POLICY AND PROCEDURE

POLICY NAME: Planned Out of Hospital Births (Home Birth or Birth Center)	POLICY ID: FL.UM.77.00
BUSINESS UNIT: Sunshine State Health Plan	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 11/9/2020	PRODUCT(S): Managed Medical Assistance (MMA) and Ambetter Marketplace members.
REVIEWED/REVISED DATE: 09/2020, 11/2020, 12/15/2020,04/2022, 4/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): 11/04/2020	

POLICY STATEMENT:
An out-of-hospital birth (home birth or birth center birth) is an elective alternative to delivery in a hospital setting. Women are encouraged to make medically informed decisions about out-of-hospital births and provision of out-of-hospital births will be considered when coverage is mandated by law or member's benefit language.

PURPOSE: Keep this concise
The purpose provides the prescribed method to follow. It includes who, what, when, where, and how steps are to be completed.

SCOPE:
Sunshine Health Utilization Department for Managed Medical Assistance (MMA) and Ambetter Marketplace members. This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

DEFINITIONS:

POLICY:
An out-of-hospital birth (home birth or birth center birth) is an elective alternative to delivery in a hospital setting. Women are encouraged to make medically informed decisions about out-of-hospital births and provision of out-of-hospital births will be considered when coverage is mandated by law or member's benefit language. Due to the increased risk of maternal and neonatal morbidity and mortality associated with planned out-of-hospital births, prior authorization is required within the first trimester accompanied by documentation of informed consent. To insure Continuity of Care (COC) for new enrollees, Sunshine Health will allow pregnant members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care with a terminated treating provider or subcontractor until completion of postpartum care. If a planned out of hospital birth had been previously authorized, the utilization management staff contacts the member's former health plan or Medicaid FFS to obtain information about the authorized service, such as the provider's name, type of service and length of service. If the member is receiving current, ongoing treatment, utilization management staff contacts the treating provider to obtain information about the member's health status, the type of care provided, the length of the treatment, and the location of the treatment. Utilization management staff begins the authorization process by entering any obtained clinical information into TruCare and executing an appropriate, timely decision. COC period for a new enrollee includes the entire course of a woman's pregnancy including the completion of the six (6) week post-partum care, regardless if the provider is non-participating.

POLICY/CRITERIA:

I. It is the policy of Sunshine Health Plan that planned out-of-hospital births are **medically necessary** when ***ALL*** of the following criteria are met:

A. For a planned out of hospital birth (home birth or birth center), the birth must be overseen by a participating and credentialed provider of the Plan who meets one of the following criteria:

a. A Midwife who is certified by the American Midwifery Certification Board (or its predecessor organizations) and is practicing within an integrated and regulated health system;

b. An Obstetrician who has obstetrics admitting privileges and active practice within a participating hospital facility;

c. A Family Physician (in an accredited Residency Training Program) under the supervision of an Obstetrician who is board certified American Board of Obstetrics and Gynecology and emergency care is planned at a participating facility where the supervising Obstetrician has admitting privileges;

B. There must be a documented, pre-existing arrangement for emergency transportation to a participating hospital that is located within 15 minutes of the member's home or birth center. The Emergency Plan must include the name of the accepting hospital, the name of the accepting obstetrician, and be documented in the member's record;

C. No pre-existing medical condition(s) exist that increase pregnancy risk (including, but not limited to obesity, substance use disorder, alcoholism, hematologic disorders, hemolytic disease, cardiovascular disease, chronic hypertension, endocrine disorders, hepatic disorders, pulmonary disorders, neurologic disorders, renal disorders, collagen vascular disorders, auto immune disorders, gastrointestinal disorders, cancer and psychiatric disorders);

D. Two licensed providers are planned for the birth. One of the providers has primary responsibility for the mother, the other has primary responsibility for the infant. The providers must have the appropriate skills, training and equipment to provide full resuscitation per the Neonatal Resuscitation Program and provide evidence of current cardiopulmonary resuscitation (CPR) training for:
    a. Adult CPR
    b. Neonatal resuscitation.

E. No previous cesarean delivery or uterine wall surgery;

F. No advanced maternal age (> 35 years at time of delivery) or young gravida (< 16 years at time of delivery);

G. No previous history of significant obstetrical complications (including, but not limited to Rh sensitization; grand multiparity or placenta abruptio;

H. No history of medical or surgical complications of pregnancy (including, but not limited to hypertensive disorders of pregnancy, gestational diabetes, cholestasis of pregnancy, severe hyperemesis, preterm labor, premature rupture of membranes, active sexually transmitted infection, intra-amniotic infection or pyelonephritis);

I. No evidence of fetal anomaly, abnormal fetal growth, abnormal placentation, abnormal amniotic fluid, intra-amniotic infection, multiple gestation;

J. Must be a singleton pregnancy;

K. Must be vertex (baby's head down) presentation;

L. The member presents in spontaneous labor between 38 weeks 0 days and 41 weeks 0 days;

M. Providers must submit Informed Consent and should include the credentials of the provider, the malpractice insurance of the provider, documentation if provider is a NICA member;

N. Provider must submit a written plan for newborn screening (to include labs, pulse oximetry, and hearing) and continuity of care throughout the intrapartum and postpartum process;

O. The member is appropriate to give birth in a setting where anesthesia is limited to local infiltration of the perineum or a pudendal block and where analgesia is limited;

II. Water births are only permitted at Birth Centers. The Birth Center must have a sanitation and disinfection protocol for the tubs. If a water birth is planned, a separate consent for water birth including discussion of the risks must be submitted.

III. It is the policy of Sunshine State Health Plan that planned out-of-hospital (home or birth center) births are considered **not medically necessary** for any circumstances other than those specified above.

Background

In the United States, certified nurse midwives and certified midwives are certified by the American Midwifery Certification Board. This certification depends on the completion of an accredited educational program and meeting standards set by the American Midwifery Certification Board. In comparison with planned out-of-hospital births attended by American Midwifery Certification Board-certified midwives, planned out-of-hospital births by midwives who do not hold this certification have higher perinatal morbidity and mortality rates. At this time, for quality and safety reasons, the College specifically supports the provision of care by midwives who are certified by the American Midwifery Certification Board (or its predecessor organizations) or whose education and licensure meet the International Confederation of Midwives Global

Standards for Midwifery Education. The College does not support provision of care by midwives who do not meet these standards.

Home births remain a controversial issue, with safety as the primary focus. Although many countries have established lists based on specific patient characteristics and risks that might compromise the safety of out-of-hospital births, no specific list exists for the United States. Planned home births must include a system that allows for collaboration, referral and transfer to hospital care if problems arise. Appropriate risk screening is paramount in evaluating which home births may lead to positive outcomes. [5, 7]

American College of Obstetricians and Gynecologists (ACOG)

ACOG does not support planned home births given the published medical data and believes that hospitals and birthing centers are the safest settings for birth. However, ACOG respects the right of a woman to make a medically informed decision regarding delivery of her infant. Women inquiring about a planned home birth should be informed of the risks and benefits based on recent evidence. This includes the appropriate selection of candidates for home birth; the appropriate certification for midwifes, as noted in the policy statement; practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals. Specifically, women should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. [5]

American Academy of Pediatrics (AAP)

The most recent policy statement concurs with ACOG, affirming that hospitals and birthing centers are the safest settings for birth in the United States while respecting the right of women to make a medically informed decision about delivery. In addition, in the United States, the AAP recommends that the delivery be attended by at least two individuals, one who has primary responsibility for the mother and one who has primary responsibility for the infant.[3]

American College of Nurse Midwives & American Public Health Association

These two organizations have policy statements supporting the practice of planned out-of-hospital birth in select populations of women.[4, 6]

World Health Organization

A recent policy statement indicates that women can choose to deliver at home if they have low-risk pregnancies, receive the appropriate level of care, and formulate contingency plans for transfer to a properly-staffed/equipped delivery unit if problems arise. [8]

REFERENCES:

1. CP.MP.136 Home Births
2. FL.UM.02.01 Medical Necessity Review and Continuity of Care (COC)
3. American Academy of Pediatrics Policy Statement. Planned Home Birth. Pediatrics 2013; 131:1016–1020. Reaffirmed December 2016.
4. American College of Nurse-Midwives. Position Statement on Planned Home Birth. December 2005. Updated December 2016.
5. American College of Obstetricians and Gynecologists. Committee on Obstetric Practice. ACOG Committee Opinion No. 697, Replaces 669: Planned Home Birth. Obstet Gynecol 2017. Reaffirmed 2018.
6. APHA. Increasing access to out-of-hospital maternity care services through state-regulated and nationally-certified direct-entry midwives. APHA Public Policy Statements, 1948 to present, cumulative Washington, DC 2001.
7. Declercq E, Stotland NE. Planned home birth. Up-to-date. Lockwood CJ (Ed.) Accessed August 27, 2019.
8. Maternal and Newborn Health/Safe Motherhood Unit of the World Health Organization, Care in Normal Birth: A practical guide. World Health Organization, 1996.

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: Utilization Management

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	**REVISION SUMMARY**	**DATE APPROVED & PUBLISHED**
New Policy Document	New Policy created	09/20/2020
Policy Update	Approved by UMC	11/2020

Policy Update	Updated criteria for midwifes and added section “D” criteria for two licensed midwifes.	12/15/2020
Annual Review	Transferred policy to current template. No changes needed.	04/05/2022
Annual Review	No changes needed.	04/03/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.

SVP Compliance____

Senior Dir. Compliance____