

Labor and Delivery

- Signs and symptoms of labor, including information regarding pre-term labor
- Breathing and relaxation exercises
- Analgesia and anesthesia
- Avoiding complications
- Coping skills
- Types of deliveries
- Episiotomy
- Support techniques
- Hospital tour (optional)

Infant Care

- Preparation for breastfeeding
- Infant feeding
- Newborn immunizations
- Infant car seat use
- Newborn attachment

Postpartum

- Postpartum physical and emotional changes, including depression

- Feelings of partner
- Potential stress within the family
- Sexual needs
- Exercise
- Importance of family planning

The provider must encourage every first-time mother to take and complete a childbirth education course. Referrals of first-time mothers to childbirth education must be documented in the beneficiary's record.

Parenting Education Group Classes

Parenting education is intended to develop positive parenting skills and attitudes, provide interaction with other parents, and possibly build a support network. Parenting education may be billed once per infant or, in the case of multiple births, once per family.

The infant's medical care provider or the MIHP provider may make a referral for parenting education classes. The services may be provided by the MIHP provider or by contract with an outpatient hospital or community-based organization. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

Parenting education classes should include but are not limited to:

- **General feeding recommendations throughout the first year of life,**
- **Normal and abnormal patterns of elimination,**
- **Common signs and symptoms of infant illness,**
- **Common childhood injuries and how to care for them,**
- **Normal range of sleep, rest, activity and crying patterns,**
- **General hygiene needs of infants,**
- **Normal developmental milestones of infants throughout the first year,**
- **Basic emotional needs,**
- **Basic protection from toxic hazard waste,**
- **Basic immunizations and health maintenance, and**
- **General day-to-day living with children.**

(Section 2.12 Parenting Education, MIHP Chapter, [Medicaid Provider Manual](#))

Required content for MIHP-reimbursable parenting education classes includes, but is not limited to, the following:

Feeding recommendations throughout the first year of life

- Nutritional requirements
- Developmental issues related to feeding children
- Breast feeding advantages
- Formula preparation and breastfeeding

Normal and abnormal patterns of elimination

- Normal range of elimination patterns and changes throughout childhood
- Toilet training issues and developmental readiness

Common signs and symptoms of infant illness

- Appropriate care for common illness
- Danger signs and when to call the health care provider

- Emergency numbers (i.e., poison control, emergency room, etc.)

Common childhood injuries and how to care for them

- Signs and symptoms to seek medical care
- Basic first aid
- Accident prevention and safety

Normal range of sleep, rest, activity and crying patterns

- How to assist an infant in settling to sleep
- Normal patterns of sleep and activity and developmental changes
- Information on Sudden Infant Death Syndrome (SIDS) and appropriate sleeping position
- Signs and symptoms of over-stimulation and under-stimulation
- How to quiet a crying baby
- How to play with a baby to encourage optimum developmental skills

Hygiene

- Hygiene needs of infants
- Appropriate care of routine problems (e.g., diaper rash, seborrhea, circumcision, etc.)

Normal developmental milestones of infants throughout the first year

- Developmental issues relating to providing care, feeding, and stimulation
- Realistic expectations of infants in relationship to their developmental level

Emotional needs

- Parent-infant interactions and attachment
- Normal changes that occur throughout the first year of life and its impact on the infant-parent interaction
- Discussion and modeling of parenting behaviors that positively impact the emotional well-being of the infant

Protection from toxic hazard waste

- Paint
- Lead
- Water

Immunizations and health maintenance

- Well baby visits
- American Academy of Pediatrics recommended schedule
- Care of the infant after immunization

Day-to-day living with infants and young children

- Appropriate methods for managing activities and stress when living with infants and children
- Secondhand smoking
- Appropriate ways of handling infant behavior

In the past, an MIHP provider could subcontract with a hospital that would provide childbirth or parenting education classes and then MIHP provider would bill Medicaid for reimbursement. This is no longer an option. Hospitals that provide these classes must directly bill Medicaid FFS or the MHP.

Immunizations

Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary (i.e., mother and/or child) immunizations.

The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. Before closing an MIHP case, the provider must have assessed immunization status, provided immunization education, and documented accordingly in the case record.

(Section 2.14 Immunizations, MIHP Chapter, [Medicaid Provider Manual](#))

MIHP providers are expected to ask the beneficiary if her own and her infant's immunizations are up to date. If she does not know, she should be encouraged to find out if she and her infant have all of the immunizations her medical provider recommends.

To see the child and adult immunization schedules recommended by the Centers for Disease Control and Prevention, US Department of Health and Human Services, go to www.michigan.gov/mihp, scroll to MIHP Links, click on *MDCH Immunization Updates*, scroll to Provider Updates, and click on *New 2010 Recommended Childhood Immunization Schedules* and *New 2010 Adult Immunization Schedule*.

Developmental Screening

Developmental screening is an intervention provided for all MIHP infant beneficiaries. The *Ages and Stages Questionnaires-3 (ASQ-3)* are used to monitor and identify issues in general infant development in the communication, gross motor, fine motor, problem-solving, and personal-social domains. The *Ages & Stages Questionnaires: Social/Emotional (ASQ: SE)* are used to monitor and identify issues in infant development in the social-emotional domain.

The *ASQ: SE* focuses deeply and exclusively on children's social and emotional behavior. It was developed at the request of professionals who felt that the *ASQ-2* did not sufficiently address the social-emotional domain. It is intended to help home visiting, early intervention, Early Head Start, Head Start, child welfare agencies, and other early childhood programs accurately screen infants and young children to determine who would benefit from an in-depth evaluation in the area of social-emotional development.

MIHP uses the *ASQ* screening tools to determine if a child should be referred to *Early On* for a comprehensive developmental evaluation. The MIHP provider informs the medical care provider of any potential developmental delays identified through ASQ screening.

The decision to require all MIHP providers to use the same screening tools is based on three reasons: 1) the *ASQ-3* and *ASQ: SE* are reliable, cost-effective, culturally-sensitive, and easy for parents to use (written at 4th - 5th grade reading level); 2) using the same screening tools for all infants is important for MIHP evaluation purposes in the future; and 3) by using these tools, we are helping to build a statewide developmental monitoring system, as more and more early childhood programs and providers are utilizing the *ASQ-3* and *ASQ: SE* as their screening tools of choice.

MIHP providers must purchase the ASQ tools, both of which are available in English and Spanish. Purchasing information is available at the following web sites:

1. *Ages and Stages Questionnaires, 3rd Edition*
Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asq/index.htm>
2. *Ages and Stages Questionnaires: Social-Emotional*
Purchase from Brookes Publishing at <http://www.brookespublishing.com/store/books/squires-asqse/index.htm>

Three training DVDs are available from Brookes Publishing at a cost of @ \$50 each (2010). These DVDs are titled:

1. The Ages and Stages Questionnaires on a Home Visit (20 minutes)
2. ASQ-3 Scoring and Referral (25 minutes)
3. ASQ: SE in Practice (26 minutes)

Jane Squires, who developed the *ASQ-3* and *ASQ: SE*, suggested that MIHP repeat the tools every 4 months (for children under 3 years of age) or every 6 months (for children over 3 years of age). If there is concern, then the tools can be repeated every 2 months.

MIHP developmental screening actually begins at program entry, when the *Infant Risk Identifier* is administered. The *Infant Risk Identifier* includes developmental screening questions from Bright Futures, an initiative of the American Academy of Pediatrics. The timing of follow-up developmental screening using the *ASQ* tools depends on the primary caregiver's responses to the Bright Futures questions, as detailed below:

Positive Bright Futures Screen:

- a. If the infant is less than two months old and at least one Bright Futures "not yet" box is checked, administer the *ASQ-3* in two weeks. (The infant must be at least one month old before it's appropriate to administer the *ASQ-3*.)
- b. If the infant is two months or older and at least two "not yet" boxes are checked, administer the *ASQ-3*. If the infant is at least three months old, also use the *ASQ: SE*. (The infant must be at least three months old before it's appropriate to administer the *ASQ: SE*.)

Based on the *ASQ* scores, do one of the following:

- a. If scores suggest "further assessment with a professional may be needed," refer the infant to *Early On* for a comprehensive developmental evaluation.
- b. If scores suggest "providing learning activities and monitoring," repeat the screenings in **two** months.
- c. If scores suggest infant does not need referral for a comprehensive developmental evaluation or learning activities and monitoring, repeat the screenings in **four** months.

Negative Bright Futures Screen (responses to Bright Futures questions do not indicate need for administration of *ASQ* tools):

If the infant screens negative on Bright Futures, administer the *ASQ-3* and the *ASQ: SE* at the next visit or as soon as the infant is old enough. (The infant must be at least one month old before it's appropriate to administer the *ASQ-3* and at least three months old before it's appropriate to administer the *ASQ: SE*.)

Different *ASQ* questionnaires are provided for infants of different ages (2 months, 4 months, 6 months, etc.). The *ASQ-3 and ASQ: SE Age Administration Charts* at www.michigan.gov/mihp indicate which questionnaire to use with an infant who falls outside of those specific ages. Also, when selecting the questionnaire that matches the child's age, it is necessary to adjust age for prematurity if a child was born more than 3 weeks before his or her due date and is chronologically under 2 years of age. The *Age Administration Charts* explain how to do this.

If the infant is in Early Head Start or another early childhood program that administers the *ASQ-3* and the *ASQ: SE*, you don't need to conduct your own screenings – just obtain copies for the beneficiary record. If the infant has had an *Early On* evaluation, has an Individualized Family Service Plan (IFSP), and the family is participating in *Early On* services, you do not need to continue *ASQ-3* and *ASQ: SE* screenings, but note this in the beneficiary record.

Copies of completed ASQ tools must be kept in the beneficiary record. Copies must be provided to beneficiaries upon request.

Referrals for Mental Health Services

A significant number of MIHP beneficiaries require referrals for mental health services. MIHP providers need current, accurate information about mental health services available from MHPs, Community Mental Health Services Programs (CMHSPs), and other community agencies that serve Medicaid beneficiaries, including pregnant women and mother-infant dyads. MIHP providers are encouraged to meet with MHPs and CMHSPs in their respective service areas to develop relationships and document the referral process to be used by MIHP providers when referring MIHP beneficiaries to MHPs and CMHSPs for mental health assessment and services.

MDCH recognizes that although some communities do have perinatal depression treatment programs and/or support groups, the reality is that it is still difficult for many MIHP beneficiaries with depression to access mental health therapy. MHPs provide up to 20 outpatient visits for beneficiaries with mild to moderate mental illness. However, many women are not enrolled in MHPs until fairly late in their pregnancies and their Medicaid coverage ends about 60 days postpartum. Also, in some areas of the state, it is difficult for MHPs to find mental health therapists who will accept Medicaid. CMHSPs provide services for Medicaid beneficiaries, but only if they have severe mental illness.

The *MIHP Maternal POC, Part 2, Stress/ Depression/Mental Health*, states that if a woman is unable (or not ready) to access mental health services, she should be referred to her medical care provider for a mental health assessment, after which her medical care provider may decide to prescribe antidepressant medication. Mental health issues are widely prevalent in this country and the vast majority of adults with mental health disorders rely on their primary care providers to make a diagnosis and manage their medications. Approximately 1 in 10 adults are treated with an antidepressant annually, and nearly three quarters of antidepressants are prescribed by general medical providers (Mojtabai R. & Olfson M. (2008) National patterns in antidepressant treatment by psychiatrists and general medical providers: Results from the national comorbidity survey replication. *The Journal of Clinical Psychiatry*, 69(7), 1064-1074). Because of the stigma of mental illness, many people will not see a mental health provider, but will discuss mental health concerns with their primary care provider, so this option may be acceptable to some MIHP beneficiaries.

A document titled, *Perinatal Depression Resources for Consumers and Health Care Providers*, is posted on the MIHP web site. The list includes a link to a chart produced by the University of Illinois at Chicago (UIC) Perinatal Mental Health Project which summarizes the research on antidepressants in human pregnancy and breastfeeding. The chart is available at [Information for Clinicians on Antidepressants During Pregnancy \(Medication Chart\) - June 2009](#).

9.0 MIHP QUALITY ASSURANCE

MIHP Provider Certification for Quality Assurance

MDCH MIHP consultants monitor and certify MIHP providers for quality assurance purposes. Provider certification requirements are listed in the [Medicaid Provider Manual](#), MIHP Chapter, Section 5. Providers are required to host onsite certification reviews to demonstrate that their protocols and operations are in compliance with Medicaid policy and the procedures specified in the *MIHP Operations Guide*. However, certification reviews are intended to be quality improvement learning opportunities for the MIHP staff, not just program monitoring sessions.

In conjunction with their monitoring and certification functions, consultants are available to provide consultation to assist new MIHP providers to achieve and maintain certification. MIHP providers are strongly encouraged to make use of the consultation services that are available to them.

There are three types of MIHP provider certification:

1. Provisional certification

When MDCH approves a new provider application, the provider is granted a provisional certification. The provisional certification allows the provider to operate during the start-up phase.

2. Initial certification

MDCH conducts the initial certification review approximately 6 months after a new provider has begun to serve MIHP beneficiaries. Subsequent to the review, the provider receives a report indicating if certification has been denied, approved, or approved pending the submission of a corrective action plan. Initial certification is granted for a period of 18 months.

3. Recertification

Once initial certification status is granted, recertification reviews are scheduled in two, 18-month cycles. This means that each provider has all aspects of their program reviewed every 36 months.

Additional information about provisional and initial certification is provided in Chapter 7 of this *Guide*. [\(link\)](#). Recertification is discussed below.

MIHP Provider Recertification Reviews

Once initial certification status is granted, the MIHP provider must undergo periodic recertification reviews for as long as the provider continues with the program. These reviews are scheduled in two, 18-month cycles, meaning that the provider has all aspects of their program reviewed every 36 months.

Two months prior to the recertification review, the provider receives a letter describing how to prepare for the onsite visit. The provider also receives the *MIHP Certification Tool and the MIHP Certification Tool Index* (both available at www.michigan.gov/mihp), along with the *MIHP Policies for Certification Review and MIHP Certification Review Agenda*. The provider is encouraged to review their program prior to the recertification review visit, so they are as prepared as possible for the onsite review.

During the review, the MDCH MIHP consultant completes the following tasks:

1. Interviews the MIHP coordinator and staff.
2. Examines the provider's written protocols for each policy noted in the *MIHP Certification Tool*.
3. Reviews open and closed charts to make certain that the provider is using the program forms correctly and has proper documentation.
4. Compares selected remittance advice and billing/beneficiary encounter slips or reports to MIHP service documentation.
5. Provides consultation on program issues, as needed.
6. Provides a summary of findings at the end of the review, identifying any corrective actions that need to be taken.

The recertification review process is very similar to the initial certification review process, except that:

- Fewer protocols are reviewed.
- Fewer charts are analyzed.
- Areas that were identified as needing improvement at previous reviews are addressed.

Within 45 days after the review is completed, the provider receives a letter indicating if certification has been denied, approved, or approved pending submission of a corrective action plan. Once MDCH approves the corrective action plan, the provider receives a letter granting certification for 18 months, signifying that all fiscal requirements, policies and protocols are in place.

Reviews may be rescheduled for good cause at the mutual agreement of the MIHP provider and the MIHP consultant. However, if a provider asks to reschedule a review a second time, the consultant discusses the request with the manager of the MDCH Perinatal Health Unit.

Decertification from MIHP could occur for two reasons:

- If an agency has continual out-of-compliance issues that are not being corrected after intense consultation and technical assistance.
- A complaint investigation or certification review reveals serious action or inaction or a pattern of activity that threatens the health, well-being and safety of MIHP beneficiaries.

10.0 MIHP PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING

MIHP is a complex, comprehensive program. In order to promote program fidelity and to keep providers updated on new developments, MDCH offers a range of consultation, technical assistance and training activities. MIHP providers are strongly encouraged to participate in these activities.

MDCH Consultation and Technical Assistance

Consultation and technical assistance activities include the following:

1. Individual Calls or Meetings with MDCH MIHP Consultants

MDCH MIHP consultants are available to respond to providers' individual questions and to assist them with problem solving on an as-needed basis. Consultants make every effort to respond to inquiries as soon as possible and welcome dialogue with providers.

2. Direct Mail and Email Communications

MDCH periodically provides written program updates, policy and procedure clarifications, and resource information to MIHP coordinators via email or direct mail. Email messages are dated and numbered for reference purposes, and are posted on the MIHP web site. When asking an MIHP consultant for clarification on a particular email message, it's helpful if the provider can give the date and number of the message in question, although it is not required.

3. Data Reports

MDCH MIHP staff provide each MIHP provider with quarterly and annual reports based on the *Maternal Risk Identifier* data that the provider has entered into the MIHP electronic database. These reports include totals and percentages for the following indicators:

- ◆ Number of pregnant women with completed screens and partially completed screens

- ◆ Number of pregnant women scoring at each risk level (no, low, moderate, high, unknown) in each domain
- ◆ Race
- ◆ Marital status
- ◆ Grade completed
- ◆ Breastfeeding status
- ◆ Discipline completing screen
- ◆ Name of staff completing screen

The MIHP provider can use the data reports to provide the local community with MIHP data, to write grant applications, and to plan program changes in order to improve the quality of services. MDCH plans to run state-level quarterly and annual reports based on all of the *Risk Identifiers* in the MIHP data base. The data from these reports will be used to evaluate the MIHP and to improve services system-wide.

4. Conference Calls and Webinars

MDCH MIHP consultants may facilitate conference calls or webinars for MIHP coordinators on critical topics, as needed.

5. Face-to-face Coordinator Meetings and Trainings

Statewide face-to-face meetings for coordinators are held at least annually in Lansing. Alternatively, regional face-to-face meetings may be held (usually at four different locations around the state) to save travel time and costs for coordinators and to allow for more interaction among participants. Meetings generally cover program and Medicaid updates, but also may include training components. Comprehensive training is provided at face-to-face meetings when major program changes are initiated. Special meetings are sometimes held with key partners, such as Medicaid Health Plans, to better collaborate in serving our mutual target population. Arrangements are made to allow for participation via conference call whenever possible.

In a few areas of the state, MIHP providers meet together on their own to develop relationships, coordinate referrals, and share mutually beneficial information. MDCH MIHP consultants may participate in these meetings to provide state updates, if invited and time permits.

MDCH Online Trainings

MDCH has developed a series of online trainings for MIHP providers. These trainings are for all MIHP coordinators and all professional staff paid with MIHP funds to work directly with beneficiaries.

Two of the online trainings are required for all staff who conduct professional visits (see *MDCH Maternal-Child Health Online Trainings* grid below), but MIHP providers should strongly encourage their staff to complete the optional trainings, as well. Completion of trainings should be documented in personnel files.

Continuing education contact hours for registered nurses and licensed social workers are available for a few of the MDCH online trainings. Eventually, CE contact hours and MDCH certificates of completion will be sought for all of the trainings.

Links to online trainings are available at www.michigan.gov/mihp under the heading of "MIHP Provider Trainings." The grid below provides information about each training, including: title, length in minutes, whether or not it's required by MDCH, and whether or not nursing CEs, social work CEs, and MDCH certificates of completion are available.

MDCH Maternal-Child Health Online Trainings					
Title	Length in Minutes	Required by MDCH (TBD)	Nursing CEs (TBD)	SW CEs (TBD)	MDCH Cert Completion (TBD)
Asthma in Pregnancy	33				
Diabetes and Pregnancy	35				
Domestic Violence	45				
Early On	15				
Fetal Alcohol Spectrum Disorders	50				
Healthy Homes	40				
Housing/MSHDA	42				
Infant Mental Health	18				
Infant Safety	20				
Interconception Care	37				
Maternal Depression and Stress	47				
Maternal Trauma and Bonding	64				
Motivational Interviewing	234 (6 modules)	Yes (1 st module only)			
Partnering with Medicaid Health Plans	8				
Plan First!	15				
Pregnancy Complications	10				
Safe Sleep*	30-60		.5		
Smoke Free Baby and Me*		Yes			
STIs in Pregnancy	31				
Tobacco	20				

*To access this training, follow these instructions:

- a. <https://learning.mihealth.org/SOLO/login.aspx>
- b. If you are not registered:
 - Click on "First Time User" and complete registration information.
 - Record user name and password for future use.
 - After registering, close the window and log into the system.
 - Click on "GO".
 - Read the Announcement Box, which provides all directions to get to the course.
- c. If you are registered:
 - Enter user name and password
 - Proceed to "My Learning Path" tab
 - Click on course title

Other Trainings Recommended for MIHP Providers

Other trainings that are recommended for MIHP providers are listed on the MIHP web site at www.michigan.gov/mihp. These include WIC trainings that are offered periodically, including *Breastfeeding Basics*.

11.0 RETENTION AND TRANSFER OF MIHP RECORDS

Retention of Records

Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records include fiscal and clinical records. Appointment books and any logs are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes), and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than seven years from the date of service (DOS), regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

(Section 13.1 Record Retention, General Information for Providers Chapter, [Medicaid Provider Manual](#))

Transfer of Care/Records

During the course of care, the beneficiary may require services from a different provider due to a move to another area or otherwise request a change of MIHP providers. When an MIHP provider is aware of a planned change in provider, information about the MIHP provider at the new location should be provided to the beneficiary. The referring provider must consult with the new provider about the case and transfer necessary information or records in compliance with the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. A copy of the completed Risk Identifier, POC, and visit notes must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary.

(Section 2.13 Transfer of Care/Records, MIHP Chapter, [Medicaid Provider Manual](#))

12.0 MIHP PROVIDER TERMINATION PROTOCOL

An MIHP provider who no longer wishes to provide MIHP services is required to submit notice to MDCH at least 30 days before termination. The written notice must include the provider's NPI number. The provider must also submit a plan addressing how and when beneficiaries, MHPs and other MIHP providers will be notified, how beneficiaries will be transferred to other MIHP providers, and how the provider will maintain beneficiary records in keeping with HIPAA requirements. MDCH may make a site visit to observe the termination process and provide consultation on problems that may arise. See *Maternal Infant Health Program Termination Protocol* at www.michigan.gov/mihp for details.

13.0 REPORTING MEDICAID BILLING FRAUD, HIPAA VIOLATIONS, AND QUALITY OF CARE CONCERNS

Reporting Medicaid Billing Fraud and/or Abuse or Suspected HIPAA Violations

The MDCH Medicaid Integrity Program Section, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDCH, contact the Medicaid Integrity Program Section. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Medicaid Integrity Program Section to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

(Section 14.1 MDCH Medicaid Program Integrity Section, General Information for Providers Chapter, [Medicaid Provider Manual](#))

MDCH encourages provider assistance in reducing and reporting provider fraud and abuse in Medicaid and violation of HIPAA Privacy regulations.

(Section 14.2 Post-Payment Review and Fraud/Abuse, General Information for Providers Chapter, [Medicaid Provider Manual](#))

Any provider, employee, or beneficiary who suspects Medicaid billing fraud, patient abuse, or violation of HIPAA privacy regulations is encouraged to contact MDCH. The phone numbers to use for reporting are given at the end of the [Medicaid Provider Manual](#) in the Directory Appendix under, "Fraud, Abuse or Misuse of Services."

For examples of Medicaid fraud or to report suspected Medicaid provider fraud and/or abuse:

MDCH Medicaid Integrity Section (formerly called Program Investigation Section)
866-428-0005 (toll free)
http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-220188--.00.html

Reporting Quality of Care Concerns or Patient Abuse

To report quality of care concerns or suspected HIPAA violations regarding an MIHP provider:

MDCH MIHP Consultant, MDCH Division of Family and Community Health. Consultant contact information is provided in Chapter 1 of this *Guide*. [\(link\)](#) The MDCH MIHP consultant will explore the situation and take action, as indicated.

To report complaints about a licensed healthcare professional (e.g., registered nurse, licensed social worker, etc):

Bureau of Health Services, Allegations Section
517-373-9196
http://www.michigan.gov/mdch/0,1607,7-132-27417_27647---.00.html

14.0 REQUIRED MIHP FORMS

MIHP providers must use standardized forms developed by MDCH. Copies of the forms are located in the MIHP Operations Guide and/or on the MDCH website. (Refer to the Directory Appendix for website information). At a minimum, the data elements included in these forms must be maintained. If additional data elements are needed, it is suggested the agency develop a separate form to accommodate their needs, to be used in addition to the state forms. The goal is to have standardized forms statewide. (Section 4, Forms, MIHP Chapter, [Medicaid Provider Manual](#))

Using MIHP Forms

MIHP providers are required to use standardized forms and protocols which were designed to increase efficiency and promote consistency across the state. All of the required and optional MIHP forms are available on the MIHP web site, along with instructions for completing each form. The forms are provided in Portable Document Format (PDF). They are available at www.michigan.gov/mihp.

General instructions for using the MIHP forms are as follows:

1. Forms are available in PDF form format only. The forms are not to be altered.
2. When you print the forms, they must look exactly like the required and optional forms on the MIHP web site.
3. You can add to the required and optional forms in any non-electronic way (e.g., typing, handwriting, using labels, stamping, etc.).
4. Although you may not add to or change MIHP required or optional forms electronically, you may develop and use your own supplementary forms, or forms developed by others (e.g., you could use the WIC Nutrition Assessment instead of the *Supplemental Maternal Risk Identifier Questions-Optional*).
5. You can use any software package to duplicate the forms, but the forms must look exactly like the required and optional forms on the MIHP web site.
6. All the required forms are available electronically and can be used in your own electronic health records (EHR) system, but a state-level MIHP EHR system is not feasible in the near future.
7. Paper charts are necessary only for reviewers and upon request.
8. Only the MIHP beneficiary brochure and the *Authorization and Consent to Release Protected Health Information* will be available in Spanish and Arabic.
9. There is no standardized demographic sheet (client name, address, phone, FOB's name, etc.), but you can develop your own.
10. We are looking into the need for including Social Security Numbers (SSN) on forms. In the meantime, you may use 999-99-9999 to fill in the SSN box.
11. When a form is revised, the date on the form will be changed. You will be notified via a coordinator email message whenever a form is changed.

General instructions for using the *MIHP Risk Identifier* forms are as follows:

1. The *Risk Identifier* is the assessment form; they are one and the same.
2. MIHP providers must obtain a signed *Authorization* before they can enter any data into the electronic database. If another provider has already done a *Risk Identifier* with a particular beneficiary, do not do another one.
3. After you administer the *Risk Identifier*, you may discuss the *POC, Part 1* during the assessment (initial) visit, if time permits. You must give the Maternal Packet or the Infant Packet to the beneficiary at the assessment visit per Medicaid policy. You may review the packet at subsequent visits, based on the beneficiary's needs.
4. If the beneficiary has an emergency situation, you can assist her to deal with the crisis before doing the *POC, Part 1*.
5. You may do the *Risk Identifiers* online only - you do not need to keep hard copies in the beneficiary charts. Paper charts will only be necessary for reviewers and upon request.
6. You cannot electronically override the computerized assessment results (*Risk Identifier* scores), but you can use your professional judgment, based on observations and information from interviewing the client, to develop the *POC*. This means that if the woman scored moderate-risk in a particular domain, but you determine, based on observation and professional judgment, that she is high-risk in that domain, you would use the high-risk interventions.

The forms are listed below, categorized under the following headings:

MIHP Beneficiary Services Forms
MIHP – MHP Forms
MIHP Provider Application/Initial Certification Forms and Related Communications

MIHP Beneficiary Services Forms

PREGNANT BENEFICIARIES

Maternal Forms Checklist
MIHP M001

Maternal Risk Identifier
MSA-1200

Authorization and Consent to Release Protected Health Information
DCH-1190

Maternal Plan of Care, Part 1, Maternal Packet
MIHP M002

Maternal Packet (list of handouts)

Maternal Plan of Care, Part 2, Interventions By Risk Level
MIHP M003 thru MIHP M018 & MIHP M021

Plan of Care, Part 3, Signature Page for Interventions By Risk Level
MIHP 008

Prenatal Communication/Notification of MIHP Enrollment Cover Letter Form A
MIHP M022 **MIHP M020**

Professional Visit Progress Note(s)
MIHP 011

Prenatal Communication/Notification of Change in Risk Factors Cover Letter Form B
MIHP M022 **MIHP M023**

Maternal Summary for Medical Care Provider/Cover Letter Form C
MIHP M026 **MIHP M025**

Supplemental Maternal Risk Identifier Questions-Optional
MIHP M036

INFANT BENEFICIARIES

Infant Forms Checklist
MIHP I001

Infant Risk Identifier
MIHP I019 **MIHP M024**

Authorization and Consent to Release Protected Health Information
DCH-1190

Infant Plan of Care, Part 1, Infant Packet
MIHP I002

Infant Packet (list of handouts)

Infant Plan of Care, Part 2, Interventions By Risk Level
MIHP I003 thru MIHP I007, MIHP I020 & MIHP I036

Plan of Care, Part 3, Signature Page for Interventions By Risk Level
MIHP 008

Infant Care Communication/Notification of MIHP Enrollment Cover Letter Form A
MIHP I010 **MIHP I009**

Professional Visit Progress Note(s)
MIHP 011

Infant Communication/Notification of Change in Risk Factors Cover Letter Form B
MIHP I010 **MIHP I012**

Infant Discharge Summary for Medical Care Provider/Cover Letter Form C
MIHP I015 **MIHP I014**

Infant Summary
MIHP I019

Nutrition Questionnaire (optional)

MIHP I018

MIHP – MHP Forms

1. MIHP Provider– MHP Care Coordination Agreement
2. MIHP – MHP Collaboration Form

MIHP Provider Application/Initial Certification Forms and Related Communications

1. MIHP Program Personnel Roster
2. MIHP Professional Staff Waiver Requirements
3. MIHP Professional Staff Waiver Application
4. MIHP Certification Tool
5. MIHP Certification Tool Index