



OPERATIONS GUIDE

**Division of Maternal and Infant Health
Bureau of Family Health Services
Population Health Administration
Michigan Department of Health and Human Services**

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Index of Frequently Used Acronyms

CC-1; CC-2	Conditional Certification-1; Conditional Certification-2
CCA	Care Coordination Agreement
CHAMPS	Community Health Automated Medicaid Processing System
CPS	Children’s Protective Services
EFC	Extended Full Certification
FC	Full Certification
FFS	Fee-For-Service
HIPAA	Health Insurance Portability and Accountability Act
IBCLC	International Board-Certified Lactation Consultant
IRI	Infant Risk Identifier
LSW	Licensed Social Worker (LBSW, LLBSW, LMSW and LLMSW)
MDHHS	Michigan Department of Health and Human Services
MHP	Medicaid Health Plan
MOMS	Maternity Outpatient Medical Services Program
MRI	Maternal Risk Identifier
NEMT	Non-Emergency Medical Transport
NFP	Nurse-Family Partnership
NPI	National Provider Identifier
NPO	New Provider Orientation
PC	Provisional Certification
PHI	Protected Health Information
POC	Plan of Care
PPIM	Prospective Provider Inquiry Meeting
RD	Registered Dietitian
RN	Registered Nurse
STI	Sexually Transmitted Infection

Section 1: Maternal Infant Health Program (MIHP) Overview

MIHP Purpose and Goals

- The Maternal Infant Health Program (MIHP) is Michigan’s largest evidence-based home visitation program for Medicaid eligible pregnant women and infants.
- MIHP promotes healthy pregnancies, positive birth outcomes, and healthy infant growth and development. The long-term goal of the MIHP is to reduce maternal and infant morbidity and mortality.
- MIHP services are designed to supplement regular prenatal/infant care and to assist healthcare providers in managing the health and wellbeing of the mother and baby.
- Medicaid enrolled pregnant women and/or primary caregivers and their infants up to 12 months are served in their homes by a team of registered nurses, licensed social workers, registered dietitians, infant mental health specialists and lactation consultants.
- Assistance is provided to help families support their basic needs, prenatal and parenting education, and referrals to community resources.
- MIHP provides preventive health services through a statewide network of providers, including: local public health departments, Federally Qualified Health Centers (FQHCs), tribal agencies, community-based organizations, hospitals, home health agencies, and individually-owned businesses, all of which are certified by the Michigan Department of Health and Human Services (MDHHS).
- MIHP serves Medicaid and Maternity Outpatient Medical Services (MOMS) beneficiaries. This program receives funding from both federal and State of Michigan sources to achieve its primary goal of reducing infant mortality and morbidity by promoting healthy pregnancies, positive birth outcomes and healthy growth and development.
- MIHP services are intended to:
 - Assist Medicaid and MOMS beneficiaries who, through health and social determinants risk assessments, are identified as those most likely to experience psychosocial or nutritional challenges during pregnancy and postpartum.
 - Supplement regular prenatal and infant care by supporting the efforts of physicians, nurse practitioners, certified nurse midwives, physician assistants and Medicaid Health Plans (MHPs) in their efforts to address the beneficiary’s health and well-being.

Medicaid Provider Manual References

- The *MIHP Operations Guide*, in conjunction with the *Medicaid Provider Manual* and *MIHP Certification Tool*, provides comprehensive program information and guidance for MIHP providers. The most current versions of these resources are found on the MIHP website, www.michigan.gov/mihp. These online resources are updated frequently throughout the year and MIHP providers are expected to become familiar with and refer regularly to the online versions to identify or verify the most current program requirements or procedures.

- The following *Medicaid Provider Manual* references pertain to MIHP providers:
 - Clinical Documentation Requirements
 - Section: *General Information for Providers*
 - Professional Services Claims Billing
 - Section: *Billing & Reimbursement for Professionals*
 - Primary Care Services
 - Section: *Federally Qualified Health Centers and Tribal Health Centers*
 - Beneficiary Coverage for Healthy Michigan Plan
 - Section: *Healthy Michigan Plans*
 - Home Health Agency (HHA) as an MIHP Provider
 - Section: *Home Health*
 - Suspected Abuse/Neglect
 - Section: *Home Health*
 - Childbirth Education Classes
 - Section: *Hospital*
 - Local Health Departments Reimbursement
 - Section: *Local Health Departments*
 - Maternal Infant Health Program Description
 - Section: *Maternal Infant Health Program*
 - Maternity Outpatient Medical Services Program (MOMS) Benefits
 - Section: *Maternity Outpatient Medical Services*
 - Medicaid Health Plans
 - Section: *Medicaid Health Plans*
 - Tribal Health Services
 - Section: *Tribal Health Centers*
 - Antepartum referral to MIHP
 - Section: *Practitioner*

Section 2: New MIHP Provider Process

Becoming an MDHHS MIHP Provider

- The Michigan Department of Health and Human Services certifies MIHP providers.
- Agencies applying to become an MIHP provider must:
 - comply with all licensing laws and regulations applicable to the provider's practice or business in Michigan;
 - not currently be excluded from participating in Medicaid by state or federal sanction;
 - provide services that are directly reimbursable per Medicaid and MDHHS policy;
 - enroll as a Medicaid provider; and
 - carefully follow the application process.

Application Process

STEP 1: An applicant interested in becoming an MIHP provider may contact the MDHHS MIHP staff via an inquiry email to the mihp@michigan.gov email box.

- The inquiry email must contain the:
 - Name of the prospective applicant
 - Contact person name, title, email address and telephone number
- MIHP staff will acknowledge receipt of the inquiry by return email to the interested agency's contact person. The acknowledgment email will contain details about the next scheduled Prospective Provider Inquiry Meeting (PPIM).

STEP 2: The prospective applicant must attend the scheduled PPIM, where they will receive important information about the application process. If an agency cannot attend the PPIM, the agency must send a new email to confirm attendance at a subsequent PPIM.

STEP 3: After attending the PPIM, the prospective applicant may complete and submit the application via email to mihp@michigan.gov by the date specified at the PPIM. **No exceptions or extensions will be given.**

STEP 4: If the application is acceptable, the agency will receive email notification of the date, time, and location of the next scheduled New Provider Orientation (NPO).

- The application will be rejected if it is received prior to the prospective applicant's attendance at the PPIM.
- The application will be rejected if it is received after the specified deadline.
- If an application is rejected for any reason, the prospective applicant must wait 18 months prior to reapplication, at which time all steps of the application process must be followed, including attendance at the PPIM.

STEP 5: Provisionally approved applicant staff must attend and successfully complete the MIHP New Provider Orientation (NPO).

- The following members of the approved applicant’s staff must attend the entire NPO:
 - Agency owner/MIHP Program Coordinator
 - Registered Nurse (RN)
 - Licensed Social Worker (LSW)
- The NPO provides an in-depth review of:
 - MIHP program operations
 - Required forms
 - Interventions
 - Criteria used during the onsite provisional certification review

STEP 6: A Provisional Certification Review will be conducted at the agency to assess the provisionally approved applicant’s readiness to begin providing services to MIHP beneficiaries.

- If the applicant passes Provisional Certification, nine-month Provisional Certification (PC) status is granted.
 - The agency will be designated an MIHP provider, listed on the *MIHP Coordinator Directory* and may begin rendering MIHP services.
- If the applicant fails the Provisional Certification Review, the agency may reapply after 18 months, and must follow the entire application process as outlined above.
- After PC status has been granted, a technical assistance site visit is conducted by an MIHP consultant within four to five months of provisional certification to assess:
 - Billing and program record charts
 - Program implementation
 - Any challenges the new provider may have encountered
- The provider engages Medicaid Health Plans (MHPs) in their service area to secure Care Coordination Agreements and Contracts.

STEP 7: The MIHP Provider will have a Certification Review scheduled approximately nine months after Provisional Certification status has been granted.

- If the new provider passes this certification review, nine-month Conditional Certification (CC-1) is granted.
- If the new provider receives 18 or more “Not Met” citations, the new provider is decertified.

STEP 8: The agency will receive another Certification Review approximately nine months after receiving the CC-1.

- If the new provider passes this review, a second nine-month Conditional Certification (CC-2) is earned.
- If the new provider receives 18 or more “Not Met” citations, the new provider is decertified.

STEP 9: The MIHP Provider will receive an additional Certification Review approximately nine months after receiving the CC-2.

- If the new provider passes this review, an 18-month Full Certification (FC) status is granted and the provider is placed in rotation schedule according to the MIHP Provider Re-certification Process.
- If the new provider receives seven or more “Not Met” citations OR three or more “Not Met” critical indicators, the new provider is decertified.

If an MIHP provider is decertified at any stage during the certification process, (e.g., PC, CC-1, CC-2, FC, or EFC), they must wait at least 18 months and then may enter the next application cycle, beginning as a prospective applicant by attending the Prospective Provider Inquiry Meeting.

Section 3: MIHP Required Staff

Staff Credential Requirements

- At a minimum, an MIHP provider staff must include a registered nurse (RN) and licensed social worker (LSW).
 - In this document, LSW refers to all Medicaid-approved licensures to practice social work (LBSW, LLBSW, LMSW and LLMSW).
- Optional staff may include the services of a registered dietitian (RD), infant mental health specialist and International Board-Certified Lactation Consultant (IBCLC).
- MIHP staff who work directly with beneficiaries in their homes or at other community settings must carry identification (ID) badges with them at all times. The ID badge must include:
 - Picture of the staff person
 - Staff person name
 - The agency name
 - The phrase “Maternal Infant Health Program (MIHP)” if it is not included in the agency name
- MIHP staff who are employed by agencies that issue ID badges to all of their employees (e.g., a local health department, FQHC, hospital system or home health agency) are not required to alter their badges to include “Maternal Infant Health Program (MIHP)” if they are not included in the agency name.
- All staff personnel files must include a copy of the *MIHP Field Confidentiality Guidelines*.
- All staff with access to protected health information (PHI), including MIHP owner and/or coordinator, must have signed confidentiality agreements before having contact with beneficiaries or handling PHI.
- Staff must meet the qualifications stated in TABLE 1 for their specific profession:

TABLE 1. Professional Staff Licensure

Profession	Credential Requirements
Nurse	<p>All nurses must possess:</p> <ul style="list-style-type: none"> • Current Michigan Department of Licensing and Regulatory Affairs (LARA) licensure to practice as a registered nurse (RN) and • At least one year of experience providing community health, pediatric or maternal/infant nursing services.
Social Worker	<p>All social workers must possess:</p> <ul style="list-style-type: none"> • Current Michigan Department of Licensing and Regulatory Affairs licensure to practice as a social worker (LSW) and • At least one year of experience providing social work services to families.
Infant Mental Health Specialist	<p>All Infant Mental Health Specialists must possess:</p> <ul style="list-style-type: none"> • Current Michigan Department of Licensing and Regulatory Affairs licensure to practice as a psychologist, master social worker or professional counselor, and • Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), demonstrating competency at the Infant Mental Health Specialist level; and • At least one year of experience in an infant health program.
Lactation Consultant	<p>All lactation consultants must possess:</p> <ul style="list-style-type: none"> • Current Michigan Department of Licensing and Regulatory Affairs licensure to practice as a registered nurse or social worker, and • Credentialing by the International Board of Lactation Consultant Examiners (IBLCE) and • Current International Board Certified Lactation Consultant (IBCLC) certification.
Dietitian	<p>Professionals who provide dietitian services must possess:</p> <ul style="list-style-type: none"> • A master’s degree in Public Health with emphasis in nutrition or a master’s degree in human nutrition or • A bachelor’s degree and certified as a registered dietitian (RD) or • A bachelor’s degree and be RD-eligible with examination pending in six months or less, and • At least one year of experience providing community health, pediatric and/or maternal/infant nutrition services.

New MIHP Staff

- All MIHP staff conducting professional visits must meet all MIHP professional requirements as outlined in the Medicaid Provider Manual, per review of license, registration, certification verification, and resume reflecting experience.
- All new staff hired or contracted must complete all training requirements and retain the *New Staff Training Completion* form in their personnel files.
- MIHP coordinators and professional staff must complete all training requirements specified by MDHHS.

Waiver of MIHP Staff Requirements

- An MIHP provider can request that certain personnel requirements be waived, with the following conditions:
 - Education and licensing/registration/endorsement requirements cannot be waived, but requirements for having a specified amount of maternal and child health experience may be waived under certain conditions upon approval of MDHHS MIHP staff.
- A waiver application must be submitted in writing to MDHHS, explaining why the waiver is being requested and attesting that the provider will assure that the appropriate in-service training will be provided for the individual in question. (Refer to the MIHP website for additional information regarding waiver of MIHP staff requirements.)
- Upon MDHHS approval of waiver of requirements, the MIHP Coordinator must ensure that the staff member completes all trainings within six months of applicant approval.
- The *Professional Staff Waiver Training Matrix* must be on file for all staff waived.

Backup Staffing Plan

- MIHP providers must have sufficient staff to meet the needs of their beneficiaries. If an agency is void of one of the required disciplines, a backup staffing plan must be implemented.
- Backup staffing plans may include collaboration with another MIHP provider or a referral arrangement with a community health agency. Written agreements with other agencies are required.
- The provider must notify MDHHS MIHP staff within five business days via email when the MIHP is void of one of the required disciplines (registered nurse or licensed social worker) for six consecutive weeks.
- Once MDHHS has been notified, the backup staffing plan will be reviewed by MDHHS MIHP staff after a three-month period.

Maintaining MIHP Personnel Documents

- Providers must use the *MIHP Personnel Roster* form to document specific information about the qualifications of each person on the MIHP staff, including any staff authorized to use the State of Michigan MILogin system for purposes of entering data.
- The *MIHP Personnel Roster* form must be updated and submitted to MDHHS within 10 business days of any personnel change.
- The MIHP coordinator and professional staff must meet all training requirements as specified by MDHHS, and documentation of completion must be included in personnel files.
- Agencies are required to have a signed *Notice of New Professional Staff Training Completion* form for all staff hired or contracted on file.
- Personnel records must include certificates confirming that the coordinator or his or her designee attended all MDHHS-required state coordinator trainings and the Michigan Home Visiting Conference.
- Personnel records must include completion certificates for the “Overview of the Maternal Infant Health Program Training Course” for all administrative staff who enter data into the MIHP database.

Communication to MIHP Staff

- The MIHP program coordinator is responsible for disseminating all communication received from the MDHHS MIHP staff to their professional and administrative staff.

MILogin Database

- The MIHP provider must authorize staff members to use the State of Michigan MILogin system in order to enter data into the MDHHS database. Unauthorized staff will be denied access.
- Each MIHP staff member authorized to use the MILogin system must have a unique MILogin user name and password.
- Acceptable browsers for MIHP MILogin use are Internet Explorer (IE) 8 or IE 11. Versions IE 9 and IE 10 are not compatible.

Section 4: Medicaid Health Plan Agreements

MIHP-MHP Contract

- MIHP providers are encouraged to establish and maintain provider contracts with all Medicaid Health Plans (MHPs) in their service area and to become in-network service providers for MHP enrollees, unless the MHP indicates otherwise.

MIHP-MHP Care Coordination Agreement

- The intent of the *Care Coordination Agreement (CCA)* is to explicitly describe the services to be coordinated and the essential aspects of the collaboration between the MHP and the MIHP provider.
- MIHP providers are encouraged to establish a CCA with all MHPs in their service area.
- MIHP providers and MHPs must also establish and maintain a CCA for in-network and out-of-network services.

Section 5: Billing and Reimbursement for MIHP Services

MIHP Applicant Billing Requirements

- All MIHP providers must apply for a National Provider Identifier (NPI) through the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS), and enroll in the Community Health Automated Medicaid Processing System (CHAMPS) through MDHHS in order to submit claims electronically.

Billing for Services

- As with all Medicaid services, MIHP provider documentation must support the services billed and paid.
- MIHP services provided to Medicaid Health Plan enrollees should be billed directly to the MHP.
- Medicaid MIHP providers must bill only the procedure codes listed in the MDHHS Maternal Infant Health Program Database, located on the MIHP website.

- Medicaid beneficiaries who are not enrolled in a Medicaid Health Plan have Fee-for-Service (FFS) Medicaid coverage, often referred to as “straight Medicaid.” Services for these enrollees should be billed directly through CHAMPS.
- Information about CHAMPS enrollment and procedures, including Medicaid provider billing and reimbursement, electronic billing, explanation codes, National Provider Identifier (NPI) Registry, provider specific information, and fraud and abuse reporting requirements, can be found on the MDHHS website.
- MIHP providers are not required to secure other insurance adjudication responses for claims for MIHP services prior to billing Medicaid MHPs or FFS, since other carriers do not cover MIHP services (Refer to the Medicaid Provider Manual’s “Billing & Reimbursement for Professionals” section for additional information).
- The MIHP provider is subject to audit by Medicaid. If any discrepancies are found, appropriate follow-up action may be taken, including but not limited to recoupment of payments, holding reimbursement on claims, or termination of Medicaid enrollment. The MIHP provider is given an opportunity for appeal if a negative action is imposed.
- In cases where services are provided through a contract with another agency, contracts and/or letters of agreement with other agencies for billable MIHP services must be current and specify the time period of the agreement, the names of the individuals providing services, and, if applicable, where the billing responsibilities lie.
- Agencies are required to maintain an adequate and confidential beneficiary record system, including services provided under a subcontract. All Health Insurance Portability and Accountability Act (HIPAA) standards must be met.

Billable Visits

- Reimbursement for professional visits include related care coordination and monitoring activities.
- The appropriate *Maternal Risk Identifier* (MRI) or *Infant Risk Identifier* (IRI) must be completed and entered into the MIHP database prior to billing for services,
- MIHP providers may not bill Medicaid scheduled services that were not or could not be provided, regardless of the reason (e.g., cancelled or missed appointments).
- MIHP providers are eligible for Medicaid reimbursement for one professional visit per beneficiary per day.
- Visits beyond the established limit cannot be billed to the beneficiary or Medicaid.
- Visits lasting less than 30 minutes or provided in a group setting are not billable.

Maternal Beneficiary Billing Specifics

- The *Maternal Risk Identifier* visit is limited to one per eligible beneficiary per pregnancy.
- The MRI visit and up to nine professional visits per woman per pregnancy are billable.
- Maternal services must conclude 60 days after the pregnancy ends or at the end of the month in which the 60th day falls.
- In certain situations, such as premature termination of pregnancy or a subsequent pregnancy within the same year, an MIHP provider may administer a second MRI to an eligible pregnant woman and receive reimbursement twice in the same year.

Infant Beneficiary Billing Specifics

- The *Infant Risk Identifier* visit is limited to one per infant.
- The IRI visit and up to nine professional visits for all infants are billable.
- Infant services must conclude before the infant reaches 18 months of age.
- An additional nine visits may be billed if deemed necessary and a physician order has been received.
- For the substance-exposed infant, with supportive documentation and with a physician order, up to 18 additional visits may be billed. This code requires billing in increments of two for one thirty-minute visit.
 - A substance-exposed infant is defined as an infant born with illegal drug(s) and/or alcohol in the circulatory system or an infant whose primary caregiver is currently using substances or is living in an environment where substance misuse and/or alcohol use is a danger or is suspected. Due to the complex nature of these cases, additional visits may be required.

Billing for Blended Visits

- When a pregnant woman and infant beneficiary are enrolled in MIHP from the same family, all visits subsequent to the *Risk Identifier* visit are considered “blended visits.” These visits are billed as blended visits under either the mother’s or the infant’s Medicaid Identification (ID) number.
- In the case of multiple births, each infant’s *Infant Risk Identifier* visit should be billed separately using each infant’s own Medicaid (ID) number.
- Blended visit provisions do not apply to infants in foster care.
 - Subsequent professional visits should be billed under each infant ID.

Place of Service

- All visits must be billed using the appropriate “place of service” code.
- The place of service must be documented in the *Professional Visit Progress Note* by the visiting MIHP professional each time a visit takes place.
- For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in her home or in the MIHP office setting.
 - This documentation must be completed for each visit occurring in the community setting.
- MIHP visits occurring in buildings contiguous with the provider’s office, in the provider’s satellite office, or rooms arranged or rented for the purpose of seeing beneficiaries, are considered to be in an office setting rather than in a community setting.
- On rare occasions, the provider and beneficiary may need to meet at a location in the community such as a coffee shop or restaurant; this will be billed as a community visit.
- Visits may not be conducted in the MIHP provider’s home.

Services Provided for the Mother and Infant on the Same Date

- When infant services are initiated, completion of the *Infant Risk Identifier* may be billed as a separate visit from the maternal postpartum visit if these services occur on the same day.
- Documentation must provide the reason why it was necessary to perform both visits on the same date.

Billing for Transportation Services

- Medicaid Health Plan Beneficiaries
 - MHPs are responsible for arranging transportation for pregnancy-related appointments.
 - MIHPs must follow the MHP's internal processes to coordinate transportation services for MIHP enrollees.
- Fee-For-Service Beneficiaries
 - Transportation services provided for a pregnant beneficiary are billed using her Medicaid ID number.
 - Maternal beneficiary visits to a mother's infant in the hospital within their two-month postpartum eligibility period are considered approved transportation services, and are billed to the mother's ID.
 - Transportation services provided for an infant beneficiary are billed using the infant's Medicaid ID number.
 - Reimbursement for transportation services provided to Fee-For-Service (FFS) beneficiaries is made according to the allowable amount established by MDHHS and aligns with rates established for non-emergency transportation (NEMT) services.
 - The MIHP provider will be reimbursed an administrative fee equal to six percent of the cost of transportation provided to MIHP FFS beneficiaries.
 - When billing, the six percent fee should be calculated and included in the amount charged, not to exceed the maximum amount allowed.
- MIHP providers may be contacted by the Nurse-Family Partnership (NFP) program to assist their beneficiaries in arranging transportation services.
 - MIHP providers must help NFP beneficiaries arrange transportation services. A completed *risk identifier* is not required to receive transportation services.

Billing Childbirth Education Classes

- MIHP providers may provide childbirth education classes directly, or contract with a local hospital's outpatient education program or a community-based organization.
- If the MIHP contracts with a local hospital or community-based organization for this service, the contract must indicate which provider is to bill and receive payment.
- A local hospital outpatient education program or community-based organization may bill Medicaid directly for Fee-For-Service (FFS) beneficiaries who attend the classes.
- An MIHP that provides childbirth education directly to beneficiaries in a group setting may bill for this service.
- The pregnant woman must attend at least one half of the classes or cover at least one half of the course content for the service to be billed.

- In cases when the beneficiary has entered prenatal care late in the pregnancy or is homebound due to a medical condition, the MIHP can provide childbirth education in the home as a separately billable service, provided case records document the need and the location where services were provided.
- The MIHP cannot bill for childbirth education classes that are offered by another organization at no cost.
- Refer to Medicaid Provider Manual for a description of required MIHP childbirth education elements.

Billing for Parenting Education Classes

- The parenting education course may be billed once per infant, or in the case of multiple births, once per family.
- The parent(s) or caregiver must attend at least one half of the classes or cover at least one half of the course content for the service to be billed.
- MIHP providers may offer parenting education classes or contract with other organizations, in which case the contract must specify which provider is to bill and receive payment.
- Refer to Medicaid Provider Manual for a list of required parenting education elements.

Billing for Lactation Support and Counseling Services

- Provision of individual, comprehensive lactation support and counseling services by an IBCLC is billable for post-partum women up to and through 60 days post-delivery.
- IBCLC services can be provided for a maximum of two visits.
- One lactation support visit per date of service is reimbursable.
- IBCLC services may be billed as a separate and distinct service on the same date on which other services are rendered by the MIHP provider, however documentation must support a separately identifiable visit.
- IBCLC services are considered a component of pregnancy-related services, and claims are submitted using the mother's Medicaid beneficiary identification number.

MIHP Quality Assurance

- MIHP coordinators are expected to routinely conduct their own internal quality assurance activities, including chart reviews and billing audits.
- Chart reviews and billing audits must be conducted on at least a quarterly basis.
- Agencies should designate a staff person to oversee chart reviews and billing audits. The agency's protocol must indicate the minimum number of charts reviewed per billing audit.

Section 6: MIHP Services

MIHP Services

- Psychosocial and nutritional assessment.
- *Plan of Care* (POC) development.
- Professional intervention services.
- Maternal and infant health and nutrition education.
- Family planning options education.
- Transportation arrangements as needed for health care, substance use treatment, support services and/or pregnancy-related appointments.
- Referrals to community services (e.g., mental health, substance use treatment, etc.)
- Coordination with other medical care providers, community agencies and Medicaid Health Plans (MHPs).

Services for Bilingual, Limited English Proficient, Visually Impaired and/or Hearing-Impaired Beneficiaries

- MIHP providers must arrange for or directly provide bilingual services and services to visually impaired and/or hearing impaired enrolled beneficiaries.
- The MIHP provider must accommodate Limited English Proficient (Arabic or Spanish speaking) beneficiaries, deaf and hard of hearing beneficiaries, and blind and visually impaired beneficiaries in one or more of the following ways:
 - Have staff with skills to meet beneficiaries' needs (e.g., are fluent in languages spoken in their service area, are proficient in American Sign Language, have experience with assistive technology, etc.).
 - Have verbal or written agreements with an identified community organization that will provide interpreter services or use assistive technology devices for interpretation.
 - Have verbal or written agreements to transfer beneficiaries to another MIHP provider who can meet beneficiaries' needs.
 - Specify that when a beneficiary requests that a family member or friend serve as interpreter, the individual must be at least 18 years old.
- MIHP providers must reference the federal Limited English Proficiency (LEP) mandate.

MIHP Office

- Requirements for facilities in which beneficiaries are seen:
 - Adequate privacy for beneficiary counseling and education.
 - Adequate privacy whenever beneficiary information is discussed with others.
 - Adequate space to meet with MIHP professionals and to accommodate MIHP MDHHS staff and MIHP reviewers in a smoke-free, pet-free room with a large table or desk, comfortable chairs, and working restroom that offers privacy.
 - Entrances, restrooms and passageways that 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.
- 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 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:
 - Entrances and spaces in the home or facility that are free of hazards and allow for secure safe passage of MIHP staff and MIHP MDHHS staff and MIHP reviewers.
 - Clean and comfortable accommodations for MIHP staff, MIHP MDHHS staff and MIHP reviewers.
 - Adequate privacy when discussing beneficiary information.
 - Adequate space to meet with MIHP professionals and to accommodate MIHP MDHHS staff and MIHP reviewers in a smoke-free, pet-free room with a large table or desk, comfortable chairs and working restroom that offers privacy.

MIHP Outreach and Specialty Populations

- MIHP providers must demonstrate the capacity to conduct outreach activities to their target populations and to the medical providers in the geographic area to be served.
- The MIHP must maintain a list of local public health programs such as WIC Nutrition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Community Mental Health (CMH), Children’s Special Health Care Services (CSHCS), and other agencies that may offer services to the beneficiary. The MIHP must work cooperatively with these agencies.
- The MIHP Coordinator Directory must indicate which providers have been designated by MDHHS as a “Specialty Provider.” This designation indicates that the agency provides educational materials geared toward the needs of the specialty population.
 - Agencies must use the *MIHP Specialty Provider Attestation* form on the MIHP website to apply for specialty provider status.

MIHP Collaborations

- MIHP providers must be actively linked to or be a member of the Great Start Collaborative in each of the counties in their service area.
- MIHP providers must also be actively linked to or be a member of the local Part C/Early On Interagency Coordinating Council.

State of Michigan Reporting Requirement

- The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse or neglect to Children's Protective Services (CPS).
- MIHP providers must make a referral to CPS as soon as child abuse or neglect is suspected.
- MIHP providers must become familiar with:
 - Obligations under the Michigan Child Protection Law (Act No. 238, Public Acts of 1975, as amended, Sections 722.621 – 722.638.).
 - Local CPS agency contact information and the referral process in each of the counties in their service area.
- Referral to CPS must be documented in the beneficiary's MIHP record.

MIHP Provider Continuous Cooperation with CPS

- MIHP providers are required to work cooperatively and continuously with their local CPS offices.
- MIHP providers are strongly encouraged to participate in local CPS Interdisciplinary Team meetings and in similar efforts to coordinate the infant's care.

Physician Orders for MIHP Services

- All physician orders for MIHP services must comply with state and federal laws prohibiting self-referral.
- Physician orders must be written and retained in the beneficiary record for the following three conditions:
 - Additional nine visits
 - Registered Dietitian services
 - Substance-Exposed Infant services
- The rationale for physician orders must accompany the orders.
- MIHP providers must communicate with the Medicaid Health Plans about the use of a physician order. The *MHP Communication Tool* has a column to designate when an MHP enrolled beneficiary meets criteria and is using a physician order during the MIHP course of care.
- The following types of providers are authorized to issue physician orders:
 - Physician
 - Physician assistant
 - Nurse midwife
 - Pediatric nurse practitioner
 - Family nurse practitioner
 - Medicaid Health Plan

Dietitian Services

- The MIHP may:
 - provide the services of an MIHP staff dietitian who meets the credentialing requirements (See TABLE 1, Section 3) after a physician's order for dietitian services has been obtained;
 - coordinate with the physician and the MHP to refer the beneficiary to a hospital dietitian; and
 - coordinate dietitian services with the MHP and WIC.
 - MIHP provider documentation must indicate the entity that provides dietitian services.

Beneficiary Record Keeping – Retention Requirements

- Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.
- Records must be retained for at least seven years from the 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/MIHP for any reason.
 - This requirement is also extended to any subcontracted provider with which the provider has a business relationship, (e.g., a transportation vendor, childbirth or parenting education vendor).
 - All subcontracts must include language requiring that subcontractors meet HIPAA standards.
- Providers arranging or rendering services upon the order or prescription referral of a physician must retain that order or prescription referral for a period of seven years.
- Records must be kept in a locked facility, room or cabinet at all times, unless a record is actively being used by a provider or agency representative.
- Records are not to be left open on a computer, in an office, open or closed on a desk or other space unless in full view of the person working with the record.
- When not in use, records are to be triple-locked (i.e., in a locked file cabinet, in a locked room within a locked facility).
- All records removed from the triple-locked space to facilitate documentation should be returned to the locked space before the close of business of the same day.
- Please see the *Protected Health Information Security Requirements Companion Guide* on MIHP's website for additional information on special circumstances involving securing PHI.

Beneficiary Record Keeping – Availability and Sharing of Records

- Providers are required to permit MDHHS personnel or authorized agents access to all information concerning any services that may be covered by Medicaid. This access does not require authorization from the beneficiary because the purpose of disclosure is permitted under the HIPAA Privacy rule.
 - Since MIHP reviewers are MDHHS personnel, no release of information is required.
 - MIHP reviewers are not required to sign a confidentiality statement prior to reviewing an MIHP provider's beneficiary records.

- Medicaid Health Plans contracting with the MDHHS must be permitted access to all information relating to MIHP services reimbursed by the plan.
- 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 from Medicaid.
- Records may only be released to other individuals or organizations if they have a release signed by the beneficiary authorizing access to 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).

Maternal-Only Providers

- Maternal-only providers are defined as agencies that were historically approved to only offer maternal services within the MIHP (this option is no longer available to providers).
- These agencies are required to serve the mother-infant dyad in one of the following ways:
 - Provide all maternal services, including the two required home visits, and after the baby is born, transfer the infant to a second certified provider, per signed written agreement.
 - Jointly provide maternal services with a second certified MIHP provider who would conduct at least one of the two required home visits, and after the baby is born, transfer the infant to the second provider, per signed written agreement.
- The first required maternal home visit must be conducted within one month of enrollment in the MIHP; the second maternal home visit is conducted postpartum.
 - Beneficiary refusal of home visits must be documented in the beneficiary’s chart.

Section 7: Beneficiary Eligibility

Beneficiary/Caregiver Freedom of Choice

- MIHP services are voluntary. Beneficiaries must be allowed the opportunity to:
 - Select an in-network provider
 - Maintain a current service relationship that extends services to the infant by the same provider who rendered maternal services
 - Change MIHP providers within the MHP network of MIHP providers
 - Decline services

TABLE 2. Description of MIHP Eligibility

DESCRIPTION	ELIGIBILITY CRITERIA	APPLICABLE TIMEFRAMES
Maternal Services	<ul style="list-style-type: none"> • Pregnant Medicaid beneficiaries • MOMS participants 	<p>Medicaid Beneficiaries</p> <ul style="list-style-type: none"> • May begin services at any time during a pregnancy but NOT after the delivery. • For purposes of closing a case, services may be provided until the end of the month in which the 60th postpartum day falls. <p>MOMS Participants</p> <ul style="list-style-type: none"> • Women may only receive MIHP services during the prenatal period. • Infant becomes eligible for MIHP at birth.
Infant Services	<ul style="list-style-type: none"> • Infant Medicaid beneficiary 	<ul style="list-style-type: none"> • MIHP services begin following the infant’s birth (after hospital discharge) and up to 12 months of age. • All infant services are concluded prior to infant reaching 18 months of age. • Refer to Section 8 - Authorization for MIHP Services Exception

Section 8: Referral and Prior Authorization Process

Medicaid Health Plan (MHP) Referral to MIHP Provider

- Within one month after the MHP determines that a pregnant woman or infant enrollee is eligible for MIHP services, the MHP will refer the enrollee to an MIHP provider.
 - The MHP is not required to refer an enrollee to an MIHP provider if enrollee attestation affirms current participation in an MDHHS-approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services.

MIHP Provider Response to MHP Referral

- Referral timeframes for maternal visits:
 - The MIHP provider must respond to all referrals within 14 calendar days after the referral is received.
- Referral timeframes for infant visits:
 - The MIHP provider must respond to referrals received from the hospital where the infant is being discharged within two business days of the hospital discharge.
 - The MIHP provider must respond to referrals received after the infant’s discharge from the hospital within a maximum of seven calendar days.
- If the MIHP provider is unable to visit the maternal or infant beneficiary within the stated timeframe, documentation must clearly support all attempts to contact or visit the beneficiary.

Prior Authorization for MIHP Services

- MHPs may not require prior authorization for any of the following types of visits when provided according to the criteria and limits established in policy:
 - *Maternal or Infant Risk Identifier* visit
 - Professional visits
 - Substance-exposed infant visits
 - MIHP lactation support visits
 - Childbirth education or parenting education classes
- MIHP services provided in excess of limits established in policy will be subject to MHP prior authorization requirements.

Out-of-Network Services

- MHPs are not required to pay for maternal services by an out-of-network MIHP provider who served the beneficiary during a previous pregnancy.
- Non-contracted MIHP providers, including those who have a current MIHP relationship with a pregnant woman or infant, are required to contact the enrollee's MHP to discuss operational details prior to providing out-of-network services.

Authorization for MIHP Services Exception

- In limited situations, when beneficiary needs surpass outlined MIHP program parameters, MDHHS MIHP staff may recommend MIHP services based on professional observation in the following circumstances:
 - Initiation of services for a child over 12 months of age
 - Continuation of services beyond 18 months of age
 - A beneficiary whose *Risk Identifier* scores "no risks" but who could benefit from MIHP services
- An MIHP provider seeking a program exception for a beneficiary must submit documentation to mihp@michigan.gov, indicating the beneficiary's identified risks and how the beneficiary may benefit from services.
- MDHHS MIHP staff are responsible for direct authorization of program exceptions for FFS beneficiaries.
- For beneficiaries enrolled in MHPs, an MDHHS MIHP staff will recommend exception visits to the beneficiary's MHP.
- MHPs are responsible for processing prior authorization requests for the services, according to their utilization management processes (e.g., for beneficiary exceptions).
- All approved, written authorizations must be kept in the beneficiary's MIHP provider file and must be available upon request. Requesting parties may include, but are not limited to, the MDHHS Office of Inspector General, MDHS MIHP staff, or the beneficiary's MHP.
- The MIHP provider is required to document all prior authorizations on the *MHP Communication Tool*.
- The care coordinator must assure the family is appropriately followed and referred for needed services.

Section 9: Risk Identifier and Plan of Care

Consent

- Before the *Risk Identifier* is administered:
 - Discuss and obtain signed *Consent to Participate in Risk Identifier/Consent to Participate in MIHP*.
 - Discuss and obtain signed Consent to Release Protected Health Information (PHI).
- Consent forms must be complete, accurate, signed and dated before the *Risk Identifier* is administered.

Risk Identifier Visit

- If beneficiary/caregiver consents to participate in MIHP
 - Administer the *Risk Identifier*
 - Administer the *Plan of Care, Part 1*
 - Address any emergency needs or referrals based on the beneficiary/caregiver circumstances
- The *Risk Identifier* assesses multiple domains of maternal and infant risk, including basic care, physical abuse, substance misuse, social behavior, and pregnancy and health history. It is also useful in determining eligibility of a beneficiary for MIHP services prior to implementing subsequent visits.
- Entry of *Risk Identifier* data into the MIHP database results in Risk Level scoring for each domain.
 - For any risk that scores “Unknown,” the highest possible Risk Level for that domain should be assigned.
- The appropriate *Risk Identifier* (Maternal or Infant) must be completed and entered into the MIHP database prior to billing for services, even if the Risk Identifier results determine the beneficiary does not need MIHP services.
- If beneficiary/caregiver is not interested in enrolling in the program, MIHP staff should ask for permission to contact them at a later date, and provide:
 - Agency contact information
 - Education packet

Risk Identifier - No Risks Identified

- In the case where the *Risk Identifier* does not score on any domain but professional judgement determines the need to serve the beneficiary, MIHP staff must send detailed rationale to mihp@michigan.gov describing the need for services.

Plan of Care, Part 1 (POC 1)

- The *POC 1* is implemented for all beneficiaries who enroll in MIHP. This is the first component of case management offered to enrolled participants.
- Required components of *POC1* implementation include:
 - Education tools (education packet or text4baby)
 - MIHP provider contact information

- *Lead Fact Sheet*
- Referral to WIC
- Written information on Healthy Michigan Plan
- As a component of *POC 1* services, the MIHP must demonstrate a system for handling beneficiary grievances.
 - The MIHP provider's internal procedure for addressing beneficiary grievances must be provided to the beneficiary at the time of enrollment.
 - Written materials must be provided regarding the beneficiary's rights and responsibilities at time of enrollment.

Plan of Care, Part 2 (POC 2)

- After completion of the *Risk Identifier* visit and based on scored risks for each domain and professional judgement, the MIHP provider, LSW and RN jointly formulate a specific, beneficiary-centered *Plan of Care, Part 2 (POC 2)*, tailoring interventions to reduce or eliminate identified risks.
- Maternal/caregiver and infant *POC 2s* are based on the social determinants of health.
 - *Breastfeeding* does not score on the *Risk Identifier*; this *POC 2* is determined using professional judgement.
 - *Birth Health* will score on the *Infant Risk Identifier* but does not have a corresponding *POC 2*. This domain exists for MDHHS data gathering purposes and for additional MIHP staff information.
 - The maternal or infant chart must include the *POC 2* with a corresponding domain for every risk identified by the *Risk Identifier* or by professional judgment.

Plan of Care, Part Three (POC 3)

- The *Plan of Care, Part 3 - Signature Page for Interventions by Risk Level* is a form used to document that the LSW and RN have jointly developed the *POC 2*, concur on the interventions to be implemented, and are responsible for implementation.
- The RN and LSW must each sign and date the *POC 3* within 10 business days. The *POC 3* can have different signature dates as long as they are within the 10-day limit. An additional signature line is provided for other disciplines that contribute to the *POC 2* development.
- The *POC 3* must be completed and signed by the RN and LSW before any professional visits are conducted or any other MIHP services are provided, unless there is a documented emergency.

Section 10: Communication with the Beneficiary's Medical Care Provider

General Requirements

- Effective, timely communication with the medical care provider is essential to coordination of MIHP intervention and maternal/infant continuity of care.
- Copies of all written communications to and from the medical care provider must be retained in the MIHP provider's beneficiary file.
- All telephonic communications with a medical care provider or their office staff must be documented on the appropriate form. This communication is documented on the *Contact Log* and the *POC 2*, if applicable.
- Information sharing between the MIHP provider and the beneficiary's medical provider must meet the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specific Time Frames

- The MIHP provider must notify the medical care provider within 14 calendar days of enrollment, using the *Beneficiary Status Notification* form.
- The MIHP provider must keep the medical care provider informed when significant change occurs with the beneficiary. This includes:
 - Additions to the *Plan of Care*
 - Beneficiary transfer from another MIHP provider
 - Beneficiary transfer to another medical provider
 - If beneficiary risk is determined to be at emergency level
- A copy of the *Discharge Summary* form must be forwarded to the medical care provider within 14 calendar days from the date the *Discharge Summary* data is entered into the MIHP database.
- Ongoing communication with the beneficiary medical care provider throughout the course of care is highly encouraged.

Section 11: Communication with the Beneficiary's Medicaid Health Plan

General Requirements

- Information sharing between the MIHP provider and the beneficiary's Medicaid Health Plan (MHP) must meet the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The MIHP must report all new MHP enrollees to the appropriate MHP using the *MHP Communication Tool* each month OR as agreed to in the *Care Coordination Agreement*.

Specific Time Frames

- The MIHP Provider must notify the beneficiary's Medicaid Health Plan within 14 calendar days after enrollment.
- The MIHP provider must keep the MHP informed when significant change occurs with the beneficiary. This includes:

- Additions to the Plan of Care
- If beneficiary risk is determined to be at emergency level
- The MIHP provider receiving a transfer must notify the MHP of the beneficiary transfer within 14 days of the completion of the consent forms.
- The MHP must be notified of beneficiary discharge of the program utilizing the *Beneficiary Status Notification* form within 14 days after discharge.

Section 12: Professional Visits

Elements of a Professional Visit

- A professional visit is a face-to-face encounter with a beneficiary, conducted by a licensed professional (i.e., licensed social worker, registered nurse, Registered Dietitian, IBCLC or Infant Mental Health Specialist) for the specific purpose of implementing the beneficiary's Plan of Care.
- Registered nurses (RNs) and licensed social workers (LSWs) are the two required MIHP provider staff. Optional staff may include a registered dietitian, IBCLC, and/or infant mental health specialist.
- Both required disciplines must regularly conduct professional visits. The expectation is that the discipline with the expertise most relevant to the beneficiary's needs will conduct the greater number of visits. However, the LSW and RN will each visit the beneficiary at least once, unless documented on the *Contact Log* that the beneficiary/caregiver does not want the services of another discipline.
- Every effort must be made to visit the beneficiary in the home, however a beneficiary has the right to refuse home visits. Such refusals must be documented the beneficiary's file.
- All professional visits require a minimum of 30 minutes spent with the beneficiary.
- Beneficiary-identified needs—or issues identified through professional judgement of the provider—must be addressed at every visit.
- Providers must address all high-risk domains within the first three professional visits, unless there is clear documentation on the *Professional Visit Progress Note* or *Contact Log* stating the reason(s) why they are not addressed.
- MDHHS requires that at least one prenatal visit occur in the home, unless the beneficiary's refusal for a home visit is documented as noted above.
- MDHHS requires that a postpartum visit be made following the infant's birth to observe bonding, infant care, nutrition and to discuss family planning.
- On rare occasions, the provider and beneficiary may need to meet at a mutually agreeable site in the community such as a coffee shop or restaurant. For documentation and billing purposes, these are considered to be "community" settings.
- The MIHP must provide for weekend and after-hour emergencies. The MIHP must schedule services to accommodate the beneficiary's situation.
- MIHP providers must use the *Professional Visit Progress Note* to record a detailed account of what transpired during the professional visits. The *Professional Visit Progress Note* must be complete, accurate and legible with respect to each required data field.
- MIHP providers must check eligibility and MHP enrollment at every visit.

Unique Elements of Infant Services

- If professional judgement determines that an infant/caregiver risks persist after the initial nine visits, an infant is eligible for an additional nine visits upon written physician order.
- Up to eighteen additional professional visits using the substance-exposed infant procedure code may be offered.

Blended Visits

- Multiple Births
 - If the infants are siblings, visits should be conducted as “blended” visits, and up to nine professional visits can be made to the family and billed under one Medicaid ID number for every visit throughout the course of care.
 - An additional nine visits may be provided upon the receipt of a written physician order, which must be retained in the beneficiary’s record. These nine visits must be billed under the same infant’s Medicaid ID number as the first nine.
- Blended Visits
 - If the MIHP is seeing an infant and the mother becomes pregnant, a *Maternal Risk Identifier* assessment visit can be completed and billed as such.
 - All subsequent professional visits for that family should be “blended visits” and billed under one Medicaid ID.
 - Both maternal and infant/caregiver needs may be addressed at blended visits.

MIHP Safety Plan

- MIHP providers must assist the beneficiary/caregiver in developing a written or verbal safety plan when the beneficiary *Plan of Care* is high risk in one of the following domains:
 - Stress/Depression
 - Abuse/Violence
 - Substance Exposed Infant
 - Infant Safety
- MIHP providers are required to document the implementation of the safety plan-related intervention number listed on the *POC 2* on the *Professional Visit Progress Note*.

MIHP Action Plan

- The *MIHP Action Plan* is a tool designed to enhance collaboration between the MIHP provider and the beneficiary being served.
- Utilizing motivational interviewing, MIHP providers will assist beneficiaries with creating a plan for something the beneficiary would like to address in their life.
- MIHP providers will collaborate with the beneficiary to complete the *MIHP Action Plan* during a professional visit.

Developmental Screenings

- In addition to the elements described above for professional visits, programs must administer the *Ages & Stages Questionnaires-3 (ASQ-3)* and the *Ages & Stages Questionnaires: Social/Emotional-2 (ASQ: SE-2)* at appropriate timepoints throughout the infant course of care.
- MIHP developmental screening begins at program enrollment, when the *Infant Risk Identifier (IRI)* is administered, and must be provided for all MIHP infant beneficiaries.
- The *IRI* includes developmental screening questions from Bright Futures, an initiative of the American Academy of Pediatrics.
- Once the *IRI* has been administered and Bright Futures screening has been repeated, if necessary, all follow-up developmental screening is conducted using the ASQ tools.
- The timing of the initial follow-up screening using the ASQ tools depends on the primary caregiver's responses to the Bright Futures questions.
- The *ASQ-3* must be completed at the first professional visit, unless the infant is not yet two months old; if it is not completed, specific reasons must be documented.
- Staff will age-adjust for prematurity when selecting the appropriate Bright Futures questions (in *Infant Risk Identifier*) at the time of infant enrollment into MIHP (age-adjustment is made if the infant was born before 40 weeks gestation).
- Coordinator assures that the appropriate *ASQ-3* and *ASQ: SE-2* age interval questionnaires are used (age-adjust for infant born at gestational age of 37 weeks or less).
- Coordinator assures that *ASQ-3* and *ASQ: SE-2* screenings are repeatedly conducted at the time intervals required in the ASQ user guides.
- Coordinator assures that referrals to Early On are made when *ASQ-3* score falls below the cutoff or the *ASQ: SE-2* score falls above the cutoff.
- Coordinator assures that learning activities were shared with the family when an *ASQ-3* or an *ASQ:SE-2* scored close to the cutoff (in the gray area) in one or more domains, the family declined Early-On, or the infant did not qualify for Early-On.
- Coordinator assures that the infant was rescreened, or documents plans to rescreen in two months when and *ASQ-3* or an *ASQ:SE-2* scored close to the cutoff (in the gray area)
- In the case of multiples, the provider must administer the *ASQ questionnaire* with each infant at the required timepoints.
- Specific, detailed instructions and guidance on the administration of the ASQ tools are included with the purchased ASQ user guides; additional information specific to MIHP providers can be found in the *ASQ Companion Guide* on the MIHP website.

Referrals

- An MIHP referral takes place when a professional:
 - Discusses a particular referral source with the beneficiary, so she clearly knows what to expect.
 - Encourages the beneficiary to seek services from the referral source.
 - Determines whether the beneficiary wishes to seek services from the referral source (the beneficiary may indicate she has an alternate resource to access).
 - Provides specific information about contacting the referral source in writing.

- Determines if the beneficiary needs assistance to contact the referral source due to limited English proficiency, low literacy, comprehension difficulties, immobilization stemming from depression, fear or stigma related to using certain services (e.g., Early On, mental health services, substance abuse services, domestic violence services, etc.), or other concerns.
- Contacts or provides assistance in contacting the referral source, if needed.
- MDHHS MIHP staff encourages the use of warm transfers when making referrals for additional services.
- If the beneficiary does not wish to seek services that the MIHP provider feels are necessary, the reasons for refusal must be documented. The provider should respectfully encourage the beneficiary to continue considering the services, explaining the potential benefits.
- The MIHP provider must refer a beneficiary who scores out moderate or high on the Stress/Depression domain to mental health or infant mental health services, or document the reason(s) why a referral was not made.
- Follow-up on a referral must take place within three visits after the visit in which the referral was made. The follow-up does not have to be by the professional who originally made the referral. The care coordinator is responsible for monitoring the chart to assure that follow-up takes place as required.

Family Planning Options and Sexually Transmitted Infection Prevention

- Family planning must be discussed at every professional visit and documented on the *Professional Visit Progress Note*.
- Prevention of sexually transmitted infections (STIs) should also be discussed.
- Family planning must be discussed with the mother or father (if he is the primary caregiver) at every infant visit unless the mother has undergone operative or non-operative permanent sterilization, or the mother or father (if he is the primary caregiver) refuses.

Immunizations Status

- Immunization status of the pregnant woman and her infant must be discussed throughout the course of care as required in the *MIHP Certification Tool*.
 - The caregiver(s) should be encouraged to obtain immunizations and be provided with assistance in making appointments and with transportation if needed.
 - The MIHP provider must offer immunization education.
- The beneficiary's Michigan Care Improvement Registry (MCIR) record should be present in their chart at the required timepoint, per the *MIHP Certification Tool*.

Dietitian Services

- If a nutrition risk level score is low or moderate as indicated on the *Risk Identifier* or as determined by professional judgement, a referral to a registered dietitian (RD) should be considered and documented on the *Professional Visit Progress Note*.
- If the nutrition risk is high, a referral and/or RD services **must** be offered.

- A physician order must be obtained for a beneficiary before a registered dietitian provides services for that beneficiary, if the MIHP provider bills for RD services. The physician order must be included in the beneficiary record.
- Beneficiaries have the right to decline dietitian or nutrition services, and this must be documented in the beneficiary record.

Termination of MIHP Services

- It is the expectation that MIHP services will be discontinued if:
 - The beneficiary (e.g., pregnant woman or infant's caregiver) no longer wishes to receive MIHP services.
 - All available visits have been used for a maternal or infant beneficiary.
 - Infant service records indicate four consecutive months of inactivity, unless the *Contact Log* clearly documents valid reasons for inactivity, or the infant reaches the age of 18 months.
 - The beneficiary's eligibility for MIHP services ends.
 - Maternal services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls.
 - Infant services may be provided until the infant reaches the age of 18 months, unless an exception has been granted.
 - The MIHP provider determines the objectives stated in the *Plan of Care (POC)* have been achieved.

Discharge Summary

- The *Discharge Summary* involves documenting the services provided, outcomes, current status and ongoing needs of the beneficiary in the MIHP database.
- The *Discharge Summary* must be completed and entered in the MIHP database within 30 calendar days after the pregnant woman's MIHP eligibility period ends or infant services are concluded.
 - Infant services are concluded based on one of the following situations:
 - Infant ages out of the program
 - All available visits have been used
 - Services are no longer required
 - Parent or caregiver requests discontinuation of services
 - There are four consecutive months of inactivity, unless there is documentation on the *Contact Log* that the case is being kept open for a specific purpose and the purpose is stated.

Section 13: Transportation Services

Overview

- The purpose of providing transportation services is to help:
 - Enrolled pregnant and infant beneficiaries access health care and pregnancy-related appointments such as:
 - Oral health services during pregnancy
 - Women, Infant and Children's (WIC) services
 - Behavioral health or substance use disorder treatment services
 - Beneficiaries attend childbirth and parenting education classes
 - An enrolled postpartum mother to visit her hospitalized infant
- The beneficiary's need for transportation assistance is determined by the completed maternal or infant *Risk Identifier*.
- A completed *Risk Identifier* is not required for Nurse Family Partnership (NFP) participants to receive transportation services through MIHP.

Transportation Arrangements Made by the Medicaid Health Plan (MHP)

- MHPs are responsible for providing transportation for pregnancy-related appointments for beneficiaries enrolled in their plans.
- MIHPs must follow the MHP's internal processes to coordinate transportation services for beneficiaries.
- For beneficiaries residing in Wayne, Oakland and Macomb counties, MDHHS contracts with a transportation brokerage company to arrange and provide non-emergency medical transportation (NEMT). MHPs may use this vendor when the beneficiary qualifies for the service and has no other means of transportation.

MIHP Fee-For-Service Beneficiary Considerations

- The MIHP provider must maintain documentation for FFS beneficiaries regarding appointments for which transportation tokens or funds are provided.
- The MIHP provider may give tokens or funds to the FFS pregnant beneficiary or to the primary caregiver of the infant beneficiary.
- The MIHP provider may contract for transportation services for FFS beneficiaries.
- The MIHP provider may fund transportation for FFS beneficiaries when no other means of transportation is available.
- An MIHP provider must determine the most appropriate and cost-effective method of transportation as allowed per Medicaid policy.
- MDHHS reimburses transportation costs at the lesser of actual cost or the maximum limit for:
 - Bus
 - Mileage (personal, including beneficiary, relative or friend)
 - Taxi

- If other, less costly means of transportation are not available or are not appropriate, the MIHP provider may make arrangements with local taxi cab companies to provide taxi service for MIHP beneficiaries.
 - MDHHS reimburses a maximum of 20 trips per beneficiary through MIHP.
- The MIHP provider must document transportation arrangements each time a trip occurs. The record must specify:
 - Name and address of the beneficiary
 - Date of service
 - Purpose of the trip
 - Address and city from which the trip begins
 - Address and city at which the trip terminates
 - Number of miles or tokens required for the trip
 - The amount the beneficiary or transportation vendor was reimbursed.
 - The provider identification information for the individual or business providing transportation
 - Verification of transportation provider’s enrollment in CHAMPS

Section 14: Childbirth Education Classes

General Considerations

- Childbirth education may be offered one time per beneficiary per pregnancy.
- MIHP providers must encourage first-time mothers to complete the course.
- The medical care provider or the MIHP provider may make a referral for childbirth education classes.
- The pregnant woman must attend at least one half of the classes or cover at least one half of the course content for the service to be billed.
- Content of the course must be aligned with Medicaid policy and the curriculum must be approved by MDHHS MIHP staff. See the *Childbirth and Parenting Education Companion Guide* for additional information.

Providing or Contracting for Childbirth Education (CBE) Classes

- MIHP providers may provide childbirth education classes directly or contract with a local hospital’s outpatient education service or clinic or a community-based organization.
- Refer to **Section 5: Billing and Reimbursement for MIHP Services** for more information.

Setting for Childbirth Education Classes

- In most cases, childbirth education classes are provided to a group, in a classroom setting.
- In situations where a beneficiary entered prenatal care late or is homebound due to a medical condition, childbirth education may be provided in the beneficiary’s home as a separately billable service.
- If the MIHP provider bills for childbirth education classes and/or transportation to classes, the dates of beneficiary attendance must be documented in the beneficiary chart.

Section 15: Parenting Education Classes

General Considerations

- Parents or caregivers may participate in a parenting education class one time per infant, or in the case of multiple births, once per family.
- Parents or caregivers must attend at least one half of the classes or cover at least one half of the course content for the service to be billed.
- An infant's medical provider or the MIHP provider may make a referral for parenting education classes.
- If the MIHP provider bills for parenting education classes and/or transportation to classes, the dates of beneficiary attendance must be documented in the beneficiary chart.
- Content of the course must be aligned with Medicaid policy and curriculum must be approved by MDHHS MIHP staff. See the *Childbirth and Parenting Education Companion Guide* for additional information.

Providing or Contracting for Parenting Education Classes

- An MIHP may provide parenting education classes directly or contract with a hospital outpatient education or community-based organization to provide this service.
- Refer to **Section 5: Billing and Reimbursement for MIHP Services** for additional information on billing for parenting education classes.

Setting for Parenting Education Classes

- Parenting education classes are provided to a group, in a classroom setting.

Section 16: Lactation Support and Counseling Services

Professional Licensure and Certification Requirements

- All lactation support must be provided by an RN or LSW with current, valid International Board-Certified Lactation Consultant (IBCLC) certification.
- The MIHP provider must keep a copy of the current, valid IBCLC certification for all lactation consultants who provide services for MIHP beneficiaries.
- A copy of the Lactation Support provider's IBCLC certification must be on file with the MIHP provider's office prior to the first lactation support visit.

Visits for Lactation Support Services

- Evidence-based lactation support services may be provided in an outpatient setting up to and including the 60th postpartum day.
- A maximum of two visits per pregnancy may be provided for either a single or multiple gestation pregnancy.
- The two lactation support visits must not occur on the same date of service as a professional visit. However, a lactation support visit can occur on the same date as a standard professional visit.

Documentation of Lactation Support Services

- Documentation of Lactation Support Services occurs on *the IBCLC Professional Visit Progress Note* and must be billed using the appropriate procedure code.

Section 17: Transfer of MIHP Services to Another MIHP Provider

General Considerations

- During the course of care, a beneficiary may request a transfer or may move to another area, which will require a transfer of services to another MIHP provider. Close coordination between MIHP providers must occur to avoid duplication of services.
- Information sharing between MIHP providers must meet the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Responsibilities of the MIHP Provider Making the Transfer to the Receiving MIHP Provider

- Obtain a signed beneficiary *Consent to Transfer MIHP Record to a Different Provider* form.
- Send the beneficiary's records (*Risk Identifier, Risk Identifier Scoring Results page, POC Parts 1-3, and Professional Visit Progress Notes*) to the receiving provider within 10 working days of the request.
- Refrain from completing a *Discharge Summary*.
- Communicate appropriately and professionally with the receiving provider to expedite the transfer in the beneficiary's best interest.

Responsibilities of the MIHP Provider Receiving the Transfer from Another MIHP Provider

- Refrain from serving the beneficiary until the beneficiary's records are received from transferring MIHP, unless an emergency is documented.
- Contact MDHHS MIHP staff if the records are not received within 10 working days.
- File a copy of the *Consent to Transfer MIHP Record to a Different Provider* form in the beneficiary's chart.
- Obtain the *Consent to Participate in MIHP and Consent to Release Protected Health Information* form from beneficiary.
- Notify the medical care provider and the MHP that the beneficiary has transferred to a different MIHP. Include the name and contact information of the receiving MIHP provider once the transfer has been completed.
- Implement the transferred *POC*, using the *Forms Checklist for Transfers*.
- Communicate appropriately and professionally with transferring provider to expedite the transfer in the beneficiary's best interest.

Section 18: Progressive Categories of Certification

General Considerations

- The MIHP Certification Review verifies the provider's compliance with program requirements.
- The provider is required to submit pre-review documents to MDHHS at least 14 days prior to the scheduled on-site review. Required documents that are missing or submitted late will result in a "not met" for indicator #1 of the certification tool. The reviewer will examine all submitted documents prior to the review.
- Providers must provide all requested medical records by 10:00am on the first day of the certification review. Agencies should have a single, complete chart that is accessible to all MIHP provider, state and federal staff. The chart should be all electronic or all hard copy. Agencies may choose to have a working chart with copies of forms, but the official chart should be complete and remain in the office.
- The number of staff who must be present at the staff interview (in addition to the coordinator) depends on the size of the staff, as noted below:
 - Agency employing 2-3 professional staff – all must participate.
 - Agency employing 4-5 professional staff – at least three must participate
 - Agency employing 6 or more professional staff – at least 50% must participate
- The MIHP Certification Review includes five categories. The newly approved provider must successfully pass provisional, conditional certifications 1 and 2, and full certification (18-month). Extended full certification is granted only to those MIHP providers who are fully certified (18-months) and then successfully complete the subsequent certification review with a score of three or fewer "Not Met" indicators, none of which are critical indicators.
- Provider certification categories include:
 - Provisional Certification (PC), duration nine months
 - First Conditional Certification (CC-1), duration nine months
 - Second Conditional Certification (CC-2), duration nine months
 - Full Certification (FC), duration 18 months
 - Extended Full Certification (EFC), duration 36 months (awarded only to those providers who have achieved an FC on the previous review).
- Provisional Certification is earned when the new provider has successfully completed training and passes provisional certification review.
- New Provider Conditional Certification
 - The First Conditional Certification (CC-1) is earned when the new provider successfully passes the MIHP Review, which takes place nine months following Provisional Certification.
 - The Second Conditional Certification, (CC-2) is earned when the new provider successfully passes the MIHP Review, which takes place nine months following CC-1.
 - At the CC-2 review, new providers may receive another conditional certification (nine months) or a full certification (18-months).

New Providers

- The first certification review is scheduled approximately nine months after provisional certification status is granted.
- New providers must have enrolled 40 beneficiaries within nine months of having been granted provisional certification.
- New providers must have:
 - At least ten beneficiaries one month before review
 - At least 35 beneficiaries two weeks before review
 - Note that no more than 10 beneficiary transfers can be counted toward the 40 cases required for a new provider's initial review.
 - New providers may be asked to submit beneficiary counts in writing one month or two weeks before their scheduled review, which MDHHS MIHP staff will cross checked using administrative data.

Existing Providers

- Existing providers may receive the following certifications:
 - Conditional Certification, earned when an agency's certification results require corrective action that is approved by MDHHS MIHP staff.
 - The agency will be reviewed again in nine months.
 - Full Certification (FC), earned when an agency successfully passes certification.
 - The agency will be reviewed again in 18 months.
 - Extended Full Certification (EFC), earned when the provider who has immediately previously received a FC successfully passes the certification review with three or fewer "Not Met" indicators, none of which are critical indicators.
 - The agency will be reviewed again in 36 months.
- Providers must enroll at least 40 beneficiaries within the 12-month period prior to the date of the certification review.

Certification Report

- Within 45 days after the review is completed, the provider will receive a letter indicating the results of the certification review, which typically includes a request for a *Corrective Action Plan*.
 - Once MDHHS receives and approves the *Corrective Action Plan*, the provider receives a letter indicating final certification status.

Termination and Decertification

- MIHP providers may be decertified at any time if it is determined that certification requirements are not met.
- If at any time a provider is unable to offer services and wishes to voluntarily terminate, they must refer to the *MIHP Termination Protocol* on the MIHP website.
- On occasion, MDHHS MIHP staff will make an unannounced site visit to an MIHP agency. The MDHHS Office of the Inspector General (OIG) also makes unannounced visits.

Unannounced visits typically take place for one or more reasons:

1. A whistleblower reports possible fraud/abuse.
2. A beneficiary lodges a complaint of a serious nature about the quality of services received.
3. Another entity lodges a complaint of a serious nature, including unethical behavior
4. There are unusual or questionable findings in a certification review.
5. Questionable financial activity is identified through a MDHHS in-house billing audit, which is separate from certification billing review.
6. Concerns are identified by an MDHHS employee and the MDHHS MIHP Unit Manager determines that they are of a serious nature.

Emergency Decertification

An emergency decertification may be authorized if a complaint investigation or certification review reveals serious action/inaction or a pattern of activity that threatens the health, well-being, or safety of MIHP beneficiaries. Emergency certification can be invoked in conjunction with the MDHHS Office of Inspector General (OIG), which is responsible for investigating alleged Medicaid fraud, waste, and abuse.

Voluntary Inactive Status

An agency with full certification may choose to become an inactive MIHP provider for a minimum period of six months, but not to exceed 12 months. The *Termination Protocol* must be followed as specified above.

Section 19: Standardized MIHP Documentation

Please refer to the MIHP website (<https://www.michigan.gov/mihp>) for the most updated MDHHS MIHP-approved forms and instructions. At a minimum, the data elements included in these forms must be maintained. If additional elements are needed to meet a MIHP provider's individual purposes, it is suggested the agency develop a separate form.