

September 2013 MIHP Coordinator Meetings Q & A

MIHP Updates (Rose Mary Asman)

1. Slide on cumulative numbers of Risk Identifiers says there were 35,784 Infant Risk Identifiers in 2012 (35,784 maternal components and 35,784 infant components). What is total # of Medicaid babies? Approximately 70,000 infants reached with MIHP.

Risk Identifiers for 35,784 infants were entered into the database as of 2012. This doesn't mean they were all entered in 2012. In 2011, Michigan Medicaid paid for 51,449 births, which was 45.1% of all live births that year.

2. What is baseline metric for MIHP to increase by 3%?

Maternal baseline: 21,881.

Infant baseline: 17,171.

3. Will all MIHP agencies be required to increase their client totals by 3%? What about agencies that are maxed out already with staff/client ratio? LHDs are not willing to add extra staff due to budget cuts.

We're looking at a 3% increase across the state, not per MIHP agency.

4. Were the six "no Not Mets" reviews in the last six months in Cycle III or Cycle IV?

Four were in Cycle 3 and two were in Cycle 4.

5. Where are the quarterly reports? We are not getting these reports.

We mailed quarterly reports out around the time of the September coordinator meetings and are preparing to send out the next round of quarterly reports out right now. If you did not receive a report in September, call your consultant.

6. Can we get copies of Agency detailed reports (for our agency) when they are run?
7. Is it possible for coordinators to get copies of their agency detailed reports for program management? Plz.

Now we're looking at how we can get the reviewer summary report to you. Later we'll work on how we can get the more detailed report (with client-specific data) to you.

8. Is the Quasi-Experimental published article linked to access on the MIHP website?

We will post the link on the web site.

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9. For certification reviews, a question about required training: How do you know MIHP staff has attended the most current training if an updated webcast has been posted on website? In other words, clarify required trainings.
10. Could you clarify the MIHP training requirements for reviews? When to complete new and updated trainings?

When a new training is required, we will identify it as such on the web site and the field will be alerted through a coordinator email.

Secondary Billing (answers to questions in this section provided by Craig Boyce)

1. Maybe you need to have a workshop for our financial billers.

MIHP Medicaid Billing trainings were conducted in four locations in November, 2013.

2. The delay in payment by going through the TPL process will affect the cash flow of private providers.

Currently, if you want to receive payment from Michigan Medicaid for MIHP services you need to follow the Coordination of Benefits rules or your claims will reject. Failure to follow the COB rules will result in no payment, not just a delay.

3. Do we need contracts with all of the private insurance carriers?

??? I'm not sure if all commercial carriers require a contract be in place in order to process claims.

4. Contracting with private insurance carriers is very time intensive.

Not really a question, more of a statement.

5. What is the turnaround time for rejections from private insurance?

I only deal with Medicaid; this is a question that would need to be directed to the individual commercial carriers.

6. We can't get any response from BCBS! As a LHD, we can't contract with BCBS because we do not have a doctor onsite every day.

Try to secure a written response stating BCBS will not enroll your provider and that MIHP services are not covered.

7. If we do get paid by the secondary insurance, what is the next step? Do we refund and send again to Medicaid or is it OK to keep the reimbursement from the commercial?

The answer depends on the payment amount. If the payment is equal to or greater than the Medicaid allowable there would be no need to refund the commercial payment. If the payment is less than the Medicaid allowable with the balance applied to a write off...then I would refund the commercial carrier and see if they can reject with an appropriate reason code. I would guess that

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once the commercial carrier knows the services are related to MIHP they would reject as non-covered.

8. What diagnosis code should we be using? Is it ok to use v6549 for both maternal and infant RI and professional visits or should we be more specific?

Michigan Medicaid cannot tell provider which diagnosis codes to use. Once the policy clarification is finalized, MDCH will be providing a range of diagnosis codes that are related to MIHP services.

9. It would be advantageous to have a separate code(s) for MIHP billing instead of using generic E&M code.

Maybe, but currently there is not a procedure code available that describes the services being rendered.

10. Dx codes:

V22.0 maternal

V24.2 postpartum

V 22.3 infant

Amount that the vendor was reimbursed.

Transportation POC for methadone.

ICD – 10.

Contact TLP and get an official letter – “MIHP is not a covered service.”

More to come related to diagnosis codes once the policy clarification is complete.

11. Client has Medicaid, Medicare, and BCBS. Who is primary, secondary, etc.? Client is on SSD R/T mental health status.

Here is a reference guide to help: <http://www.medicare.gov/Pubs/pdf/02179.pdf>

12. If client has tribal insurance, does it have to be addressed on the claim form?

The only insurance that needs to be addressed on the claim to Medicaid will be listed in the patient's TPL file in CHAMPS.

Medicaid

1. Need better guidance on transportation guidelines. What can be billed from mom if infant case is open and vice versa?

Please refer to the MIHP policy on transportation. For specific questions, contact your consultant.

2. Transportation address requirement – we have current list of all providers easily accessible to all MIHP staff in electronic record. Addresses are not on transportation form. Had previous approval to do this. Is this still approved?

We need more information from you about this. Contact your MIHP consultant.

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3. Can infant transportation for initial well baby and/or other well baby visits or medical problems be billed under mom's MA, as infant does not have MA yet? Or does an infant IRI need to be done and then bill once MA is effective?

Since this is a medical appointment, coordination for transportation should be done through the health plan.

4. Can transportation assistance be provided to a mother paid under an infant ID# in the following situations:
 - a. Mother was not enrolled in MIHP, but will be discussing PPD and anti-depressants at her 6 week checkup.
If mom is not enrolled in MIHP the transportation, this is coordinated by the health plan.
 - b. Mother is in counseling and/or seeking medical treatment for PPD after her MIHP case is closed?

This should be coordinated by the health plan.

Medicaid Health Plan is not paying for services and/or she is not eligible for transportation assistance.

Refer to MIHP policy section on transportation.

5. Medicaid Health Plans send out explanation of visit and payment made to clients.
6. Our clients has called and stated they have received statements in the mail for services billed by MIHP.

Medicaid Health Plans do not bill beneficiaries.

7. Carol Lowe stated at lunch – Plan First is on its way out. What are MIHP plans for the transition?

There are no plans for changing Plan First at this time. You will be notified of any change.

8. Why are our pregnant moms being dropped off Medicaid during their pregnancy?

They should contact their DHS caseworker.

9. Could there be some exception to Medicaid policy on who can serve as a care coordinator? I have a BA in community services and is very much capable of providing these services.

No, please refer to provider manual or contact your consultant.

10. Why can't we use LPNs? Staffing is a problem not getting the clients.

LPN's are not able to provide services per Medicaid policy.

11. LPN's should NOT be allowed to provide service. MIHP is trying to improve quality of series. RN's have a much better understanding through education to provide quality assessment/teaching/interventions.

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Forms – General

1. Electronic format – if you move to pdf documents, we would still need access to the unprotected Word documents for our EMR system.

Contact your consultant for the form to request unprotected documents.

2. Please review process with multiples – consents, RI's, notification letters, POC's, D/C summaries, documentation on progress recording for infant we are not billing under. Very confusing!! Especially when multiples have multiple, different risks on POC.

We will be developing guidelines on serving multiples.

3. Please consider putting new forms separate/below the old forms on the website and including the last updated date in the heading to make it easier to verify we are using the latest version. It was very cumbersome when the 10/2012 forms were posted.

We have separated the new and old forms on the web site. The new forms are above the old forms with the dates that they are effective.

4. Please consider adding page numbers "page 1 of 3" to all forms especially the POC 2s.

We have considered this, but the answer is no, because there are implications for providers who have electronic medical records.

Consents

1. Why isn't signed consents a critical indicator?

We felt there were other indicators that were more critical for model fidelity and wanted to limit the number of critical indicators to four.

2. 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.

3. Please review use of consents – both Consent to Participate in MIHP and Release of PHI. If opened prenatally, both consents are valid for the baby when opened, correct? We just need to add baby's medical provider and add other applicable agencies to release info (WIC, Early On, etc.).

Correct.

Maternal Forms Checklist

1. MIHP 400 – Consent to Participate, etc.
MIHP 401 – Consent to Release PHI

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We don't understand this question.

2. Forms Checklist: What dates do you want on this form for POC1, POC2, and POC3?

Use the date that the second person signs the form.

MRI

1. Members in household – “child” should be an option.
2. On MRI household members, brother and father of baby are missing.

We've removed the list of household member options from the hard copy. On the electronic form, you can choose from the list of options and type in any other household members under “other.”

3. On MRI Basics, can the work question be on page 2? It makes sense to keep it with work hours.

Yes, we have done this.

4. When did last pregnancy end? Would be nice to know if it was live birth, stillbirth, AB.

This is addressed in a later question in this section.

5. STI's – if have/had more than one STI, document all whether under care, resolved, etc.
6. STI – what if some STI in the past, treated, resolved, but currently have one being treated or needs appointment?

Document information on more than one STI in the comments section.

7. Chancroid typo (several people said this)

We have corrected this.

8. On health history, the line “Have you ever been treated or told you have:” is missing before Hypertension, Asthma, Diabetes.

We have corrected this.

9. Missing language on health history, chronic disease section. Have you been treated or told you have...?

We have corrected this.

10. Also need to differentiate if Hypertension, Asthma was once a concern but is no longer/has resolved.

Note this in the comments section.

11. MO15 (Asthma) - high intervention 9 – half grayed out.

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We have corrected this.

12. POC 2 Asthma - the moderate interventions don't line up with the moderate risk line in column 2 – it does on all the others.

We have corrected this.

13. Take beneficiary name, Medicaid #, and BD off every section.
14. PLEASE take off the beneficiary name, Medicaid ID#, and DOB on every page of MRI.

We have corrected this.

15. Pg 16. Abuse and Violence (2 of 3). Can "Termination" be added?

Not at this time. Check "other" box and write "parental rights terminated" in "specify" box. We'll look at this as an enhancement the next time the form is revised.

16. CPS often refers to non-intensive services (including MIHP). Should there be a checkbox for this?

Check "other" box and write a note in "specify" box.

17. In stress and depression, the numbering for scoring is incorrect on questions 2 and 3 of the PSS 4 and questions 5, 6, 7, 8, 9, 10 on the Edinburgh.

We have corrected this.

18. Adding mom's comfort level as a question on the Risk Identifier. Maternal Considerations on the Infant Communication forms.
(These two were on same card – not sure if they're supposed to go together.)

We need more information about this.

19. Add question about being in treatment to the drug section.

Note this in the comments section.

20. Be consistent with "1 of 2" in the gray header boxes. Sometimes it's OF, of, oF, Of.

We have corrected this.

21. Please make sure the risks that cause a domain to "score out" are listed on each domain (Risk Information.) For example, Family Planning.

The risk description on the POC 2 is different from the algorithm. The algorithm takes specific question responses and combines them for a score. If you would like a copy of the algorithm, contact your consultant.

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22. If Family Planning SSO shows “low” from state, can we indicate “moderate” on progress note – do we have to show this on POC 3?

The risk level on the POC 2 must match the risk level on the progress note. If you change the risk level on the POC 2, you need to document the date of the change on the POC 2. You don't have to update the POC 3 when you change the risk level on the POC 2.

23. Please consider, again, having a mechanism for the identification of “Risk Screen Only” for women who agree to a risk screen but decline ongoing services. This would save all the work of doing Discharge Summaries on these.

We'll discuss this further.

24. If level of education is included in the U of M report/research, the data will be skewed if you are unable to capture grades between 8 and 12. A mom who has completed the 11th grade is better educated than one who completed junior high, yet the RI will not reflect. Appears as though “shaping data” to support pre-conceived opinions about the Medicaid population.

The demographic categories being used to capture education level will not compromise our evaluation in any way.

25. On pg 17 of MRI, “ahold” is not a word. A better way to say this is: What is the best way to contact you?

We chose not to make this change.

26. Last page of MRI – professional credentials should be the line under the “screener name” and “date.” Not by “entered by name.” This is out of order.

We have corrected this.

27. Confused – why do we have to be concerned about addressing optional areas with NA if doing by hand, when it's mandatory to put in SSO? Print out will look much different.

We do not understand this question.

28. Do you want under abuse: Have you ever been emotionally or physically abused by your partner – do you want to add sexual here? And boxes for who, what, how long? Or use other question under emotional abuse: Has anyone forced you to have sexual activities...? Do you want box for by whom, what, when, how long?

We did add “sexually abused” to this question. We chose not to add additional boxes because it would require changing the database in order to do so.

29. Has your partner or someone else now in your life (Remove ? and add : This is not a question to answer, the statements below are the questions to answer.

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We did not make this change, but will consider it the next time we change the form and the database.

30. Abuse-violence, page 15. Has your partner...is not a complete? Suggest: Place refused as last choice.
31. Under abuse and violence – Has your partner...delete the first “refuse” box because each question has a refused option.

We did not make this change, but will consider it the next time we change the form and the database.

32. The question asking about having a mental health disorder. It should say: Have you been diagnosed with a mental health disorder. This is to verify that a professional has evaluated them.

We chose not to make this change at this time.

33. Scoring is wrong on EPDS and answers in #4 are in the wrong order.
34. Stress questions – reverse coding #2 and #3.

We have corrected this.

35. After RI is entered, is there any possible way that we could have the system populate the POC 2's? This would be so awesome! Please.

We agree it would be awesome, but we aren't there yet. If you have your own EMR system, you possibly could program it to populate the POC 2.

36. I work 6 days a week with a Master's degree and have difficulty paying my bills.

We understand what you're saying, but thought it was important to ask the question on the Risk Identifier.

Infant Risk Identifier

1. On the IRI, there is no option under “smoking” for a mom who quit smoking during her pregnancy and has stayed quit of smoking postpartum.

We will look at this when we revise the IRI, although we have no plan to revise it at this time.

POC 1

1. Do we need to give both the infant and mother educational packets on both openings? Right now when we open an infant, we give the infant educational packet. When we open a pregnant woman, we give only the mother educational packet.

DCH looks at this as all one packet to be given out at the time of enrollment.

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POC 2

1. Why isn't there a date next to "refused all interventions"? Just for reference.

You may add a date there if you choose to.

2. On some POC 2s, emergency (social support, depression – these are examples only; there are more than two) the intervention has "inform MHP and medical care provider" is one intervention (and others too).

We've corrected this.

3. Plan of Care 2 – first column. What date goes in the space that says Date: under "low" and "moderate?"

This is the date that a change in risk level is documented or the date that the domain was added after the POC 2 was initially developed.

4. Many of the POC2's do not match the risks identified on the Risk Identifier. An example is "drug use." If mom reports using a drug only once during her pregnancy, she scores out as a "high." The risk info on Drugs POC2 "High" states "currently using drugs." What level is she if she is NOT currently using drugs but used 1x in pregnancy?

Document that she used drugs once during pregnancy and provide interventions pertaining to current drug use.

5. Be consistent with punctuation at end of sentences in POC2's column 3. Sometimes has a period, sometimes not.

We will do this the next time we revise the form.

6. CPSx2 in ETOH POC.

We have corrected this.

7. If nutrition POC is meant to be used by RN & SW, what does the RD do? How should they document?
8. If MIHP staff RD does an individualized POC for each beneficiary who gets nutrition counseling, do these POCs have to be in the record? Isn't this a Medicaid policy requirement?

All professional staff are to use the existing POC 2s. Anything addressed outside of the POC 2 needs to be documented under "other visit information" and additional services addressed under "plan for next visit" on the Professional Visit Progress Note.

9. Get rid of the asterisk on Nutrition POC.

We have corrected this.

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10. Can we write anything on POC other than dates?

You must check boxes and insert dates as required, but you can add non-required documentation for your own purposes.

11. Change column 1 “Date” to “Date risk level changed” and “Date domain added.”

*The column 1 “Date” field is used to document the date the risk level was changed **or** the date a new domain was added to the POC 2. If you do add a new domain, the POC 3 must be updated and signed, and the medical provider must be notified of the update.*

12. Breastfeeding – remove column 1 intervention based on risk level. Put based on professional’s judgment – score low, mod, or high.

We have corrected this.

13. Referral Follow-Up form doesn’t provide a space for “outcome of referral” which is required on progress note.

If you use the optional Referral Follow Up form, you still must document the outcome of the referral on a progress note.

14. Pregnancy Health – previous adverse pregnancy outcome scores out.

15. Pregnancy Health – previous adverse pregnancy outcome – remove box.

This has been corrected.

16. Pregnancy Health – please include interventions 7, 8, 9, and 10 for all levels.

We have made this change.

17. Stress/Depression – What is definition of “baby blues?” Should we say “postpartum depression?”

There are three types of depression women may experience during the perinatal period (from start of pregnancy to 12 months after giving birth):

1. The Baby Blues

- *Common reaction the first few days after delivery*
- *Crying, worrying, sadness, anxiety, mood swings*
- *Usually lifts in about 2 or 3 weeks*
- *Experienced by 50 – 80% of women*

2. Perinatal Depression

- *Major and minor episodes of clinical depression during pregnancy or within first year after delivery*
- *More than the Baby Blues - lasts longer and is more severe*
- *Symptoms:*

- *Sad, anxious, irritable*
- *Trouble concentrating, making decisions*
- *Sleeping or eating too much or too little*
- *Frequent crying and worrying*
- *Loss of interest in self care*
- *Loss of interest in things that used to be pleasurable*
- *Shows too much or too little concern for baby*
- *Not up to doing everyday tasks*
- *Feelings of inadequacy*
- *Intrusive thoughts*
- *Suicidal thoughts*
- *Symptoms last more than 2 weeks*
- *Co-occurs with anxiety disorder for 2/3 of women:*
 - *Generalized Anxiety Disorder*
 - *Panic Disorder*
 - *Obsessive-compulsive Disorder*
 - *Other*
- *Often co-occurs with substance use disorder*
- *Experienced by 10-20% of all women but prevalence is much higher for low-income and minority women (30 – 60% in various studies)*

3. Postpartum Psychosis

- *A rare disorder (one or two in 1,000 women)*
- *A severe form of perinatal depression that can be life-threatening*
- *Symptoms: extreme confusion, hopelessness, can't sleep or eat, distrusts others, sees or hears things that aren't there, thoughts of harming self, baby or others*
- *A medical emergency requiring urgent care*

For much more information on perinatal depression, see the "Implementing the MIHP Depression Interventions" webcast at the MIHP web site.

18. These POCs have no statement to use low along with moderate – moderate or high not identified: family planning, diabetes, and NTN.

This has been corrected.

19. Where do the moderate Family Planning interventions start (or are they exactly the same as low?)

They are the same.

Progress Note

1. Please add box on progress note for "see referral follow-up form."
2. Outcome of previous referral on pg 2 of Progress Note: Do we need to write "see referral follow-up form" on EVERY progress note?

You will need to document the outcome of a previous referral on the progress note.

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3. Since referral follow-up form is optional, if we have developed our own, can we use our own or will we be required to use state's optional form? They are similar.

You can use your own because the Referral Follow Up form is optional.

4. Give example of when to check N/A box under educational packet or section instead.
5. Add box after NA on Professional Visit Progress Note for "Education Packet reviewed this visit."

This has been addressed on the new progress note. The "NA" box has been replaced with a "Neither" box.

6. Progress Note and SE Progress Note need checkbox for education packet discussed this visit.

The checkbox has been added on both progress notes.

7. Tech question: Why are we unable to place "x" inside the progress note boxes?

This has been corrected.

8. Progress Note and SE Progress Note – wants signature, credentials and date on page 3. This was not on the current forms. Is this correct or an error?

This has been corrected.

9. If you see MSS client, can we check either the MSS or ISS box if we teach on infant safety or do we have to check maternal box?

If it's a maternal client, check the maternal box.

10. Why haven't Date of Birth not on the progress note.

We did not feel it was necessary.

11. Please add a blended visit box to substance abuse form.

This has been corrected.

12. There is no area to put the medical record # on the progress note that is now required (for billing purposes).

We're not aware that the medical record number must be on the progress note for billing purposes. If you use a medical record number in addition to the Medicaid ID number, you can add it to the top or bottom of the progress note, as long as you do not change the form.

Discharge Summary

1. Discharge Summary Transition – have 2 d/c electronic summaries available – if entered prior to 10-7-13, the old d/c automatically opens. If entered after 10-7-13, new d/c summary opens.

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We asked our IT people and what you are suggesting is not technologically possible. We are aware that there will be a period of time during the transition when the Discharge Summary fields will not match exactly.

2. Can we use the screening date as an indicator to give us access to utilize the old form for a period of time?

We asked our IT people and what you are suggesting is not technologically possible.

3. When programming new form, PLEASE make sure that referrals are listed in the same order as on the progress note! (and all included)

Yes, we plan to do this when we create the new electronic Discharge Summary.

Infant Discharge Summary

1. Twins and triplets are billed as a blended service under one infant. Please explain how to complete the Discharge Summaries when the POC 2s are not the same for each infant in the family and the Professional Visit Progress Note domains match only the child being billed.

For the twin whose Medicaid ID number was used for billing purposes, complete the Discharge Summary in its entirety. For the other infant or infants, only fill in the section at the top (demographics) and the last four boxes on the form (signature, date, etc.). Do not fill out the sections on interventions and referrals.

2. With multiples, do we do SSO for both and discharge both? Send MD the letter for both babies.

Yes, you do a separate Risk Identifier for each infant and a separate Discharge Summary for each infant, entering the data from all four forms into the data base. (See question above on completing Discharge Summaries for multiples.) You also send separate communications for each infant to the MD.

3. On SSO: how to address sleep – does a Pack 'N Play or bassinet mean a bed?

Yes.

4. Why on Infant Discharge Summary under drug-exposed “pre-contemplation” is not selectable?

The stage of change is matched to the specific substance exposed infant intervention. If a mom admits she has a drug problem, she's no longer pre-contemplation. Pre-contemplation only applies to specific drug-exposed POCs.

5. Transportation – not a risk addressed on infant Discharge Summary.

Transportation does not score out for an infant and there is no transportation POC 2 for an infant.

6. Infant Discharge Summary needs to be able to print maternal and infant separate. Some moms don't want their info going to baby's doc and there's no way for us to separate it out.

At this time, it's not possible to print the maternal and infant information separately with a hard copy. However, with the electronic version, you can send the baby's information only.

Infant Care Communication

1. Can you please give complete instructions on completion of Infant Care Communication form with respect to Maternal Considerations? Is it expected that each of the Maternal Considerations be listed? What if she has refused to release her information to infant's doctor – does this need to be noted on Infant Communication Form?

If you have permission from the mother to release her PHI to the infant's doctor, insert the maternal considerations in the "family living arrangement section" of the Infant Care Communication form. Include all of the maternal considerations identified. You do not need to note it on the form when a mother refuses to release her PHI to the infant's doctor.

2. Confusion with notification letter to doctor when baby opened to MIHP:
 - a. Do we or don't we list maternal risk factors?

Yes, see question #1 above.

- b. Do we notify baby's doctor if new maternal risks arise later (update)?

You would do this only if the mother wants this information to be shared.

- c. Does mom need to consent to release her PHI to her doctor if we are opening baby? How can we include mom's risks for doctor letter?

Yes, see question #1 above.

Nutrition Presentation

1. Is it possible to have access to the nutrition PowerPoint so we can review the information with staff?
2. Please email out Nutrition Presentation slides. I'd like to use as resources for our clients.
3. Can you email updated nutrition slides? Print out at meeting didn't contain all of the info. Thx.
4. Can the Nutrition Information PowerPoint be accessed on the MIHP website?

We can email the PPT to you upon request. Contact your consultant.

5. We had a very informative session today on nutrition. Could you please comment on scope of practice within a multi-disciplinary MIHP team? For example, if SW is the case manager and mother refuses visits from RN or RD, can SW provide nutrition interventions? Can RD provide interventions R/T stress/depression?

The SW can provide nutrition education (for all pregnant women and mothers), but not nutrition counseling (for women or infants with health problems affected by diet). Only the RD can provide nutrition counseling, which requires specific credentials and a physician's order. An RD can provide

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stress/depression interventions if she walks into a situation requiring her to do so, but she must follow up with the SW or RN to engage them in addressing stress/depression.

6. Resources for free breast pumps?

Check with WIC or the local hospital.

7. When is the next resource fair?

MIHP at the state level does not sponsor resource fairs.

8. Will the following information be placed on the website to give to moms?

Breastfeeding Matters
Making Milk
Making It Work
Questions about Medications, Alcohol and Smoking
Limited Breastfeeding
NICU
Fact Sheets

This information has been posted.

9. When our clients are struggling to get food, how effective can the teaching be regarding the food plate?

We understand what you're saying - the beneficiary may not be receptive to your teaching because of her situation. All you can do is the best you can, based on your perception of her ability to take in the information.

Medicaid Health Plans

1. How do we get the Health Plans to send reports in a more timely fashion? Not coming monthly; report generated for a given month is not mailed until the next month; clients are due the month after receiving report. Also, they give us incomplete information. PHP is sending with no addresses. When we called, we were told they can no longer provide addresses. Other plans don't give EDC, or phone number, or if lives outside county.

We will share your concern with the Medicaid Managed Care Plan Division.

2. The MHPs who are required to refer clients to agencies can do a lot more by making beneficiaries aware of the program and that it is a benefit of their insurance. Making "cold calls" to clients from lists - they sometimes are not very receptive - they think we are selling something. It would go a long way for them to have some familiarity with the program. Possibly a letter from the MHPs like Molina does would help.
3. It would be very helpful if the MHP's would send a letter (or otherwise recommend/encourage/push) their MSS/ISS eligible clients to accept MIHP services.

We will share your suggestions with the Medicaid Managed Care Plan Division.

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4. Health Plan will not provide transportation within county (Shiawassee). Will only provide out-of-county transportation. Can we provide transportation to this client for her in-county doctor visits?

Talk to your consultant about this situation and she will follow up with the Medicaid staff person who oversees the DCH contract with the Medicaid health plan.

Training and TA Requests

1. Please have forms training up and going before having requirement to use forms.

The forms training was posted several months before January 1, 2014, when use of the revised forms will be required.

2. Please send out full agenda for coordinators meeting ahead of time. It would have been great to have my billing coordinator attend this morning!

We will try to do this in the future.

3. Training domains would be beneficial for staff in the field vs coordinators; prefer to get program/policy info only.

We wish we had the resources to directly train all MIHP staff face-to-face, but we do not, so we provide as much online training for them as we possibly can. However, since the coordinator ultimately is responsible for all aspects of the program, including staff training, it is imperative for you to have a thorough working knowledge of how the interventions in all of the MIHP domains are supposed to be implemented.

4. A speaker should have command of the English language. How can a professional person not know how to pronounce the words associated with their profession?

We're grateful to all of the speakers who volunteered to present at our September meetings.

5. When was the last update done on the maternal and infant chart review tools?

The new chart review tools are on the web site.

6. Any way we could set up an online forum so we could post questions and share resources (of course mediated by the consultants)?

We don't have the staff resources to do this at this time.

7. Please send an email to coordinators when any changes or updates are made to the MIHP website (forms, webinars, etc.).

8. Anytime a form is updated, we need an email. Most helpful would be to only update 2x/year on a routine schedule. There is a form updated late August that we found and have not received an email on it.

12/5/13

An error occurred in August when the Discharge Summary was reformatted. It was still the 9-1-12 version but the footer was entered incorrectly. This was a formatting change only. We do send an email when changes are made to required forms.

9. It would be so helpful to have coordinators emails go out one time without multiple revisions – sometimes in the same day or within 24 hours.

We apologize and will try to do a better job in the future.

New Providers

1. It is very difficult for a new agency to obtain 40 clients in 6 months. There are agencies that have been open for 1½ years that are at 40 or 50. Please reconsider this change.

We are not changing this requirement. MIHP is a complex program that cannot be efficiently implemented on a part-time basis.

2. New providers start date should begin once they have been approved in CHAMPS. Without CHAMPS approval, you are unable to proceed with services. We have emails from provider enrollment but no approval after 1 month.

Once a potential provider is approved by MIHP, they are instructed to begin working with CHAMPS immediately. All new providers must be enrolled in CHAMPS before attending the new provider orientation. Effective 10-01-13, we are requiring proof of CHAMPS enrollment prior to attendance at orientation.

Other

1. Please have providers identify who specializes in Arabic-speaking and or Spanish-speaking clientele.

We will take this under consideration.

2. Spanish MIHP brochures

The Spanish and Arabic versions of the MIHP brochure are posted on the MIHP web site.

3. Do we leave ASQ's in home, except summary? Then how do we know if it was scored correctly (that is on the certification chart review tool)?

Yes, you leave the ASQ questionnaire with the family. The summary sheet is used for the correct age questionnaire and as documentation of administration.

4. For chronic problems, i.e., mental health, to show improvement, can there be evaluation that says treatment is working? For PNC – RI identifies Hx of risk – evaluation health birth outcome? Or postpartum hosp? Or something to that effect?

We are not sure what is being asked here.