Maternal Infant Health Program Healthy Moms, Healthy Babies Pilot Program Guidance

This document is intended to provide program guidance to support the MIHP Healthy Moms, Healthy Babies pilot. **All questions associated with participation in the pilot must be submitted to MDHHS-HMHBpilot@michigan.gov.**

Beneficiary Eligibility

- Beneficiaries enrolled on or after June 1, 2021, are eligible for pilot services.
- Beneficiaries who receive an overall score of high or unknown risk* on the Risk Identifier are eligible to receive enhanced pilot services.
- Professional judgement must not impact the eligibility to receive pilot services. If the overall score on the Risk Identifier is high, the beneficiary/caregiver is eligible.
- Risk Identifier must be complete and overall score provided prior to conducting pilot services.
- Maternity Outpatient Medical Services (MOMS) Beneficiaries
    - MOMS beneficiaries are eligible for all pilot services including pilot services provided after delivery.
        - Additional information regarding MOMS beneficiaries enrolled in the HMHB pilot can be found in the "Additional Home Visit (H1001)" and "Discharge Summary Documentation" sections.
- Birth Health Domain
    - A risk score in the birth health domain does not have an associated plan of care, however if a beneficiary scores unknown or high in birth health they are eligible to participate.
- Unknown Risk*: if the domain that scores unknown is one of the domains below, the beneficiary/caregiver is **not** eligible for pilot services.
    - Maternal Risk Identifier
        - Smoking
        - Family Planning
    - Infant
        - Family and Social Support
        - Smoking
- Transfer Beneficiary Ineligibility
    - A beneficiary who transfers to or from a HMHB pilot MIHP agency is no longer eligible for pilot services.
    - Pilot services cannot be provided by multiple agencies for a single beneficiary even if the agencies are in the same group (treatment or control).
- Blended Visit Eligibility
    - Separate billing for pregnancy related services for a pregnant person are not eligible for the pilot program if the mother is already enrolled as a part of a blended infant/caregiver dyad where the infant is enrolled/receiving HMHB pilot services.
    - Pregnancy related services are not eligible for pilot services if the mother is a part of the blended infant/caregiver dyad whose MIHP infant services began prior to June 1, 2021 (start of pilot project).

  - An agency my choose to discharge an infant beneficiary and enroll the pregnant person (for pregnancy related services) then the newly enrolled pregnant person is eligible for pilot services.
  - For a family with multiple births and all infants are eligible for the pilot project, all pilot services, billing, and survey administration must only be conducted for one infant throughout the course of care.
- Beneficiaries in an Integrated Care Organization
  - Beneficiaries enrolled in Integrated Care Organizations (ICOs) through MI Health Link, are not eligible to receive pilot services. MI Health Link beneficiaries can be identified by reviewing their assigned benefit plan, which shows as ICO-MC.

Additional Home Visit (H1001)

- One additional professional visit per beneficiary is permitted and may be conducted at any point during the course of care.
  - Professional visit must be conducted in accordance with all Medicaid and MIHP standards.
  - Professional visit may be reviewed through MDHHS MIHP certification review process.
- This additional professional visit is eligible for reimbursement through telehealth.
- Additional Home Visit is available for Treatment Group only.
- Program Requirement Implication:
  - At least one postpartum visit must be conducted and billed with the standard MIHP professional visit code (99402) or the Complex Home Visit with Additional Face-to-Face Time (99600) for maternal beneficiaries.
    - This must occur to ensure accurate documentation of postpartum visits received on the Discharge Summary (refer to Discharge Summary Documentation).
  - MOMS Beneficiary Exception
    - The requirement for a postpartum professional visit billed as 99402 or 99600 does not apply to MOMS beneficiaries.

Documentation Requirement:

- Completed *Professional Visit Progress Note* [MDHHS-5635 and MDHHS-5636]
  - "Healthy Moms, Healthy Babies (or HMHB) pilot participant" must be documented in the "Other visit information" section.

Complex Home Visit with Additional Face-to-Face Time (99600)

- Any professional visit provided during the course of care that lasts at least 60 minutes, including the 'Additional Home Visit (H1001)' may utilize this billing code.
- Professional visit must be conducted in accordance with all Medicaid and MIHP standards.
- Professional visit may be reviewed through MDHHS MIHP certification review process.
- Professional visit is eligible for reimbursement through telehealth.

Documentation Requirement:

- Completed *Professional Visit Progress Note* [MDHHS-5635 and MDHHS-5636]
  - Beneficiary Information Section
    - Time In/Time Out

- Must account for at least 60 minutes.
- "Healthy Moms, Healthy Babies (or HMHB) pilot participant" must be documented in the "Other visit information" section.

Enhanced Care Coordination (T2022)

- Care coordination activities eligible for reimbursement are beyond the current requirements of the Maternal Infant Health Program.
  - For example: time spent creating and sending the required communication (Beneficiary Status Notification Form) at enrollment to the beneficiary's medical care provider is not eligible for reimbursement. If additional communication is conducted and there is 30 minutes of cumulative time of care coordination in each calendar month – care coordination reimbursement is appropriate.
- Billable care coordination activities must be completed by home visitors and/or MIHP Coordinators. Other administrative staff activities and time are not eligible for reimbursement.
- At least 30 cumulative minutes of home visitor and/or MIHP Coordinator time must bespent on care coordination activities per individual beneficiary to be eligible for reimbursement.
- Care coordination may be billed once per calendar month between the Risk Identifierand the date of Discharge Summary for a beneficiary, where appropriate.
- Telehealth billing modifier is not required for this service.

Documentation Requirement

- *Care Coordination Form* [MDHHS – 5955 Pilot] must be completed once per calendar month and kept on file at the agency.
- Document must include each beneficiary whose Medicaid ID will be billed for care coordination.
- At least one care coordination activity and one topic(s) addressed category must be completed and documented to be eligible for reimbursement.
- Activities that occur in care coordination are eligible to meet MIHP requirements, however there must be documentation in the chart on the *Professional Visit Progress Note* [MDHHS-5635 and MDHHS-5636] to support completion of required activities (e.g., referrals sent to the beneficiary that satisfy program requirements).

Discharge Visit (H1004)

- Discharge Visit must be conducted by a social worker or nurse and in accordance with all Medicaid and MIHP standards regarding professional visits.
- Discharge Visit will not be reviewed through MDHHS MIHP certification review process.
- Discharge Visit is eligible for reimbursement through telehealth.
- Discharge Visit is an additional visit that is separate from the required MIHP professional visits.
- Discharge Visit must be completed prior to the Discharge Summary (see additional note below on documentation).
- Discharge Visit may be completed on the same day as an Infant Assessment Visit.
  - Home Visitor must document reasoning for an infant Assessment Visit being completed on the same date as a maternal Discharge Visit.
- Home Visitor and Beneficiary/Caregiver Survey
  - Home visitor completing the Discharge Visit and survey must be knowledgeable in the care the beneficiary/caregiver received. It may be necessary to review previous visit

notes and case conference with other staff members to ensure thesurvey is capturing accurate information.

- For additional guidance on survey administration see "MIHP Outcomes Survey Administration – Guidance for Home Visitors."

Documentation Requirement

- Completed *Discharge Visit Form* [MDHHS-5955]
- Home Visitor survey

Additional Program Guidance

- **Telehealth Billing**
  - Medicaid defines "face-to-face" to include in-person and telehealth services.
  - The telehealth modifier is required for all services provided via telehealth. This includes:
    - Additional Home Visit (H1001)
    - Complex Home Visit with Additional Face-to-Face Time (99600)
    - Discharge Visit (H1004)
      - Enhanced Care Coordination Time does not require a telehealth modifier. MDHHS Pilot Compliance Monitoring
- **Billing Audits**
  - MDHHS MIHP will complete monthly billing audits to ensure compliance with pilot billing standards.
  - Agencies will be notified if there are inconsistencies in billing claims in reference to pilot services and offered technical assistance.
  - If inconsistencies continue, agencies will be notified and excluded from the pilot.
  - The Office of Inspector General (OIG) has the authority to audit pilot documentation for compliance.
  - If any entity (i.e., MHP, medical care provider) requests documentation related to the pilot services, please notify MDHHS MIHP staff.

- **Discharge Summary Documentation**
  - Documentation on the Discharge Summary for number of visits may not exceed the maximum number of visits allowed.
    - Maximum Number of Allowable Visits
      - Maternal Beneficiaries: 9
      - Infant Beneficiaries: 36
  - The number of visits may include visits billed with the Complex Home Visit with Additional Face-to-Face Time (99600) code if utilized during the course of care.
  - The Additional Home Visit (H1001) and the Discharge Visit (H1004) must not be included in the total number of visits on the Discharge Summary however activities that occur during these visits are eligible to meet program requirements.
  - MOMS Beneficiaries
    - Pilot services provided after delivery must not be documented on the Discharge Summary.