



## **Operations Guide**

**Maternal Infant Health Program  
Division of Maternal and Infant Health  
Bureau of Health and Wellness  
Public Health Administration  
Michigan Department of Health and Human Services**

**Operations Guide: Cycle 8  
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# MIHP Operations Guide: Cycle 8

## Table of Contents

- Section 0 – General Certification Requirements ..... 5
  - Protocol Approval Process ..... 5
  - During Certification Review..... 5
  - Certification Categories..... 5
  - After Certification Review ..... 6
  - Decertification ..... 6
  - Voluntary Inactive Status and Termination..... 6
- Section 1 – Personnel & Training ..... 7
  - Personnel Roster ..... 7
  - Home Visitor Credential and Experience Requirements..... 7
  - Confidentiality ..... 7
  - Training..... 7
  - Internal Communication..... 8
- Section 2 – Facility, Technology & PHI ..... 8
  - ID Badges ..... 8
  - Provider Phones ..... 8
  - Provider Office..... 8
  - Protected Health Information (PHI) ..... 9
- Section 3 – Quality Assurance ..... 10
  - Quality Assurance..... 10
  - Grievances ..... 10
- Section 4 – Contracts & Community Engagement ..... 10
  - Contracts ..... 10
  - Arrangements for Beneficiary Services ..... 11
  - Resources ..... 12
  - *Early On* ..... 12
  - Children’s Protective Services ..... 12
- Section 5 – Outreach & Enrollment..... 13
  - Outreach..... 13
  - Accommodations..... 13
  - Referrals to MIHP ..... 13
  - Assessment Visit..... 13

## MIHP Operations Guide: Cycle 8

○ Enrollment Exception .....	15
○ Plan of Care, Part 2 (POC 2).....	15
○ Plan of Care, Part 3 (POC 3).....	16
○ Beneficiary Transfers.....	16
○ Forms.....	17
● Section 6 – Communication & Professional Visits.....	17
○ Communication with Medical Provider.....	18
○ Communication with Medicaid Health Plan.....	18
○ Professional Visit Logistics.....	18
○ Professional Visit Content .....	19
○ MIHP Safety Plan .....	20
○ MIHP Action Plan.....	20
○ Referrals .....	20
○ Maternal-Specific Components.....	21
○ Infant-Specific Components .....	21
○ Physician Orders.....	21
○ Blended Visits .....	22
○ Multiple Births.....	23
○ Developmental Screenings.....	23
○ Beneficiary Discharge .....	24
● Section 7 – Claims.....	25
○ Childbirth and Parenting Education .....	25
○ Blended Visits / Multiple Births.....	25
○ Substance Exposed Infant .....	25
● Companion Guides .....	25

## MIHP Operations Guide: Cycle 8

### Index of Acronyms and Definitions

CPS	Children’s Protective Services
HIPAA	Health Insurance Portability and Accountability Act
IBCLC®	International Board-Certified Lactation Consultant
Home Visitor	Any staff who conducts billable MIHP home visits
MCIR	Michigan Care Improvement Registry
MDHHS	Michigan Department of Health and Human Services
MDHHS MIHP	MDHHS staff associated with MIHP
MHP	Medicaid Health Plan
MOMS	Maternity Outpatient Medical Services Program
PHI	Protected Health Information
POC	Plan of Care
Provider	Entity authorized by Medicaid and MDHHS to provide MIHP services
RD	Registered Dietitian
RN	Registered Nurse
Social Worker	Licensed Social Worker (LBSW, LLBSW, LMSW and LLMSW)

## MIHP Operations Guide: Cycle 8

### Section 0 – General Certification Requirements

This section details policies relevant to the certification review process. The purpose of the certification review is to verify the provider's compliance with policies put in place by Medicaid and MDHHS MIHP. Additional guidance can be found in the Certification Companion Guide.

#### Protocol Approval Process

- Provider must submit protocols in accordance with the protocol specification requirements.
- MDHHS MIHP will provide feedback regarding compliance with specifications.
- Provider will submit any necessary edits.
- MDHHS MIHP will approve protocols to be implemented by providers.

#### During Certification Review

- Provider must provide all requested documents by 10:00 A.M. on the first day of the certification review.
- Provider is required to produce one complete chart for each beneficiary. Only documents in the identified chart will be reviewed.

#### Certification Categories

- Provisional Certification (new providers only)
  - MDHHS MIHP grants new providers Provisional Certification upon completion of the new provider training requirements and onsite provisional certification review of protocols.
  - A follow up certification review will occur approximately nine months after Provisional Certification status is granted.
  - MDHHS MIHP will conduct a consultation visit approximately four months after the provider receives Provisional Certification status.
- Extended Full
  - Existing provider receives at least 97% on the certification review.
  - Next certification review will occur approximately 36 months after Extended Full status is granted.
  - MDHHS MIHP will offer a consultation approximately 18 months after provider receives an Extended Full Certification. This consultation is voluntary.
- Full Certification
  - Existing provider receives at least 90% on the certification review.
  - Next certification review will occur approximately 18 months after Full Certification status is granted.
- Conditional Certification
  - Existing or new provider receives at least 70% on the certification review.
  - Next certification review will occur approximately nine months after Conditional Certification status is granted.
  - MDHHS MIHP will provide one consultation to providers who receive Conditional Certification.

## MIHP Operations Guide: Cycle 8

### **After Certification Review**

- MDHHS MIHP will send the Certification Report Letter within 30 calendar days after the certification review is completed.
- Based on the outcome of the certification review, a Corrective Action Plan (CAP) may be required.
  - Provider must submit a CAP to address any critical indicators (those weighted a 3, 4, or 5) that were found to be not met.
  - Provider must submit a CAP using the *Corrective Action Plan Submittal Form* to [MIHP@Michigan.gov](mailto:MIHP@Michigan.gov) within 21 calendar days of receiving the Certification Report Letter.
  - MDHHS MIHP will review the CAP and will approve or return for revisions within 14 calendar days of receipt.
  - Provider will submit CAP revisions within five business days.
  - CAP must be approved within three submissions to receive full credit on the next certification review.

Note: Improvement regarding indicators on CAP will be evaluated during certification reviews beginning with Cycle 9. Please see details in Section 3 - Quality Assurance.

### **Decertification**

- MDHHS MIHP will decertify an existing provider that receives Conditional Certification status for two successive reviews.
- MDHHS MIHP will decertify an existing provider that receives less than 70% on their certification review.
- MDHHS MIHP may authorize an emergency decertification if there is a pattern of activity that threatens the health, well-being, or safety of a beneficiary.
  - MDHHS MIHP may make an unannounced site visit, based on one or more of the following:
    - A whistleblower reports or MDHHS MIHP suspects possible fraud/abuse.
    - A beneficiary or other entity lodges a complaint of a serious nature regarding unethical behavior or quality of services.
    - There are unusual or questionable findings in a certification review, during a consultation visit or through other communication.
  - Provider may be decertified based on the information acquired during this visit.

### **Voluntary Inactive Status and Termination**

- Provider with Full Certification or Extended Full Certification status may request to move into inactive status for a minimum of six months and a maximum of 12 months.
- Provider may request to terminate at any time.

Note: Termination Protocol must be submitted to MDHHS MIHP and followed. Please see Certification Companion Guide for details.

## MIHP Operations Guide: Cycle 8

### Section 1 – Personnel & Training

This section details policies relevant to personnel, training, and agency communication. The purpose of this section is to ensure beneficiaries receive services from qualified and trained home visitors.

#### Personnel Roster

- Provider must use the *Personnel Roster* to identify all staff.
- *Personnel Roster* must be updated and submitted to MDHHS MIHP within 10 business days of any personnel change.
- *Personnel Roster* must correspond with MILogin, identifying all personnel who have access to the database.
- Each MIHP staff member authorized to use the MILogin system must use their unique MILogin username and password.

#### Home Visitor Credential and Experience Requirements

- Provider must continuously ensure home visitors meet the qualifications defined by the Medicaid Provider Manual, and proof of qualifications must be maintained in the staff file.
- Provider staff must include a program coordinator, a nurse and a social worker
  - Program coordinator may also serve as a nurse, social worker, RD or infant mental health specialist.
- Other staff who can provide billable services include an RD, an infant mental health specialist and an IBCLC® who is also a nurse or social worker.

Note: Internships do not count toward the one year of experience required

- Waiver of Professional Experience Requirement
  - Provider may request experience requirement be waived for any of the following professional staff who meets all other requirements in Medicaid policy:
    - Registered Nurse
    - Licensed Social Worker
    - Registered Dietician
    - Infant Mental Health Specialist
  - MDHHS MIHP *Waiver Approval Letter* must be maintained in the staff file.

Note: For details regarding Home Visitor credentialing and experience requirements, please see Medicaid Provider Manual, Section 1.2.

#### Confidentiality

- Staff must sign a confidentiality statement upon hire.

#### Training

- All staff must complete the following trainings:
  - Overview of Maternal Infant Health Program Training
  - Introduction to Health Equity
  - Systemic Racism
- Home Visitors must complete all MIHP Required Trainings.

## MIHP Operations Guide: Cycle 8

Note: MIHP Required Trainings are dictated by staff start date. Course completion certificates will be reviewed for staff hired prior to 10.01.19.

- *Notice of New Professional Staff Training Completion* must be completed and maintained in staff files.
- *Notice of Staff Waiver Completion* and *Professional Staff Waiver Training Matrix* must be completed and maintained in staff file for all waiver staff.
- Coordinator or their designee must attend all MDHHS MIHP coordinator meetings.
- Coordinator or their designee must attend the entirety of the Michigan Home Visiting Conference, including the MIHP Model Day session.
- All documentation must be maintained in staff files.
- All required trainings and other waiver staff requirements must be completed prior to conducting home visits independently.

### **Internal Communication**

- Coordinator is responsible for disseminating all communication to agency staff, including:
  - Weekly updates
  - Regional coordinator meeting program updates and content
  - MIHP alerts
  - MDHHS MIHP correspondence
  - Great Start Collaborative correspondence

## **Section 2 – Facility, Technology & Protected Health Information (PHI)**

**This section details policies relevant to the facilities, technology and methods for handling protected health information. The purpose of this section is to verify that beneficiaries are able to identify and contact providers, facilities are ADA compliant, and beneficiary program and protected health information is documented and protected appropriately.**

### **ID Badges**

- Home Visitors must carry identification (ID) badges with them when conducting home visits. The ID badge must include:
  - Picture of the staff person
  - Staff person name
  - Provider name

### **Provider Phones**

- Provider must have a business phone listed in the MIHP Directory with a message that includes after-hours emergency information, including directions to call 9-1-1 or go to the nearest emergency room.

### **Provider Facility**

- Requirements for facilities in which beneficiaries are seen:
  - Adequate privacy for beneficiary counseling and education.
  - Adequate privacy whenever beneficiary information is discussed with others.



## MIHP Operations Guide: Cycle 8

- A space to accommodate MDHHS MIHP in a smoke-free, pet-free area with a table or desk, chairs and working restroom.
- Entrances, restrooms, passageways, and other public areas are readily accessible and usable by individuals with disabilities, including individuals who use wheelchairs.
- Aisles, passageways and service rooms that are free of hazards, kept clean and orderly and will assure staff and beneficiary safety and safe passage.
- No objects protruding from walls.
- Handrails installed in stairways having four or more risers.
- Floors, platform stair treads, and landings that are maintained and free from broken, worn, splintered or loose pieces that would create a tripping or falling hazard.
- Two or more exits that permit prompt escape in case of fire or other emergencies.
- Functioning fire alarm system.
- Well-lit and well-ventilated exits, hallways, restrooms and offices/meeting rooms.
- Fire extinguishers located where they are readily seen and accessible along normal paths of travel, maintained in a fully charged and operable condition, and kept at a designated place and ready to use.
- Requirements for facilities in which beneficiaries are not seen:
  - A space to accommodate MDHHS MIHP in a smoke-free, pet-free area with a table or desk, chairs and working restroom.

### **Protected Health Information (PHI)**

- Storage
  - All PHI must be kept in a triple-locked system unless a record or document is actively in use.
- Travel
  - Provider must carry only the minimum identifiable information necessary to perform their job duties.
  - When removing records from the office, provider must maintain at least a double-locking system. Records should be returned to the office by close of business. When this is not feasible, records must maintain at least a double-lock.
    - Paper records must remain locked inside of a box or bag.
    - Electronic records must remain password protected.
    - Records must be kept in a locked vehicle, trunk, room or building.
- Communication
  - Staff communicating PHI electronically must do so in compliance with Health Insurance Portability and Accountability Act (HIPAA) by using fax, an email encryption software or a secure EMR system.
- Retention
  - Provider must retain records, including any applicable physician orders, for at least seven years from the last date of service, unless a longer retention period is otherwise required under federal or state laws or regulations, regardless of change of ownership or termination of participation in Medicaid or MIHP.
  - Records must remain at least triple-locked.
  - Records must be destroyed appropriately after the end of the retention period.

## MIHP Operations Guide: Cycle 8

- Accessibility
  - Provider must permit MDHHS MIHP access to all information concerning services reimbursed by Medicaid. This access does not require authorization from the beneficiary because the purpose of disclosure is permitted under the HIPAA rule.
  - Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination as a Medicaid provider.
  - Records may only be released to other individuals or organizations if they have a consent signed by the beneficiary authorizing release of the records, or if the disclosure is for a permitted purpose under all applicable confidentiality laws.
    - Any information released is limited to the intent of the "need to know" standard (i.e., limited to the information needed to accomplish the purpose of the person to whom the record is being released).

### Section 3 – Quality Assurance

**This section details policies relevant to internal provider quality assurance and mechanisms for beneficiary to file a grievance. The purpose of this section is to institute a system for identifying opportunities for improvement that lead to process changes and responding to beneficiary feedback to improve services.**

#### Quality Assurance

- Care Coordinator must monitor their records in accordance with the Medicaid Provider Manual, Section 2.6.
- Chart audits
  - Must be conducted at least quarterly.
  - Must be documented and documentation must be onsite for review.
- Billing audits
  - Must be conducted at least quarterly.
  - Must be documented and documentation must be onsite for review.
- Documentation is maintained in accordance with provider protocol.
- Provider must demonstrate improvement in critical indicators, starting in Cycle 9.

#### Grievances

- Provider must document a process for handling beneficiary grievances.

### Section 4 – Contracts & Community Engagement

**This section details requirements for contracts, community engagement and relationship building with specific entities.**

#### Contracts

- Contracts and letters of agreement with external entities providing beneficiary services must be current and include:

## MIHP Operations Guide: Cycle 8

- Time period of the agreement
- Names of the individuals providing services
- Where the billing responsibility lies
- Language that meets HIPAA standards

### **Arrangements for Beneficiary Services**

- Provider must arrange for backup staffing for nursing and social work services.
  - Backup staff personnel must meet the minimum required standards in Medicaid policy. Arrangements must include at least one of the following:
    - Collaboration with another MIHP provider.
    - Individual professional provider.
    - Arrangements with a community agency.
    - Use of internal staff.
  - Arrangement must be in writing with verification that the external agency or individual agrees to the arrangements.
  - Backup staff must complete the following trainings before independently conducting visits:
    - Overview of the Maternal Infant Health Program Training Course
    - Introduction to Health Equity
    - Systemic Racism
    - Prenatal Basics for Home Visitors
    - Child Development: Secrets of Baby Behavior
- Provider must notify MDHHS MIHP within five business days via email when they are void of a nurse or social worker for six consecutive weeks.
- Provider must notify MDHHS MIHP within five business days via email when a backup staff has been in place for 12 consecutive weeks.
- Provider must arrange for beneficiaries to be seen by supplementary disciplines, including an RD, infant mental health specialty, and IBCLC®.
  - Provider must identify the entity by name.
  - Provider must illustrate process for referring beneficiaries under required circumstances.
- Maternal-Only providers must establish a written agreement with another MIHP provider for the purpose of referring a beneficiary for infant services.
- Provider must arrange for interpretation services, including limited English proficient, deaf and hard of hearing, and visually impaired beneficiaries.
  - Provider must identify how they will arrange for services under each circumstance, including at least one of the following:
    - Staff with the skills to meet beneficiary needs.
    - Verbal or written agreement with an identified community organization.
    - Assistive technology devices for interpretation.
    - Verbal and written agreement with another MIHP provider for the purpose of transferring beneficiaries.
  - Provider's protocol must reference the federal Limited English Proficiency (LEP) mandate (Executive Order 13166, August 11, 2000).

## MIHP Operations Guide: Cycle 8

### Notes:

- Use of family or friends over the age of 18 may be used when requested by the beneficiary, however this cannot be a provider's sole interpretation service plan.
- Provider must identify verified sources, such as those provided by an agency of the State of Michigan, a community services referral agency, or an intermediate school district. Providers are responsible for paying for the cost of services that are provided on a fee basis.
- Use of interpretation software is permissible, provided the developer has certified that the software is HIPAA compliant and documentation of such certification is made available upon the request of MDHHS MIHP.
- Under the "reasonable accommodation" provision of the Americans with Disabilities Act (ADA) of 1990, MIHP agency staff may read documents to blind or visually impaired beneficiaries or otherwise make use of assistive technology. Similarly, agency staff may provide written materials to deaf/hard of hearing or hearing impaired beneficiaries or may communicate with beneficiaries via writing.

### **Resources**

- Provider must be able to demonstrate linkage with the Great Start Collaborative in each county in their service area.
- Provider must demonstrate knowledge of community resources in each county in their service area.

### **Early On**

- Provider must identify local entity providing *Early On* services and establish a referral protocol.

### **Children's Protective Services (CPS)**

- The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and other covered entities to report cases of suspected child abuse or neglect to CPS.
- Provider must establish protocol that complies with the reporting requirements mandated by the Michigan Child Protection Law (Act No. 238, Public Acts of 1975), which must include:
  - Time frame for reporting.
  - Reporting method identified by provider.
  - Time frame to file a written report, if using phone method for reporting.
  - Person in charge to be notified that a report has been made.
- Provider must demonstrate efforts to coordinate with CPS, including establishing protocol that defines how provider will:
  - Make referrals to CPS.
  - Initiate follow-up contact with CPS.
  - Attempt to participate in multidisciplinary team meetings involving infant beneficiaries.

## MIHP Operations Guide: Cycle 8

### Section 5 – Outreach & Enrollment

This section details policies for connecting with and enrolling beneficiaries. The purpose of this section is to ensure beneficiaries receive streamlined care across providers and are enrolled according to program requirements.

#### Outreach

- Provider must conduct outreach and document outreach activities.

#### Accommodations

- Provider must accommodate beneficiary schedules or refer the beneficiary to another MIHP.

#### Referrals to MIHP

- Provider must respond to all referrals for maternal beneficiaries within 14 calendar days after the referral is received.
- Provider must respond to all referrals for infant beneficiaries using the following timelines:
  - Infants referred prior to discharge from hospital: two business days after discharged
  - Infants referred after discharge from hospital: seven calendar days after the referral is received
- Referral date must be documented on the appropriate forms checklist.
  - *Maternal Forms Checklist*
  - *Infant Forms Checklist*
- Provider must document all attempts to contact beneficiaries on the *Contact Log*.

#### Assessment Visit

- Consent Forms
  - Home Visitor must review content and obtain beneficiary/caregiver signature on the appropriate *Consent to Participate* before administering the Risk Identifier.
    - *Maternal Consent to Participate*
    - *Infant Consent to Participate*
  - Home Visitor must review content and obtain beneficiary/caregiver signature on the appropriate *Consent to Release PHI*.
    - *Maternal Consent to Release PHI*
    - *Infant Consent to Release PHI*
  - Provider must only communicate with the medical provider when the beneficiary has given consent for them to do so.
- Risk Identifier
  - Nurse or social worker works with the beneficiary/caregiver to complete the appropriate Risk Identifier.
  - Risk Identifier must be completed prior to additional MIHP services, unless an emergency is documented on the *Professional Visit Provider Note (PVPN)* or *Contact Log*.
  - Risk Identifier must be entered into MILogin and scoresheet obtained prior to billing for the visit.

## MIHP Operations Guide: Cycle 8

- Specifications regarding Assessment Visits for an infant:
  - Home Visitor must complete at least 90% of Infant Risk Identifier visits in the home or a community setting.
  - Home Visitor must document reasoning for an infant Assessment Visit being completed on the same date as a maternal postpartum Professional Visit.
- If beneficiary/caregiver declined services after the Risk Identifier, home visitor must:
  - Complete *Plan of Care, Part 1*
  - Provide beneficiary/caregiver with the Education Packet, text4baby flyer, or list of approved phone applications
  - Provider may choose whether to complete the *Discharge Summary* at this time. If not completed, provider should maintain contact with the beneficiary to determine future interest in participation. Contact should be documented on the *Contact Log*.
- Plan of Care, Part 1 (POC 1)
  - Home Visitor must complete activities associated with the appropriate *POC 1*.
    - *Maternal POC 1*
    - *Infant POC 1*
- Welcome Packet/Assessment Visit Documents
  - Home Visitor must give beneficiary/caregiver a provider specific Welcome Packet.
  - Components of the Welcome Packet must include at least the following:
    - Education tools, including at least one of the following:
      - Education Packet
      - text4baby flyer
      - List of approved phone applications

Note: Providers must be able to access and provide the Education Packet to beneficiaries/caregivers who do not have adequate access to technology or request a physical document.
    - Provider contact information
    - Lead Fact Sheet
    - Healthy Michigan Plan
    - *Your Rights and Responsibilities as an MIHP Participant [MDHHS 5707]*
    - Information on filing a grievance with the provider
- Emergency Needs/Referrals
  - Home Visitor must address any emergent needs and referrals the beneficiary/caregiver has identified during the assessment visit.
  - Content addressed during this visit may be documented on the *Contact Log* and/or *POC 1*.

Note: Home Visitors may address needs of the beneficiary during the assessment visit. However, referrals given and interventions provided for high risk domains must be addressed again within the first three Professional Visits.
- All documentation as to why a requirement did not occur must be from the beneficiary's perspective.

## MIHP Operations Guide: Cycle 8

### Enrollment Exception

- Provider may request enrollment exceptions in the following instances:
  - Infant over 12 months of age
  - Continuation of services beyond 18 months
  - Risk Identifier scores no risk, but professional judgement indicates a need for services.
- Provider must request approval from MDHHS MIHP.
- Provider must refrain from providing services until approval has been received.
- Approval documentation must be kept in the beneficiary's chart.

### Plan of Care, Part 2 (POC 2)

- All POC 2 identified on the Risk Identifier scoresheet or by professional judgement must be added to the beneficiary's chart; these may include:
  - Maternal POC 2
    - Abuse Violence
    - Alcohol
    - Breastfeeding\*
    - Family Planning
    - Food/Nutrition
    - Housing
    - Medical Considerations
    - Pregnancy Health
    - Social Support
    - Stress/Depression
    - Substance Misuse
    - Tobacco
    - Transportation
  - Infant POC 2
    - Infant Breastfeeding\*
    - General Infant Development
    - Infant Feeding
    - Infant Health Care
    - Infant Safety
    - Family and Social Support
    - Substance Exposed Infant\*
  - Provider must check the appropriate Intervention Level based on the Risk Identifier or professional judgement.

\*Indicates POC 2 that can only be identified through professional judgement, these domains do not have a score on the Risk Identifier.

#### Notes:

- Birth Health may score as a result of the Risk Identifier but does not have a plan of care. However, services may still be offered for the beneficiary based on the professional judgement of the provider.
- POC 2 Intervention Level Adjustments
  - Home Visitors may decide to adjust the Intervention Level on a given POC 2 on or after the first Professional Visit.
  - If this occurs, Home Visitor must:
    - Check the new Intervention Level
    - Document the date of the change on the POC 2

## MIHP Operations Guide: Cycle 8

- POC 2 Additions
  - Home Visitors may add POC 2 when professional judgement indicates the beneficiary/caregiver meets criteria for a POC 2 that did not score on the Risk Identifier or for those who do not produce a score (e.g., Breastfeeding). This can occur at two different times:
    - Prior to signing the POC 3, Home Visitor must write the date of the Risk Identifier on the POC 2 and check the appropriate Intervention Level
    - After signing the POC 3
      - Home Visitor must:
        - Document the reason for the POC 2 addition on the PVPN or Contact Log.
        - Write the date the new POC 2 was added to the beneficiary's chart under the appropriate Intervention Level.
      - Nurse and a social worker must sign the POC 3 to acknowledge the addition of the POC 2.

### **Plan of Care, Part 3 (POC 3)**

- Nurse and social worker must sign the POC 3 to verify they are aware of and consent to the POC 2 developed for the beneficiary.
  - Signatures must be within 10 business days of each other.
  - Case Manager must be established
  - Both signatures must be obtained prior to providing any additional services, unless an emergency is documented on the *PVPN* or *Contact Log*.
- Nurse and social worker must sign the POC 3 within 10 business days of each other when any additional POC 2 is added throughout the course of care.

### **Beneficiary Transfers**

- Provider receiving beneficiary records must:
  - Obtain a signature on *the Consent to Transfer MIHP Record to a Different Provider*.
  - Send signed *Consent to Transfer MIHP Record to a Different Provider* to sending provider.
  - Refrain from serving the beneficiary prior to receiving documents from the sending provider, unless an emergency is documented on the *PVPN* or *Contact Log*.
  - Obtain a signature on the *Consent to Participate and Consent to Release Protected Health Information*.
  - Notify the beneficiary's medical provider of the transfer.
  - Use the *Forms Checklist for Transfers*.

Note: Provider may contact MDHHS MIHP staff if the records are not received within 10 business days.
- Provider sending beneficiary records must:
  - Send the following documents within 10 business days of receiving the signed *Consent to Transfer MIHP Record to a Different Provider* is received:
    - Risk Identifier
    - Risk Identifier Score Sheet



## MIHP Operations Guide: Cycle 8

- POC 1
- All POC 2
- POC 3
- All Professional Visit Progress Notes
- Refrain from completing a Discharge Summary

### Forms / Documents

- General
  - Provider must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.
  - Providers must use standardized forms developed by MDHHS MIHP.
  - MDHHS MIHP forms must be complete and accurate in accordance with form instructions.
  - Altering Records
    - Home Visitor alters information on a program form by drawing a single line through the error and writing their initials next to the error
      - The original information must remain visible. White-out, permanent marker or scratching out errors are not acceptable.
    - Only the Home Visitor who completed the original form may alter the record.
    - Electronic record systems must have a tracking mechanism to identify who altered program documents and what content was changed.
- The following forms must be present, when applicable, and complete with respect to the required data elements indicated on the instructions:
  - *Forms Checklist*
  - *Contact Log*
  - *Consent to Participate*
  - *Consent to Release PHI*
  - *Beneficiary Status Notification*
  - *Maternal Prenatal Communication*
  - *Infant Care Communication*
  - *Risk Identifier*
  - *Risk Identifier scoresheet*
  - *Plan of Care, Part 1*
  - *Plan of Care, Part 2*
  - *Plan of Care, Part 3*
  - *Professional Visit Progress Notes*
  - *All necessary MCIR printouts*
  - *All ASQ Information Summaries*
  - *Discharge Summary*
  - *Physician Orders*
  - *Notification of Multiple Charts Open*
  - *Consent to Transfer Records*
  - *Transfer Checklist*
- *Contact Log*
  - *Contact Log* must illustrate any required program element that can occur throughout the course of care but is not demonstrated in the chart. This includes:
    - Instances when a beneficiary was not seen in a given month at any point between the Risk Identifier date and Discharge Summary date
    - A maternal beneficiary who did not receive a home visit once during pregnancy and once postpartum

## MIHP Operations Guide: Cycle 8

- At least one visit conducted by both a nurse and a social worker
- Addressing all POC 2 domains
- Discussing and/or developing a Safety Plan, under the required circumstances
- Discussing and/or developing an Action Plan
- Initiating a referral for a beneficiary whose POC 2 includes the Stress/Depression domain
- Initiating a referral for a beneficiary whose POC 2 includes the Food/Nutrition domain at a high risk intervention level
- A maternal beneficiary whose immunizations were not discussed, chart does not include a MCIR, or with whom infant immunizations were not discussed
- Provider may document these items on the *PVPN* during the course of care. When a chart is closed, this information must be transferred to the *Contact Log*. Indicators relevant to the above items will be reviewed for closed charts using the *Contact Log* only.

### Section 6 – Communication & Professional Visits

**This section details specific requirements throughout the beneficiary’s course of care. The purpose of professional visits and beneficiary-specific communication is to support beneficiaries and families during the perinatal period.**

#### Communication with Medical Provider

- Provider must communicate with the beneficiary’s medical provider using the *Beneficiary Status Notification* and appropriate *Communication Form* within 14 calendar days under the following circumstances:
  - Beneficiary enrolls in MIHP
  - Beneficiary transfers to a new MIHP provider
  - Beneficiary is discharged from MIHP
    - Provider must send a copy of the *Discharge Summary*.
- Documentation must be maintained in the beneficiary’s chart.
- Provider must comply with HIPAA requirements.

#### Communication with Medicaid Health Plan (MHP)

- Provider must update and send the *MHP Communication Tool* at least monthly.
- Provider must comply with HIPAA requirements.

Note: Beneficiary does not have to provide consent for the provider to communicate with the Medicaid Health Plan.

#### Professional Visit Logistics

- The standard program includes nine Professional Visits. Information regarding additional visits for infants can be found below (see Infant-Specific Components and Physician Orders).
- Home Visitor must conduct a visit with each beneficiary each month.
  - If a beneficiary is not seen once in a given month, document the reason on the *Contact Log*.

## MIHP Operations Guide: Cycle 8

- If a beneficiary is seen more than once in a given month, document the reason on the *PVPN* or *Contact Log*.
- Nurse and social worker must each conduct a visit with the beneficiary during the course of care.
  - If either the nurse or social worker does not conduct a visit with the beneficiary during the course of care, there must be documentation in the *Contact Log* as to why not.
- Home Visitor must conduct visits in the home. If a beneficiary/caregiver declines, the visit may be completed in the provider's office or at an agreed upon site in the community.
  - For a community visit, there must be documentation on the *PVPN* as to why.
  - Home Visitor must conduct at least one prenatal and one postpartum visit in the home, unless documentation on the *Contact Log* demonstrates the beneficiary declined.
  - Home Visitor must conduct at least 80% of infant visits in the home or a community setting.
- Home Visitor must visit the beneficiary for a minimum of 30 minutes. Documentation of this must be clear on the *PVPN*.
- Home Visitor must address all domains in the beneficiary's POC 2 prior to discharge, or there must be documentation on the *Contact Log* that states why this did not occur.
- All documentation as to why a requirement did not occur must be from the beneficiary's perspective.

### **Professional Visit Content**

- Home Visitor must address at least one of the following at every visit, as documented on the *PVPN*:
  - POC 2 risk domain interventions
  - Topics identified by the beneficiary
  - Topics identified through professional judgement of the Home Visitor
- Home Visitor must address all POC 2 designated as high risk within the first three professional visits and appropriately document on the *PVPN*.
  - Home Visitor must document on the *PVPN* or *Contact Log* if this requirement is not met.
- Home Visitor must document a detailed account of what transpired during each visit on the *PVPN*.
  - Beneficiary/caregiver's response to the visit interventions/issues must be documented.
  - Beneficiary/caregiver's feedback regarding the visit must be documented.
- Nurse or social worker with an IBCLC® certification may provide up to two lactation visits per beneficiary.
  - Lactation visits for maternal beneficiaries must occur postpartum.
  - Lactation visits must be documented on the *MIHP IBCLC® Postpartum Lactation Support and Counseling PVPN*

Note: For additional specifications, please see Medicaid Provider Manual, Section 2.13.

## MIHP Operations Guide: Cycle 8

### MIHP Safety Plan

- Home Visitor must discuss/develop a written or verbal safety plan with the beneficiary/caregiver when any of the following domains are designated as high risk, and the POC 2 intervention number for that domain must be documented as listed:
  - Stress/Depression: Intervention #13
  - Abuse/Violence: Intervention #12
  - Substance Exposed Infant: Intervention #9
  - Infant Safety: Intervention #6
- Home Visitor may discuss/develop a written or verbal safety plan with any beneficiary/caregiver for any reason. MDHHS MIHP encourages this practice.

Note: Beneficiary/caregiver's response to the Safety Plan must be documented (e.g., developed safety plan, declined to develop safety plan) in the Beneficiary Response to Intervention section.

- If the Home Visitor does not present the Safety Plan under the required circumstances, the reason why must be documented on the *Contact Log*.

### MIHP Action Plan

- Home Visitor must assist every beneficiary/caregiver to create at least one Action Plan.
- Home Visitor must document the development or review of an Action Plan through the checkbox on the *PVPN*.
- If an Action Plan was not developed, the reason why must be documented on the *Contact Log*.

### Referrals

- Home Visitor must make referrals throughout the beneficiary's course of care. Referrals must be documented on the *PVPN*.
- Home Visitor must follow up on referrals within three subsequent visits, or document on the *PVPN* or *Contact Log* the reason this did not occur.
- Home Visitor must document the status of the referral in the "Outcome of Previous Referrals" section on the *PVPN*.
- Required referrals based on POC 2:
  - Home Visitor must refer a beneficiary/caregiver for mental health services from a mental health professional or medical care provider whose POC 2 includes the Stress/Depression domain.
  - RD must provide nutrition counseling or Home Visitor must refer a beneficiary for RD services whose POC 2 includes the high risk for the Food/Nutrition domain.
    - If providing and billing for nutrition counseling, provider must obtain a physician order prior to providing this service.
  - If any required referral is not made, documentation on the *Contact Log* must explain why.

## MIHP Operations Guide: Cycle 8

### Maternal-Specific Components

- Maternal beneficiaries must receive at least one home visit during pregnancy and one home visit postpartum. If either of these required home visits do not occur, the reason must be documented on the Contact Log.
- Maternity Outpatient Medical Services Program (MOMS) participants cannot receive postpartum visits.
- Home Visitor must discuss immunizations during care.
  - Home Visitor must discuss the beneficiary's immunization status at least once during the course of care. This must be documented on the checklist of the *PVPN*.
    - Michigan Care Improvement Registry (MCIR) record or a screenshot of the attempt to obtain it must be included in the chart at least once during the course of care.
  - Home Visitor must discuss infant immunizations at least once during the maternal course of care. This must be documented on the checklist of the *PVPN*.
  - If either the maternal or infant immunizations are not discussed during the course of care, the reason must be documented on the *Contact Log*.
- Maternal-Only Provider must refer maternal beneficiary to another MIHP provider for the purpose of offering infant services.

### Infant-Specific Components

- Home Visitor must discuss the beneficiary's immunization status with the caregiver at every home visit. This must be documented on the checklist of the *PVPN*.
  - MCIR record must be accessed and discussed when the infant is five months of age or at the first visit after the infant has reached five months of age.
    - A printout or screenshot of an attempt to access the record in this timeframe must be maintained in the chart.
    - For infants enrolled after five months of age, MCIR must be accessed and discussed at the first professional visit.
  - MCIR record may be accessed at any time during the course of care.
  - If immunization status is not discussed at a given visit or the MCIR is not accessed at the appropriate timeframe, *PVPN* or *Contact Log* must illustrate the reason why.
- Substance Exposed Infant Visits
  - Provider must add the Substance Exposed Infant POC 2 to the beneficiary's chart as soon as circumstances meet criteria, as defined on the POC 2.
  - Home Visitor may utilize interventions from the Substance Exposed Infant POC 2 at any visit prior to the 19th visit. MDHHS MIHP encourages this practice.
  - Home Visitor must utilize interventions from the Substance Exposed Infant POC 2 at every visit after the first 18.
  - Provider must obtain a physician order for any visits after 18 (see Physician Orders below).

### Physician Orders

- Provider may request authorization from a physician for the following instances:
  - Beneficiary receives nutrition counseling from an internal RD.

## MIHP Operations Guide: Cycle 8

- Infant beneficiary demonstrates the need for additional visits beyond the standard nine.
  - Up to nine additional visits may be authorized.
- Infant beneficiary is identified as substance exposed and would benefit from additional visits beyond 18.
  - Up to 18 additional visits may be authorized.
- Provider must obtain the physician order prior to administering services based on the above instances.
- Physician orders can only be authorized for 12 months and must be updated annually.
- Physician orders may be authorized for:
  - Individual beneficiaries
  - All beneficiaries who meet criteria authorized by the physician
- Provider must maintain a current physician order in the beneficiary's chart.
- Entities approved to authorize physician orders include:
  - Physician
  - Physician Assistant
  - Nurse Midwife
  - Pediatric Nurse Practitioner
  - Family Nurse Practitioner
- Provider must ensure physician order includes:
  - Provider's agency name
  - Medical provider's name, address, phone number
  - Medical provider's signature and credentials (CNM, DO, MD, NP, PA)
  - Date of signature
  - Rationale for the visits

### **Blended Visits**

- Blended Visits can occur under these instances:
  - Mother of enrolled infant becomes pregnant
  - Sibling of enrolled infant is born

Note: Multiple Births is another form of Blended Visit, but holds different requirements. See Multiple Births below.
- Provider may complete a Risk Identifier for each beneficiary in the instances stated above.
- Documentation specifications
  - Notification of Multiple Open Charts must be in each beneficiary's chart, unless using a single-family chart.
  - Home Visitor must use one *PVPN* for billing purposes:
    - Home Visitor must check the "Blended Visit" box on the *PVPN*.
    - Home Visitor must document information regarding the other beneficiary in the "Other Visit Information" section of the *PVPN*.
    - *PVPN* must be filed in the appropriate chart.

Note: All program requirements apply to all beneficiaries in these scenarios.

## MIHP Operations Guide: Cycle 8

### Multiple Births

- Provider must serve all infants in the instance of multiple births.
- Provider must complete all of the following documents for each infant:
  - *Consent to Participate*
  - *Consent to Release Protected Health Information*
  - Risk Identifier
  - Plan of Care
  - ASQ-3 assessments and Information Summary Sheets
  - ASQ: SE-2 assessments and Information Summary Sheets
  - Discharge Summaries
- Documentation Specifications
  - *Notification of Multiple Open Charts* must be in each beneficiary's chart, unless using a single-family chart.
  - Home Visitor must complete the *PVPN* for one identified infant for the entire course of care. Home Visitor must:
    - Check the "Blended Visit" box on the *PVPN*
    - Document information regarding the other infant(s) in the "Other Visit Information" section of the *PVPN*
    - File the *PVPN* in the chart of the infant identified as the beneficiary and whose Medicaid ID is used for reimbursement of all visits

### Developmental Screenings

- Required Screening Time Frame and Logistics
  - Bright Futures
    - Age adjustment must occur for infants born at gestational age of less than 40 weeks
    - Home Visitor must repeat questionnaire within two weeks utilizing the appropriate Bright Futures or ASQ-3 questionnaires if the Risk Identifier scores for Infant Development.
  - Ages & Stages Questionnaires-3 (ASQ-3)
    - Age adjustment must occur for infants born at gestational age of 37 weeks or less.
    - Home Visitor must complete the age-appropriate ASQ-3 questionnaire at the first professional visit.
    - Home Visitor must complete ASQ-3 questionnaire with the caregiver every four months for infant whose score is in the white area.
  - Ages & Stages Questionnaires: Social/Emotional-2 (ASQ:SE-2)
    - Age adjustment must occur for infants born at gestational age of 37 weeks or less.
    - Home Visitor must complete each of the following screenings throughout an infant's enrollment:
      - 2 months (1 month, 0 days – 2 months, 30 days)
      - 6 months (3 months, 0 days – 8 months, 30 days)
      - 12 months (9 months, 0 days – 14 months, 30 days)

## MIHP Operations Guide: Cycle 8

- 18 months (15 months, 0 days – 20 months, 30 days)
- 24 months (21 months, 0 days – 26 months, 30 days)
- 30 months (27 months, 0 days – 32 months, 30 days)
- 36 months (33 months, 0 days – 41 months, 30 days)
- Provider must follow guidelines outlined in the ASQ-3 and ASQ: SE-2 User Guides.
- Home Visitor must document reason for any screening that is not completed at the appropriate visit or in the appropriate timeframe on the *PVPN* or *Contact Log*.
- Follow-Up
  - Home Visitor must provide ASQ-3 Learning Activities to caregiver in the following three circumstances:
    - Infant's score is in the gray area in one or more domain on the ASQ-3 Information Summary
    - Caregiver declines referral to *Early On*
    - Infant was referred but did not qualify for *Early On* services
  - Home Visitor must rescreen infant in two months if infant's score is in the gray area on one or more of the domains on either the ASQ-3 or ASQ:SE-2
- Referral
  - Home Visitor must refer infant to *Early On* service provider in the beneficiary's county if infant's score is in the black area in one or more domain on either the ASQ-3 or ASQ:SE-2 Information Summary.
  - If the infant did not qualify for *Early On* services, Home Visitor must begin conducting ASQ-3 and ASQ:SE-2 once that information is received.
- Documentation
  - ASQ-3 Information Summary
    - Home Visitor must complete Sections 1-4
  - ASQ:SE-2 Information Summary
    - Home Visitor must complete Sections 1-5
  - Information Summaries must be maintained in the beneficiary's chart
  - For ASQ-3 or ASQ:SE-2 completed by another entity, Summary must be obtained and filed in the beneficiary's chart
    - If Information Summary is not present in the chart, document attempts to acquire Summary on the *PVPN* or *Contact Log*.
  - Home Visitor must document reason for any screening that is not completed at the appropriate visit or in the appropriate timeframe on the *PVPN* or *Contact Log*.

### **Beneficiary Discharge**

- Provider must discharge beneficiaries within 30 days of the end of eligibility.
  - Maternal beneficiaries are eligible for participation up to 60 days postpartum, or the last day of the month in which the 60<sup>th</sup> day postpartum falls.
  - Infant beneficiaries are eligible until they turn 18 months of age.
- Discharge Summary printout or screenshot must be maintained in the beneficiary's chart.



## MIHP Operations Guide: Cycle 8

### Section 7 – Claims

#### Childbirth and Parenting Education

- Provider billing for childbirth or parenting education must follow curriculum consistent with Medicaid requirements. For more information, please see Medicaid Provider Manual, Section 2.11.

#### Blended Visits / Multiple Births

- Blended Visits
  - Provider must bill each Risk Identifier using the Medicaid ID for the appropriate infant or maternal beneficiary.
  - Provider must bill subsequent visits according to the PVPN used for the visit (maternal or infant).
- Multiple Births
  - Provider must bill each Risk Identifier using the Medicaid ID for the individual infant.
  - Provider must select and consistently use one infant's Medicaid ID for subsequent visits for all siblings in the group.

#### Substance Exposed Infant

- Provider must use code 96167 for visits 19-36 when authorized.
- Provider may use code 96168 for additional time spent with the beneficiary.
  - Code 96168 indicates an additional 15 minutes spent with the beneficiary.
  - Provider may use code 96168 up to two times per visit.

### Companion Guides

Additional information regarding many of these topics are posted on the website in Companion Guides. Providers will not be required to demonstrate compliance with information in the Companion Guides during the certification process. These documents are intended to provide guidance based on best practices and provider experiences. They will be updated periodically. Please refer to these documents to learn more.