

Q & A
MIHP Regional Coordinator Meetings – September 2012

TRANSPORTATION

NOTE: Comments on proposed revisions to the transportation policy that were submitted on index cards at the September regional meetings were forwarded to MSA on 10-01-12.

1. In our area we have no taxi service – no way to transport women when they need it. This new policy will cause many women not to keep their doctor appointments. I thought the goal in MI was healthy pregnancy, delivery and baby. Many women can't afford gas and need the money back quickly to afford their next visit. How long will it take for reimbursement?
2. What is your turn-around time for transportation reimbursement to clients from Medicaid Health Plans?

You would need to obtain this information from each of the MHPs in your service area.

3. Grid for transportation, if it is not supposed to be out for public view – will a grid be available when changes come?

This document has been updated and broken out into two parts – MHP contacts and transportation (two tabs). You should have received it in late January. You need to develop a relationship and rapport with each of the MHPs in your service area in order to efficiently coordinate transportation for Medicaid beneficiaries.

4. Are dental services included under medical care as far as MHP covering transportation to and from appointments? I had a client who was refused transportation to a dental appointment.

Yes, dental services are included.

5. Can you confirm mileage reimbursement effective 10/01/12: 21 cents to client, bill 23 cents?

You can bill a maximum of 23 cents per mile, including an administrative fee equal to 6% of the cost of the transportation.

6. Can MIHP offer mileage reimbursement for moms going to NICU to visit infant?

Yes.

7. Question: For MIHP women enrolled in a MHP who choose not to use their MHP for transportation, they have a car but lack ability to pay for gas, can the MIHP reimburse the woman for all appointments related to her pregnancy (i.e., medical, WIC, education classes)?

All medical/health care transportation services should be arranged by the MHP. If an MIHP beneficiary chooses not to use her MHP transportation services, you cannot reimburse her mileage to medical/health care appointments. However, you can reimburse her mileage to WIC

and education classes (if not covered by the MHP). See MSA Bulletin 12-64, effective January 1, 2013.

8. Are we allowed to pay mileage, bus tickets and taxi to MIHP clients who have a MHP?

All medical/health care transportation services should be arranged by the MHP. However, you are allowed to pay mileage reimbursement or pay for bus tickets or taxi services for travel to other designated services (if not covered by the MHP). See MSA Bulletin 12-64, effective January 1, 2013.

BOTH RISK IDENTIFIERS

1. Error Message 500 – can the time be changed from 5 minutes to 10 minutes? Five minutes can easily go by when you're doing a Risk Identifier and having a conversation with a client. You aren't leaving your desk to so you don't think to "close out" so it then becomes a problem.

This is a data security issue and we are not able to change it.

2. Is there a way to determine if a patient is enrolled in another MIHP other than entering their info on the first page as if they're a new intake?
3. Inquiry to see if a beneficiary is with another provider – when trying to "inquire" via name and DOB, it always says "not found" and if we use MCD ID – unless it is someone we previously had – it doesn't come up. If you go under new screener, that's the only time it will alert you to a beneficiary being enrolled in a different MIHP. What can we do?

At this time the only way to determine if a beneficiary is enrolled in another MIHP is to enter their info on the first page as if they're a new intake. However, we are working with the programmers to see if it's possible to come up with a better way.

4. Will scoring of the depression screening part of the Risk Identifier ever be included in the database, so that at the end of the Risk Screen, we would know the total score for the Edinburgh?

This is not planned. The low, moderate or high risk designation is correlated to the EPDS score.

1. Does the entire Risk Identifier need to be saved in the EMR, or just the scoring results page? Previously we were told to save and import just the RI scoring results page, so that's what we have been doing.

You need to save the entire Risk Identifier in the EMR.

2. There are occasions when the entire Risk Identifier cannot be completed during one visit (others present in same room as visit, mom needs to leave unexpectedly). How do we complete the Risk Identifier (on SSO) if not all info is collected (i.e., abuse/violence, depression, family planning) especially if no further visits are able to be completed?

You cannot bill for an incomplete Risk Identifier. If it takes two visits to complete the Risk Identifier, you can only bill for one Risk Identifier visit. You may not bill for a second visit until you complete the Risk Identifier.

3. When filling out the Risk Identifier, it's confusing to answer the SA questions when client has a medical marijuana card. "Is client taking street drugs or drugs not prescribed by doc?" I think the answer is no. Then later, you are asked about drug use – yes for marijuana. Medical marijuana is very confusing with breastfeeding, etc.

If the client is taking medical marijuana, you are correct in answering "no" to the question "Is the client taking street drugs or drugs not prescribed by the doc?" However, marijuana is a drug and the implications for breastfeeding are the same whether it is prescribed or not, so the breastfeeding interventions would be applicable.

4. Who can enter identifiers? Only RN? Only MSW? Maybe coordinator/advocate?
5. If the SW/RN do the assessment on paper in the home, can our secretary enter the info into the SSO?

Any staff authorized by the coordinator to use the SSO system may enter Risk Identifier data. This includes support staff.

MATERNAL RISK IDENTIFIER

1. New Maternal Risk Identifier: Would like a more accurate way of measuring transportation problems.

Additional transportation questions have been added to the new Maternal Risk Identifier.

2. On revised Maternal Risk Identifier, please include space for MD name, question on if client is enrolled in WIC and who client is living with (alone, with FOB, with family).

The WIC and living situation questions have been added to the new Maternal Risk Identifier. The space for MD name has not been added because of the likelihood that MD name will change.

3. The current domestic violence questions address relationships with serious physical abuse. It would be good to have questions that address power and control issues because current questions send the message that you're not in a DV relationships unless you're being physically abused.

There are questions that address power and control in the new Maternal Risk Identifier.

4. When doing the Maternal Risk Identifier, is it better to have the FOB in the room? We want to include him if he comes, but staff feel uncomfortable with the questions which put the client at more risk. Ask the FOB to leave the room or ask sensitive questions in front of him?

You need to determine this based on your assessment of the particular situation.

5. In the abuse/violence domain, all interventions are tailored to DV/IPV, but women are flagged as moderate/high risks if there is abuse from a family member, fights at school, attack by a stranger, etc. Suggestion to address in new Maternal Risk ID.

The algorithm was fixed and the new Maternal Risk Identifier does include questions about abuse by the woman's partner or other persons. Once the new Maternal Risk Identifier is operational, the interventions will be modified to match it.

INFANT RISK IDENTIFIER

1. Is there any way possible to update the Infant Risk Identifier so there is an umbrella to only enter the infant demographic info once and to combine it into one database, rather than two?
2. Would it be possible to make a change in SSO for the Infant Risk Identifier for data that is answered on both forms – i.e., mom's age @ delivery can prefill on the other identifier?

We will look into this.

3. The SSN error in the infant component of the Infant Risk Identifier: When you click "ok" to acknowledge the error message, it takes you back to the maternal component screen of the Infant Risk Identifier.

This has been fixed.

4. When entering the Infant Risk Identifier (maternal portion), I cannot/didn't receive a scoring. When I tried to enter the Infant's portion, I received a message stating that there is another infant with the same ID#. There are major problems with the Infant Identifier.

This has been fixed.

5. Some suggestions for the Infant Risk Identifier:

- Instead of a delete function, have the client deleted out when you use the cancel button (just like the maternal screener).

We don't understand this statement.

- Make both infant and maternal components one screener to avoid entering the info twice.

IT has informed us that the components must be separate.

- Make it easier to switch from the IRI to the MRI without having to exit the application and start all over.

As IT redesigns the Maternal Risk Identifier, this will be addressed.

- We have gotten a couple of errors, once one component has been entered. Both errors cite Medicaid ID#s either "match another beneficiary" or "does not match the infant entered." This prevents us from completing both components. Please explain this.

This has been fixed.

- Thank you for creating the direct links to the pages with errors on the IRI.

6. Multiple births: Could there be a button on the Infant Risk Identifier that would indicate multiple births, so that the maternal component would be prepopulated and only entered into the system once?

Good suggestion. We will look into this.

7. I completed infant component of the IRI and saved + exit before I printed the score result sheet. I tried to re-enter to print it, and couldn't. I tried going through inquiry + deleted+ non-complete – stated “no record found.” Tried to go through new screen – message came up w/already been entered.

This has been fixed.

8. Domestic Violence scored “high” for no reason. It only happens once in a while, not on a consistent basis.

This has been fixed.

9. Repeat questions that don't automatically fill in (married, age, etc.).

We are looking into this.

10. Question that asks “How many children?” Does this include the infant? If so, how to report his/her age?

Count the number of children born.

11. “Age first received formula” ___ months? If at birth?

Enter “0” months if the infant first received formula at birth.

12. “How often does baby eat?” Should answer be how many times?

We don't think this distinction is significant enough to justify re-programming.

13. WIC question is out of order.

We don't understand this question.

14. Infant screener allows you to submit more than once, and once you to delete it, it says, “Are you sure you want to delete tot record?”

We don't understand this question.

15. Is there a reason that on the maternal section of the Infant Screener, under mental health/depression, it asks about hx of depression, bipolar, but does not ask about history of anxiety, like the Prenatal Screener does?

The Infant Risk Identifier- Maternal Component does ask about a history of anxiety.

16. For infants in foster care, do we have to complete the maternal component of the Risk Identifier?
17. Please clarify how to enter an Infant Risk Identifier maternal component when father has custody or if child is in foster care.

This has been fixed.

18. Please investigate the algorithm for Abuse/Violence in the new Infant Risk Identifier. We have an example of one that the abuse was in the past and she answered “no” to question “are you afraid of your partner or anyone you listed above?” Yet, she scored “high” in abuse/violence.

This has been fixed.

19. The format of the newest Infant Risk Identifier is difficult to follow. Many of the questions could be overlooked. There are no lines for the responses.

The electronic Infant Risk Identifier is being modified to make it more user-friendly. If you have questions about it, watch the forms webcast or contact your state consultant.

20. Take SSN off Maternal Risk Identifiers. We don't need it.

This is an optional field; you are not required to enter the SSN. Medicaid does not want this field to be deleted.

21. How do you enter screener for twins, guardian, etc.?

You would enter two separate Infant Risk Identifiers for twins. The Infant Risk Identifier – Maternal Component will have a checkbox so that a guardian will only complete the fields that apply.

22. What to do about a drug-exposed infant whose mother answers no about drug questions?

Use the interventions that are most appropriate (positive at birth, primary caregiver use, or environmental). If the mother does not admit exposure, she is likely in the pre-contemplation stage.

23. Are you doing anything to prevent pregnancy? “Yes” and “No” are options. Have option: “I am not having sex.”

“Not having sex” falls under the “No” option, which is fine for our purposes.

24. How soon after D/C from hospital (not NICU)?

We do not understand this question.

DISCHARGE SUMMARY

1. In regards to completing the initial risk identifier – after a summary is generated and a domain isn't identified as a risk but we still pull a plan of care – do we identify it as initial on the Discharge Summary even if it didn't score out?

No. Only the risks that score out on the Risk Identifier should be indicated as initial risks on the Discharge Summary. If you identify another risk on the same day that Risk Identifier was administered, it should be indicated as a highest interim risk on the Discharge Summary.

2. The purpose of the Highest Interim Risk is uncertain. What difference does it make to identify this? Providers will not understand or care about this. The note could be made in comments section.

The purpose is to capture information about additional risks and risk level changes during the service delivery period (e.g., housing was stable at intake, then the beneficiary became homeless, then she found stable housing again).

3. Can we change the risk level (on the progress note) after the first visit to match the highest interim risk on the Discharge Summary?

You would not do this in order to match the Discharge Summary. When there's a change in risk level, it should be noted on the POC 2 along with the date of the change. The risk level change must be based on the criteria in Column 2 of the POC 2.

4. Do we have to enter previous infant Risk Identifier in order to generate an online Infant D/C Summary? If we chose not to (it is time consuming because all the bugs are not worked out), is the paper form acceptable?

If there's a Risk Identifier for the beneficiary in the SSO system, you must use the electronic Discharge Summary. If not, you must use the paper version.

5. Idea for Discharge Summaries: Make form with a list of numbers for each POC. Then make it possible to check off interventions as completed (per PVN) as you go.

This is already incorporated in the electronic version, but not in the paper version. You may create a cheat sheet for the paper version if you would like to do so.

6. On the D/C Summary, is the chronic disease CP supposed to automatically come up low, even if there is no risk?

Correct.

7. On the D/C Summary, the asthma CP does not have a low domain (just moderate, high and emergency) and there is not a high domain on the actual care plan.

This was an error on the paper form, and it has been corrected.

8. Do you plan to capture local agency ID risk factors (from state domains) that are not captured on Maternal/Infant Risk Identifiers, especially in relation to D/C Summaries being populated?

Yes, as soon as we are able.

9. It would be helpful if the date ID could be populated on the D/C Summary when ID on.

We don't understand this question.

10. Please take the social security number of the printed version of Discharge Summaries.

This is an optional field; you are not required to enter the SSN. Medicaid does not want this field to be deleted.

11. When you print the Maternal or Infant Discharge Summary it is very small print, hard to read, and prints many pages.

12. M200 Discharge Form on web site is different format than the SSO form. Can the form please be consistent so staff do not have to enter the data twice?

13. What to send to doctor as the current D/C form is not a clean copy?

14. Regarding Discharge Summaries to providers when printed from online SSO – can we send only the last sheet, which is a summary? Complete Summary is way too much paper.

No, you must send the entire Discharge Summary to the medical care provider. You may send a copy of the 2-page paper Discharge Summary or print out and send the entire electronic Discharge Summary. Some agencies have found it helpful to complete it online first, and then transfer the applicable info to the 2-page paper form. While this does require double entry, it makes it easier for physicians to read and understand the Discharge Summary. We have submitted a service request to change the font and format of the electronic Discharge Summary printout, so it is less unwieldy and more reflective of the paper version.

15. For Maternal Discharge Summary, may need to have unknown put in some electronic screeners let contact person know.

We don't understand this statement.

16. Suggest extending completion of Maternal Discharge Summary to 90 days due to putting in gestational age and birth weight at DOB. Otherwise, you have to keep the info somewhere else – i.e., duplicate paperwork.

We suggest that you don't start entering the data until you are ready to complete the Discharge Summary.

17. If a client drops out of MIHP, we are told to complete a D/C Summary. If we are not sure of the birth outcome, there is not an “unknown” option and we cannot move on to next section. Do we click “other?”

Yes, click “other” and write “unknown” or “lost to care” or other explanation of why you do not know the birth outcome.

COMMUNICATIONS WITH MEDICAL CARE PROVIDER

1. Does the form need to be sent to Provider every time a new Care Plan is added?

Yes.

2. It would be nice if the MIHP notification letter to the beneficiary’s provider had a space to note updates or changes instead of completing a whole new letter and summary. Would save time!!

Sorry.

3. Where should Maternal Considerations be documented on the letter to the provider for Infant (housing, depression, etc.)? There is no specific area identified.

In the box titled “Family, Living Arrangement, Language and Environmental Considerations.”

POC2

1. The outcomes for POC2 for Fdg and Nutrition could be elaborated. The only two are: Discuss breastfeeding and refer to WIC. These two things alone will not necessarily reduce the initial risk. Most moms by the time Risk ID is completed are already breastfeeding or not and too late to ___ at two weeks postpartum.

POC 2 interventions are being retooled in conjunction with modifications to the Maternal Risk Identifier. The POC 2breastfeeding interventions are available now.

2. Need POC2’s for Breastfeeding, Language Barrier, and Cognitive Impairment. It would be nice to add some additional qualifiers under the Infant Fdg/Nutrition POC2: slow weight gain, reflux, lack of knowledge related to infant fdg, early (< 6 months) intro of solids (not in bottle!)

- *The POC 2 breastfeeding interventions have been completed and will be available in the future.*
- *Providers must specify how they will address language barriers in their protocol on “Accommodations for Limited English Proficient, Deaf and Hard of Hearing, and Blind and Visually Impaired Persons” in keeping with the federal Limited English Proficiency mandate.*
- *We have posted some resources on working with parents with cognitive limitations on the MIHP web site.*
- **We will take these suggestions for nutrition under considerations for future POC2s.**

3. When working on the Infant POC2 Nutrition, or Maternal POC2 Food, it says “Referred to WIC” but what do I do if she is already on WIC? Technically, I didn’t refer her, but it seems incomplete to leave it blank.

Document that beneficiary is already in WIC on a progress note.

4. Do we pull an environment substance exposure CP for medical marijuana (father, not mother)?

Yes.

5. Drug exposed interventions do not apply for suboxone/methadone positive babies because it is considered a treatment.

Although suboxone and methadone are prescribed for treatment purposes, they are still drugs that have implications for the infant, and the substance exposed infant interventions are applicable, at least in part, depending on the situation (positive at birth, caregiver using, environmental exposure).

6. Why can’t we start drug exposed POC @ first 9 visits? Most of the time we lose mom/baby before the 9 are complete. We are waiting too long.

You absolutely can start using the substance-exposed infant interventions for the first 9 visits, which means that you will also use the substance-exposed infant Professional Visit Progress Note. However, you cannot start using the substance-exposed infant billing code until after you have completed the first 18 infant visits.

7. We need a POC for foster parents.

*Stay tuned. **The Infant** Risk Identifier is being revised. Further direction will be provided once it is operational.*

8. If the Infant Risk Identifier is done and the scoring results come out as “no risk” for Health, but “moderate or high risk” for Birth Health, do we pull POC2 Infant health or not? Bay Co HD.

No, do not pull a POC 2 domain if there are no health risks. There is no POC 2 domain for birth health.

9. Not all interventions are applicable to every client (i.e., referral for mental health or applied for Plan First).

Correct.

10. POC2 - Family Planning, “check off” items in right column, first one is “method identified.” Often women do not decide on a method until after post-partum. Consider other items such as “received information on methods available.”

Just check off the boxes as applicable.

11. What does the date under the domain on the new POC's represent?

It is to document the date that there was a change in risk level.

12. How do you add an additional domain (update) at time of closure?

You would do this during the course of service delivery, not at the time of closure.

CONSENT

1. How do we have consent to share maternal considerations information with the pediatrician on the Infant Discharge Summary?

You are not required to share maternal considerations with the pediatrician, but if you do, the pediatrician's name must be listed on the Consent to Release PHI. The pediatrician can be listed in section on mother's health information that may be released or, if the case is opened after the birth of the infant, in the section on infant's health information that may be released.

2. If the beneficiary declines to release her protected health info, how can the info from the MIHP Risk Identifier be entered into SSO?

When she signs the Consent to Participate in the Risk Identifier/Consent to Participate in MIHP, the beneficiary is authorizing data entry into the SSO system because SSO is part of MDCH. It is not a separate entity that would require a signed Consent to Release Protected Health Information form.

3. When a client is transferring to another provider, is it sufficient to have the agency that is to release the information (the record) be listed on the Release of Information or does the transfer of Record need to be signed/sent as well?

It must be signed and sent and sent as well.

4. Do we need to copy consent forms for transfers? New agency gets new consent, but date will not be consistent with opening if not sent with transfer.

No.

5. If you're giving the Health Plans access to MIHP PHI, do you have to change the consent form? Does it say we share info with Health Plans? Do we have to write it in?

No. You do not need a signed Consent to Release PHI in order to communicate with MHPs. MDCH legal counsel has informed us that this is covered under HIPAA.

6. Regarding Maternal Risk Identifier, if woman initially declines and signs consents to decline, she then changes her mind, can she sign same consent with new date to enroll in program?

Use a new consent form in this situation.

INFANT ELIGIBILITY FOR MIHP

1. Our agency had a transfer from another county on a 22-month old. Are we normally able to provide services this old?
2. Is it ok to enroll an 18-month old for Infant Services if there are moderate or high risks? On the screen there is not a Bright Futures for this age.

MIHP is designed for pregnant women and infants up to one year of age. Occasionally services are provided slightly older children with the intent of transfer to a more age-appropriate program. The Infant Risk Identifier and interventions are not geared to the developmental needs of toddlers.

3. Does a baby on MICHild qualify for MIHP?

No, an infant on MICHild does not qualify for MIHP at this time. A pregnant teenager would apply for Healthy Kids.

REQUESTS FOR TRAINING AND SUPPORT

1. It would be very helpful and appreciated if a notice could be sent out to coordinators when updates or changes are posted on the MIHP web site (webinars, new forms, MIHP brochure, etc.). It is frustrating to have to “come upon it.” Notice by email is likely the easiest for all. Notifications need to be made when changes are made to pamphlets, forms, etc.!!

We do our best to notify you of changes via coordinator emails. Coordinator emails are sent when there are several updates to report. Contact your consultant if you have any questions.

2. Please consider setting up some type of list-serve for MIHP coordinators. It would be great to have a mechanism for coordinators to share tools that help our program/staff to meet fidelity expectations.

This is a good idea, but we don't have the staff capacity to manage a list-serve at this time.

3. Offer opportunities for “field” workers to review/critique/give input into updated forms and audit tools prior to release of utilization.
4. Before moving forward with next steps, get feedback from providers.

We do our best to solicit and use input from you when major changes are in the works. For example, we recently facilitated six different conference calls to get your input on the revision of the Maternal Risk Identifier.

5. Can changes in forms, processes, IT, etc. be cycled in groups rather than changed throughout the year? For example, changes 1-5 are all implemented Oct. 1 of Year One. Then the next group of changes (6-10) are implemented Oct. 1 of Year Two.

We do try to bundle changes together. Changes in forms were made in May 2010, Jan 2011, and Oct 2012. Additional changes are projected to be made in late 2013.

6. Please consider - as an end user - that as we move toward evidence-based practice, that we don't just add and add but rather look at what we have, delete when appropriate, and add when needed.

We do our best to add and delete as appropriate.

7. Please offer instructions and/or guidance on completing the MIHP Consent and Consent to Release Protected PHI that were released many months ago!
8. Please provide detailed instructions on how to complete the Release of Information form.

Detailed instructions will be developed and posted on the MIHP web site when Joni has time to get to it.

9. More examples of staff-to-client ratio would be helpful (visits weekly, 2x/month, and monthly).

We will discuss this at our March 2013 regional meetings.

10. There should be some training on scope of practice so it is better understood which domains/interventions are to be provided by which discipline. Ex: Can RD and SW document on Family Planning?

We will take this under consideration.

11. I consistently have to ask for my program's quarterly reports. Can a mass email be sent out to coordinators when quarterly reports are sent? The only way I know they are available is from other coordinators.

Quarterly reports are sent in January, April, July, and October. Contact your consultant if you do not receive your report by the end of these months.

12. WHO growth charts – can we get these for use in MIHP?

These are available online.

13. Is there any possible way the list of MIHP providers can be broken down by county? This would be extremely helpful when looking for a provider if a client needs to transfer.

The MIHP Coordinator Directory is now an Excel spreadsheet, which allows you to sort by county. The Directory is sent to you in a Coordinator email. It is updated frequently, so be sure to use the most recent version. Please note that the Coordinator Directory on the web site is in PDF format, so the sort function doesn't work.

14. MDCH/MSU staff should do data collection, not frontline staff or providers.

This is not feasible. It would be too time-consuming and costly.

15. Please make sure MIHP is up to date on Medicaid changes. I have heard several times today that “they” (Medicaid) forgot to send info to MIHP providers.

MIHP providers are getting communications from Medicaid on new policies or policy clarifications that affect MIHP.

16. Did not like location of conference. Hard to find. Bathrooms not nice, toilets not flushing, cold water. No Wi-Fi.

MOMS PROGRAM

1. Will Medicaid pay for MOMS clients to participate in MIHP?

Yes.

2. Postpartum visit for women on MOMS?
3. When did MOMS start allowing MIHP to bill postpartum? This wasn't always the case and I would like to know when it changed.

Women in the MOMS program have medical coverage until 60 days postpartum. They can only participate in the MIHP program for prenatal care. Postpartum care is limited to medically necessary ambulatory services only. See Medicaid Provider Manual, MOMS Chapter, Section 2.1. This is a clarification from the training sessions.

REIMBURSEMENT

1. Professional visits need to be reimbursed at a higher amount, especially infant visits. They are very time-consuming and costly for gas to travel to home.

The rates for MIHP are actually higher than other provider rates, and have not been subject to rate decreases as the other providers have experienced.

2. Please consider the pay for an RN in MIHP. It is insulting that my clerk makes just about the same as I do. Does your education not count for anything? We too have a huge turnover rate because you can't keep RNs for the amount you are paying them.
3. The RN rate should be increased or allow LPNs to do visits.

Each MIHP provider determines how much they will pay their professional staff. MDCH does not determine salaries. MDCH reimburses MIHP providers on a fee-for-service basis.

4. Please make discharges billable, for example (administrative fee) \$20 - \$25.

The rates for MIHP are actually higher than other provider rates, and have not been subject to rate decreases as the other providers have experienced.

5. Transportation rate is unacceptable.

The mileage reimbursement rate is determined by the IRS.

6. This program services a population of low-income people who have limited resources of transportation. Can we please consider reinstating \$21.31 per transportation?

The transportation policy follows IRS regulations. We are unable to change the rates at this time.

7. If we (Spectrum Health) provide MIHP services to a client of another MIHP program, can we bill for that service? We have an MIHP SW stationed in a high-risk OB office in Grand Rapids. She recently saw a client of a rural county MIHP at this office. She collaborated with that MIHP and helped to improve communication between the physician and the MIHP and helped the client better understand caring for her gestational diabetes. In this case, we reviewed the POC with the MIHP provider before seeing the patient.

Through a contractual agreement with another MIHP, you can work out an arrangement to serve the same client in certain situations. Please see the Maternal-Only Program Guidelines.

8. Community vs. office visit: visit at a satellite office (adolescent health clinic) 5 miles and 8 miles from the main office. Should this be billed as an office or community visit?

MIHP Operations Guide (pg. 26) states that 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: This statement is in error in the Operations Guide; it should read "where four or more beneficiaries are invited/scheduled to be seen on a given day." The error will be corrected.*

On pg. 27, the Operations Guide states:

If you see four women on the same day at the same restaurant, DHS, school, etc., you would bill for four office visits.

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.

DOCUMENTATION QUESTIONS RESULTING FROM FIDELITY REVIEW RESULTS/REPORTS

1. Fidelity Report – where do you document:

- Reasons for infrequency of visits, such as unable to contact?
- Reasons for judgment on who visits (i.e., does not respond to RN calls, etc.) that are currently on our communication log?

This information is not requested for the fidelity review. However, if you choose to, you may document this information on a Professional Visit Progress Note.

2. Based on feedback, most of documentation is limited to check boxes; difficult to gauge what is truly going on.

Documentation includes check boxes, narrative on ‘the mother/caregiver’s reaction to interventions provided’, narrative under “other visit information”, narrative under “outcome of previous referrals” and narrative under “plan for next visit.”

3. How does a provider document a success? For example: When Risk Identifier is completed, beneficiary is couch-hopping and has a moderate or high housing risk. Two months later, she finds safe, affordable house and has a plan in place to stay in housing (employed, can afford rent/utilities). It is important to document this under Domain on visit note but what is the level now and what is the intervention?

On the Professional Visit Progress Note, you would check the box that reflects the risk level on the POC 2, and under “mother/caregiver’s reaction to intervention provided”, you would note something like: “Mother said she is happy to have safe and reliable housing again.” This success is also documented on the Discharge Summary. In addition, for some domains (e.g., housing), there’s an expected output box on the POC 2 that you would check off to reflect a positive change in the client’s situation (e.g., has consistent, reliable housing).

4. What if the client has moderate risk for depression and is already seeing a therapist. Should we still address this on the second visit?

Yes. Encourage her to continue to address her issues with her therapist. MIHP is a care coordination model, a critical element of which is to support the client to follow-through with treatment.

5. % of depression addressed at first visit – if client has a more pressing issue (i.e., eviction), even if sent SW out to address need, must we always address depression if scores out as moderate or high at first visit with client no matter what?

If the client is in an emergency situation such as imminent eviction, it’s appropriate to address the emergency first. Be sure to document the reason why you did not address depression at the first visit. As you know, it is likely that her depression will make it difficult for the client to take action to reduce the other risks that have been documented in her POC.

(NOTE: In the New Certification Tool for Cycle IV, #33 e. will state “At least 80% of charts reviewed indicate that all domains that scored out as high risk are discussed with beneficiary within the first three visits, unless there is clear documentation stating the reason why this has not been done.” This is a new requirement being implemented in Cycle IV.

I am OK with this

MHPs

1. Is MIHP going back into the MHP's capitated rate structure? When this occurred in the past, the MHPs tried to further "micro-manage" an already capitated program and it was an administrative nightmare. It is also a concern for local health departments who received MA cost-based reimbursement, as we cannot get this when clients are enrolled in a health plan.

There are no plans to change MIHP's status as a FFS program, as far as we know.

2. Some health plans are issuing cards with a different number than their mcaid ID# (has added digits at the beginning). I found this with McLaren MHP.

Check CHAMPS for Medicaid ID verification, not the individual beneficiary's mihealth card.

3. UPHP wants to pilot access to MIHP quarterly data in addition to plan of allowing Health Plans view-only access to Risk Identifiers.

There is no plan at this time for HPs to view MIHP quarterly data. At this point the only way to access quarterly data is to get it from the individual MIHPs.

NICU FOLLOW-UP HOME VISITING

1. I think the CSHCS/MIHP interventions are great! I am so glad that you are thinking outside the box. My question to you is with having a nurse be required to do these visits – are we not allowing the richness of the multi-disciplinary interventions/teamwork that could aid these families greatly? Please don't limit these effects.

The decision to allow nurses only to provide NICU Follow-Up home visits was made by upper-level MDCH administrators in the early stages of development of this initiative and it does not appear likely that this decision will be reversed.

2. We have some babies born in South Bend Memorial (Indiana). Who is tracking out-of-state sites?

The mechanism for coordinating with out-of-state hospitals that deliver Michigan infants has not yet been developed.

3. Will NICU follow-up be provided to non-Medicaid clients?

Yes. The payment mechanism for NICU follow-up with non-Medicaid infants is still in development.

OTHER

1. How do we get feedback after initiating a remedy ticket problem (as an MIHP agency)?

Remedy tickets can only be submitted by consultant.

2. I have a concern with agency's NPI being published.

NPI numbers are in the public domain, which means that they are available to anyone.

3. Two quarterly reports due to two NPI #'s. How do we correct this at local level?

All MIHP activities should be under one NPI number. Contact your consultant and she will work with the state IT team to move all of your data under the NPI number that you choose for MIHP purposes.

4. On POC1, what does it mean to check off "text4baby?" Does it mean the client or MOB signed up for it during the visit, or does it mean we gave her info about how to receive "text4baby?"

At a minimum, it means that you gave the client information on how to sign up for text4baby. Our preference is that you actually assist her to sign up during the visit.

5. Is it possible to update the SSO system to reflect MIHP transferred patients? I've had requests for transfers because I'm listed as the patient's MIHP. However, the patient has already been transferred to another MIHP.

No, because at this time only intake and discharge data is collected through the SSO system, which are static moments in time.

6. Do we need to get re-approval for using incentives yearly? Do we need to get new approval if the incentive method changed?

Annual re-approval of the same incentive plan is not required. However, prior approval is required if you intend to change your incentive plan. Your consultant will review your new plan and determine whether or not it is approved.

7. CPS told us if we are aware that someone in the home has a CSC charge, it is mandated to be reported. Do you recommend viewing the state registry for FOBs? We may not know all in the home or an FOB may have a charge not related to a child.

The key words are you aware. It is not required by MIHP that the state registry be checked for all FOBs. If there is a concern, please check it or if you are informed by someone in the household or close to them, follow up. Deb, does this sound OK?

8. Home visit barriers: Client absolutely declines home visits – she lives with parent who told her no one can come to her house. We document this, but ___ client mentioned about chose to stop the program. She didn't want to hear any more about a home visit. Barrier?

If the client declines home visits, document this in her file. You do not need to continually ask her about this. Policy requires that efforts must be made to make at least two home visits during pregnancy and that 80% of infant visits must be in the home.

9. Does Medicaid foster care policy outline the mental health assessment required by the state as part of the physical?

The policy has not yet been released for distribution, but our understanding at this time is that the primary care physician is responsible for conducting a behavioral health assessment with children in foster care, using a validated and normed screening instrument.

10. Ingham Co HD has EHR. Interested.

The data interface project is in the pilot phase with three LHD Insight users. MIHP agencies will be informed when others may participate in this effort.

11. The world changes life – evidence-base – nothing stays the same. The companies need to realize life is changes. Always be prepared for changes. So thanks you guys - Joni, Rose Mary, Ingrid - for your hard work.

12. We've elected a stupid president in the past! They keep putting food out and that's mean.