05-29-14 (3)
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MIHP Coordinator Meetings, March 2014
Q&A

Risk Identifiers

1. On the infant assessment, could there be an "I don't know" answer to the questions "When do you plan to start solids with your infant?" and "When do you plan to first take your baby to the dentist?" More often than not with a brand new first time mother, they have no idea when is an appropriate time for this, and it seems more useful to know that they are unaware of these timeframes.
   MDCH is currently working on enhancing the Infant Risk Identifier and we will take your suggestion under consideration.

2. When are the depression questions going to be fixed on the RI?
3. The paper MRI question answer (selections) don't match the electronic SSO:

   a. Alcohol – first question
   b. Depression – second and fourth questions
   c. Depression follow-up – second question

   The paper MRI has been fixed and is posted on the web site.

4. Are you going to bring back the asterisks on the Risk Identifier? We loved the asterisks (*).
   No. Asterisks were utilized prior to development of the electronic Risk Identifiers. They are no longer needed because you receive a score sheet identifying each beneficiary's risks.

5. Please add page #s to the Infant RI.
   MDCH is currently working on enhancing the Infant Risk Identifier and we will take your suggestion under consideration.

6. Does Medicaid ID number need to be on every page front and back?
   This is required on Professional Visit Progress Notes, but not on Risk Identifiers.

Plans of Care

1. When charting on a client who was opened to service prior to Oct 1, 2013 – but who continues to receive services, should the original care plans be used or should staff switch to the new care plans?
   You can use the original care plans.

2. When should the substance exposed infant care plans be added to the chart in cases where the risk is known form the initial assessment…at the opening or once you reach the 19th visit and start to bill for substance exposed infant visits?

You have the option of using the SEI plans of care and progress notes before or after the 19th visit. However, you cannot bill the SEI procedure code until after the 19th visit. Whenever you use the SEI plans of care, you must use the SEI progress notes.

3. New POC 1 example in packet has new 39 weeks info but still says revised 10/1/13.
   The revised POC 1 will be rolled out in the summer with the other revised forms and it will be dated at that time.

4. Can you add labor and delivery to the POC 1?
   Labor and delivery would be discussed under the POC 1 Pregnancy Health Domain, which covers: benefits of OB care to mother and fetus; recommended frequency of prenatal visits; what to expect during pregnancy; and danger signs of pregnancy complications and how to access emergency medical assistance.

Progress Note

1. Add to progress note: EDC/delivery date to help with knowing which code to bill.
2. Is there any chance a check off for the trimester could be added to the progress note to facilitate using the correct ICD-10 code?
3. Once ICD-10 comes into place, can the progress notes be updated with:
   Trimester #1 __ #2__ #3__ check-off?
4. With the code change, can the progress note reflect which trimester the pregnant woman is in?
5. ICD-10-CM will ask which trimester when billing. This needs to be included on the progress note so billers will know what trimester to bill.
6. Can you add 1st trimester, 2nd trimester, 3rd trimester to the progress note to assist with ICD-10 diagnosis code?
   When the progress note is revised this summer, trimesters will be added.

7. To assist with using the right code for billing, can some things be added to the progress note to indicate EDC to determine trimester and other indicators for things such as: premature infant, postpartum visit, nutrition, high risk pregnancy?
8. Add "trimester" to top of electronic progress note by type of visit. Also, for infant add "under 8 days old", "8-28 days old."
   When the progress note is revised this summer, only trimesters will be added - not the other fields suggested here.

9. Don't see the purpose of adding trimester to the progress note – easier to get this to biller in encounter data entry process. No need to have on progress notes.
10. Biller doesn't look at the progress note. Please let each agency set up its own policy.
    Each agency can set up its own process but one way we'll assist is to add trimesters to the progress note.

11. Is a miscarriage considered a previous pregnancy with these codes, or is the first full pregnancy considered the first one?
12. First pregnancy or subsequent pregnancy – what if it is the 2nd pregnancy but the 1st one was an early loss or termination. Does it still count as "1st pregnancy" or "other normal pregnancy?
    Miscarriage is considered a pregnancy with these codes. Every time a woman has been pregnant is considered a pregnancy, regardless of outcome.

13. In regards to billing ICD-10 codes and to ease identification of the correct diagnosis code, could it be programmed as part of the electronic progress note that is being built into the SSO? We already ask mothers if it is their first pregnancy and what their EDC is which would provide the needed information so that the system would automatically populate a filed on the electronic progress note for that given date of service with the correct code. Does this make sense?
Yes, it does make sense, and we'll look at this when we develop the electronic progress note.

14. Please place in writing on how to document the PlanFirst since it is going away but is on the progress note.
Until the progress note is revised this summer, write "NA" next to the PlanFirst! checkbox in the "new referrals" section. After the progress note is revised, you will be required to document that you have referred the beneficiary to the Healthy Michigan Plan and/or Title X family planning clinic.

15. For electronic progress note entry, all staff doing visits will need SSO MIHP access/training. Would this be made available on the MIHP web site prior to electronic progress note activation date? My specific concern is my RD.
Training will be available prior to activation of the electronic progress note.

16. What is the time-frame for mandatory electronic notes (expense)? Expense of unit for each staff person plus WI/FI access or expense of employee designated to enter all progress notes plus communication back and forth with staff for clarification.
We don't have a timeline for completion of the electronic progress note. We hope it will be done within the next two years, but several other IT projects must be completed before we get to the electronic progress note.

17. Is it possible to add safe sleep to progress visits notes?
Yes, safe sleep will be added to the progress note.

18. Put safety alert field on progress note or somewhere else in chart.
Each community is different and no way to standardize this field. Each individual agency must determine how best to inform staff of potential safety concerns. Please check with local law enforcement to discuss potentially unsafe neighborhoods and situations.

Discharge Summaries

1. On the current electronic discharge summary, the initial risk level that is auto-filled always states "unknown risk" for transportation and stress/depression. Does staff need to put a note in the comment section for every single closing stating the problem and the correct initial risk?
This is happening because the current Risk Identifier does not match the current Discharge Summary. Yes, it is recommended that you put a note in the comment section of each Discharge Summary, indicating the problem and the correct initial risk.

2. Electronic discharges are very confusing between old and new paperwork. Will there be two different discharge summaries online – one for closing old charts and one for closing new charts (ones opened after Oct 1, 2013)?

No, when the new Discharge Summaries are rolled out, the only option will be to complete the new version online. However, agencies will be alerted several months in advance so they can use the old version of the Discharge Summary with old charts before it goes offline.

3. How are charts to be handled for closing in which the maternal portion was opened using the new care plans, for it was prior to the new infant care plans, so there is a mixture of new maternal care plans and old infant care plans?
4. Please place in writing the policy of trying to discharge with new/old forms and doing the best you can to complete the discharge accurately.
   We are aware that interventions identified on the Discharge Summary will not be accurate for all beneficiaries between Oct 1 2013 and the rollout of the new Discharge Summaries this summer. The rest of the Discharge Summary data will continue to be accurate – it's just the interventions that don't match.

5. When will the "unknown" risks of Depression and transportation be fixed on the discharge summary?
   The new Discharge Summaries have been programmed and this has been fixed.

6. Why are we not able to print the Discharge Summaries immediately after completing? We need to back and search for it in order to locate and print.
   The new Discharge Summaries have been programmed and this has been fixed.

7. On new electronic Discharge Summary, please have option to click "Client declined after screening" that eliminates need to fill out other info.
   This is not an option. Every client who has had a Risk Identifier completed must have a Discharge Summary completed.

8. Once ISS client is discharged but care continues, how do we proceed?
   If you have discharged a beneficiary who later returns to service, delete the Discharge Summary and continue to implement the POC.

9. You mentioned contact log in case of a legal issue – you should document all of you attempts to contact, etc., but on the D/C you want the last date of face-to-face visit date as the D/C date. So, if this ever goes to court it looks like we D/C'd months prior, even though we had made numerous attempts to contact and continue services. It seems the last contact attempt should be the actual discharge date. Going back – doesn't show what we really did.
   Check with your own legal counsel for guidelines pertaining to taking documentation to court.

10. Discharge Summary: only want info on domains we worked with client on. Information from column to side with some info (i.e., chose BC plan, etc.) too much to look at.
    Using the electronic Discharge Summary significantly reduces the possibility of error.

11. We have been unable to access some RIs when trying to complete some discharge summaries. Staff completed paper forms for client records. Is this acceptable? Any problem for SSO's?
    Prior to Nov 2013, MDCH allowed completion of infant discharges on paper only. After that date, it was required that all infant Discharge Summaries be entered into the SSO. Maternal Discharge Summaries were required to be entered into the SSO since 2012. If you have questions regarding specific documents, please contact your consultant.

Medicaid

Healthy Michigan Plan

1. Will of Healthy Michigan Plan recipients be eligible for MIHP services equivalent to Medicaid recipients?
   Yes.

2. Will Healthy Michigan Plan women be eligible for MIHP? How do we submit? Still to straight Medicaid?
   Yes. Claim submission guidelines are unchanged.

3. Will Healthy Michigan cover MIHP services?
   Yes.

4. Healthy Michigan and MIHP coverage?
   Healthy Michigan Plan benefits include MIHP services.

5. Under the Healthy Michigan Plan if a female becomes pregnant, would she qualify for MIHP services every time or if not, under what circumstances?
   Yes.

6. If pregnant and is already on Healthy Michigan Plan, do they have to apply for Healthy Kids Medicaid or can they remain with Healthy Plan Michigan? If so, how do we bill for MIHP?
   If a woman is eligible for the Healthy Michigan Plan, the plan provides comprehensive benefits including all pregnancy related services.

7. If Healthy Michigan Plan will cover MIHP and Healthy Michigan requires the beneficiary to share some of the costs, will there be a copay for MIHP?
   Healthy Michigan Plan benefits include MIHP services. There are no copays for pregnancy related services.

8. Pregnant women on Healthy Kids can have MA coverage for their infants through his/her first birthday. Healthy Michigan Plan does not cover infants so will there be an expedited process for getting this babies enrolled in MA?
   The process for enrolling eligible infant children remains unchanged.

9. Is "straight" Medicaid going away? (These are the folks MIHP pays transportation for.) If not, who is eligible (i.e., Medicare/Medicaid)?
   No. Certain individuals will continue to be an excluded or voluntary population for enrollment in a health plan under the Healthy Michigan Plan. The example of dual Medicare/Medicaid eligible individuals does not apply because individuals who are enrolled in or qualified for Medicare are not eligible for the Healthy Michigan Plan.

10. Why is pediatric services included under Healthy Michigan Plan if age eligibility is ages 19-64?
    Persons eligible for the Healthy Michigan Program who are age 19 and age 20 are eligible for pediatric services as part of the federal EPSDT program.

11. Will women still be eligible for Medicaid at up to 185% poverty level when they don't have insurance? If they did not enroll in an ACA plan?
    Yes.

12. Will women who receive PlanFirst automatically be enrolled in a Michigan Health Plan or should we encourage them to enroll?
    Many, but not all women in Plan First are eligible for the Healthy Michigan Plan. If appropriate, women should be encouraged to apply for medical assistance to see if they meet eligibility requirements for the Healthy Michigan Plan or other state programs.

13. Should MIHP require referral to Healthy Michigan Plan instead of PlanFirst?

    If appropriate, women should be encouraged to apply for medical assistance to see if they meet eligibility requirements for the Healthy Michigan Plan or other state programs.

14. In regards to MOMs insurance (non-USA residents), what type of insurance will they qualify for? (Healthy Michigan)
    Eligibility for the Maternity Outpatient Medical Services program has not changed.

<u>Policy - Transportation</u>

1. What about taxi transport for women with straight Medicaid and no Health Plan benefit? Can MIHP provide and bill for this?
   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 the MIHP.

2. Should you be allowed to use transportation… is it no longer permissible for the maternal mother to be able to bring additional siblings?
   The program does not provide additional reimbursement for non-MIHP enrolled beneficiaries.

3. MIHP Operations Guide states that MIHP provider can do "1" primary doctor transportation service if required to open a new claim by the beneficiary or if the beneficiary had an appointment scheduled for 30 days or more at time of enrollment or trying to get beneficiary to sign up or enroll in the program. Is this correct?
   When a beneficiary is enrolled in FFS Medicaid and is receiving MIHP transportation services, and is then enrolled in a MHP, the MIHP may continue to provide transportation services to medical/health care visits that were previously scheduled for up to 30 days after MHP enrollment.

4. If we aren't able to get clients access to transportation via MHP, can MIHP providers provide in ER situation and bill?!
   The Care Coordination Agreement between the MIHP and the MHP should specify how best to provide for transportation needs. MHPs are responsible for transportation services to all medically-related services.

5. Our MIHP caseload numbers are down at DHD#10 since the transportation changes. HELP! We need to manage our clients' transportation needs and provide reimbursement. We can bill the MHPs for the mileage, even if we can't bill MA. We need the state to push this option to the health plans!!
   Comment is duly noted.

6. Share MIHP data with MHPs to facilitate MIHP providers providing transportation reimbursement to increase participation and access to medical services.
   Comment is duly noted.

7. Try to get transportation back to MIHP agencies rather than health plans.
   Comment is duly noted.

8. Can mother's visit to counseling or dr. appointment be covered when infant is on program?
   When the infant is enrolled in the MIHP, transportation is available for the infant and the primary caregiver to attend the <u>infant's</u> appointments. For women and infants who are enrolled in an MHP, all medical/health care transportation services should be arranged by the MHP. The MIHP may arrange or provide transportation services for the remainder of the MIHP services for the enrolled beneficiary.

9. Can mother's visit for methadone treatment be covered when infant is on program?
   When the infant is enrolled in the MIHP, transportation is available for the infant and the primary caregiver to attend the <u>infant's</u> appointments. For women and infants who are enrolled in an MHP, all medical/health care transportation services should be arranged by the MHP. The MIHP may arrange or provide transportation services for the remainder of the MIHP services for the enrolled beneficiary.

<u>Policy - Other</u>

1. If an infant becomes hospitalized after the initial opening, can a visit be performed with the mother?
   For infant services, the infant and primary caregiver must be present at all visits. Infant visits cannot be conducted at a hospital or prison.

2. Is there any consideration of allowing more visits per pregnancy, possibly 15, as opposed to 9?
   Not at this time.

3. Can a 30 minute visit be done on the day of the Risk Identifier if need warrants (related to interventions done on day of Risk Identifier). If yes, does it have to be a different discipline than the one that did the Risk Identifier? For instance, if SW does MRI and EPDS=30, it doesn't make sense to send RN.
   The Risk Identifier and Plan of Care must be completed before professional visits are initiated. Rarely on the same day as the initial visit will a problem need to be addressed immediately. In these cases, a professional visit can be made later the same day by a different professional discipline. The professional visit must last at least 30 minutes.

4. Is it possible to have the woman "opt out" of MIHP rather than "opt in?"

At this time, as with other Medicaid program benefits, a beneficiary has the option to engage with health care providers.

5. Stats indicate all Medicaid should have MIHP – mandatory.
   At this time, as with other Medicaid program benefits, a beneficiary has the option to engage with health care providers. MIHP is an entitlement program. This means that Medicaid beneficiaries are automatically eligible for MIHP. However, as MIHP is a voluntary program, beneficiaries must choose to participate. They cannot be mandated to do so.

6. Parenting classes are limited (in terms of billing) to parents who have given birth. The billing is conducted under the infant's Medicaid number. Why isn't the benefit available to the pregnant mom? The first-time expectant mother could really benefit from a parenting class.
   Elements of infant care and feeding are topics that are to be covered in childbirth education classes offered to expectant mothers. The parenting education classes provide additional support as needed.

7. Is there a way that counseling could be incorporated into the MIHP? I know social workers are responsible for educating on topics, however, if an individual is using substances, I think it would be beneficial to the client to have a professional who is certified in substance abuse such as a CAADC (Certified Advanced Addiction Drug Counselor). It is needed. Life skill, self-esteem skill, budgeting, etc… These are needed and a counselor would be excellent for this program. Not a mandatory professional but it should be optional and agencies should be able to bill under Other Special Counseling V65.45. Thank you.
   Counseling services for substance use disorders are a Medicaid covered benefit for MIHP beneficiaries through the Community Mental Health Services Program.

<u>Transitioning to MIHP EHRs</u>

1. Are we able to log onto CHAMPS from iPads? I have not been able to log onto Single Sign On from Apple devices.
   CHAMPS will be moving to a new user interface and developers expect deployment in September 2014. With this upgrade, it is anticipated that CHAMPS will facilitate greater accessibility via multiple browsers and, subsequently, additional electronic devices.

2. Electronic progress notes via iPad? So will the State update their technology to support new systems like iPads/tablets? Currently you cannot use an iPad on any system that does not support Internet Explorer.
   The state has initiated plans to make MIHP documents mobile accessible. This may not be available until next year due to other system changes that need to occur first.

<u>MIHP Reimbursement Rate</u>

1. Is there any discussion about given MIHP the 8% of payment that was taken? We really need it.
2. Is there anything that can be done about the reimbursement rate? We are suffering financially – barely staying afloat with this rate. Maybe an administrative fee per a ___?
3. Recommendation – at some time to be able to include some form of infrastructure support (financial) for program administration.

4. I know in the Medicaid waiver program, providers receive an administrative cost. Is there any way possible that you can advocate on behalf of us providers to Medicaid – can we please receive an administrative cost?
5. MIHP providers are requesting pay increase for additional data input necessary to operate the program.
6. Can we get more reimbursement for the Maternal Risk Identifier? It is taking us a lot longer. Our agency used to enroll mothers into MIHP when they were at the HD for WIC but now it takes too long the get through the whole assessment. Thanks!
7. Need an increase in Medicaid reimbursement rate to offset costs for:

   Longer RIs = longer TIME
   Form changes
   Copy/printing educational materials.
   Change to electronic health records, i.e., iPads, laptops, etc…
   We have endured all the costs of these changes.

8. Medicaid reimbursement must be increased to cover expense of lengthy, more complicated visits. Physicians are able to bill at a higher level.
9. Please take a look at the reimbursement rate. The providers have had an increase in operation cost due to all of the changes to improve the program.
10. Medicaid reimbursement is not increasing, meanwhile, more and more documentation is required, and entering things electronically takes so much time. We need to get higher MCD reimbursement rates to be successful (not lose money trying to administer the program!)
11. New RI form is 80% longer. Currently 10 pages but it will be 18 pages and no increase in payment for MIHP providers.
12. Reimbursement rate for services has not changed in several years. This is most noted as a concern with the new Maternal Risk Identifier, which increased significantly in length, but reimbursement rate did not increase.
13. The increase in time/staffing to comply with all the new regulations of MIHP over the past 5 years is being covered by the provider with NO increase in reimbursement (electronic MRI, MDS, etc. are much more labor intensive, as is POC). This can result in decreased staffing time for visits and negatively impact the beneficiary. Please increase reimbursement rates to better cover the increasing staff time!!!
14. No increased reimbursement rate to go along with increased cost of program updates (i.e., longer risk screeners, changes in all domains and progress notes, etc.). Cost of re-educating staff, increased time on documentation, printing out all new forms and wasting old forms, going electronic as a non-electronic agency.
15. Increase reimbursement 2 (with a 0 next to it at the top?) increased paperwork, increased amount of paper used, increased gas prices.
16. Can Medicaid increase the reimbursement rate for providers? Please! Please!
17. With the changes in MIHP and the increased cost to implement these changes, is Medicaid going to increase the amount per visit paid to the MIHP agency?
18. Program requirements have led to increased costs to providers. Is there movement to increase funding? Payments?

    Concerns regarding low reimbursement rates for providers are shared by many, including the Michigan Department of Community Health. The correlation between ensuring patient access to quality health care and the effect of reimbursement rates affecting provider participation is well recognized. A crucial element of these competing factors remains inextricably linked to

the current State of Michigan's budgetary constraints. Balancing access to care and providing adequate reimbursement for that quality health care remains a significant consideration in deference to the fiscal responsibility that the Michigan Medicaid program has toward state budget neutrality.

Other

1. Is there going to be or could there be an online training for ICD-10 to review?
   MDCH does offer some ICD-10 information and training for providers. Additional information can be accessed through the MDCH website. Additionally, there are many resources available through Centers for Medicare & Medicaid Services and commercial coding entities.

Quarterly Reports

1. Are we still going to have quarterly reports? We are not getting them.
2. Quarterly Reports - CHC Branch County MIHP
   Effective May 1, 2014, coordinators will be notified via email when new quarterly reports are available. Reports will be accessed through the DCH-MIHP File Transfer areas of the Single Sign On (SSO) system. File Transfer allows MIHP providers to secure web-based access to vital program related communications 24 hours per day, seven days per week. A maximum of two staff members per agency may request subscriptions to File Transfer areas.

3. What are you going to do with the reports (MRI, IRI, etc.)? It would be helpful if this information was routinely (quarterly) shared with MIHP providers.
   Quarterly reports currently incorporate MRI data. They also will incorporate data from the Infant Risk Identifier and Maternal and Infant Discharge Summaries, once the data warehouse has that capability.

Certification Reviews

1. Existing agencies must have 40 clients. Is that 40 active clients at the time of the review OR 40 clients that were active that year OR active and recently discharged?
   In order to be reviewed, new (now) and existing agencies (as of August 1, 2014) must have at least 40 cases. This may be any combination of open and closed cases since program start-up or the last review. The only agencies that are currently exempt from this requirement are tribal MIHP agencies. An agency seeking an exemption must make a written request to MDCH, providing a detailed rationale.

2. Please review how many staff have to be at a review. If you are at a large site it could be 15-20 people.
   The number of staff who must be present (in addition to the Coordinator) depends on the size of the staff, as noted below:

   Up to three professional staff: All must participate
   Four to five professional staff: At least three must participate
   Six or more professional staff: At least 50% must participate

   Although this could be 15-20 people at a large site, it's the only way to ascertain that an adequate sample of the total staff is knowledgeable about program policies and procedures.

3. Suggestion for Cycle V Certification Tool: for indicators that require 80% of the charts to be 100% accurate and then only 3-4 charts are reviewed, one error could cost the entire indicator. One suggestion would be to say 100% of charts reviewed must be at 80-90% correct.
   We are looking at this issue as we work on the Cycle 5 Cert Tool.

4. When will the Cycle 5 tool be available?
   Our goal is to issue it on Aug 1, 2014.

Training and TA Requests

1. Please send "Before 39 Weeks" slide presentation out to coordinators.
2. Please send "Healthy Michigan" slide presentation to coordinators.
3. Please send the research slide presentation to coordinators.
4. Please email PowerPoint on Evaluation Related Topics.
5. Can you please supply an electronic version of the bed bug presentation so we can also train staff? Thanks.
6. Can you share PowerPoint slides so I can share with staff?
   We will post the PPT presentations, as we get permission from the presenters.

7. Please send the "Before 39 Weeks" slide deck to:
   Angela Winfrey awinfrey@allegancounty.org
   Lori Budahn lbudahn@allegancounty.org
   Dorothy McMillan Dorothy@magdalenecare.com
   Done.

8. Is it possible to get a copy of the risk algorithm that causes the RI to score out at different levels?
9. Please add algorithm to web site if possible.
10. Can algorithm for MRI and IRI be on web site?
    The *Risk Identifier* algorithms are posted on the web site.

11. Put friendsnrc.org link on the MIHP web site.
    We will do this when new web site is rolled out.

12. Developmental Training – how (what) to teach moms when their babies score in the gray area on ASQ. They aren't eligible for Early On, but would benefit from targeted interventions.
    We will focus on this as MIHP moves forward.

13. Please notify coordinators by email whenever there is anything added or changed on the MIHP website (i.e., revised form – like the recent change in the formatting to the Infant Discharge Summary or the format change with the MRI from 20 pages to 18 pages).
    You are notified in a coordinator email whenever there's a major change.

14. Can we have a Q&A area about the new SSO system? So when I post a question, everyone can look at it at the same time?
    We have examined this possibility and found that we are unable to do so.

15. For coordinator emails – can there be a schedule (i.e., every two weeks) so we can be on the lookout for them? I haven't received a coordinator email since Feb 9, 2014 and I'm sure I've missed some. If there is a schedule, it would be easier to know how many emails have been missed.
    It is not possible for us to stick to a strict schedule for a variety of reasons. One big reason is that some notifications are time-sensitive and cannot be delayed. However, with the new File Transfer process, you will be able to log onto SSO at any given time and see the coordinator emails that have been posted.

16. Regarding SSO (coordinator emails), will those be archived there forever to reference?
    Yes, eventually.

17. For IT issues (such as AV SSO crash for a specific client, unable to get score sheet), is there an IT contact phone number?
    You must go through your consultant in order to address an IT issue.

18. Can you send us a formal list of things to check before we call you with IT questions?
    We cannot, because IT issues are often specific to the agency/user and they constantly change.

19. Why isn't there an IT help desk for MIHP? There is one for other programs such as WIC. Lots of IT issues are happening.
20. MIHP help desk.
    We do not have the resources at this time.

Coordinator Meetings

1. Q&A session should be in the afternoon at the end of the day or a timed interval for Q&A at the end of the presentation.
   We have experimented with this in the past and found it was not satisfactory.

2. Have you considered attendance at coordinator meetings via webcast?
   We have experimented with this in the past and found it was not satisfactory.

3. Why does everyone have to participate in the continuing education portion of the program?
   All of the information presented at coordinator meetings is important for the coordinator to have and share with staff. This includes program updates as well as training on special topics. CEs are offered for training on special topics as a benefit for persons who must participate in ongoing professional development for licensure, but all coordinators are responsible for being familiar with the content of these trainings. It is imperative for the coordinator to understand this. Furthermore, coordinator meetings offer valuable opportunities for you to network with your peers.
   Certificates documenting participation of at least one staff (coordinator or alternate) in every coordinator meeting are required at the time of certification review. If these certificates are not presented to the reviewer, the training indicator (#44) will be rated as Not Met. Participants must stay for the entire day in order to receive the certificate. There are no exceptions. For this reason, it is best to have two staff participate in each meeting in case one

becomes ill or has another emergency. If only one staff plans to attend, there should be a back-up staff who can participate in case of an emergency.

4. Good meeting! Very informative!
   We're glad you thought it was helpful.

5. Thank you for providing the MIHP coordinator's meetings on a local basis (UP) – personal networking is very valuable and important.
   You're welcome. We try hard to provide the same the same learning opportunities for MIHP agencies in the UP that we provide to agencies in the LP.

6. Health officers need to hear MHP coordinator meeting.
   Health officers are welcome at coordinator meetings as the second participant.

Operations Guide

1. Can we have some input with the Operations Guide developments?
   We have incorporated a great deal of information in response to questions asked by providers at coordinator meetings or submitted to MDCH via their consultant.

2. Could you send sections of the Op Guide out so Policies and Procedures can be revised for upcoming certifications?
   Many of the changes to the Op Guide are clarifications that you have already received in Coordinator emails, Q&A documents, etc. (e.g., clarification on ASQ-3 and ASQ: SE which has been posted on the web site). Generally speaking, we give you three months advance notice whenever a new requirement will be implemented.

3. Please address handling multiples in the MIHP Operations Guide.
   Yes, we are doing this.

4. Can inter-rater reliability overview be shared with MIHP agencies so we can be sure we are doing what's required? Could it be in guidance manual? I understand that reviewers and consultants are now in agreement. What if we were told to do what was not agreed to be the correct method?
   The process of improving inter-rater reliability is a time and labor intensive undertaking that involves review of charts by multiple individuals, assessment of each individual's ratings for each chart, and comparison of each individual's ratings to the ratings of a "gold standard reviewer" to determine the extent to which their ratings concur. It is not something we can share with MIHP agencies. However, through this process, we have identified many points that needed to be clarified and we are including these clarifications in the Operations Guide, coordinator emails, etc. Through this process, inter-rater reliability has improved among reviewers and consultants.

5. I need the part about keeping the 3200 for our self in writing. Should the 3200 be included as part of the chart?
6. CPS reporting.
   Yes, the 3200 should be included as part of the chart. We are not stating in writing that you must keep a copy for yourself. Please check with your local CPS office about this.

Educational Materials for Limited English Proficient Persons

1. Do I need permission from DCH to translate Educational Packet into Burmese?
   Yes, you do need DCH permission to translate MIHP materials into another language.

2. Branch County has a large Arabic population. There is little education on the MIHP web site. I have reached out to several MIHPs in Dearborn for educational materials – no responses. When will MIHP web site include Arabic resources as they do for Spanish? Or, do you have a credible source we should use for Arabic? Right now, we use Medline.
   The MIHP education packet and the consent forms are posted in Arabic on the web site. If you have specific questions, please contact your consultant.

Consents

1. Please add lines on the consents for beneficiary name, relationship, signature and MIHP provider signature and dates.
   Because consents are fillable forms, it's not possible to insert lines.

2. In the Q&A from Sept 2013 coordinator meeting, please see #2 under consents – this answer does not make any sense. Client lists who she agrees to release information to in the grid. Why wouldn't you check "I do consent to …" if the entity isn't on grid, you don't release. It seems you would only mark "I do not…" when she refuses to release <u>any</u> information.
   Below is the Sept 2013 question and answer you reference:

   > **If a mother consents to release information to a particular entity but refuses to release to another entity, should she check the box "I do consent to …" or "I do not consent to…"? Do you check "I do not" only when she refuses to release any information?**
   >
   > ***Check both boxes and specify the name of the entity that is not authorized to receive PHI.***

   The mother may also check "I do not" if she refuses to release any information. Sometimes the beneficiary wants to make it explicitly clear that you cannot release to a specific entity. We're sorry that our Sept 2013 answer was not as clear as it could have been.

Transfers

1. How can a mom transfer <u>faster</u> from one MIHP to another without having to wait so long to be released from prior MIHP program?
   If the receiving agency does not obtain the beneficiary's information within 10 working days, they must document their efforts to get the information from the transferring provider, and contact their consultant. The only time the receiving agency can see the beneficiary prior to receipt of this information is in an emergency, which must be a documented on a progress note. Two business weeks is a reasonable period to wait before seeing a transferring beneficiary when there is no emergency.

2. Please make a checklist for agencies of required forms for a transfer and note that discharge summary should not be done.

3. There are multiple cases where we received transfers and the previous agency completed a discharge. Written guidelines for transfers would be helpful. Are they in progress?
   We have included a section on this in the revision of the Operations Guide. When a request for transfer is received, the transferring agency has 10 working days to send or fax copies of all appropriate documents to the receiving MIHP agency. At a minimum, the following documents must be transferred:

   1. ***Risk Identifier***
   2. ***Risk Identifier scoring results page***
   3. ***POC, Parts 1-3***
   4. ***Professional Visit Progress Notes***

   The receiving agency cannot do a visit until these records are received unless the beneficiary is in an emergency situation. The transferring agency does not complete a Discharge Summary. If they do, it will be deleted.

4. Our agency received clients from an agency that closed. When requesting the necessary documents (Risk Identifier, score sheet, notes, etc.), our requests were never fulfilled. We have several charts that don't have these mandatory forms. We have created POCs for these clients based on RN & SW observations but we are worried about how this will affect our certification. Please advise.
   If the receiving agency does not obtain the beneficiary's information within 10 working days, they must document their efforts to get the information from the transferring provider and contact their consultant. The consultant will instruct the transferring provider to release the documents. If this is not possible, your consultant will provide documentation to alert you reviewer to the situation.

5. FYI. One MIHP provider in our area absolutely refuses to transfer a case. All the complaining to the state consultants has not resulted in the proper transfers. I have accepted the fact that they do not transfer. Has the state?
   Have you submitted a formal, written complaint? If not, please do so and provide detailed information so that follow up can be done.

Lead

1. Currently lead level V10 and over are referred to Early On. New CDC guidelines – are these Early On referral V5?
   There are no plans to change the eligibility from V 10 and over to V 5 for Early On at this time (per State Of Michigan Early On Coordinator).

2. Talk more about waiving fees for training and certification of lead inspectors.
   MDCH will waive fees for employees of Health Departments.

3. Could a nurse become a certified lead inspector?
   Absolutely! There are several that are! If they are employees of a Health Department, they can have their fees waived for training and certification.

4. Can a doctor choose to only send in lead results for Medicaid kids and not for kids with private insurance?
   No, according to the Public Health Code- Administrative rule R325.9087, ALL lead results must be reported to the State within 5 business days of the analysis date.

MIHP Evaluation Results

1. Can you put research results (i.e., women enrolled in MIHP have better outcomes) in the beneficiary brochure? I want to be able to persuade more women into enrolling!
   We have had several recommendations to revise our brochure to include this crucial information and we are considering the feasibility of pulling the marketing committee together to update the brochure. The web site has been updated to include a summary of the evaluation results.

2. Why aren't we disseminating our evaluation results to interagency partners at the state level? They may not have time to read the research articles, but the PPT presentation would get their attention.

   We are in the process of developing a plan to distribute information about our recent evaluation findings among our state partners.

3. When MSU states "enrolled in 1st or 2nd trimester and at least three additional contacts during pregnancy." What are contacts?
   Contacts are professional visits.

Getting Women Enrolled in MIHP Earlier Based on Evaluation Results

1. If MIHP enrollment in 1st or 2nd trimester shows such a significant impact on decreasing adverse birth outcomes, a stronger (required) link with WIC should be considered. All new pregnant women in WIC should be required to be referred to MIHP. WIC gets moms early! And make sure MHPs refer all pregnant women!! MIHP saves MHPs $!
   We are currently in discussions with WIC about increasing referrals to MIHP.

2. Can we streamline MA application and health plan enrollment? Need to start services ASAP when MIHP is most effective. Enroll in health plan with application would be nice to start MIHP services quickly.
   This is being discussed at the state level.

3. UP Health Plan – Currently MHPs cannot refer pregnant women to MIHP until they are enrolled in the Health Plan. If we are to impact MIHP enrollment in the 1st and 2nd trimester, we need to consider the MHP referral process of pregnant women to MIHP. MHPs receive identification of women pregnant as early as "The notification from a Health Department positive pregnancy test" with her plans to apply for Medicaid; she also gives two of our local HDs (Delta and Menominee) authorization to communicate pg test results with UPHP.
   This is a unique situation because the UP Health Plan (UPHP) is the only MHP serving the UP, and the UPHP wants to know as soon as a woman is pregnant so they can expedite her enrollment. In Delta and Menominee Counties, a pregnant woman can sign a release allowing the HD to send her pregnancy test results to the UPHP before she has even applied for

Medicaid. During your UP MIHP-MHP teleconferences, you could discuss how all of the MIHP programs in the UP might adopt this practice.

4. Health Plan referrals to MIHP providers.
   We don't understand what you are asking here.

Other

1. I believe that MIHP could benefit from an advisory committee. What are your thoughts?
   We are talking with our administrators about this recommendation.

2. Has the new consultant worked MIHP?
   Cherie Ross-Jordan has worked in home visiting programs and has a wealth of other relevant experience. She has not worked for an MIHP.

3. Is there an MIHP guideline about hazardous weather in regards to home visiting? I recently have heard both Early and Early Head Start have policies to not visit if the ISD or local school districts are closed. Do we have a similar policy?
   We do not have a hazardous weather guideline. This determination would be made by the administration of each MIHP agency.

4. How do we handle an open case when a baby previously open to MIHP with bio mom is now in foster care and foster family desires MIHP to continue?
   You can continue to serve the baby.

5. All health plans should be represented at every coordinator meeting.
   All health plans are always invited but we cannot require their attendance.

6. How do we handle name changes of clients? Do we go back and change our notes and what if they are in the SSO and EMR?
   You simply document in the record that there has been a name change. You cannot go back and change the name in the SSO and EMR.

7. Re: HUB. We are a rural agency – Branch County – so no HUB in our area. However, some mothers deliver in Kalamazoo or Ann Arbor if high-risk situations exist (NICU, etc.). Do we need to be involved with HUBs in those areas? If so, to what extent? Thank you.
   No, you do not need to be. If the HUB exists in your county, your involvement is highly recommended.

8. Once the hospitals become required to refer to MIHP, how will it be evenly distributed to make sure all agencies get the referrals?
   This has not been worked out yet.

9. If providers are required to do a business plan, then the state should be evaluating the economic impact of protocol changes in quality improvement initiatives.
   New providers are required to develop a business plan so they are aware of how many other providers are serving the same county/area and so they understand all that is involved in

laying the groundwork for a successful, timely MIHP start-up. We are not sure how this relates to the "economic protocol changes in quality improvement initiatives."

10. Can you document the intervention number that specifies that a safety plan was developed for stress or abuse/violence? Will this suffice?
    Yes, this will suffice.

11. Education packet – new 44 pages.
    The education packet on the web site is not new – it has always had 44 pages. However, the other packet with the individual black and white pages was removed from the web site because agencies were giving out individual pages. Medicaid's intent is that every beneficiary receives the entire education packet or signs up for text4baby when the Risk Identifier is administered.

12. Parenting education
    We are not sure what you are asking or stating here.