MATERNAL INFANT HEALTH PROGRAM

OPERATIONS GUIDE

Cycle 10

Cycle 10 Start Date: August 1, 2025 **Version:** February 25, 2026

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KEY TO ICONS

Below is a list of icons used throughout this guide and their meanings.

Icon	Description*
C	Denotes an area which has related Certification Specifications.
P	Denotes an area which has related Protocol Specifications.
M	Denotes an area which has related policy language in the Medicaid Provider Manual.

*While these icons support identification of compliance measures, MIHP providers must adhere to **all requirements** (per the MIHP Operations Guide, MIHP forms and programmatic documents, and the Medicaid Provider Manual). These icons are intended as reminders to review related resources.

INTRODUCTION

The **Maternal Infant Health Program (MIHP) Operations Guide** is designed to support MIHP providers in program implementation. This Guide is to be used **in conjunction with the** Medicaid Provider Manual. The MIHP Operations Guide should not be construed as a substitute for the Medicaid Provider Manual, which is the authoritative source for the Maternal Infant Health Program.

When applicable, updates made to the MIHP Operations Guide will be published twice per year. MIHP providers must use the most current version of the Guide. Additionally, time-sensitive program guidance may be issued via email prior to an official Operations Guide update (e.g., Important Update, Bi-Weekly Update, issuance of question/answer documents, etc.). This information must be followed accordingly and will be incorporated at the next Operations Guide update. Previous versions of the Operations Guide are located on the Policy and Operations page of the MIHP website (www.Michigan.gov/MIHP) or via request.

Throughout this guide, program forms are identified by *italicized font*. All forms are available on the MIHP website, and a summary of where to locate each form is provided at the end of this guide.

The MIHP website offers additional resources such as Promotional Materials, Provider Training, and more. When applicable, this document will reference information located on the MIHP website.

A Note for New or Prospective Providers

Because of the unique processes involved, the MIHP Operations Guide does not include detailed information related to becoming a new provider. However, MDHHS MIHP provides extensive support during this process by way of meetings, document review, consultation, and more. Resources can be found on the Prospective Provider webpage and the Companion Guide: Becoming a new MIHP Provider.

ACRONYM INDEX AND GLOSSARY

While not an exhaustive list, commonly-used acronyms and titles are listed below.

Term	Definition
CPS	Children’s Protective Services
HIPAA	Health Insurance Portability and Accountability Act
IBCLC®	International Board-Certified Lactation Consultant
Home Visitor (HV)	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
Program Coordinator	Person identified as the central representative of the program
Provider	Entity authorized by Medicaid and MDHHS to provide MIHP services; may also be referred to as “agency”
PVPN	Professional Visit Progress Note
RD	Registered Dietitian
RI	Risk Identifier (MRI for Maternal Risk Identifier, IRI for Infant Risk Identifier)
RN	Registered Nurse
SW	Licensed Social Worker (LBSW, LLBSW, LMSW and LLMSW)

SUMMARY OF REVISIONS

All updated language is identified by highlighted text as follows:

- Yellow highlighting refers to language included in the original release of Cycle 10 Operations Guide on March 5, 2025.
- Green highlighting refers to the language changes that have occurred after the original release.

The purpose of this update is to establish comprehensive guidance for Cycle 10. Cycle changes also include updates to associated documents such as Forms, Certification Specifications, and Protocol Specifications.

CYCLE 10 IMPLEMENTATION TIMEFRAME

Upon release of Cycle 10 documents, a comment period is enacted for feedback on Operations Guide language. This process may lead to an updated version with minor revisions for clarification. Concurrently, finalized Cycle 10 forms will be posted online for use.

MDHHS MIHP **requires implementation on August 1, 2025**. Regarding *PVPNs* specifically, updated *PVPNs* must be used for all visits conducted on or after August 1, 2025.

Please see additional Cycle 10 quality and compliance information in Section 0.

MIHP OVERVIEW

The Maternal Infant Health Program (MIHP) is an evidence-based home visiting program for pregnant people and families of infants who are eligible for Medicaid insurance. Families are partnered with caring, trusted, and knowledgeable home visitors who serve the goals and needs of each family.

MIHP services are administered by a network of certified provider agencies throughout the state. These providers represent a variety of entities such as health departments, federally qualified health centers, hospital-associated programs, tribal partners, and independent community-based agencies. Services are intended to supplement the family's regular prenatal/infant care in order to achieve the programmatic goals of reducing maternal and infant morbidity and mortality, while promoting healthy pregnancies, positive birth outcomes and healthy infant growth and development.

MDHHS SUPPORT AND CONTACT INFORMATION

MDHHS MIHP staff are available to provide program consultation and technical assistance to providers. Additional support is available via email communication, meetings, the MIHP website, and more.

MDHHS MIHP Contact Information	Purpose
MIHP@michigan.gov	General inquiries, submission of *Personnel Rosters*, *Agency Information Change Request forms*, etc.
MDHHS-MIHP-Cert-Review@michigan.gov	Submission of certification-related documents
MDHHS-MIHP-Advisory@michigan.gov	MIHP advisory efforts
Phone: 1-833-644-6447	As needed
Fax: 517-763-0366	As needed

MIHP Bi-Weekly Updates and MIHP Important Updates

MDHHS MIHP distributes routine email communication regarding program updates, resource sharing, and more. **MIHP Coordinators must ensure such communication is shared with staff**. These include:

- MIHP Bi-Weekly Updates
  - Sent to all subscribers: Click here to subscribe.
- MIHP Important Updates
  - Sent to list of MIHP Coordinators

Consultation

MIHP providers may use this form to request a consultation session with MDHHS MIHP staff.

MDHHS Medicaid Provider Support Resources

Medicaid Provider Website | ProviderSupport@michigan.gov | 1-800-292-2550

For billing concerns and/or supportive care coordination, please contact the respective health plan. For Fee-for-Service (FFS) inquiries, please contact Medicaid Provider Support. Health plan contact information is available on the Policy and Operations section of the MIHP website.

SECTION 0: QUALITY ASSESSMENT AND COMPLIANCE CERTIFICATION

Providers undergo routine reviews to ensure high quality care is provided and fidelity to the model is maintained. Adequate certification results are required to maintain status as an MIHP provider.

Purpose and Timeline: Quality and Compliance

TYPE	PURPOSE	TIMELINE FOR CYCLE 10
MIHP Quality Assessment	Solely for the purpose of understanding agency practices.	Providers who have already participated in the Quality Assessment (during Cycle 9) will receive a Quality Assessment Follow-up between **August 1, 2025 and June 30, 2026** to discuss Reflection Reports and quality improvement efforts. Providers who have not participated in the Quality Assessment will receive a full Quality Assessment during this period.
MIHP Compliance Certification Review	Measures compliance with policies and standards documented in the Medicaid Provider Manual, MIHP Operations Guide, and MIHP forms.	All Providers will receive at least one Cycle 10 Compliance Certification Review between **August 1, 2026 and December 31, 2027.**

*Providers requiring a compliance review before August 1, 2026, will be reviewed using the Cycle 9 Certification specifications and tool.

Quality Assessment

The Quality Assessment aims to measure and support best practices in home visiting. The goals are to:

- Allow providers to review best practices as outlined in tools such as the **Michigan Home Visiting Quality Assessment System** (MHVQAS) and identify opportunities for improvement.
- Allow MDHHS to understand program-wide quality and identify opportunities for support.
- To allow MDHHS to understand the strengths of MIHP within the continuum of home visiting.

Quality Assessment Process

The MIHP Quality Assessment (QA) includes the following:

1. Home Visitor Survey
2. Document and Chart Submission
3. Coordinator Interview
4. Debrief
5. Reflection Report
6. QA Follow-up Support from MDHHS

Providers receive detailed guidance throughout the QA process. At its conclusion, providers receive a comprehensive QA Survey, which summarizes the information gathered and assessed. Providers are also offered the opportunity to implement a Quality Improvement activity based on the results.

MIHP Resource Page

Find Quality Assessment resources here: MIHP Quality Assessment

Compliance Certification Review M

The Compliance Certification Review (also referred to as "Certification" or "Review") assures and measures compliance with policies and standards documented in the Medicaid Provider Manual, MIHP Operations Guide, and MIHP forms. Certification Reviews are conducted by the MDHHS MIHP Quality Improvement Team.

Cycle 10 Compliance: Cycle 10 requirements must be implemented on/after August 1, 2025. Certification Reviews, designed to assess Cycle 10 compliance, will be scheduled on or after August 1, 2026.

Certification Specifications

The *Certification Specifications* document provides a list of indicators which will be assessed during the Certification Review, the scoring approach per indicator, and the weight of each.

Before the Certification Review

MDHHS MIHP will contact the MIHP Program Coordinator to schedule the review. The Provider will receive a detailed scheduling letter. This letter contains:

- Date of the Pre-Certification Review Meeting
- Date of the Certification Review
- Deadline by which the provider must submit requested documentation.
  - All requested documentation must be submitted by the date/time indicated.
- A selection of charts is reviewed as part of the Certification process and must be submitted by the specified date/time. Open and closed charts are selected randomly based on:
  - Enrollment: Charts are prioritized for beneficiaries enrolled after the last review or within the last 18 months. However, charts may be requested beyond the 18-month timeframe in order to obtain an adequate number of charts. Records must be available for request in accordance with retention policies.
  - Number of paid claims for professional visits: Agencies with a larger number of paid claims will have a larger number of charts requested.

During Certification Review

Certification Review consists of introductions, agency observation, chart review, and document review. The review will take place over the span of 1-3 business days, depending on the size of the provider's caseload and number of charts to be reviewed. The format is currently virtual (Via Microsoft Teams).

After Certification Review

Within 45 calendar days of the review, MDHHS MIHP will send the **Certification Results Letter** and **Certification Tool**. This will provide the agency with their score (indicated as a percentage) and certification status. Providers must obtain a "full" or "conditional" certification to maintain active status.

Corrective Action Plan

Based on the outcome, 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) found to be "not met". The CAP must be submitted to MDHHS MIHP within the specified timeframe and approved by MDHHS MIHP within three submissions. Critical indicators must show improvement during the next review. See details in Critical Indicators, Section 3.

MIHP Resource Page

Find Certification resources here: Provider Certification.

Certification Status – Scoring Categories

SCORE	STATUS	ADDITIONAL NOTES
85% - 100%	Full	Certification is maintained as an MIHP provider. Next review is due during the next certification cycle.
70% – 84%	Conditional	Certification is maintained as an MIHP provider. However, two successive instances will result in Decertification. MDHHS MIHP consultation is required. Next review is due approximately nine months after Conditional Certification status is granted.
< 70%	Decertified	Comply with guidance per MDHHS MIHP and *Decertification Protocol.*
N/A: New Providers Only	Provisional	Granted upon completion of the new provider training requirements and provisional Certification Review. MDHHS MIHP will schedule and conduct periodic consultation visits after the provider receives Provisional Certification status. Next review is due approximately nine months after Provisional Certification status is granted.

Decertification

- MDHHS MIHP will decertify a provider that receives Conditional Certification status for two successive reviews or receives less than 70% on their Certification Review.
- Violations of requirements within the MIHP Operations Guide or the Medicaid Provider Manual may constitute the need for corrective action or immediate decertification.
- 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.

Supportive Drop-In Visits

MDHHS MIHP Staff may conduct drop-in visits to provider offices for purposes of supportive presence and relationship-building. These visits are designed to include all providers and are **not** intended to be punitive in nature nor a hindrance to service delivery. Providers will receive notification prior to such visits.

Concerns Regarding MIHP Services Provided

If there is reason to believe substandard services are being provided, providers may receive unannounced visits and/or unannounced requests for information, including beneficiary records. For example, MDHHS MIHP may conduct an unannounced site visit to better understand allegations related to a grievance. Similarly, the Office of the Inspector General may request beneficiary records for review to assess concerns related to billing or care provision. Providers are required to permit MDHHS personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. Reasons for these requests may include, but are not limited to:

- A whistleblower reports or MDHHS MIHP suspects possible fraud/abuse.
- A complaint is lodged of a serious nature regarding unethical behavior or quality of services.
- Questionable findings identified during a certification review, consultation, or other contact.

Additional Oversight

As Medicaid providers, MIHP providers are subject to audit by the Office of the Inspector General. If such audits identify that billing practices are in violation of MIHP Medicaid Policy, this may result in recovery of overpayments. If a negative action is imposed, the MIHP provider is given an opportunity for appeal.

Protocol Approval Process Ⓒ

Protocols are the agency practices implemented to ensure compliance and best practice for MIHP services. Protocols are reviewed when becoming an MIHP Provider, when changes are made, and at Certification Reviews. Providers must submit protocols in accordance with the Protocol Specification Requirements. If a protocol is revised mid-cycle, it must be submitted as soon as possible following the updates, along with the *Protocol Signature* document located on the Certification page. It is important to ensure protocols are maintained, up-to-date and are congruent with the actual practices in place (such congruency is reviewed as part of the Certification process).

- Protocol Specifications are available on Certification section of the MIHP website.
- Protocols must describe the provider-specific process in place for each specification.
    - For example, a protocol may identify staff role(s) responsible, documentation method, frequency, etc. It is not permissible to submit protocols that are composed primarily of information copied directly from the Operations Guide.
- Submit protocols to: MDHHS-MIHP-Cert-Review@michigan.gov.
    - MDHHS MIHP will review and provide feedback; Provider will submit any necessary edits.
    - MDHHS MIHP will approve protocols to be implemented by providers.
    - When changes are made to existing protocols, they must be submitted with the *Protocol Signature* document, which can be found on the Certification section of the MIHP website.

Provider Status Changes

Providers must notify MDHHS MIHP **within five business days** if services will be suspended for any reason and for any length of time. Prior to determining a status change, it is encouraged to contact MDHHS MIHP staff for support, troubleshooting, and guidance. Additionally, providers unable to enroll new beneficiaries due to capacity issues must notify the MDHHS MIHP team **within five business days** of reaching capacity and must refer to another MIHP or appropriate service provider.

Suspension or Termination of Services May Include Either:

- **Voluntary Inactive Status**: Provider with Full Certification status may request to move into inactive status for a **minimum of six months and a maximum of 12 months**. Providers may enter inactive status **up to two times in a certification cycle**. It is not permissible to enter inactive status a third time – Instead, closure must be pursued.
- **Voluntary Closure**: Provider may request to voluntarily close at any time.

Process for Suspension or Termination of Services

In either instance (Voluntary Inactive Status or Closure), the *Voluntary Closure Protocol* form must be completed and submitted to MDHHS MIHP **within 10 business days** of notice to close or suspend services.

- Providers are expected to adhere to the information provided in the *Voluntary Closure Protocol*.
- Providers not submitting and/or adhering to the *Voluntary Closure Protocol* will not be considered for reapplication as an MIHP provider.
- Provider must communicate updates to MDHHS MIHP for pertinent changes to the Closure Protocol such as updated contact information, location of files, etc.

Re-initiating Services Following Suspension or Termination

To re-enter active status, the provider must have both disciplines on staff (Registered Nurse and Social Worker), without dependency on backup staffing.

- See additional guidance in Backup Staffing, Section 4.

SECTION 1: PROVIDER DIRECTORY, STAFFING, AND TRAINING

This section details information related to agency personnel, training, and communication.

MIHP Provider Directory and Map

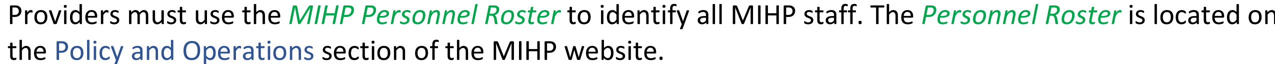
An MIHP directory and interactive map are available and maintained online. They list all active, certified providers' contact information and counties served, so that agency information is easily accessible. These resources are located on the MIHP home page and maintained by MDHHS MIHP.

- In order to list a county, the provider must be willing to serve the county in its entirety.

Updates to Agency Information, MIHP Directory and Map

To update agency information, providers must submit an *Agency Information Change Request* **within 10 business days of the change.** Such updates include changes to agency name, address, contact information, NPI, counties served, etc. The information captured in this form is used to update the MIHP Directory and Map. The *Agency Information Change Request* form can be found on the Policy and Operations page of the MIHP website. Upon completion, email the form to MIHP@Michigan.gov.

Personnel Roster



Providers must use the *MIHP Personnel Roster* to identify all MIHP staff. The *Personnel Roster* is located on the Policy and Operations section of the MIHP website.

- The *Personnel Roster* must be updated and submitted to MDHHS MIHP **within 10 business days** of any personnel change.
- Submission occurs via email (MIHP@Michigan.gov), with information included in the body of the email regarding what changes were made.
- The *Personnel Roster* includes an area for the MIHP Coordinator to authorize users that need access to the MIHP database and/or MCIR in MILogin.
    - More information can be found in the Database Access section.

Staff and Credential Requirements

At minimum, MIHP staff must include:

1. MIHP Program Coordinator
2. One registered nurse (RN), and
3. One licensed social worker (LLBSW, LLMSW, LBSW, or LMSW).

The Program Coordinator may also serve as an RN, SW, RD, IBCLC®, or IMHS. Similarly, a professional with multiple licenses may fulfill multiple staff roles (e.g., an RN, LLBSW could function in both capacities).

Other staff who can provide billable services include a Registered Dietitian (RD), Infant Mental Health Specialist (IMHS), and International Board-Certified Lactation Consultant (IBCLC®) who meet requirements dictated by Medicaid.

Professional staff must also have one year of related experience, in accordance with the Medicaid Manual. A waiver may be requested for staff that do not meet experience requirements. Provider must continuously ensure staff meet the qualifications defined by Medicaid and proof is maintained in the staff file. Verification of licensure via the Michigan Department of Licensing and Regulatory Affairs (LARA) must be maintained in each HV's file at the onset of employment.

- Note: Internships do not count toward the one year of post-licensure experience required.

Waiver of Professional Experience Requirement

Occasionally a potential home visitor meets licensing requirements but not the experience requirements indicated by Medicaid Policy. When this occurs, the provider may apply for a waiver for the following staff: RN, SW, or RD. IMHS staff are not eligible for a waiver.

Supervision of Waiver Staff
The waiver staff must be supervised by an RN or SW. In the case of Registered Dietitians, they must receive supervision by an RN or SW but may receive RD-specific support from another RD. In some instances, a provider may not have an RN or SW on staff to provide supervision. It is acceptable to obtain this supervision from another MIHP provider who has the discipline on staff and has agreed to provide such support.

Two types of waivers are available:

1. A **Full Waiver** is available for SW, RN, and RD staff with less than one-year of post-licensure/certification/endorsement experience that meets the Medicaid experience requirement. IMHS staff are not eligible for a waiver (full or amended).
    - Applicable to Michigan or another state licensure.
2. An **Amended Waiver** is available for SW staff who lack the required one-year post-licensure experience but have obtained at least three years post-graduate experience providing social work services to families prior to licensure.
    - These staff may apply for an amended waiver once licensure is obtained.
    - RN, RD, and IMHS staff are not eligible for an Amended Waiver.
    - Applicable to Michigan licensure, another state licensure, or states without licensure.

Waiver Application
A waiver application must be approved by MDHHS prior to MIHP employment. To be considered, a **waiver application must be submitted to MDHHS MIHP with the following**:

1. A cover letter which includes both the reason for requesting a waiver and a description of actions taken to employ a professional who does not require a waiver.
2. A copy of the waiver applicant's resume or curriculum vitae, including work experience.
3. A copy of the waiver applicant's LARA verification.
4. A copy of the resume and LARA verification of the same discipline staff who will be providing supervision to the waived staff.

Waiver Approval and Waiver Training
If approved, MDHHS MIHP will provide a **Waiver Approval Letter**, which must be maintained in the staff file. Training expectations are listed in the *Required Training for New, Waiver, Office and Backup Staff* and *Notice of Staff Training Completion Form.* These are located on the Staff Training page.

Void of Discipline and/or Need for Backup Staffing

Provider must arrange backup staffing for nursing and social work services. Additionally, provider must notify MDHHS MIHP **within five business days** via email when they are void or know they will be void of a nurse or social worker for six consecutive weeks. See additional guidance in Backup Staffing, Section 4.

Coordinator Responsibilities

Each provider must have an MIHP Coordinator. The Coordinator provides oversight of all aspects of the program, maintains compliance with Medicaid and MIHP requirements, and ensures high quality services are provided. For an example of a position description developed by MIHP Providers across the state, please see Appendix I.

Confidentiality Statement

Staff must sign a confidentiality statement upon hire.

Care Coordinator

For each beneficiary, a Care Coordinator (sometimes referred to as the Case Manager) must be designated. The Care Coordinator is responsible for coordinating and monitoring all services provided to the beneficiary, including referrals and follow-up.

- The Care Coordinator must be an RN or SW, and this role is identified during the joint development of the *Plan of Care*, after administration of the *Risk Identifier*.
- This role (and any updates to it) is documented on the *Plan of Care 3.*

NEW: Reimbursement for Care Coordination Activities

As part of MIHP Enhanced Services, per Medicaid Bulletin MMP 24-36, providers may be reimbursed for Enhanced Care Coordination Time when at least 30 cumulative minutes of time is spent on care coordination activities conducted by, or delegated by, an RN or SW*. Care coordination may be reimbursed per beneficiary, per calendar month, following completion of the *Consent to Participate*, the *RI* and *POC 1*. This applies to activities conducted on or after October 1, 2024.

*Care Coordination time may be performed by a Home Visitor who is an RN or SW **or** another staff member if delegated by the RN or SW and in accordance with their scope of practice. Therefore, the activities may be performed by other staff such as the coordinator, clerical staff, other home visitors that are not RNs/SWs, as long as delegation and documented attestation is provided by the RN or SW. See details below.

- **Documentation**: The *Care Coordination Form* must be maintained in the beneficiary record and include monthly initials by the Home Visitor who is the RN or SW that conducted or delegated the activities. The form is identical for both beneficiary types (same document regardless of infant or maternal beneficiary).
- **Billing**: The billing code is T2022 but providers must comply with all Medicaid billing requirements, including the Enhanced Services bulletin MMP 24-36.
- **Frequency:** Care coordination may be billed once per calendar month, per beneficiary.
- **Activities:** Activities that qualify for reimbursement are described on the *Care Coordination Form*, which must be completed and maintained in each beneficiary's chart. These include communication with the medical provider, health plan or other resource; non-billable contacts, case conference, research to support plan/care, and reflective supervision.
- **Length of Time**: At least 30 cumulative minutes or more per beneficiary, per calendar month. This may be cumulative time spent across multiple activities within the same calendar month.

Additional Information: MIHP Enhanced Services: Guidance and Frequently Asked Questions.

Database Access

Frequently used databases are summarized below. The system that allows entry into each of these databases is MILogin.

- The **MIHP Application** is the administrative database for MIHP. It is used for electronic documentation of all *Risk Identifiers* and *Discharge Summaries*. It is also used to identify if a beneficiary is enrolled with another provider. MDHHS MIHP oversees this access, following provider request.
- The **Michigan Care Improvement Registry (MCIR)** is used to review beneficiary status for immunizations, hearing screening, and blood lead level screening. MDHHS MIHP oversees this access, following provider request.
- The **Community Health Automated Medicaid Processing System (CHAMPS)** is the web-based MDHHS Medicaid claims processing system. It used for tasks such as Medicaid Provider enrollment, submitting/reviewing claims data, eligibility verification, etc. This access is managed by Medicaid Provider Enrollment. Additional claims information can be found in Section 7.

Requesting Access

The process for gaining access to the databases above include:

1. Register in MILogin.
    a. Take note of your MILogin username. This will be needed for the *Personnel Roster*.
2. If access to MCIR is needed, submit a request via MILogin. Instructions are available here.
    a. Need your MCIR PIN? Users receive a follow-up email containing the MCIR PIN. Guidance is also available here: How to Find your MCIR PIN.
3. If access to the MIHP application is needed, submit a request via MILogin. Instructions are available here.
4. After submitting requests in MILogin, email MDHHS MIHP as follows:
    a. Attach the *Personnel Roster* with checkmarks authorizing access needed **and**
    b. Include the following information in the body of the email – staff name, email address, MILogin username, access needed (MCIR, MIHP Application, both).
5. MDHHS MIHP will review requests and provide appropriate access.
6. If CHAMPS access is needed, follow guidance on the Medicaid Provider Enrollment website. This access is not managed by MDHHS MIHP.

Training

MIHP training requirements are dependent on staff role, as outlined below.

Trainings

MIHP training requirements are dependent on staff role. Please refer to the list of trainings per staff role, which can be found on the MIHP Provider Training section of the MIHP website and the *Required Trainings for New, Waiver, Office, and Backup Staff document*.

Timeline for Completion of Trainings

- **All professional staff** (waiver, backup, and new) must complete required training prior to independently offering MIHP services.
- **Other staff** listed on the personnel roster must complete required training prior to working with beneficiaries (answering phones, etc.)

Training Documentation

All documentation must be maintained in staff files. This includes both of the following:

- Course **certificates** for specific trainings, as indicated on the Provider Training website and the *Required Trainings for New, Waiver, Office, and Backup Staff document*.
- The **training completion form**:
  - For **all staff** (including temporary back up staff) hired on or after September 22, 2025, this form should be completed and retained in each staff member's personnel file: *Notice of Staff Training Completion Form*

Annual MIHP Coordinator Meetings

MDHHS MIHP hosts an annual, required meeting for MIHP Coordinators, often referred to as the "MIHP May Coordinator Meeting." This event offers an opportunity to enhance knowledge of home visiting practices, obtain programmatic updates, and network with other MIHP providers.

- The MIHP Program Coordinator or designee **must attend** the MDHHS MIHP Coordinator Meeting.
- MDHHS MIHP provides notice and shares registration information in advance of this meeting.

Michigan Home Visiting Conference

The Michigan Home Visiting Conference is held every other year and serves as an opportunity for home visitors and families to learn and gain support towards continuing to achieve positive outcomes. This conference spans multiple days and includes a "Model Day" session. The MIHP Coordinator (or designee), beginning 2026 and thereafter, must attend Model Day session.

Community of Practice (COP) Webinars

MDHHS MIHP hosts optional, virtual webinars for the purpose of fostering educational development and supporting high quality care. These webinars typically occur monthly and highlight speakers who have expertise in a variety of topics such as oral health, immunization, chronic health conditions, and more.

- COP information is available on the MIHP Provider Training website.

Internal Communication

Program Coordinator is responsible for disseminating all communication to agency staff, including:

- MIHP Bi-Weekly Updates.
- MIHP Important Updates (previously known as MIHP Alerts).
- MIHP Coordinator Meeting updates (information obtained from attending the meeting).
- MDHHS MIHP correspondence.
- Updated community resources.

MIHP Resource Pages

Find archived Bi-Weekly Updates and Important Updates here: Communications

Find provider Training guidance here: MIHP Provider Training.

SECTION 2: FACILITY, TECHNOLOGY, AND RECORDS

This section details policies related to the facilities, technology, and methods for handling protected health information (PHI).

Provider Facility

While the standard location of MIHP services occur in homes, visits may occur in the MIHP provider's office when necessary and appropriate. Provider facilities must ensure adequate privacy for beneficiary counseling and education. Similarly, appropriate accommodations must be in place in the event that MDHHS MIHP staff conduct a site visit, compliance review, or other meeting, regardless of format (virtual or on-site). Virtual accommodations include, but are not limited to: adequate privacy, necessary equipment to support virtual communication, and stable internet connection. On-site accommodations include but are not limited to: adequate space for MDHHS MIHP, a smoke-free, pet-free environment, and a table or desk, chairs and working restroom.

ID Badges

Home Visitors must carry identification (ID) badges with them when conducting home visits. The ID must include the name of the staff person, photograph of the staff person, and name of agency.

Communication: Provider Phone

Provider must have a *business phone* listed in the MIHP directory/map. The *business phone* must include a voicemail system that provides guidance in case of emergencies. Specifically, the message must inform the caller to "Call 9-1-1 or go to the nearest emergency room."

Communication: Correspondence with MDHHS

Provider must be responsive to MDHHS inquiries and emails within the required timeframe. In instances where a timeframe is not specified but MDHHS MIHP has contacted an agency for information, a response is expected **within 72 hours**. If changes occur related to service delivery or contact information (void of staff, use of backup staff, change of address, etc.), the provider must communicate such changes to MDHHS MIHP **within 10 business days** of the change and ensure appropriate forms are submitted (i.e., the Information Change Request form and/or the Personnel Roster). Additional information can be found in Section 1: Provider Directory, Staffing, and Training.

Privacy, Security and Confidentiality

HIPAA is the Health Insurance Portability and Accountability Act of 1996. MIHP providers are bound to all HIPAA privacy and security requirements as federally mandated. Therefore, providers must ensure proper protections for all protected health information (PHI) and electronic protected health information. The information below highlights key aspects pertaining to MIHP and field confidentiality.

Provider Responsibility and Contract Language

MIHP providers are considered HIPAA "covered entities" and maintain responsibility as such. MIHP staff are responsible for maintaining the privacy and security of all confidential information that they transport, store or access regardless of location (home office, home visit, community, etc.). All MIHP staff must adhere to HIPAA requirements. If an agency violates HIPAA, the agency, not MDHHS, is responsible for securing legal counsel should it become necessary. Agency contracts must include language requiring

contractors to meet HIPAA standards, including record retention requirements for contractors who store the agency's paper or electronic records.

HIPAA Privacy and Security Overview

The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule refers to this information "protected health information (PHI)".
"Individually identifiable health information" is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The HIPAA Security Rule protects a subset of information covered by the Privacy Rule, which is all individually identifiable health information a covered entity creates, receives, maintains or transmits in electronic form. The Security Rule calls this information "electronic protected health information" (e-PHI). The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting e-PHI. With this, entities must:

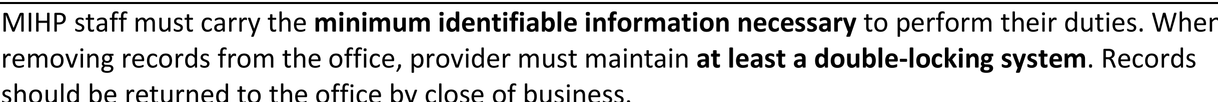
- Ensure the confidentiality, integrity, and availability of all e-PHI they create, receive, maintain or transmit,
- Identify and protect against reasonably anticipated threats to the security or integrity of the information, and
- Protect against reasonably anticipated, impermissible uses or disclosures; and ensure compliance by their workforce.

Storage of PHI (C)

All PHI must be kept in a **triple-locked system** unless actively in use (see the exception below with regards to transport). This involves three layers of protection for PHI to prevent unauthorized access.

- Example: locking filing cabinet inside a room that locks, inside a building with locking exterior doors and windows.
- Example: password protected database on a password protected computer inside a room that locks.

Transporting PHI (Field Confidentiality) (P)



MIHP staff must carry the **minimum identifiable information necessary** to perform their 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.

- **Vehicle Storage:** While it is recommended that PHI not be stored in vehicles due to the inability to maintain triple-locking security, it may be necessary. In such instances, the provider must use at least a double-locking system (preferably in a locked box within the trunk of a locked car).

Telehealth and PHI

MIHP providers must comply with Medicaid telehealth policies, including all PHI-related guidance. MDHHS requires a HIPAA compliant real-time interactive system. Sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of identifiable information.

Communication and Network Security

Providers must avoid verbal discussion of beneficiary information in any setting with unauthorized persons, regardless of whether identifying information is shared. Regarding communication with beneficiaries, it is permissible to communicate via text message if a beneficiary has agreed to communication via text messaging (as indicated on the RI).
Electronic communication or transfer of information containing PHI must occur using appropriate safeguards such as fax, email encryption, or a secure EMR system.

- All electronic records containing PHI must be stored in an encrypted or password protected file.
- Anti-virus software must be installed on all computers and mobile devices used for MIHP business.
- Employees must maintain updates to current operating systems (e.g., software updates/patches).

Technical Safeguards

Below are key points on technical safeguards as indicated within the HIPAA Security Rule.

- **Access Control**: A covered entity must implement technical policies and procedures that allow only authorized persons to access electronic protected health information (e-PHI).
- **Audit Controls:** A covered entity must implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI.
- **Integrity Controls:** A covered entity must implement policies and procedures to ensure that e-PHI is not improperly altered or destroyed. Electronic measures must be put in place to confirm that e-PHI has not been improperly altered or destroyed.
- **Transmission Security:** A covered entity must implement technical security measures that guard against unauthorized access to e-PHI that is being transmitted over an electronic network.

Record Retention and Availability of Records

Providers must ensure record keeping is maintained in accordance with Medicaid policy. Below is a summary of such record keeping expectations.

Record Retention

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. Provider must retain records (including any applicable physician orders) **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 or MIHP.

- Agencies that no longer operate an MIHP remain bound by this requirement.
- Records must be destroyed appropriately after the end of the retention period. This includes hard copy and electronic records.

Availability 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 rule.

- All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. MDHHS conducts post-payment reviews to verify services, providers, settings, and billing. Health plans contracting with MDHHS must be permitted access to all information relating to services reimbursed by the health plan.

- Records may only be released to other individuals/organizations if they have a consent signed by the beneficiary authorizing release, or if release is permitted under applicable confidentiality laws.

SECTION 3: QUALITY ASSURANCE

This section details expectations for internal quality assurance and mechanisms for filing a grievance.

Chart and Billing Audits C P

MIHP providers must conduct **chart audits and billing audits (at least quarterly)** as part of quality assurance. Such audits must be conducted in accordance with the information below and in alignment with the provider-specific protocol (frequency, staff responsible, number of charts to be reviewed, etc.). MDHHS MIHP has templates available for use, or providers may use their own version.

Chart audits must be:

- Conducted at least quarterly.
- Documented; documentation must be on site for review.
- Signed and dated (electronic is acceptable).

Billing audits must be:

- Conducted at least quarterly.
- Documented; documentation must be on site for review.
- Signed and dated (electronic is acceptable).

Alteration of Records C

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 is not acceptable.
- Only the Home Visitor who completed the original form may alter the record.
- As a reminder, consent forms cannot be altered.

Electronic record systems must have a tracking mechanism to identify who altered program documents, what content was changed, and the date on which the change occurred. P

MIHP Resource Page
Find MIHP Chart Review and Billing Chart Review Tools here: Certification.

Critical Indicators C

Critical indicators are those with a point value of 4 or 5 on the Certification Tool (and Certification Specifications document). All critical indicators that are "not met" must show the following improvement:

Number of Critical Indicators "Not Met" During Cycle 9 Review	Number of Critical Indicators in Which Improvement Must be Demonstrated During Next Review
6 or more "not met"	4 or more
4-5 "not met"	3 or more
1-3 "not met"	1

Beneficiary Grievance Process P

Grievances: Provider must document a process for handling beneficiary grievances. As a reminder, providers must identify a protocol related to grievances and include information about the grievance process within the Welcome Packet.

MIHP Data

Providers are encouraged to review internal systems for purposes of data analysis and quality assurance (such as EMR reports). Below are additional methods for obtaining MIHP data:

CHAMPS Reports

Quarterly CHAMPS reports are available. Instructions can be found on the Policy and Operations website.

Data Requests from MDHHS MIHP

In order to request MIHP data from MDHHS MIHP, the requester must submit the *MIHP Data Request form*, which is available on the Policy and Operations website.

SECTION 4: CONTRACTS AND COMMUNITY ENGAGEMENT

This section details requirements for contracts, arrangement of services, and community resources.

Contracts

MIHP providers must establish and maintain provider contractual agreements with the MHPs in their service area to receive payment for in-network services provided to MHP enrollees unless the MHP indicates otherwise. MIHP providers are encouraged to contract with the MHPs in their service area.
In cases where billable services are provided through a contract with another entity, the contract or letter of agreement must be on file for review. It must be current and specify the time period of the agreement, the names and titles of the individuals providing services, where the billing responsibility lies, and language that meets HIPAA standards.

Care Coordination Agreements M

MIHP providers are encouraged to establish Care Coordination Agreements (CCAs) 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. The intent of the CCA is to explicitly describe the services to be coordinated and essential aspects of collaboration between the MHP and the MIHP provider.

- An example is available on the Policy and Operations section of the MIHP website.
- As a reminder, Care Coordination activities may be eligible for reimbursement as part of MIHP Enhanced Services. See more details in the Care Coordination section.

Arrangement for Beneficiary Services M

Providers must ensure proper arrangements are provided in a manner which allows full participation.

Accommodations for Family Availability

Provider must accommodate beneficiary/caregiver schedules or refer the family to another MIHP.

Language Access Accommodations

Provider must arrange for interpretation services, including **limited English proficient individuals and those who are deaf, hard of hearing, blind, or have low vision**. Providers are responsible for the cost of services provided. Provider must develop a protocol to describe accommodations such as:

- Provider staff with the skills to meet beneficiary needs.
- Verbal or written agreement with an identified community organization to provide interpreter services or otherwise assist the provider.
- Assistive technology devices for interpretation.
- Verbal or written agreement with another MIHP provider for purposes of transferring beneficiaries.

Use of interpretation software is permissible, provided the software is HIPAA compliant. Use of family or friends over the age of 18 may be used when requested by the beneficiary but cannot be a provider’s sole interpretation services plan. Under the “reasonable accommodation” provision of the Americans with Disabilities Act (ADA) of 1990, MIHP agency staff may read documents to beneficiaries who are blind or have low vision or may make use of assistive technology. Similarly, agency staff may provide written materials to beneficiaries who are deaf or hard of hearing or may communicate via writing.

Transportation

Medicaid Health Plans: MHPs are responsible for providing transportation for pregnancy-related appointments for MHP-enrolled MIHP and Nurse-Family Partnership (NFP) participants.

- Refer to the Medicaid Manual for detailed guidance.

Fee-for-Service: The MIHP may provide transportation to MIHP Fee-for-Service (FFS) beneficiaries for medical/health care services and pregnancy-related appointments when no other means of transportation are available. The MIHP may also contract for transportation services.

- For beneficiaries residing in Wayne, Oakland and Macomb counties, MDHHS contracts with a transportation company to arrange and provide non-emergency medical transportation (NEMT). MHPs may use this vendor when the beneficiary qualifies and has no other means of transportation.

Detailed guidance can also be found in the Medicaid Manual.

Childbirth Education

Childbirth education (CBE) is a series of group classes focused on the information such as bodily changes during pregnancy, the childbirth process, the postpartum period, and infant care. First-time pregnant people must be encouraged to complete the course.

CBE may be provided through either of the following:

- The MIHP provider or medical care provider may make a referral for CBE.
- The MIHP provider may conduct CBE directly or have a contract with a local hospital's outpatient. An outpatient hospital clinic that provides this service may bill Medicaid directly for FFS beneficiaries. The contract must indicate which provider is to bill and receive payment.

When conducted by the MIHP provider, CBE is considered a maternal service and may be billed once per pregnancy, only during pregnancy (not postpartum). CBE must be provided in-person and to a group of individuals in a classroom situation. It cannot be conducted via telehealth.

CBE must include, at minimum, the following topics:

- Pregnancy,
- Labor and delivery,
- Infant care and feeding,
- Postpartum care, and
- Family planning.

Detailed guidance can also be found in the Medicaid Manual.

Parenting Education

Parenting education is a group class focused on developing positive parenting skills and attitudes.

Parenting education may be provided through either of the following:

- The MIHP provider or medical care provider may make a referral for parenting education.
- The MIHP provider may conduct parenting education directly or have a contract with an outpatient hospital or community-based organization. The contract must indicate which provider is to bill and receive payment.

When conducted by the MIHP provider, parenting education is considered an infant service and may be billed once per infant, or in the case of multiple births/blended visits, once per family. It must be provided in-person and to a group of individuals in a classroom situation. It cannot be conducted via telehealth.

Parenting education must include, at minimum, the following topics:

- General feeding recommendations throughout the first year of life,
- Normal and abnormal patterns of elimination,
- Common signs and symptoms of infant illness,
- Common childhood injuries and how to care for them,
- Normal range of sleep, rest, activity and crying patterns,
- General hygiene needs of infants,
- Normal developmental milestones of infants throughout the first year,
- Basic emotional needs,
- Basic protection from toxic and/or hazardous waste,
- Basic immunizations and health maintenance, and
- General day-to-day living with children.

Detailed guidance can also be found in the Medicaid Manual.

Provider Catchment Area and Capacity

- Agencies must make their services available to all eligible beneficiaries residing in the county or counties listed on the MIHP Directory and Map.
- Agencies unable to enroll new beneficiaries due to capacity issues must notify the MDHHS MIHP team **within five business days** of reaching capacity and must refer to another MIHP or appropriate service provider.

Supplemental Disciplines

Provider must ensure a referral process is in place to arrange services for beneficiaries to be seen by supplementary disciplines, including an RD, Infant Mental Health Specialist, and IBCLC®. Provider must identify the entity by name.

Backup Staffing

Provider must arrange backup staffing for nursing and social work services. Backup staff must meet the minimum required standards in Medicaid policy. Arrangement must be in writing with verification that the agency or individual agrees to the arrangements. 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

Backup Staffing Training

Backup staff must complete the required training prior to conducting independent MIHP services.

- See guidance in Training, Section 1.
- See the *Notice of Staff Training Completion Form* located in the MIHP Staff Training section of the MIHP website.

Notification of Staffing Gaps or Backup Staff Implementation

- Provider must notify MDHHS MIHP **within five business days** via email when they are void or know they will be 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. See more guidance in Backup Staffing section.

Timeline Allowed for Backup Staffing in Place

Implementation of backup staffing is intended to be temporary. If a backup plan has been in place for 12 consecutive weeks, monthly updates to MDHHS MIHP are required. Implementation of a backup plan must not exceed nine consecutive months. If there continues to be a void in a required discipline after nine consecutive months, the provider must enter inactive status or close.

Required Community Partnerships and Resources C M

Provider must demonstrate knowledge of community resources in each county of their service area. These must include, but are not limited to, the following:

Early On P

Provider must identify their local entity coordinating Early On services and establish a referral protocol.

Children's Protective Services (CPS) P

Health care professionals and other covered entities must report cases of suspected child abuse or neglect to CPS. The provider must establish a protocol that complies with MIHP protocol specifications, and the reporting requirements mandated by the Michigan Child Protection Law (Act No. 238, Public Acts of 1975).

Referrals Identified Throughout Care

A comprehensive list of resources and organizations is necessary to provide referrals throughout the course of care (such as referral sources for WIC, interpersonal violence, mental health, RD, etc.).

Additional Partnership Opportunities and Resources

MIHP Regional Provider Network Meetings

MDHHS MIHP encourages collaboration among MIHP Providers, including the Regional MIHP Provider Network Meetings (sometimes referred to as Coordinator Meetings). These are facilitated at the **local level** and are opportunities for networking and collaboration among MIHP providers and partners.

- A list is available on the Policy and Operations section of the MIHP website.

Additional Resources Related to Maternal Infant Health

Additional resources that may be helpful include:

- MIHP Family Resources and Intervention Resources: www.Michigan.gov/MIHP
- Division of Maternal and Infant Health Website: www.Michigan.gov/MIH
- Regional Perinatal Quality Collaboratives: www.Michigan.gov/MIPQC
- Local Leadership Groups: www.Michigan.gov/HomeVisiting
- MDHHS Clearinghouse: www.HealthyMichigan.com

SECTION 5: OUTREACH, ELIGIBILITY, AND ENROLLMENT

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

Outreach Plan and Documentation P

Provider must develop an outreach plan, conduct outreach activities and document activities, including the dates of activities, for **each county** in their service area. Documentation (often referred to as an Outreach Log) must be maintained and in one location.

Promotional Material and Outreach Conduct

Providers may utilize a variety of materials when conducting outreach. As a reminder, it is important that materials do not unintentionally include images such as an infant sleeping unsafely.

MIHP Brochures and Information Sheets

Brochures and one-pager information sheets are available on the Promotional Materials section of the MIHP website (in English, Spanish, and Arabic). Customizable versions are also available, so that agencies may include their local agency contact information.

Use of the MIHP Logo

Providers are encouraged to use the MIHP logo, with MDHHS MIHP approval. All materials containing the logo must be submitted and approved prior to use.

- The Logo Permission Request Form is available on the Promotional Materials section of the MIHP website.
- The logo must only be used:
  - By a certified MIHP provider or contracted MHP.
  - On a website or promotional materials such as brochures, staff badges, business cards or other items to advertise MIHP services.
  - In the exact form provided by the MDHHS. The color, proportions, spacing or other aspects of the logo must not be modified. However, adjusting the overall size is acceptable.

Outreach Conduct

MDHHS expects all MIHP providers to conduct their outreach activities professionally, fairly, and ethically. This includes, but is not limited to, the following:

- Not offering incentives (e.g., diapers, gift cards, etc.) to encourage enrollment.
- Not using false advertising or promising more than can be delivered.
- Not entering a beneficiary's name in the MIHP database as a placeholder.
- Refraining from seeing beneficiaries who are already being seen by other MIHP providers.
- Respecting outreach relationships developed by other MIHP providers.
- Sharing information with other providers as appropriate

MIHP Resource Page

Find Logo Information and Promotional Materials here: Promotional Materials

Beneficiary Eligibility for MIHP Services M

Below is a summary of eligibility for maternal and infant beneficiaries. For information on variations, see Physician Orders and Policy Exceptions. Families may only enroll with **one MIHP provider** at a time.

Maternal Beneficiaries – Medicaid (Fee-for-Service and Medicaid Health Plans)

Insurance	Pregnant individuals enrolled in, or eligible for, Medicaid insurance.
Enrollment	May enroll any time during pregnancy (but not after delivery).
Discharge	Discharge in the postpartum period, with an ideal transition to enrolling the infant. A beneficiary is considered discharged once the Discharge Summary is entered into MILogin (regardless of whether a Discharge Visit was conducted). Providers must discharge beneficiaries within 30 calendar days of completing maternal services or upon reaching 12 months postpartum (whichever comes first). Completion of maternal services is defined as beneficiary request for discharge or upon completion of all eligible visits.
Postpartum Extension	Remaining maternal visits may continue up to 12 months postpartum. This applies to enrolled maternal beneficiaries who experienced live birth or other pregnancy outcomes such as pregnancy loss or termination. • See more in Medicaid Postpartum Extension.
Enhanced Services	Eligible for enhanced services, for dates of service on or after October 1, 2024.

Maternal Beneficiaries – Maternity Outpatient Medical Services (MOMS)

Insurance	Pregnant individuals enrolled in Maternity Outpatient Medical Services (MOMS).
Enrollment	May enroll any time during pregnancy (but not after delivery).
Discharge	Discharge within 30 calendar days after delivery, with an ideal transition to enrolling the infant. A beneficiary is considered discharged once the Discharge Summary is entered into MILogin. Because eligibility concludes at delivery, MOMS billable services, including the optional Discharge Visit, must be completed prior to delivery. Completion of maternal services is defined as beneficiary request for discharge or upon completion of all eligible visits.
Postpartum Extension	Not eligible for MIHP Medicaid Postpartum Extension Services.
Enhanced Services	Eligible for enhanced services, for dates of service on or after October 1, 2024, for services provided during MOMs course of care (during pregnancy but not after delivery).

Infant Beneficiaries

Insurance	Infants under 12 months of age who are enrolled in, or eligible for, Medicaid insurance.
Enrollment	May enroll between birth (after hospital discharge) and up to 12 months of age.
Discharge	Must discharge within 30 calendar days of the end of eligibility (completion of services or by 18 months). A beneficiary is considered discharged once the Discharge Summary is entered into MILogin. Completion of infant services is defined as family request for discharge or upon completion of all eligible visits.
Enhanced Services	Eligible for enhanced services, for dates of service on or after October 1, 2024.

Referrals for MIHP Services M P

Providers are expected to contact potential beneficiaries within specified timeframes as detailed below and are expected to schedule visits based on the beneficiary's availability/schedule.

Referral Sources

Providers may obtain referrals from a variety of resources. Below are statewide processes that support the beneficiary referral process.

Medicaid Health Plans (MHPs): 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. Providers also communicate directly with MHPs via the monthly Communication Tool, described below.

- Note: 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.

MI Bridges and 2-1-1: Families may use these systems to send a referral directly to providers. Providers may also enter dispositions and track referrals within the systems.

- MI Bridges: Providers are encouraged to register as a referral partner to allow this functionality. Additional information is available on the MI Bridges Community Partner website.
- 2-1-1: Providers are encouraged to register as a 2-1-1 provider to allow this functionality.

MDHHS MIHP Website and Program Finder: Active providers are automatically listed on the MIHP Map and Directory (www.Michigan.gov/MIHP), and the Home Visiting Program Finder (www.HomeVisiting.com). Families may review this information and contact agencies directly.

Response to MIHP Referrals

Maternal: Provider must respond to all referrals for maternal beneficiaries within **14 calendar days** after the referral is received.

Infant: Provider must respond to all referrals for infant beneficiaries using the following timelines:

- Infants referred prior to discharge from hospital: **two business days** after discharge.
- Infants referred after discharge from hospital: **seven calendar days** after the referral is received.

Capacity Concerns: If a referral is received and the program is not able to serve the family, it is the expectation that the family be referred to another home visiting program in their community.

MIHP Referral Documentation

Information such as the "referral date" and "date of first contact" must be documented on the appropriate form checklist (*Maternal Forms Checklist or Infant Forms Checklist).* If contact is not made within the required timeline, attempts must be documented on the *Contact Log*.

- As a reminder, the MHP *Communication Tool* is a required document used to communicate referral status to MHPs. See more information in the Communication with MHP section.

Eligibility Confirmation

Providers must review Medicaid eligibility and review the MIHP Application in MILogin (for a Risk Identifier) to ensure the family is not already enrolled with another provider. While searching the MIHP Application, it is important to perform an exhaustive search using name and date of birth **only**, as well as a search using Medicaid ID **only**. When conducting these searches, the "existing" button must be selected rather than the "inquiry" button. During care, it is incumbent upon MIHP providers to check eligibility and MHP enrollment at every visit.

Premature Enrollment Documentation

It is not permissible to enter demographic information into the Risk Identifier database for purposes of "holding" a potential enrollee prior to conducting the Risk Identifier. An *RI* may only be entered into MILogin after an *RI* has been completed, even if it takes multiple visits to complete.

MIHP Forms Overview

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.
- MIHP forms are available on the respective Forms section of the MIHP website.

Documentation Format

Providers must use current versions of the required standardized forms (as posted online). Providers interested in electronic documentation of MIHP forms (e.g., integrate into an existing electronic health record, or EHR) must ensure all required data elements are included and maintained in the same order as current versions.

- For providers integrating MIHP forms into their EHR system, an "unprotected" version of the MIHP form may be necessary. To obtain these, please submit an email request to MIHP@Michigan.gov, with exact form numbers/names requested.
- If an agency experiences delays with integrating forms changes into their EHR, please contact MDHHS MIHP to request an exception.
- Regardless of internal documentation format, providers must also enter the *Risk Identifier* and *Discharge Summary* into the MIHP Application (the online database within MILogin).

Timeline for Forms Updates and Implementation

Forms are typically updated each cycle. To allow time to review changes and update documentation systems, MDHHS MIHP publishes updated forms prior to the required implementation date.

Electronic Signatures on Forms

In accordance with the Uniform Electronic Transactions Act (MCL 450.831 et seq), an electronic signature is acceptable so long as it is intended to be a signature, and the creation of the signature can be attributed to the person. This includes practices such as using signature pads or typing a name for purposes of signing, given the appropriate attribution measures are in place. For example, attribution may include, but is not limited to: staff using a secure log-in to type their own signature, a beneficiary typing into a form while witnessed by staff, mailing forms to be signed, and faxing forms to be signed.

Alteration of Records

Record alterations are described in the Quality Assurance section.

MIHP Forms and Chart Documentation

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 (RI)
- RI Scoresheet
- Plan of Care, Part 1
- Plan of Care, Part 2
- Plan of Care, Part 3
- Care Coordination
- Professional Visit Progress Notes
- MCIR printouts
- ASQ Information Summaries
- Discharge Summary
- Physician Orders
- Notification of Multiple Charts Open
- Consent to Transfer
- Transfer Checklist
- Discharge Form

Forms Locations

A list of Forms and their location are available at the end of this Guide: Forms at a Glance.

Forms Checklist

The *Forms Checklist* is a required document that helps ensure comprehensive documentation. It allows tracking of timelines to ensure requirements are met from the time of referral to the time of discharge, succinctly capturing information reviewed for compliance.

Contact Log

The *Contact Log* must be used to indicate any required program element that did not occur throughout the course of care with rationale (details can be found in the instructions). The *Contact Log* may also be used for requirements completed in a manner that varies from program guidance (such as conducting more than one visit in a month).

- Provider may document these items on the *PVPN* during the course of care. **However, when a chart is closed, this information must be transferred to the *Contact Log*.**
- Because services are family-driven, unmet requirements must be based on the needs of the family (not based on the preference or ease of the provider). This approach of beneficiary perspective must therefore be reflected in the rationale. Variations to this rationale approach may apply only to limited circumstances such as a beneficiary who is lost to follow-up.

Enrollment: The Assessment Visit M

The MIHP enrollment visit is also known as the "Assessment Visit," or "Risk Identifier Visit" and is conducted by either an RN or SW. This process and associated forms are described below.

Consent Forms C

Consent to Participate: Home Visitor must review content and obtain beneficiary/caregiver signature on the *Consent to Participate Form (Maternal or Infant)* prior to administering the Risk Identifier. This form must also designate the medical provider with which the MIHP provider can exchange information. A separate consent is not required to exchange information with the medical provider or payor.

- If a medical provider is not in place at the time of enrollment or a new medical provider is identified during the course of care, refer to the Changes to Medical Provider section.
- Verbal consent for the *Consent to Participate* is acceptable if conducted in accordance with the Telehealth section.

Consent to Release Protected Health Information: Home Visitor must review content and obtain beneficiary/caregiver signature on the appropriate *Consent to Release Protected Health Information (PHI) Form (Maternal or Infant).* A *Consent to Release Protected Health Information (PHI) Form (Maternal or Infant)* is only needed when a beneficiary desires that information in their MIHP record is exchanged with another entity other than the medical provider indicated in the *Consent to Participate*.

Referral partners are to be included on this consent when the MIHP provider will facilitate communication with the referral partner on the beneficiary's behalf. If instead, information is provided to the beneficiary as a resource for them to initiate contact, documentation on the *Consent to Release PHI* is not necessary but the referral source should be documented on the *PVPN* and followed up on in within three visits. See more in the *Resource and Referral* section.

Additional details:

- A beneficiary signature must be obtained for the *Consent to Release PHI* and may not be authorized via a verbal consent. Such a signature may be obtained as a physical signature or as an electronic "e-signature". See details in the Electronic Signature section.
- Please ensure only information specific to MIHP documentation is included when consent to release information is obtained.
- For release of substance use treatment records, a specific consent form is required and described below.
- If no medical provider is identified, refer to the Exceptions to Notifying the Beneficiary's Medical Provider section, item #2.

Consent to Transfer to Another MIHP Provider: See details in the Beneficiary Transfer section.

Consent to Release Substance Use Treatment Records: If treatment records for substance use disorder have been received from another entity and must be released, a separate consent must be obtained. Detailed information and the consent form can be found here: Michigan Behavioral Health Standard Consent Form. This consent must be obtained via a physical or electronic signature (verbal consent is not acceptable).

- Of note, self-reported substance use information reported on the RI and in professional visits is not subject to this additional consent.

Revisions to Consent Forms

- Alterations are not acceptable on any consent form. For any changes (including the addition of

parties to share information with), a new consent must be obtained. The original, and any previous versions, must be maintained in the beneficiary record.

- When additional parties are identified for the *Consent to Release Protected Health Information*, a new consent must be obtained that is inclusive of all active parties. This may or may not include parties listed on previous version(s). The most recent *Consent to Release PHI* should contain all parties to whom PHI may be disclosed (i.e., if WIC was on the original consent and additional communication with WIC is necessary, they must be added to the new version).

For guidance on **telehealth (verbal) consent**, please see the Telehealth section.

Risk Identifier

The *Risk Identifier (RI)* is a mandatory tool utilized during the assessment visit to identify beneficiary risks and inform the *Plan of Care* development. It must be conducted by the RN or SW and assures appropriate services are identified prior to initiation of services. These tools include the *Maternal Risk Identifier* and *Infant Risk Identifier*.

RI and Eligibility: To enroll a beneficiary in MIHP, they must obtain a risk score on the *RI* scoresheet (low, moderate, or high) for at least one domain.

- Exceptions may be requested in limited circumstances. See the Policy Exceptions section.
- Note regarding the *IRI*: If either the infant **or** the caregiver obtains a score within the *IRI*, this infant beneficiary is eligible. For example, if the infant does not obtain a score for infant-specific domains but the caregiver obtains a score within the *IRI*, this infant is eligible to enroll.
- In the case of unknown risk, the highest level should be assigned for an individual domain.
- A risk score for “Birth Health” does not have a POC, however, services may still be offered based on professional judgement, without requesting an exception.

RI Documentation: The *RI* must be completed, entered in MILogin, and a scoresheet received prior to providing additional MIHP services (unless an emergency is documented on the *PVPN* or *Contact Log*).

- Previous requirements indicated that the *RI* also had to be billed prior to conducting additional MIHP services; however, this is no longer required.
- If the *RI* is not completed within one visit, the second visit must be within 14 calendar days. If this occurs, providers may only bill for one *RI* visit and not until it is fully administered. The date of the second visit is considered the date that the *RI* was administered.
- If a Medicaid ID is not yet available, this field may be left blank temporarily. However, it must be updated as soon as the Medicaid ID is known and prior to completion of the *Discharge Summary*.
- It is permissible to complete multiple RIs for a family on the same day (for example, enrolling twins, enrolling siblings, etc.).
- If an infant visit assessment visit occurs on the same day as a maternal postpartum professional visit, rationale must be documented on the *Contact Log*. See detailed guidance on documentation for multiple family members in the Blended Visits section.
- If the Risk Identifier is completed via telehealth, follow guidance in the Telehealth Section.

Revising or Deleting Ris: If an *RI* needs to be revised or deleted within the MIHP database, please see the tipsheet “Instructions to Delete or Correct Risk Identifiers and Discharges” located on the Policy and Operations section of the MIHP website. As a reminder, detailed instructions are available for all forms, including the *MRI* and *IRI*.

RI Billing: Billing guidance is available in Section 7. Some elements unique to the *RI* include:

- There are times when submitting a claim for an *RI* is not feasible (e.g., beneficiary moved,

change in insurance, etc.). If the *RI* is not billed, please make a note on the *Contact Log*.

Declination of MIHP Services after RI

If beneficiary/caregiver declined services after the Risk Identifier, Home Visitor must:

- Complete *Plan of Care, Part 1 (POC 1);* POC 2 and 3 are not required if services have been declined.
- Provide beneficiary/caregiver with the Education Packet or list of approved phone applications.
- Complete a *Discharge Summary* within 30 calendar days of declination.

Plan of Care, Part 1 (POC 1)

Home Visitor must complete activities associated with the appropriate *Plan of Care 1*. This POC includes activities such as discussing expectations, reviewing content of the Welcome Packet, and documenting referrals or interventions completed.

- *Maternal Plan of Care 1*
- *Infant Plan of Care 1*

Emergent Needs and/or Domains Addressed During Assessment Visit

Home Visitor must address any emergent needs and referrals the beneficiary/caregiver has identified during the Assessment Visit. Content addressed during the Assessment Visit must be documented on the *Contact Log* and/or *POC 1*. Domain(s) and/or intervention(s) addressed during the Assessment Visit do not need to be repeated during a professional visit.

Welcome Packet

At the Assessment Visit, the Home Visitor must give the beneficiary/caregiver a provider-specific Welcome Packet. This may be provided electronically or physically. If a physical version is requested by the beneficiary, it must be provided. The Welcome Packet must include, at a minimum, the following:

1. Education Tool – **Updated phone app options**
2. Contact Information
3. Lead Fact Sheet – **Updated version**
4. Immunization Fact Sheet – **Newly added handout**
5. Your Rights and Responsibilities as an MIHP Participant
6. How to File a Grievance

Detailed descriptions of the required Welcome Packet elements can be found below:

1. Education Tool

At least one of the following must be provided:

a. **MIHP Education Packet** as posted on the Parent/Family Resources section of the MIHP website.

b. **Information about at least one MDHHS-approved phone application ("app").** This includes Pregnancy+, What to Expect, or CDC's Milestone Tracker. App-specific flyers are available on the Parent/Family Resources section of the MIHP website.

An all-encompassing MDHHS handout is also available with links to both the Education Packet and available phone apps. This can be found on the Parent/Family Resources section of the MIHP website.

2. Contact Information

a. The Provider is responsible for including their contact information within the Welcome Packet.

3. Lead Fact Sheet

a. This can be found on the Forms section of the MIHP website, under POC 1.

4. **Immunization Fact Sheet**
    a. This can be found on the Forms section of the MIHP website, under POC 1.
5. **Your Rights and Responsibilities as an MIHP Participant**
    a. This can be found on the Forms section of the MIHP website, under POC 1.
6. **How to File a Grievance**
    a. The Provider is responsible for including information on filing a grievance with the provider.

Policy Exceptions M

In limited situations, when beneficiary needs surpass program parameters, providers may request an exception to initiate or continue MIHP services. Requests must receive approval before providing services, and not all requests may be approved.

An exception may be requested **only for the following circumstances**:

Policy Exceptions Available for Request
1. Enrollment of an infant between 12 through 15 months of age. Discharge is required by 18 months of age with transition to a more age-appropriate program. **2.** Continuation of services beyond 18 months of age for purposes of providing support for end-of-life concerns. **3.** Risk Identifier scores no risk, but professional judgement indicates a need for services. **4.** Additional visits for postpartum maternal services if visits have been exhausted but infant is in the Neonatal Intensive Care Unit (NICU) and therefore unable to enroll in infant services.

Note: A risk score for "Birth Health" does not have a POC because it is a one-time assessment of the infant at birth. However, services may still be offered based on professional judgement, without requesting an exception.

Process for Exception Requests

Provider must send request for approval to MDHHS MIHP staff via encrypted email or fax. To enhance submission of policy exception requests, a fillable form is available on the Policy and Operations webpage. The request must contain the following:

- Beneficiary name
- Medicaid ID
- Date of birth
- Payor source for beneficiary (health plan or fee for service)
- Type of exception (of the allowable exceptions listed above)
- Number of visits conducted thus far if applicable.
- Number of additional visits requested if applicable (visits requested above policy)
- Rationale for the exception which must include as appropriate:
  - Identified risks.
  - Support to be provided.
  - A transition plan if applicable.

Upon Submission: Requests are reviewed within 15 business days and based on the order in which they were received. Processing time may take up to one month. After MDHHS review, a response will be provided as follows:

- FFS Medicaid: MDHHS MIHP staff will review and provide the decision to the MIHP provider.
- Medicaid Health Plan (MHP): MDHHS MIHP staff will review the request and provide the recommendation to the MHP, while including the provider in this correspondence. MHPs are responsible for care coordination for approved activities outside the scope of MIHP.
- Provider must refrain from providing services until approval has been received.
- Approval documentation must be kept in the beneficiary's chart.
  - For beneficiaries enrolled in an MHP, the exception must be documented on page 2 of the *MHP Communication Tool* sent monthly to the beneficiary's Health Plan.

Considerations for Exception Denials

In some instances, MDHHS MIHP may not approve an exception request. This is most applicable to requests that exceed the scope of MIHP service and fidelity to the model. However, the provider and health plan may come to an agreement to continue services outside of the scope of MIHP.

- MDHHS MIHP will continue to review exception requests to determine alignment with current policy and program exceptions. If not in alignment, MDHHS MIHP may recommend that the provider contact the MHP case manager directly for care coordination and billing for services that are not within the scope of MIHP.
- MDHHS MIHP also encourages the provider to harness community supports such as MHP case managers, DHHS case workers, and Community Health Workers.

Plan of Care, Part 2 (POC 2) M

The POC 2 is developed based on the *Risk Identifier Scoresheet* and professional judgement. For every domain that "scores" on the *Risk Identifier* or is identified by professional judgement, the related POC 2 must be pulled and added to the chart. All POCs are available on the Forms section of the MIHP website. POC 2s contain a list of interventions for each domain, allowing a Home Visitor to use these standardized set of interventions for documentation.

Maternal POC 2 Domains

- Abuse/Violence[R]
- Alcohol[R]
- Breastfeeding*
- Family Planning
- Food/Nutrition[R]
- Housing
- Medical Considerations
- Pregnancy Health
- Preventing Adverse Childhood Experiences (PACEs)*
- Social Support
- Stress/Depression[R]
- Substance Misuse[R]
- Tobacco
- Transportation

Infant POC 2 Domains**

- Breastfeeding*
- Family and Social Support
- Feeding
- General Infant Development
- Infant Health Care
- Infant Safety[R]
- Preventing Adverse Childhood Experiences (PACEs)*
- Substance-Exposed Infant*[R]
- Transportation*

R = Indicates domains that are associated with required interventions. See more information in the Summary of Required Interventions/Referrals.

*Indicates POC 2 that can only be identified through professional judgement (not via a score on the RI).

The infant beneficiary's POC 2 **also includes any applicable maternal domains (referred to as Maternal Considerations).

Preventing Adverse Childhood Experiences POC 2 (PACEs POC 2) - NEW for Cycle 10

The PACEs POC2 is now available for use and encouraged for appropriate families, as determined by professional judgement. A decision guide and intervention resources are available on the MIHP PACE POC 2 website: Preventing ACES Plan of Care 2. Please note that the PACEs POC2 is the same for both infant and maternal beneficiaries.

POC 2 Interdisciplinary Development

Co-development of the POC 2 by the RN and SW ensures agreement among both disciplines, as evidenced on the POC 3. Conducting a case conference to develop the plan of care may lead to optimal service delivery by coordinating efforts to provide well-rounded, comprehensive care. During the plan's development, the Care Coordinator is identified and documented on the POC 3.

POC 2 Documentation and Intervention Levels

All POC 2 domains identified on the *Risk Identifier* Scoresheet or by professional judgement **must be added to the beneficiary's chart**. On each POC 2, the provider must check the appropriate intervention level based on the *Risk Identifier* or professional judgement. Detailed guidance is included in the form instructions.

- In the case of unknown risk, the highest level available should be assigned for an individual domain.
- Note: Birth Health may score as a result of the *Risk Identifier* but does not have a *POC 2*. However, services may still be offered based on the professional judgement, without requesting an exception.

POC 2 Revisions

Adjustment of Intervention Levels

Home Visitor may adjust the Intervention Level on a given *POC 2* on or after the first professional visit. If this occurs, the HV must:

- Check the new Intervention Level.
- Document the date of the change on the *POC 2*.
- The *POC 3* does not need to be updated when changing an Intervention Level.

Addition of POC 2s

Home Visitor may add *POC 2s* when professional judgement indicates the beneficiary/caregiver meets criteria for a *POC 2* that did not score on the *Risk Identifier* or for POC 2s that do not produce a score (breastfeeding, infant transportation, PACEs, and substance-exposed infant).

POC 2s may be added at the time of enrollment or anytime during the course of care. Any additions made to the beneficiary's scoresheet and/or initial *POC2* must be documented in the *POC3,* including the date of the change and signed by the individual making the change. To summarize, POC 2 additions must be documented as follows:

- Add the *POC 2*, identifying an Intervention Level .
- Update the *POC 3* section "Care Plan Revisions."
  - Complete *POC 3* updates prior to the next visit.
- As of Cycle 10, rationale is not required when *POC 2* additions are made.

Implementing POC 2 Interventions and Documentation

Before discharge, the Home Visitor must address all domains outlined in the beneficiary's POC2.

- Using Motivational Interviewing, MIHP providers should implement appropriate interventions for the family and document them on the *PVPN*.
- Intervention numbers may be used in place of full statements.

Plan of Care, Part 3 (POC 3)

The *POC 3* assures a multi-disciplinary approach to the development of a beneficiary's *POC 2*. The Care Coordinator/Case Manager must also be established and documented on the *POC 3*. The *POC 3* must be completed and signed as follows:

- **Developed at Enrollment:** The *POC 3* developed at enrollment reflects both the domains that are indicated by the scoresheet and domains indicated by professional discretion, as captured in their respective sections of the form. While the top section reflects domains identified by the scoresheet, professionals may add additional domains within the "Care Plan Additions and/or Revisions" if applicable. The "Additions" section may also be used for domains identified during care, as noted below. Both disciplines must sign the POC 3 prior to the first professional visit, unless an emergency is documented on the *PVPN* or *Contact Log*. As of Cycle 10, the signatures do not need to fall within 10 calendar days of each other.
- **If Domains Are Identified During Care:** If domains are added during the course of care, after the initial development, the *POC 3* must be updated to reflect any domain(s), prior to the next visit. The updated POC 3 must be signed and dated by the professional who added them. POC domains may be added by the RN, SW, IMHS, or RD.

POC 3 Documentation if Missing a Discipline

If an agency lacks a discipline, enter such documentation beneath the signature line. For example, "Agency currently without SW/RN." Upon filling the position, the professional should review and sign the *POC 3*, on or near the signature line, and with the current date.

Beneficiary Transfers C M P

Beneficiaries may transfer to another provider for a variety of reasons. Providers must honor all requests to transfer and ensure a timely, professional, supportive transition. Providers who integrate beneficiary feedback into their quality assurance process must ensure such communication honors family autonomy. Therefore, an agency who wishes to inquire about services provided (e.g., satisfaction survey, reason for transfer, etc.), should occur after the transfer has been completed to avoid disruption of the transfer process. However, to respect agency autonomy, an agency could respectfully follow-up on satisfaction concurrently as long as there is no disruption in the transfer process.

Overview of Transfer Process

The overall process occurs as follows:

- Obtain beneficiary *Consent to Transfer* (verbal consent is acceptable). Ensure this is sent to the Transferring Provider or may be obtained by the Transferring Provider.
    a. Either provider may initiate this step. However, to encourage the continuity of services and ease of transfer process, it is recommended that the Transferring Provider contacts the Recipient Provider to confirm capacity, obtain consent to transfer, and support a warm handoff for the family.
- Transferring Provider sends records per the guidance below (Transferring Provider Role).
- Recipient Provider receives records per the guidance below (Recipient Provider Role).

Transferring Provider Role

Provider **transferring/sending** beneficiary records must:

1. Obtain *Consent to Transfer* or ensure it has been obtained appropriately and received (verbal consent is acceptable).
2. Send the following documents within 10 business days of receiving the completed *Consent to Transfer*: *Risk Identifier and Scoresheet, POC 1, all POC 2s, POC 3,* all *PVPN*s, MCIR records, and all ASQ-3 and ASQ:SE-2 if applicable.
    - May use the *Transfer Fax Cover Sheet*.
3. Refrain from completing a *Discharge Summary*. If documents have been sent but the Recipient Provider does not successfully enroll the beneficiary, the original provider may use their discretion to discharge the beneficiary after sufficient time has elapsed. If after discharging, the Recipient Provider re-engages the family regarding the transfer, contact MDHHS to delete the Discharge Summary so that services may be initiated.

Recipient Provider Role (Provider Accepting the Transfer)

Provider **receiving/requesting** beneficiary records refrain from serving the beneficiary prior to receiving documents from the sending provider (unless an emergency is documented on the *PVPN* or *Contact Log*). The Recipient Provider must:

1. Ensure *Consent to Transfer* is obtained or has been obtained appropriately and sent to the Transferring Provider (verbal consent is acceptable).
2. Await documents from the Transferring Provider (due within 10 business days).
    - Use the *Forms Checklist for Transfer Received*.

3. Once all documents are received, initiate services for beneficiary.
    - Obtain *Consent to Participate* and *Consent to Release PHI.*
4. Notify the beneficiary's medical provider of the transfer.
5. It is strongly encouraged that both disciplines review the beneficiary record once received.
6. Develop a new *POC 3* with both disciplines and sign prior to the first visit with the family. The agency must indicate which domains were added by the previous agency.
7. Address high risk POC 2s within the first three visits following transfer unless there is evidence that they have been addressed by the transfer agency.

Provider may contact MDHHS if records are not received within 10 business days.

SECTION 6: COMMUNICATION AND PROFESSIONAL VISITS

This section details requirements throughout the beneficiary's course of care. These requirements are in place to ensure comprehensive support and care coordination for families.

Communication with Medical Providers C P

Providers must inform the beneficiary's medical provider within 14 calendar days of MIHP enrollment, identification of a medical provider, discharge, and/or transfer (if applicable).
This notification is accomplished by sending the medical provider the *Beneficiary Status Notification* and appropriate Communication Form (*Maternal Prenatal Communication* form or *Infant Care Communication* form) within 14 calendar days of the following circumstances:

- Beneficiary enrolls in MIHP.
- Beneficiary transfers to a new MIHP provider.
- A medical provider has been identified.
- Beneficiary is discharged from MIHP.
    - Provider must include a copy of the *Discharge Summary*.

Documentation must be maintained in the beneficiary's chart and in compliance with HIPAA.

Changes to Medical Provider

Changes may occur to the medical provider information due to situations such as:

- Identifying a provider after one was not in place at the time of enrollment
- Identifying a new provider because the beneficiary changed providers during the course of care

In any instance of a new or updated medical provider, document the new provider's information on the *Forms Checklist (Maternal or Infant)* and send the appropriate communication forms within 14 calendar days of identifying the new provider information.

Exceptions to Notifying the Beneficiary's Medical Provider
Below are exceptions to this requirement. Do not send the *Beneficiary Status Notification* and *Communication Form* to the medical provider if: 1. The beneficiary's medical provider is co-located with an MIHP who has direct access to MIHP records via an Electronic Medical Record (EMR). For providers with this practice in place, a protocol must be in place to describe this process. 2. The beneficiary does not have a medical provider. When this occurs: • Indicate "No provider" on the "Medical Provider" field within the *Consent to Participate* and:

	• Assist the beneficiary in obtaining a medical provider within the first three visits. • Once the medical provider is identified, add this to the *Forms Checklist (Maternal or Infant).* Submit the appropriate communication forms within 14 calendar days of identifying the new provider. • If a medical provider is **not** identified within the first three visits, the MIHP Provider must add the *Pregnancy Health* or *Infant Health Care* POC 2. Any intervention may be documented, including interventions #1 and #2 which emphasize the importance of identifying barriers and establishing a relationship with a medical provider.

Communication with Medicaid Health Plans (MHP)

Routine communication with Medicaid Health Plans may include contract initiation, attendance at health plan meetings, and receiving referral information for eligible beneficiaries.

Communication Tool Requirement

The *Communication Tool* is required for use by MIHPs and MHPs. The tool must be used **each month** to share information about mutual beneficiaries. It is located on the Forms section of the website.

- The MHPs are required to use the form to send referrals to the MIHP provider.
- MIHP providers are required to report disposition of beneficiaries on the form.

Provider must update and send the MHP *Communication Tool* **at least monthly** and comply with HIPAA requirements. For each beneficiary who has an MHP and enrolls with an MIHP provider, the MIHP provider must provide documentation on the *Communication Tool* at the appropriate intervals (enrollment, discharge, physician order use, etc.). This includes beneficiaries who were not referred by an MHP but enrolled in an MIHP (e.g., a referral obtained via outreach but has an MHP). As a reminder, a beneficiary does not have to provide consent for the provider to communicate with the MHP.

MHP Contacts

A contact list is available on the Policy and Operations section of the MIHP website. This list includes contacts for Contracts/Provider Services, Care Coordination, Billing Issues, and Dental Benefit Managers.

Quarterly Meetings with Medicaid Health Plans

Providers are encouraged to attend the quarterly meetings offered by the Medicaid Health Plans. These provide opportunities to learn about current efforts, understand available case management services, and discuss any billing concerns.

Billing Medicaid Health Plans

See Section 7: Claims and Medicaid Resources.

Professional Visits and Total Visits Available Per Beneficiary M

The standard Maternal Infant Health Program includes **nine professional visits**. The term “professional visit” refers to a visit conducted by a licensed MIHP professional, for the purpose of implementing the Plan of Care. These visits occur after the Assessment Visit (Risk Identifier) and are documented on the *Professional Visit Progress Notes (PVPNs).*

NEW: MIHP Enhanced Services Integration

Effective for dates of service on and after October 1, 2024, in addition to current covered program services, Medicaid will reimburse MIHP providers for:

- One Additional Home Visit
- Complex Home Visits (lasting at least 60 minutes)
- Enhanced Care Coordination Time
- One Discharge Visit

The enhanced services above are a result of the Healthy Moms, Healthy Babies MIHP Pilot. While this pilot was focused on high-risk beneficiaries, the enhanced services have been integrated into MIHP service delivery and are applicable to **all** enrolled infant and maternal beneficiaries (regardless of score) receiving services on or after October 1, 2024. This applies to beneficiaries who are already enrolled as of this date or newly enroll on/after this date. These services are not required but are available to provide enhanced support for families. Z-codes are not required but are encouraged to include in all claims for enhanced services. Please refer to ICD-10 category range of Z55-Z65.

Program requirements that must be completed during the course of care, may be completed during Enhanced Services visits.

See more information in the Policy and Operations section of the MIHP website: MIHP Enhanced Services: Guidance and Frequently Asked Questions.

Total Visits Available Per Beneficiary

Below is a summary of all visits available to maternal and infant beneficiaries (enrollment, professional and discharge). This includes historically standard services in addition to enhanced services. Each visit type also has a detailed section within this Operations Guide and related support in the Medicaid Manual and/or bulletins. All visits may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).

MATERNAL VISITS AVAILABLE

Maternal beneficiaries are eligible for the following:

- One Assessment Visit **and**
- Up to nine Professional Visits (Standard 30-minute or Complex 60-minute*) **and**
- One Additional Visit* **and**
- Two Postpartum Lactation (IBCLC) Visits **and**
    - MOMS beneficiaries are not eligible for postpartum visits, including lactation (IBCLC) visits.
- One Discharge Visit*

*Denotes optional visits that have been added are part of the MIHP Enhanced Services.

Below is a summary of each visit type available to maternal beneficiaries.

Maternal Assessment Visit (H1000 or H2000)
One (1) assessment visit (enrollment) per person, per pregnancy. This may be conducted in-person, via telehealth (audiovisual), or via telephone-only.

<table>
<tr><td colspan="2">Maternal Professional Visits (99402 or 99600)
Up to nine professional visits may be provided per person, per pregnancy. At least one visit must occur postpartum (a professional visit or an additional visit). Of these nine professional visits, they may be conducted as any combination of
• Standard 30-minute visits, or
• Complex 60-minute or longer visits</td></tr>
<tr><td>1. Standard Professional Visit – 30 min (99402)</td><td>Length of Visit</td></tr>
<tr><td>Up to nine (9) professional visits per person, per pregnancy (at least one must occur postpartum). These may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).</td><td>30 minutes or more</td></tr>
<tr><td>2. Complex Professional Visit – 60 min (99600)</td><td>Length of Visit</td></tr>
<tr><td>As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, visits lasting 60 minutes or more are eligible for increased reimbursement and referred to as Complex Home Visits. Within the total allowable complement of professional visits, up to 9 professional visits per 12-month period may qualify as Complex Visits. Assessment Visits, Discharge Visits, and Additional Visits do not qualify as Complex Visits. Complex Visits have a unique billing code and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). The 12-month period begins on the date of the first complex visit and restarts 12 months later, if visits still remain. Therefore, if a complex visit was first conducted on 1/1/2025, up to 9 complex visits may be provided by 1/1/2026. It is an agency’s responsibility to track visit types so that compliance is maintained.
• Documentation: Until Cycle 10 PVPNs are updated, use the Contact Log to document all visits that are being billed as Complex Visits (e.g., visit date and notation of “Complex Visit”).</td><td>60 minutes or more (this timeframe differs slightly from the Medicaid bulletin but has been confirmed as accurate)</td></tr>
</table>

Maternal Additional Visit (H1001)
As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, up to one (1) Additional Home Visit may be conducted per person, per pregnancy. This visit must be at least 30 minutes and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). This additional visit has a unique billing code and does not require a physician order.

Maternal Lactation Visits (Postpartum Only) (S9443)
A nurse or social worker with IBCLC® certification may provide up to **two lactation visits** per pregnancy and must be provided in the postpartum period. As a reminder, MOMS beneficiaries are not eligible for postpartum visits, including lactation (IBCLC) visits. An IBCLC visit can be provided on the same day as an assessment visit, professional visit, or Discharge Visit. Documentation must support a separately identifiable visit. Lactation visits may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). Lactation visits must occur postpartum and documented on the lactation MIHP *IBCLC® PVPN*. See the related forms instructions for additional guidance.

Maternal Discharge Visit (H1004)

As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, up to one discharge visit may be provided per beneficiary, per pregnancy. This must last at least 30 minutes and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).

- This is an optional visit but if provided, it must be completed prior to submission of the *Discharge Summary* in MILogin.
- The *Discharge Visit* is intended to address transitional services and thus does not qualify as the required postpartum professional visit. Therefore, a postpartum professional visit, focused on POC implementation, is still required.
- A Maternal Discharge Visit may be completed on the same day as an Infant Assessment Visit, but rationale must be documented on the *Contact Log*. The Discharge Visit has a unique billing code. The Discharge Visit does not require a physician order.
- **Documentation**: The *Discharge Visit* form must be completed and in the beneficiary record.

MOMs Beneficiaries: Because eligibility concludes at delivery, MOMS billable services must be completed prior to delivery, including a Discharge Visit, if provided.

INFANT VISITS AVAILABLE

All infant beneficiaries are eligible for the following:

- One Assessment Visit **and**
- Up to Nine Professional Visits (Standard 30-minute or Complex 60-minute*) **and**
- One Additional Visit* **and**
- One Discharge Visit*

Some infant beneficiaries are also eligible for the following:

- Nine additional visits via physician order, when needs extend beyond the standard 9 visits.
- Eighteen additional visits for substance-exposed infants (SEI), only via physician order.
- This information is detailed in the Physician Order section below.

*Denotes optional visits that have been added are part of the MIHP Enhanced Services.

Infant Visits Available to All (No Physician Order Necessary)				**Infant Visits per Physician Order Only**	
One (1) Assessment Visit	Up to nine (9) Professional Visits, which may be standard or complex.	Up to one (1) Additional Visit.	Up to one (1) Discharge Visit (per Enhanced Services).	Up to nine (9) additional professional visits, via physician order, for a maximum of 18 professional visits. This number excludes the Additional Visit.	Up to 18 additional visits for substance-exposed infants, via physician order, for a maximum of 36 total professional visits. This number excludes the Additional Visit and Discharge Visit.

Below is a summary of each visit type available to infant beneficiaries, referenced above.

Infant Assessment Visit (H2000 or T1023)
One (1) assessment visit (enrollment) per infant. This may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).

<table>
<tr><td colspan="2">Infant Professional Visits (99402 or 99600)
Up to nine professional visits may be provided, per beneficiary (or per sibling/multiples group), without physician order. Of these nine professional visits, they may be conducted as any combination of
Standard 30-minute visits, or
Complex 60-minute or longer visits</td></tr>
<tr><td>1. Standard Professional Visit – 30 min (99402)</td><td>Length of Visit</td></tr>
<tr><td>Up to nine (9) professional visits per beneficiary (or per sibling/multiples group in instances of blended visits). These may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).</td><td>30 minutes or more</td></tr>
<tr><td>2. Complex Professional Visit – 60 min (99600)</td><td>Length of Visit</td></tr>
<tr><td>As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, visits lasting 60 minutes or more are eligible for increased reimbursement and referred to as Complex Home Visits. Within the total allowable complement of professional visits, up to 9 professional visits per 12-month period may qualify as Complex Visits. Assessment Visits, Discharge Visits, and Additional Visits do not qualify as Complex Visits. Complex Visits have a unique billing code and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93).
The 12-month period begins on the date of the first complex visit and restarts 12 months later, if visits still remain. Therefore, if a complex visit was first conducted on 1/1/2025, up to 9 complex visits may be provided by 1/1/2026. It is an agency's responsibility to track visit types so that compliance is maintained.
Substance-Exposed Infants (SEI): The Complex Visit code may be used in place of SEI visit codes if the visit lasts at least 60 minutes, a physician order is in place for SEI visits, and available visits remain. In these instances, SEI requirements remain applicable, even if conducted as Complex Visits. As a reminder, the complement of visits for SEI should not exceed 36, excluding the additional and discharge visit. See details within the Physician Orders section.
Documentation: Until Cycle 10 PVPNs are updated, use the Contact Log to document all visits that are being billed as Complex Visits (e.g., visit date and notation of "Complex Visit").</td><td>60 minutes or more (this timeframe differs slightly from the Medicaid bulletin but has been confirmed as accurate)</td></tr>
</table>

Infant Additional Visit (No Physician Order Required) (H1001)
As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, up to one (1) Additional Home Visit may be conducted per beneficiary. This visit must be at least 30 minutes and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). This additional visit has a unique billing code and does not require a physician order.

1. Additional Visits per Physician Order (99402 or 99600)
If the infant demonstrates need for additional visits beyond the standard complement, up to nine additional visits may be authorized via physician order. These visits must be concluded during the eligibility period. They may be provided as either standard 30-minute visits or complex 60-minute visits. These visits may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). • See details in the Physician Order section. • The Additional Visit, as part of MIHP Enhanced Services, does not require a physician order. • It is an agency's responsibility to track the complement of visits and type of visit (standard, complex).
2. Substance-Exposed Infant (SEI) Visits per Physician Order (96167 and 96168)
If the infant is identified as substance-exposed and would benefit from additional visits, up to 18 additional visits may be authorized via physician order. These visits must be concluded during the eligibility period and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). See details in the Physician Order section.

Infant Discharge Visit (H1004)
As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, up to one discharge visit may be provided per beneficiary. This must last at least 30 minutes and may be conducted in-person, via audiovisual telehealth (modifier 95), or via telephone-only (modifier 93). • This is an optional visit, but if provided, it must be completed prior to submission of the *Discharge Summary* in MILogin. • The Discharge Visit has a unique billing code and does not require a physician order. • **Documentation**: The *Discharge Visit* form must be completed and in the beneficiary record.

Documentation

For each visit, the appropriate *Professional Visit Progress Note* is used for documentation.

- *Maternal Professional Visit Progress Note.*
- *Infant Professional Visit Progress Note.*
- *IBCLC Professional Visit Progress Note (Postpartum Lactation support and Counseling).*

Visit Frequency and Duration

Home Visitor must conduct a professional visit with each beneficiary **each month.** Each visit must last a minimum of **30 minutes**. Different billing codes are used to differentiate reimbursement of 30-minute vs 60-minute ("Complex") visits.

Monthly Visit Requirement

Visits are required to occur each calendar month, in order to assure consistent MIHP support throughout the beneficiary's eligibility. Increasing visit frequency may limit available visits for ongoing care. Any adjustments to monthly visits must be family-directed and documented accordingly:

Postponed Visits:

- If a beneficiary requests to delay visits for multiple calendar months, document the timeframe on the *Contact Log*.
- Example: If the next visit is scheduled in three months, one comprehensive statement on the *Contact Log* is sufficient instead of monthly entries.

Postpartum Visits:

- If a maternal beneficiary has remaining visits and their case remains open for potential emergency support, document the situation on the *Contact Log.*
- Discharge must be completed within 30 calendar days of the beneficiary's eligibility period ending.

Multiple Visits in One Month:

- If a beneficiary is seen more than once per month, document rationale in the *Contact Log.*

Exceptions (no additional documentation required):

- The first professional visit may occur sooner than one calendar month after the Assessment visit,
- A Discharge Visit or an Additional Visit (for enhanced services) may occur sooner than one calendar month after the most recent professional visit

60-Minute Complex Visits (Effective 10/1/2024)

As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, visits lasting 60 minutes or more are eligible for increased reimbursement and referred to as Complex Home Visits.

- Complex Home Visits may be conducted in-person, via audiovisual telehealth, or via telephone-only and must be reported with the appropriate billing code and any applicable modifier.
- For detailed information, see the Medicaid Bulletin MMP-2436.
- See additional information here: Maternal Complex Visits and Infant Complex Visits.

Non-Billable Visits

At times, a MIHP professional visit may occur but does not meet policy requirements (such as lasting at least 30 minutes). Such visits are considered “non-billable” and may be documented as such on the *PVPN*. Activities conducted during a non-billable visit are not reviewed during Certification Compliance.

As part of MIHP Enhanced Services, for dates of service on or after October 1, 2024, some non-billable contacts may be eligible for reimbursement if they qualify as a Care Coordination Activity. See details on the forms’ instructions and in the Care Coordination section.

Visit Location

Efforts must be made to visit the beneficiary in the home. Professional visits may be provided in a clinic/office setting, the beneficiary's home/place of residence, including homeless shelter, via telehealth, or at a mutually agreed upon community location.

- For community and telephone-only visits, rationale must be documented on the *PVPN*.
- Visits may not be provided during hospitalization or incarceration.

- For information on Place of Service codes, please see Section 7.
- For information on Telehealth documentation of Visit Location, see the Telehealth section.

Staff Discipline Conducting Visits C

A nurse and social worker **must each** conduct a visit with the beneficiary during the course of care. If not, there must be documentation on the *Contact Log* as to why not.

- The discipline that conducts the assessment visit counts towards this requirement.

Lactation Visits

A nurse or social worker with IBCLC® certification may provide up to **two lactation visits** per pregnancy and must be provided in the postpartum period. IBCLC visits are provided to, and billed under, maternal beneficiaries only. Lactation visits must occur postpartum and documented on the lactation MIHP *IBCLC® PVPN*. As a reminder, MOMS beneficiaries are not eligible for postpartum visits, including lactation (IBCLC) visits. An IBCLC visit can be provided on the same day as an assessment visit, professional visit, or Discharge Visit without additional documentation on the *Contact Log*. Lactation visits may be provided via telehealth (audiovisual) and telephone-only.

Care Coordination

As part of MIHP Enhanced Services, providers may be reimbursed for Enhanced Care Coordination Time conducted on or after October 1, 2024, when at least 30 minutes is spent on care coordination activities per beneficiary during a calendar month. Such activities may be performed by an RN or SW **or** performed by another staff member if delegated by the RN or SW and in accordance with their scope of practice. Acceptable activities that qualify for reimbursement are described on the *Care Coordination Form*, which must be completed and maintained in each beneficiary's chart. Care coordination may be billed once per calendar month between the date of enrollment and the date of entry of the Discharge Summary.

- For detailed information, see the Medicaid Bulletin MMP 24-36 and MIHP Enhanced Services: Guidance and Frequently Asked Questions.
- Note regarding HMHB Pilot Providers that utilized pilot forms: Agencies experiencing delays to integrating forms changes into their EMR, please contact MDHHS MIHP to request an exception.

Physician Orders M C

Provider must request authorization from a physician (or other eligible entity) prior to the following:

1. Beneficiary receives nutrition counseling from an internal RD.
2. Infant demonstrates need for additional visits beyond the standard complement (nine professional visits + one optional additional visit):
    - Up to nine additional visits may be authorized via physician order, for a total maximum of 18 professional visits. This number does not include an Additional Visit, if provided. These visits must be concluded during the eligibility period.
    - Substance-Exposed Infant (SEI): Infant is identified as substance-exposed and would benefit from additional visits beyond the 18 professional visits referenced above. In addition to these, up to 18 additional visits may be authorized via physician order for substance-exposed infants, for a maximum total of 36 professional visits. This number does not include an Additional Visit, if provided. These visits must be concluded during the eligibility period. For guidance on using Complex Visit codes vs SEI visit codes, please see the Infant Complex Visit section.
        - SEI visits have additional requirements for billing and PVPN documentation. See additional details in the Substance-Exposed Infant section.

Physician orders may be authorized for individual beneficiaries, or all beneficiaries who meet criteria authorized by the physician. Entities approved to authorize physician orders include: a Physician, Physician Assistant, Certified Nurse Midwife, Pediatric Nurse Practitioner, or Family Nurse Practitioner. Physician orders must comply with state and federal laws prohibiting self-referral.

Physician order must include:

1. MIHP agency name.
2. Medical provider's name, address, and phone number.
3. Medical provider's signature and credentials.
4. Date of signature.
5. Rationale for the visits (RD services, additional infant needs, and/or substance exposure).

Physician orders must be **updated annually** and can only be authorized for **up to 12 months**. Provider must maintain a current physician order in the beneficiary's chart and it must be added to the chart prior to offering services related to the order. The use of a physician order must be documented on the *Forms Checklist*, including the date of the order. As of Cycle 10, the Forms Checklist no longer requires rationale and date of implementation (however, date of the order itself must be documented).

Professional Visit Content and Documentation

Home Visitor must document a detailed account of what transpired during each visit on the *PVPN*. This includes interventions, referrals, beneficiary/caregiver's response, and beneficiary/caregiver's feedback. Home Visitor must address at least one of the following at every visit, as documented on the *PVPN*:

- POC 2 domain interventions.
- Topics identified by the beneficiary.
- Topics identified through professional judgement.

Home Visitor must address **all domains in the beneficiary's POC 2 prior to discharge**. Home Visitor must document on the *Contact Log* if this requirement is not met.

Home Visitor must address all POC 2 designated as **"high risk" within the first three professional visits**. Home Visitor must document on the *Contact Log* if this requirement is not met.

It is acceptable to conduct a visit without addressing a specific domain as long as *PVPN* documentation demonstrates the content within "Other Visit Information". As of Cycle 10, fields have been added to the "Other Visit Information" section to specify such topics that are identified by the beneficiary or professional judgment. However, if there is a pattern (two or more instances) where documentation in "Other Visit Information" correlates to risk criteria listed on a POC 2 (criteria for low, moderate, or high risk), the HV must add that POC 2 to the Plan of Care. For example, if the "Other Visit Information" area indicated that the beneficiary was expressing a history of baby blues, and this was documented two or more times, the Stress/Depression POC2 should be added. Alternatively, if this area demonstrates that a topic was discussed in general with no risk identified, a POC 2 does not need to be added.

MIHP Safety Plan

Home Visitor may discuss/develop a written or verbal *Safety Plan* with any beneficiary/caregiver for any reason (MDHHS MIHP encourages this practice.) However, safety plans are **required in certain instances**, as indicated below. A *Safety Plan* form is available for use, or providers may use their own version. A copy of the *Safety Plan* does not need to be maintained in the chart. If not completed as required, rationale must be documented on the *Contact Log*.

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**. Each of these POC 2 domains has an intervention specific to safety plans. Therefore, documentation must include the following intervention numbers:

- Abuse/Violence: #12
- Infant Safety: #6
- Stress/Depression: #13
- As of Cycle 10, the required SEI intervention (#9) has been updated from Safety Plan development to Plan of Safe Care development. See below.

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 of the *PVPN*.

MIHP Action Plan

Home Visitor must assist **every** beneficiary/caregiver to create at least one *Action Plan*. An *Action Plan* form is available for use, or providers may use their own version. If not completed as required, rationale must be documented on the *Contact Log*. Document the development or review of an Action Plan via the checkbox on the *PVPN*. A copy of the *Action Plan* does not need to be maintained in the chart.

MIHP Plan of Safe Care (POSC) - NEW for Cycle 10

A **Plan of Safe Care (POSC)** is a personalized tool designed to support families affected by substance use. It focuses on family strengths, healthy pregnancies, and keeping families together safely.

Who Needs a POSC?
A POSC is **required** to be co-developed with the family or discussed for:

- **Maternal beneficiaries** with the *Alcohol* or *Substance Misuse POC2*.
- **Infant beneficiaries** with the *Substance-Exposed Infant POC2*.

Required Documentation:
If these domains are included in the POC2, documentation must include the following intervention numbers:

- **Alcohol**: #18
- **Substance Misuse**: #18
- **Substance-Exposed Infant**: #9

POSC Implementation & Documentation or POSC Use & Documentation

- A POSC template is available on the MIHP website and is encouraged. It is also acceptable to use another version if it contains at least all of the same elements.
- If a POSC is **not completed** as required, **document the rationale** in the *Contact Log*.
- A copy of the POSC does not need to be kept in the beneficiary's chart. It may be maintained by the beneficiary and discussed at future visits or they may share it with other partners involved in their care. If, however, the HV maintains a copy of the POSC and identifies a need to share it with another provider, consent must be obtained and documented on the Michigan Behavioral Health Standard Consent Form.

POSC as a replacement for Action & Safety Plans

- The POSC incorporates elements of both an *Action Plan* and *Safety Plan* and may replace them with appropriate documentation on the PVPN: Along with documenting the intervention number for the POSC, mark *Action Plan* on *PVPN* checklist and/or list the intervention number associated with the *Safety Plan* (to reflect whichever plan is being met via the POSC).

- New concerns may require additional Action Plans or Safety Plans during the course of care (or it may be a combined POSC that incorporates all safety concerns).

Additional Resources
For training and guidance, visit the MIHP Plan of Safe Care Website.

Resource and Referral Coordination (Referral to Community Resources)

Definition of Referral

Coordination of resources and facilitating referrals is a key element of MIHP service delivery and thereby involves detailed requirements and documentation as described in this section. For MIHP purposes, referral requirements can be met either by the MIHP provider initiating a referral through direct communication with a referral source on the beneficiary's behalf (after a *Consent to Release PHI* is secured) **or** by providing a specific resource to the beneficiary for them to initiate contact. Such resources must be frequently assessed to ensure they are active and appropriate. Whether a service is pursued by a referral or by resource provision, both instances require documentation on the *PVPN* and appropriate follow-up as described below and in the *Plan of Care 2s*. Referral/resource documentation is required as described below.

Referral Documentation and Follow-up*

Home Visitor must make referrals throughout the course of care and document in the "New Referrals" section of the *PVPN*. Home Visitor must follow up on referrals **within three subsequent visits**. This includes referrals made at enrollment. Home Visitor must document the status of each referral in the "Outcome of Previous Referrals" section on the *PVPN*. If follow-up does not occur or a required referral is not provided, rationale must be documented on the *Contact Log*.

If, however, a referral is offered but declined, document the declination within the "Narrative about beneficiary's reaction to intervention provided." For declinations, the referral does not require documentation in the New Referrals section and does not require subsequent follow-up within three visits.

*This provides general expectations; however, information on **Required Referrals** is indicated below.

Required Referrals

When referrals are required, the respective domain has a specific intervention which must be used. If a required referral is not discussed, documentation on the *Contact Log* must explain why.

Mental Health Referral – Stress/Depression Domain
If the *RI* indicates, or professional judgment determines, a **moderate or high score** in the Stress/Depression domain, the Home visitor must discuss a referral for mental health services. This must be documented as follows:

- If the beneficiary/caregiver is not already receiving mental health services, the HV must provide a referral and document **intervention #12** on the *PVPN*, and:
    - Also include this referral in the "New Referrals" section of the *PVPN*.
    - If, however, the referral is declined, document intervention #12 **and** document the declination within the *PVPN* section "Narrative about beneficiary's reaction to intervention provided."
- If the beneficiary/caregiver is receiving mental health services, the HV must document **intervention #11** on the *PVPN* (therefore, a referral is not necessary).

Registered Dietitian Referral – Food/Nutrition Domain

If the *RI* indicates, or professional judgment determines, a **high score** in the Food/Nutrition domain, the Home visitor must discuss a referral for Registered Dietitian services or have a provider-employed RD provide nutrition counseling. As a reminder, internal RD visits require a physician order prior to implementation. Referrals for RD services must be documented either of the following:

- HV must offer a referral and document **intervention #13** on the *PVPN* and:
    - Also include this referral in the "New Referrals" section of the *PVPN*.
    - If, however, the referral is declined, document intervention #13 **and** document the declination within the *PVPN* section "Narrative about beneficiary's reaction to intervention provided."
- If a visit is conducted by an RD employed by the provider, the referral requirement is met and documentation of intervention #13 is not required.

Summary of Required Interventions/Referrals

The information above (Safety Plan, Action Plan, POSC, and Referrals) has been summarized below.

POC 2 DOMAIN	IF	THEN	INTERVENTION #
All beneficiaries	Enrolled	Action Plan required	PVPN checkbox
Abuse/Violence	High risk	Safety Plan required	12
Alcohol	ANY risk	POSC required	18
Food/Nutrition	High risk	RD services required (RD referral or visit conducted by RD with physician order)	13, if RD referral provided; if RD visit occurs instead, this referral requirement is met
Infant Safety	High risk	Safety Plan required	6
Stress/Depression	Moderate risk	Referral to mental health services required	11 or 12 (discuss treatment or refer for treatment)
Stress/Depression	High risk	Safety Plan required **and** referral to mental health services required	11 or 12 (discuss treatment or refer for treatment) 13 (safety plan)
Substance Misuse	ANY risk	POSC required	18
Substance-Exposed Infant	ANY risk	POSC required	9

Transition Planning Ⓟ

Transition planning is a critical component to supporting a family in understanding how they will be supported when exiting the program. Ideal transition planning promotes a seamless shift from MIHP to whatever serves as the next step (e.g., a community support, another home visiting program, etc.). MDHHS MIHP expects providers to discuss the transition process with families early and often, and strongly encourages warm handoffs be provided whenever possible. As of Cycle 10, transition planning requirements include the following:

- Transition planning must be discussed at enrollment, as listed on the *Plan of Care 1*. Based on family response and needs, transition planning may also be discussed throughout the course of care.

- A protocol must be developed (as described in Protocol Specifications).
- A required training module must be completed by all Home Visitors (as listed in the Required Trainings documents).

Maternal-Specific Components

Maternal Immunizations

For all maternal beneficiaries, the Home Visitor must complete the following:

- Discuss maternal immunization status during the first professional visit following enrollment,
- Discuss infant immunization status at least once during the maternal course of care, and
- Assess the beneficiary's official immunization record via the Michigan Care Improvement Registry (MCIR) at least once during the course of care, prior to the last home visit. MCIR can be a key assessment tool to enhance immunization discussions, provide education, and facilitate care coordination. MCIR provides a detailed record of immunizations received and immunization status.
    a. Please note: All MCIR assessments must occur after the *Consent to Participate* is completed. Therefore, it is acceptable to review MCIR at the enrollment visit as along as consent has been obtained *prior to* the MCIR retrieval.

Document maternal immunization requirements as follows:

- Discussion of maternal immunization status: *PVPN* checklist
- Discussion of infant immunization status: *PVPN* checklist
- MCIR assessment: A copy of the beneficiary's MCIR record must be located in the beneficiary chart prior to the last home visit.
    - The record can be downloaded by selecting "VIEW" and choosing any format for export.
    - If a MCIR record is searched but cannot be located ("Person not Found"), a screen shot of this attempt must be entered in the chart. The screen shot must contain the name, date of birth, and the error message.
    - MCIR tip sheets are available in the MCIR section of the Policy and Operations page.

If the immunizations are not discussed or the MCIR record is not included in the beneficiary chart, the reason must be documented on the *Contact Log* or *PVPN*.

Medicaid Extension and Maternal Postpartum Services

In alignment with the extension of Medicaid coverage for 12 months postpartum, MIHP maternal visits may continue in some situations. For maternal beneficiaries **with visits remaining** (of the total nine), these visits may be used to provide MIHP maternal services during the postpartum timeframe, up to 12 months from the end of their pregnancy (regardless of pregnancy outcome). As a reminder, MOMs beneficiaries are not eligible for postpartum services.

These visits are intended to address maternal-specific support such as postpartum concerns and transition to the caregiver role. This extension may also apply to situations where the infant is separated from the maternal beneficiary or in instances of pregnancy loss or infant loss.

Unique aspects of this service delivery, reminders, and documentation expectations are included below:

- Upon enrollment of the infant, subsequent visits are considered blended and have unique documentation and billing components. See details in the Blended Visits section.
    - Postpartum visits should **not** delay enrollment of the infant in MIHP infant services.
- The monthly visit requirement remains applicable: If more than one visit within a month is

conducted with the same beneficiary (or family), justification must be entered on the *Contact Log*. If a maternal chart remains opened during the postpartum timeframe but a visit does not occur monthly, justification must be present on the *Contact Log* or *PVPN*. This may be accomplished with a statement indicating the timeframe for which visits will not occur.

- Subsequent Pregnancy: If a maternal beneficiary is receiving visits as part of Medicaid Postpartum Extension and becomes pregnant, the MIHP provider is expected to conclude the services related to the initial pregnancy, perform a new *MRI* and provide up to nine visits for the new pregnancy.
- See detailed guidance in the Blended Visits section.

Infant-Specific Components

Infant Immunizations

For all infant beneficiaries, the Home Visitor must complete the following:

- Discuss infant immunization status at every visit,
- Discuss maternal/caregiver immunization status at least once during the course of care, and
- Assess the beneficiary's official immunization record via the Michigan Care Improvement Registry (MCIR) at least once during the course of care, prior to the last home visit. MCIR can be a key assessment tool to enhance immunization discussions, provide education, and facilitate care coordination. MCIR provides a detailed record of immunizations received and immunization status.
    a. Please note: All MCIR assessments must occur after the *Consent to Participate* is completed. Therefore, it is acceptable to review MCIR at the enrollment visit as along as consent has been obtained *prior to* the MCIR retrieval.

Document infant immunization requirements as follows:

- Discussion of infant immunization status: *PVPN* checklist
- Discussion of maternal/caregiver immunization status: *PVPN* checklist
- MCIR assessment: A copy of the beneficiary's MCIR record must be located in the beneficiary chart prior to the last home visit.
    - The record can be downloaded by selecting "VIEW" and choosing any format for export.
    - If a MCIR record is searched but cannot be located ("Person not Found"), a screen shot of this attempt must be entered in the chart. The screen shot must contain the name, date of birth, and the error message.
    - MCIR tip sheets are available in the MCIR section of the Policy and Operations page.

If the immunizations are not discussed or the MCIR record is not included in the beneficiary chart, the reason must be documented on the *Contact Log* or *PVPN*.

Infant Hearing Screening

The Home Visitor must **discuss** the infant beneficiary's hearing screening results as soon as possible following enrollment but **no later than the third professional visit**. Such results are located in MCIR, within the "Hearing (EHDI)" tab.

- This discussion is documented on the checklist section of the *PVPN*.

While inclusion of MCIR records is not required for hearing or lead levels, MCIR should be used to assess such results and harnessed as a tool for enhancing education and care coordination.

- As a reminder, all MCIR assessments must occur after the *Consent to Participate* is completed. Therefore, it is acceptable to review MCIR at the enrollment visit as along as consent has been obtained prior to the MCIR retrieval.

- MCIR tip sheets are available in the MCIR section of the Policy and Operations page.

Infant Lead Prevention and Screening Discussion

Home Visitor must discuss lead prevention and screening **at least twice**, as follows:

1. Discuss lead exposure prevention and provide Lead Fact Sheet **during the Assessment Visit**, as part of the Welcome Packet.
   - This discussion is documented as part of the *Plan of Care 1*.
2. Discuss lead screening **by the last home visit (on or prior to this date).** Such results are located in MCIR, within the "Lead" tab.
   - This discussion is documented on the checklist section of the *PVPN*.

While inclusion of MCIR records is not required for hearing or lead levels, MCIR should be used to assess such results and harnessed as a tool for enhancing education and care coordination.

- As a reminder, all MCIR assessments must occur after the *Consent to Participate* is completed. Therefore, it is acceptable to review MCIR at the enrollment visit as along as consent has been obtained prior to the MCIR retrieval.
- MCIR tip sheets are available in the MCIR section of the Policy and Operations page

Summary of Infant Immunization, Hearing, and Lead Requirements (Discussions and MCIR)

VISIT	IMMUNIZATION	HEARING	LEAD
Enrollment/Risk Identifier visit	Discuss and provide Immunization Fact Sheet (include in Welcome Packet).	n/a	Discuss and provide Lead Fact Sheet. • Document: POC 1
Every professional visit	Discuss infant's immunization status. • Document: *PVPN* checklist	n/a	n/a
No later than the 3rd professional visit	n/a	Discuss hearing screening. • Document: *PVPN* checklist	n/a
By the last home visit (on or prior to this date)	Discuss caregiver's immunization status. • Document: *PVPN* checklist Assess infant MCIR. • Document: Include MCIR record within chart.	n/a	Discuss lead screening. • Document: *PVPN* checklist

Developmental Screenings

Below are the required screening timeframes and logistics. Home Visitor must document reason for any screening not completed at the appropriate visit or timeframe on the *PVPN* or *Contact Log*.

Bright Futures

The Bright Futures questionnaire is embedded in the Infant Risk Identifier.

- Age adjustment must occur for infants born at gestational age of less than 40 weeks.
- If the Risk Identifier scores for Infant Development, Home Visitor must repeat questionnaire **within two weeks** utilizing the appropriate Bright Futures or ASQ-3 questionnaires.

Ages & Stages Questionnaires-3 (ASQ-3)

Providers are responsible for obtaining access to all necessary ASQ materials (ASQ-3 and ASQ:SE-2).

Screenings must be performed as described below.

- Age adjustment must occur for infants born at gestational age of 37 weeks or less.
    - Consider using the ASQ calculator.
- HV must complete the age-appropriate ASQ-3 questionnaire **within the first three visits.**
- Provider must follow guidelines outlined in the ASQ-3 User Guides.
- **Follow-up required, based on score:**
    - **White**: If infant's score is in the **white area**, HV must complete ASQ-3 questionnaire with the caregiver every **three to four months**.
    - **Gray**: If infant's score is in the **gray area** for one or more domains, HV must rescreen infant **in two months** and provide Learning Activities to the caregiver.
    - **Black**: If infant's score is in the **black area** for one or more domains (for either the ASQ-3 or the ASQ:SE-2), HV must **refer infant to Early On** service provider in the beneficiary's county. Providers are encouraged to continue providing ASQ-3 Learning Activities when an infant scores in the black area and the family is awaiting support from Early On.
    - Regardless of score, if a caregiver or home visitor notes a developmental concern in any area of the Information Summary, it is strongly encouraged that the HV provide a referral to Early On and/or add the *Infant Development POC 2*.

HV **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.

Ages & Stages Questionnaires: Social/Emotional-2 (ASQ:SE-2)

Providers are responsible for obtaining access to all necessary ASQ materials (ASQ-3 and ASQ:SE-2). Screenings must be performed as described below.

- Age adjustment must occur for infants born at gestational age of 37 weeks or less.
    - Consider using the ASQ calculator.
- Provider must follow guidelines outlined in the ASQ: SE-2 User Guides.
- Home Visitor must complete each of the following screenings throughout the course of care:
    - 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)
    - 18 months (15 months, 0 days – 20 months, 30 days)

- **Follow-up required for ASQ:SE-2, based on score:**
    - **White:** If infant's score is in the **white area**, HV must complete ASQ:SE-2 at the next required timeframe.
    - **Gray**: If infant's score is in the **gray area** for one or more domains HV must **rescreen infant in two months**.
    - **Black**: If infant's score is in the **black area** for one or more domains (for either the ASQ-3 or the ASQ:SE-2), HV must **refer infant to Early On** service provider in the beneficiary's county.

ASQ: Early On 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 ASQ Information Summary. If the infant did not qualify for Early On services (or declines), the HV must resume conducting ASQs once they become aware.

ASQ: Documentation

ASQs completion must be documented as follows:

1. The ASQ Information Summaries must be maintained in the beneficiary's chart. For the ASQ-3 Information Summary, the HV must complete Sections 1-4. For the ASQ:SE-2 Information Summary, the HV must complete Sections 1-5. If the ASQ is completed by another entity, the Summary must be obtained and filed in the beneficiary chart. See additional guidance below.
2. Screening dates must be documented on the Infant Forms Checklist.
3. When ASQs are conducted on multiples (twins, triplets, etc.), providers may use the Infant *ASQ Tracking for Multiples* form. However, documentation is required on the *Infant Forms Checklist* for the billable infant.

ASQs Conducted by Other Entities

For ASQ-3 or ASQ:SE-2 completed by another entity, the Information Summary Sheet must be obtained and filed in the beneficiary's chart. **This is not required if the family is currently receiving Early On services.** If the Information Summary Sheet is not present in the chart, document attempts to acquire it on the *PVPN* or *Contact Log*.

MIHP agencies must review the documentation (ASQ Information Summary Sheet with Follow-up Actions Taken) provided by the outside entity to ensure all follow-up occurs in alignment with ASQ and MIHP requirements. This may include referrals, learning activities, or re-screening. If appropriate follow-up is not documented by the outside entity on the ASQ Information Summary Sheet, the MIHP provider is responsible for this action and documentation. For example, if an infant scores in the black area, a referral to Early On must be documented (either by the outside entity or by the MIHP provider). The *Contact Log* may be used to demonstrate follow-up taken by the MIHP provider if not completed by the outside entity.

ASQ Follow-up Flowchart: ASQ Screening Results and Expected Follow-up

This decision tree summarizes the previous information and may be helpful to ensure ASQ screenings and follow-up align with MIHP requirements.

ASQ Conducted

Score in WHITE Area

Which ASQ was conducted?

- ASQ: 3 → Re-screen every **3-4 months.**
- ASQ: SE-2 → Re-screen at next required timeframe (2, 6, 12, 18 months).

Score in GRAY Area

Re-screen in **2 months.**

AND

Provide ASQ Learning Activities.

Score in BLACK Area

Provide referral to Early On.

Did family enroll in Early On?

- YES → No additional ASQ screenings required if the family is served by Early On. However, Learning Activities are encouraged while awaiting Early On enrollment.
- NO → Resume screenings. If ASQ 3, also provide ASQ Learning Activities.

Substance-Exposed Infant Visits

Provider must add the *Substance-Exposed Infant (SEI) POC 2* to the beneficiary's chart when Substance Misuse scores on the Risk Identifier or as soon as circumstances meet criteria, as defined on the *POC 2*.

- HV must utilize interventions from the *SEI POC 2* **within the first three visits** once the *POC 2* is added (regardless of score) to the beneficiary's plan of care.
  - Reminder: Intervention #9 (Plan of Safe Care) required for all infants with the SEI POC.
  - As a reminder, if Substance Misuse scores for the caregiver or when added due to circumstances meeting criteria, the SEI POC 2 must be added. This includes circumstances such as environmental exposure, suspected exposure, caregivers who are not currently using substances but had a history of use, and other indicators as listed on the POC form.

- HV must utilize interventions from the *SEI POC 2* **every visit after the first 18 visits**.
- A maximum of 36 professional visits and the initial assessment visit may be reimbursed for a substance-exposed infant. Provider must obtain a physician order for any visits after 18 visits. See Physician Order section for more information. Of note, infants receiving SEI visits are eligible to receive an Additional Visit and Discharge Visit during their eligibility period, which do not require a Physician Order.

Blended Visits M

Blended visits refer to providing visits to a family with multiple family members enrolled at the same time. More specifically, this refers to when multiple *Risk Identifiers* within the family are open at the same time without a completed *Discharge Summary*. **All program requirements apply to all beneficiaries in these scenarios**. However, there are unique documentation and billing requirements applicable to blended visits, as described below.

Blended Visits Include:
Maternal/Infant Visits
- Such as: the mother of an enrolled infant becomes pregnant and enrolls; an enrolled maternal beneficiary gives birth, the infant enrolls, and both beneficiaries continue to receive services; a maternal beneficiary enrolls during pregnancy and has an infant under 12 months to enroll;

Sibling Visits (non-multiples)
- Sibling of enrolled infant is born.

Multiples Visits (twins, triplets, etc.)
- The provider must serve all infants in the instance of multiple births.

Note regarding foster siblings: Infants who come from separate birth families may be served as individual cases and do not constitute blended visits.

Documentation and Billing Approach for Blended Visits

1. An *RI* is conducted for each family member and billed separately under their own Medicaid ID.
2. If an enrollment for one family member is conducted on the same day as a professional visit for another (infant enrollment on same day as postpartum maternal professional visit), the *Contact Log* must include rationale for why both visits were conducted on the same date of service.
3. All subsequent visits (professional visits) must be blended and billed under **one** beneficiary's Medicaid ID for the entire course of care. It is not permissible to go "back and forth" between IDs.

   The current exception to this (#3) is Maternal/Infant Blended Visits **with** Medicaid Postpartum Extension. In this instance, billing may go "back and forth" between Medicaid IDs to reflect the beneficiary of focus during that visit. General guidance for postpartum extension is available here.

4. The *Notification of Multiple Open Charts* form must be in each beneficiary's chart, unless using a single-family chart.
5. All professional visit documentation must be blended and documented under the billable beneficiary's chart.
   a. *PVPN* documentation: Mark the "Blended Visit" checkbox on the *PVPN*. Complete the form based on the billable beneficiary's information and document information for the non-billed beneficiary in the "Other Visit Information" section of the *PVPN*. File the *PVPN* in the billable beneficiary's chart.
   b. If all infants have the same medical provider, only one *Infant Care Communication* form needs to be sent. Document information about the non-billed infant in the "Comments."

c. Do not complete the *Infant Forms Checklist* for each infant - only for the billable infant.
d. Additional standard requirements as noted in the Additional Documentation section.

The exception to this is Maternal/Infant Blended Visits **with** Medicaid Postpartum Extension. In this instance, documentation reflects the beneficiary of focus during that visit. Beneficiary-specific requirements and associated documentation are to be within that beneficiary's chart (rather than utilizing the "Other Visit Information" section).

6. A *Discharge Summary* must be conducted for each beneficiary.

Blended Visits – Additional Documentation Required

Provider must complete all of the following documents **for each beneficiary**:

- *Consent to Participate*
- *Consent to Release PHI*
- *Risk Identifier and Scoresheet*
- *Plan of Care (POC 1, POC 2s, POC 3)*
- ASQ-3 Assessments and Summaries
- ASQ: SE-2 Assessments and Summaries
- *Discharge Summaries*
- MCIR Documentation

Telehealth in MIHP C M P

MIHP Providers are also required to follow all Medicaid telemedicine policy requirements. This includes Medicaid MMP 23-10 and MMP 23-17. MIHP providers may provide up to 40% of all visits via telehealth while at least 60% of all visits must be provided in person. These percentages are calculated across the total agency caseload. Agencies are strongly encouraged to create their own tracking mechanism to meet current telehealth requirements.

Appropriate Use of Telehealth

Examples of appropriate use are included in the Medicaid Bulletin MMP 23-17. In alignment with home visiting research demonstrating favorable outcomes for families, MDHHS MIHP strongly encourages home visits be provided early in the course of care.

- Providing in-home visits early in pregnancy and infancy can allow a more thorough lens of assessment during a time when early intervention can be maximized.
- MDHHS MIHP will continue to assess the complement of in-home visits versus telehealth and may re-evaluate the number of home visits per beneficiary if necessary.

Telehealth vs Telephone-Only

Telehealth visits must include an audiovisual platform while assuring privacy and security is maintained. Telephone-only visits are allowable only when a beneficiary barrier exists for use of an audiovisual platform (e.g., lacks smart phone or internet). Telephone-only visits must have rationale documented.

MIHP Services and Telehealth Allowance

All MIHP services* (including Enhanced Services) are eligible to be delivered via telehealth: audiovisual (modifier 95) or telephone only (modifier 93).

***The exception is childbirth education and parenting education, which cannot occur via telehealth.

MIHP Requirements Remain Applicable

All MIHP requirements, as indicated in the Policy and Operations Guide, apply to billable telehealth services (e.g., duration of visit, number of allowable visits, etc.). Any required hard-copy documentation normally provided at the Assessment Visit must be discussed during the telehealth visit and presented at the first in-person visit. MIHP Providers must ensure a telehealth protocol is in place that complies with program and Medicaid requirements.

Visit Location and Place of Service

Place of service codes must reflect the code that would be reported as if the beneficiary were in-person for the visit along with any appropriate modifiers. Examples are described below.

Telehealth (audio/visual) Visit Location Documentation

For assessment visits (Risk Identifier visits) conducted via audio-visual telehealth:

- Form documentation:
  - On the *Risk Identifier*, complete the "Location" section by selecting the location where the visit would have taken place if in-person, **and** include the following in the "comments" area of the *RI*: Completed via audio/visual telehealth.
- Billing documentation:
  - Select the Place of Service (POS) code to reflect where the visit would have taken place if in-person, **and** include modifier 95

For professional visits conducted via audio-visual telehealth:

- Form documentation:
  - On the *PVPN*, select the "Telehealth" box in the "Location of the Visit" section **and** select the location that would be reported if the beneficiary were in-person for the visit.
- Billing documentation:
  - Select the Place of Service (POS) code to reflect where the visit would have taken place if in-person, **and** include modifier 95

Telephone-Only (audio only) Visit Location Documentation

For assessment visits (Risk Identifier visits) conducted via telephone-only:

- Form documentation:
  - On the *Risk Identifier*, complete the "Location" section by selecting the location where the visit would have taken place if in-person, **and** include the following in the "comments" area of the *RI*: Completed via telephone-only.
  - On the *Contact Log* or the "comments" area of the *RI*: Enter rationale for telephone-only.
- Billing documentation:
  - Select the Place of Service (POS) code to reflect where the visit would have taken place if in-person, **and** include modifier 93.

For professional visits conducted via telephone-only:

- Form documentation:
  - On the *PVPN*, select the "Telephone-Only" box in the "Location of the Visit" section **and** document rationale in the "If telephone or other, why?" section.
- Billing documentation:
  - Select the Place of Service (POS) code to reflect where the visit would have taken place if in-person, **and** include modifier 93

Verbal Consent via Telehealth

Obtaining verbal consent is allowable for the *Consent to Participate* and the *Consent to Transfer*. This may be documented by marking "verbal" on the consent form. As of Cycle 10, obtaining an in-person signature following verbal consent, is no longer required.

Verbal consent is **not** an acceptable method to sign the *Consent to Release PHI.* This is effective as of Cycle 10 and applies to all *Consents to Release PHI* documented on or after August 1, 2025.

Telehealth Billing

- See MMP 23-17 and the Telehealth Section.

Discharge C

A beneficiary is considered discharged once the Discharge Summary is entered into MILogin. All beneficiaries must be discharged (Discharge Summary entered) within 30 calendar days of the end of eligibility. The eligibility period is defined as:

Maternal: Eligible until completion of maternal services or upon reaching 12 months postpartum (whichever comes first). Completion of maternal services is defined by completion of all eligible visits: risk identifier + nine professional visits + an additional visit (if provided) + two lactation visits (if provided) + a discharge visit (if provided).

- As a reminder, although the Discharge Summary must be completed within 30 calendar days of the end of eligibility, all billable services must be completed prior to the end of eligibility (completing services or reaching 12 months postpartum).
- For information on Medicaid Extension, see Maternal-Specific Components.

Infant: Eligible until completion of infant services or upon the infant turning 18 months of age. Completion of infant services is defined by completion of all eligible visits: risk identifier + all eligible professional visits + an additional visit (if provided) + a discharge visit (if provided).

- As a reminder, although the Discharge Summary must be completed within 30 calendar days of the end of eligibility, all billable services must be completed prior to the end of eligibility (completing services or reaching 18 months of age).

MIHP Discharge Visit – Optional

As part of MIHP Enhanced Services, MIHP providers may bill for a discharge visit when conducted in accordance with MMP 24-36. If provided, it must be completed prior to entering the Discharge Summary in MILogin. See more in the Discharge Visit sections – Maternal Discharge Visit and Infant Discharge Visit.

MIHP Discharge Summary

The Discharge Summary is documented in the MIHP Application (in MILogin). The printout must be maintained in the beneficiary's chart. For guidance on revising or deleting a Discharge Summary within the MIHP Application (MILogin), please see the tipsheet "Instructions to Delete or Correct Risk Identifiers and Discharges" on the Policy and Operations page.

Beneficiary Re-enrollment After Discharge

If a beneficiary remains eligible and wishes to re-enroll after a discharge has been processed, providers may submit a *Database Record Revision Request*. It is not required to wait for the discharge deletion to be completed before resuming services to a previously discharged beneficiary and their family. Additionally, include documentation on the *Contact Log* regarding the resumption of services.

SECTION 7: CLAIMS AND MEDICAID RESOURCES

Detailed Billing Support and Codes M

For comprehensive guidance on billing and reimbursement, refer to the Medicaid Provider Manual and the beneficiary's Medicaid Health Plan or Integrated Care Organization.

- See the Billing and Reimbursement and the MIHP section of the Medicaid Provider Manual.
- MIHP billing codes and fee schedules can be found on the Policy and Operations page.

Place of Service Codes

Providers are responsible for accurate place of service documentation. The CMS Place of Service Code Set provides a comprehensive list of POS codes and descriptions. Commonly used POS codes related to MIHP encounters include 11 (Office), 12 (Home), and 99 (Other, which is typically used for community visits). For visits conducted in an FQHC setting, please note that the FQHC-specific POS of 50 must be used.

- For telehealth Place of Service information, see the Telehealth section.

Blended Visits / Multiple Births

For Blended Visits billing guidance, please refer to the Blended Visits section.

Substance Exposed Infant (SEI)

- 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.
- Complex visit codes may be used in place of SEI visit codes if the visit lasts at least 60 minutes, a physician order is in place for SEI visits, and available visits remain. See details within the Physician Orders section.

Transportation

See guidance in the Transportation section.

Billing/Claims Issues or Disputes

Billing concerns associated with MHPs and Integrated Care Organizations (ICOs) must be addressed with the appropriate plan. Fee for Service concerns should be addressed with Medicaid Provider Support.
If concerns remain unresolved, please contact MDHHS MIHP for assistance.

- For Medicaid Health Plan contact information, review the Medicaid Health Plan Resources section of the Policy and Operations page.

APPENDIX I

Provider-Developed Position Description for the MIHP Coordinator

MDHHS MIHP does not prescribe qualifications necessary for the Coordinator role; however, the information below offers a position description that was developed by MIHP providers across the state:

MIHP Coordinator responsibilities may include, but are not limited to, the following:

- Implementing policies and protocols that comply with Medicaid and MDHHS MIHP requirements.
- Developing and overseeing billing processes and contracts.
- Supervising staff, monitoring workload, and coordinating professional development.
- Facilitating case consultation across disciplines.
- Maintaining a list of community resources for use by staff and beneficiaries.
- Coordinating outreach activities.
- Communicating with partners such as MHPs, medical care providers, community agencies, etc.
- Overseeing beneficiary referral, intake, and follow-up.
- Preparing for, and participating in, Certification Reviews.
- Conducting quality assurance reviews such as chart reviews and data analysis.
    - Implementing quality improvement strategies based on the findings.
- Ensuring entry of MIHP data into the MIHP Database.
- Providing direct services (home visits).

Qualifications

- Bachelor’s degree preferred.

Experience

- Experience coordinating a health or human services related program or project.

Skills and Knowledge

- Ability to implement a program in compliance with required policies and procedures.
- Quality improvement process skills.
- Leadership and supervision skills.
- Ability to organize and coordinate the work of others.
- Communication and interpersonal skills.
- Training skills.
- Computer skills.
- Ability to problem-solve.
- Ability to follow through.
- Ability to multi-task.
- Detail-oriented.

MIHP FORMS AT A GLANCE

FORM	LINK TO LOCATION ON WEBSITE
Action Plan - Same form for either beneficiary	Forms – Infant, Forms – Maternal
Agency Information Change Request	Policy and Operations
ASQ Tracking for Multiples	Forms – Infant,
Beneficiary Status Notification - Same for either beneficiary	Forms – Infant, Forms – Maternal
Billing Chart Review Tool	Certification
Care Coordination Agreement	Policy and Operations
Care Coordination Form (Enhanced services) – Same for either beneficiary	Forms – Infant, Forms – Maternal
Case Manager Chart Review Tool (Optional)	Certification
Certification Specifications	Certification
Chart Review Tool	Certification
Confidentiality Statement	Provided at Orientation
Consent to Participate	Forms – Infant, Forms – Maternal
Consent to Release Protected Health Information	Forms – Infant, Forms – Maternal
Consent to Transfer - Same form for either beneficiary	Forms – Infant, Forms – Maternal
Contact Log	Forms – Infant, Forms – Maternal
Database Record Revision Request	Policy and Operations
Decertification Protocol	Policy and Operations
Discharge Summary	Forms – Infant, Forms – Maternal
Discharge Visit (Enhanced services) – Same for either beneficiary	Forms – Infant, Forms – Maternal
Family Information Sheet	MIHP Promotional Materials
Forms Checklist	Forms – Infant, Forms – Maternal
Forms Checklist for Transfer Received	Forms – Infant, Forms – Maternal
Handout for Families: MIHP Educational Tools	Parent and Family Resources
Infant Care Communication	Forms – Infant
Lead Fact Sheet (POC 1 activity)	Forms – Infant, Forms – Maternal
List of Approved Mobile Phone Apps	Parent and Family Resources
Logo Permission Request	Policy and Operations
Maternal Prenatal Communication	Forms – Maternal
MHP Communication Tool - Same for either beneficiary	Forms – Infant, Forms – Maternal
MIHP Education Packet	Parent and Family Resources
Notice of Staff Training Completion Form	New Employee, Waiver, and Backup Staff
Notification of Multiple Open Charts - Same for either beneficiary	Forms – Infant, Forms – Maternal
Personnel Roster	Policy and Operations
Plan of Care 1	Forms – Infant, Forms – Maternal
Plan of Care 3	Forms – Infant, Forms – Maternal
Plans of Care 2	Forms – Infant, Forms – Maternal
Professional Visit Progress Note	Forms – Infant, Forms – Maternal
Protocol Specifications	Certification
Risk Identifier	Forms – Infant, Forms – Maternal
Safety Plan - Same form for either beneficiary	Forms – Infant, Forms – Maternal
Transfer Fax Cover Sheet - Same form for either beneficiary	Forms – Infant, Forms – Maternal
Voluntary Closure Protocol	Policy and Operations
Your Rights and Responsibilities as an MIHP Participant	Forms – Infant, Forms – Maternal