410 MATERNITY CARE SERVICES

REVISION DATE: 10/25/2023, 6/08/2022
EFFECTIVE DATE: August 5, 2021
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Exhibit F3, Contractor Chart of Deliverables

PURPOSE

This policy establishes requirements for the Division of Developmental Disabilities (Division) regarding Maternity Care Services.

DEFINITIONS

1. "Certified Nurse Midwife" or "CNM" means an individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, Postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

2. "Free Standing Birthing Centers" means an out-of-hospital, outpatient obstetric facility, licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to assist with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities are affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.
3. "High-Risk Pregnancy" means a pregnancy in which the birthing mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
4. "Licensed Midwife" or "LM" means an individual licensed by the Arizona Department of Health Services (ADHS) to provide Maternity Care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. Title 9, Chapter 16 This provider type does not

include Certified Nurse Midwives licensed by the Board of Nursing as a nurse Practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.

5. "Maternity Care" means identification of pregnancy, Prenatal Care, labor or delivery services, and Postpartum Care.
6. "Maternity Care Coordination" means the following Maternity Care related activities:
    a. Determining the member's medical or social needs through a risk assessment evaluation;
    b. Developing a plan of care designed to address those needs;
    c. Coordinating referrals of the member to appropriate service providers and community resources;
    d. Monitoring referrals to ensure the services are received; and
    e. Revising the plan of care, as appropriate.
7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Postpartum" means the period beginning on the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy. For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in Maternity Care quality improvement may utilize different criteria for the Postpartum period.
9. "Postpartum Care" means care provided during the period beginning the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy.
10. "Practitioner" means certified nurse Practitioners in midwifery, physician assistants, and other nurse Practitioners.

11. "Preconception Counseling" means the provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventive care visit and does not include genetic testing.
12. "Prenatal Care" means health care provided during pregnancy and is composed of three major components:
    a. Early and continuous risk assessment,
    b. Health education and promotion including written member educational outreach materials, and
    c. Medical monitoring, intervention, and follow-up.

13. "Providers" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
14. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
15. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following Maternity Care Services are covered for all eligible, enrolled ALTCS members of childbearing age:
    a. Medically necessary Preconception Counseling;
    b. Identification of pregnancy;
    c. Medically necessary education and written member educational outreach materials;
    d. Treatment of pregnancy-related conditions;
    e. Prenatal services for the care of pregnancy;
    f. Labor and delivery services;
    g. Postpartum Care;
    h. Outreach;
    i. Family Planning Services and Supplies; and
    j. Related services.
2. The Division shall require all Maternity Care Services to be delivered by qualified Providers and in compliance with the most current ACOG standards for obstetrical and gynecological services.

3. The Division shall allow LM's to provide Prenatal Care, labor, delivery, and Postpartum Care services within their scope of practice, while adhering to AHCCCS risk-status consultation and referral requirements.
4. The Division shall require all cesarean sections include medical documentation of medical necessity.
    a. The Division shall require all inductions and cesarean sections done prior to 39 weeks follow the ACOG guidelines.
    b. The Division shall require any inductions performed prior to 39 weeks or cesarean sections performed at any time that are found not to be medically necessary are not eligible for payment.
    c. The Division shall require related services such as outreach and Family Planning Services and Supplies are covered, when appropriate, based on the member's current eligibility and enrollment as specified in AMPM 420.

B. REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

1. The Division shall have a written Maternity and Family Planning Services Annual Plan as specified in AMPM 410 that addresses:
   a. Minimum requirements;
   b. Objectives that are focused on achieving Division and AHCCCS requirements; and
   c. Monitoring and evaluation activities for these minimum requirements as specified in AMPM Exhibit 400-2A and AMPM 410.
2. The Division shall require the AdSS to establish and operate a Maternity Care program with program goals directed at achieving optimal birth outcomes.
3. The Division shall coordinate care for THP Members to ensure the same requirements are met.
4. The Division shall require the following minimum requirements of the Maternity Care program are met:
   a. Sufficient numbers of qualified local personnel to meet the requirements of the Maternity Care program for eligible enrolled Members and achieve contractual compliance;

b. Provision of written Member educational outreach utilizing mechanisms for Member dissemination to meet the following requirements as specified in AMPM Exhibit 400-3:

i. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation;

ii. Healthy pregnancy measures addressing at a minimum:

a) Nutrition;

b) Sexually transmitted infections;

c) HIV testing;

d) Alcohol, opioids, and substance use and other risky behaviors;

e) Measures to reduce risks for low or very low infant birth weight; and

f) Recognizing active labor.

iii. Dangers of lead exposure to birthing mother and baby during pregnancy and how to prevent exposure;

iv. Postpartum depression;

v. Postpartum services available and the importance of timely prenatal and Postpartum Care;

vi. Provision of information regarding the opportunity to change health plans to ensure continuity of Prenatal Care to newly assigned pregnant women and those currently under the care of an out-of-network Provider;

vii. Postpartum warning signs that require contacting a Provider;

viii. Maternity Care practices that are supportive of breastfeeding, and breastfeeding information;

ix. Safe sleep and ways to reduce Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) risk;

x. Interconception spacing recommendations and family planning options, including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) as specified in AMPM Policy 420;

xi. Ways to minimize interventions during labor and birth as recommended by ACOG;

xii. Support resources and programs such as:

a) Arizona Supplemental Nutrition Program for Women, Infants, and Children (WIC),

b) Strong Families AZ home visitation programs,

c) Arizona Department of Health Services breastfeeding hotline,

d) Early Head Start or Head Start, and

e) Birth to Five Helpline.

xiii. Information on how to obtain pregnancy related services and assistance with scheduling appointments;

xiv. A statement that there is no copayment or other charge for pregnancy-related services as specified in ACOM Policy 431;

xv. A statement that assistance with medically necessary transportation is available to obtain pregnancy

related services as specified in AMPM Policy 310-BB; and

xvi. Other selected topics.

c. Implementation of written protocols to inform pregnant women and Maternity Care providers of voluntary prenatal HIV or AIDS testing, and the availability of medical counseling and treatment, as well as the benefits of treatment, if the test is positive.

i. The Division shall require the AdSS to include information to encourage pregnant women to be tested and provide instructions on where testing is available as specified in AMPM Exhibit 400-3.

ii. The Division shall require the AdSS to report the number of pregnant women who are HIV or AIDS positive, as specified in Contract, and AMPM 410 Attachment A.

d. Conducting outreach and educational activities to identify currently enrolled Members who are pregnant and enter them into Prenatal Care as soon as possible.

i. The Division shall require programs include protocols for service Providers to notify the AdSS promptly when Members have tested positive for pregnancy.

ii. The Division shall require the AdSS to notify the Division at maternalandchildhealth@azdes.gov and dddcctreferral@azdes.gov when Members have tested positive for pregnancy.

iii. The Division shall require the AdSS to have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant women and implement different activities if activities prove to be ineffective.

e. Participation in community and quality initiatives, including but not limited to, efforts to reduce maternal mortality and morbidity and address health disparities in maternal and infant health within the communities served by the AdSS.

f. Designation of a Maternity Care Provider for each Member who is pregnant for the duration of her pregnancy and Postpartum Care.

i. The Division shall require the AdSS to allow for freedom of choice, while not compromising the continuity of care.

ii. The Division shall require the AdSS to allow Members who transition to a different AdSS or become newly enrolled with an AdSS during their third trimester to complete Maternity Care with their current AHCCCS registered Provider, regardless of contractual status, to ensure continuity of care.

g. Written new Member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool from ACOG covering psychosocial, nutritional, medical and educational factors.

h. Mandatory Maternity Care Coordination services for all pregnant women to include:

i. Identified barriers with navigating the health care system, evident by missed visits,

ii. Difficulties with transportation, or

iii. Other perceived barriers.

i. Demonstration of an established process for assuring:

i. Network Physicians, Practitioners, and LMs adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults or referrals for increased-risk or high-risk pregnancies using ACOG criteria;

ii. Maternity Care Providers educate Members about healthy behaviors during the perinatal period, including:

a) The importance of proper nutrition;

b) Dangers of lead exposure to birthing mother and child;

c) Tobacco cessation;

d) Avoidance of alcohol and other harmful substances, including illegal drugs;

e) Prescription opioid use;

f) Screening for sexually transmitted infections;

g) The physiology of pregnancy;

h) The process of labor and delivery;

i) Breast-feeding;

j) Other infant care information;

k) Interconception health and spacing;

l) Family planning services and supplies, including IPLARC;

m) Postpartum follow-up; and

n) Other education as needed for optimal outcomes.

iii. Members are referred for the following support services to:

a) Special Supplemental Nutrition Program for WIC,

b) Home visitation programs for pregnant women and their children, and

c) Other community-based resources to support healthy pregnancy outcomes.

iv. Maternity care providers maintain a complete medical record, documenting all aspects of Maternity Care;

v. Pregnant women have been referred to and are receiving appropriate care from a qualified physician; and

vi. Postpartum services are provided to Members within the time frame that aligns with performance measures as specified in AMPM 970.

j. Mandatory provision of initial Prenatal Care appointments within the following established timeframes and as specified in ACOM Policy 417:

i. First trimester - within 14 calendar days of a request for an appointment;

ii. Second trimester - within seven calendar days of a request for an appointment;

iii. Third trimester - within three business days of a request for an appointment; or

iv. High risk pregnancies as expeditiously as the Member's health condition requires and no later than three business days of identification of high risk by the AdSS, Division or Maternity Care Provider or immediately, if an emergency exists.

k. Verification of Members who are pregnant, to ensure that the above timeframes are met, and to effectively monitor Members are seen in accordance with those timeframes.

l. Monitoring and evaluation of infants born with low or very low birth weight, and implementation of interventions to decrease the incidence of infants born with low or very low birth weight.

m. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, and implementation of interventions to decrease occurrence, including addressing variations in provider cesarean section rates for first-time pregnant women with a term, singleton baby in a vertex or head down position.

n. Monitoring and evaluation of maternal mortality and implementation of interventions to decrease the occurrence of pregnancy-related mortality and health disparities in both the prenatal and Postpartum period.

o. Monitoring and evaluation to ensure that Maternity Care practices that support breastfeeding success are being utilized per ACOG and American Academy of Pediatrics (AAP) guidance.

p. Identification of Postpartum depression with the required use of any norm-criterion referenced validated screening tool to assist the Provider in assessing the Postpartum needs of women regarding depression and decisions regarding health care services provided by the Maternity Care Provider or subsequent referral for behavioral health services if clinically indicated.

q. Process for monitoring Provider compliance for perinatal and Postpartum depression screenings conducted at least once during the pregnancy and then repeated at the

Postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

r. Return visits scheduled in accordance with ACOG standards. A process shall be in place to monitor these appointments and ensure timeliness.

s. Inclusion of the first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider on claim forms to AHCCCS regardless of the payment methodology.

t. Continued payment of obstetrical claims upon receipt of claim after delivery and shall not postpone payment to include the Postpartum visit. The AdSS shall require a separate zero-dollar claim for the Postpartum visit.

u. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB.

v. Monitoring and evaluation of Postpartum activities and implementation of interventions to improve the utilization rate where needs are identified.

w. Participation in reviews of the Maternity Care Services program conducted by the Division as requested, including Provider visits and audits.

C. MATERNITY CARE PROVIDER REQUIREMENTS

1. The Division shall require Providers adhere to the following Maternity Care requirements:
   a. Maternity Care Providers follow the ACOG standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.
   b. LMs, if included in the AdSS Provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.
2. The Division shall monitor the AdSS to ensure that all Maternity Care Providers adhere to the following:
   a. Division Members have been referred to a qualified Provider and are receiving appropriate care;
   b. All pregnant women are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester and appropriate intervention and counseling

shall be provided, including referral of Members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment, for those Members receiving opioids;

c. All pregnant women are screened for Sexually Transmitted Infections (STI), including syphilis during:
   i. First prenatal visit,
   ii. Third trimester, and
   iii. Time of delivery.

d. Members are educated about the following healthy behaviors during pregnancy:
   i. The importance of proper nutrition;
   ii. Dangers of lead exposure to birthing mother and child;
   iii. Tobacco cessation;
   iv. Avoidance of alcohol and other harmful substances, including illegal drugs;
   v. Prescription opioid use;
   vi. Screening for sexually transmitted infections;

vii. The physiology of pregnancy;

viii. The process of labor and delivery;

ix. Breastfeeding;

x. Other infant care information;

xi. Interconception health and spacing;

xii. Family Planning Services and Supplies, including IPLARC;

xiii. Postpartum follow-up; and

xiv. Other education as needed for optimal outcomes.

e. All pregnant women receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed,

f. Providers utilize evidence-based practices per ACOG and the AAP to increase the initiation and duration of breastfeeding including:

i. Provider recommendation for breastfeeding;

ii. Placement of the infant in skin-to-skin contact;

iii. Early initiation of breastfeeding;

iv. No food or drink other than breastmilk; unless medically necessary; and

v. Rooming in.

g. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the Postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.

i. Postpartum depression screening is not a separately reimbursable service as it is considered part of the global service.

ii. Providers shall refer to any norm-referenced validated screening tool to assist the Provider in assessing the Postpartum needs of birthing mother regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to a behavioral health Provider, if clinically indicated.

h. Member medical records are appropriately maintained and document all aspects of the Maternity Care provided.

i. Members are referred to the following for support services to support healthy pregnancy and infant outcomes:

   i. Special Supplemental Nutrition Program for Women, Infants and Children (WIC),

   ii. Strong Families Az home visiting programs,

   iii. Arizona Department of Health Services breastfeeding hotline,

   iv. Birth to Five Helpline, and

   v. Other community-based resources.

j. Members are notified where they may obtain low-cost or no-cost maternity services, in the event they lose AHCCCS eligibility.

k. The first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider are submitted on all claim forms, regardless of the payment methodology used.

l. Postpartum services as clinically indicated are provided to Members within the Postpartum period and adhere to current AHCCCS minimum performance measures.

1. The Division shall require Maternity Care Providers utilize a separate zero-dollar claim for the Postpartum visit.

D. PREGNANCY TERMINATION

1. The Division shall cover pregnancy termination, if one of the following criteria is present:
   a. The pregnant woman suffers from the following, which places the Member in danger of death unless the pregnancy is terminated, as certified by a physician:
      i. A physical disorder;
      ii. Physical injury; or
      iii. Physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself.
   b. The pregnancy is a result of incest;
   c. The pregnancy is a result of rape; or

d. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant woman by:

i. Creating a serious physical or behavioral health problem for the pregnant woman;

ii. Seriously impairing a bodily function of the pregnant woman;

iii. Causing dysfunction of a bodily organ or part of the pregnant woman;

iv. Exacerbating a health problem of the pregnant woman; or

v. Preventing the pregnant woman from obtaining treatment for a health problem.

2. The Division shall require the following to be met regarding Prior Authorization (PA) except in cases of medical emergencies:

a. The Provider obtains a prior authorization for all covered pregnancy terminations;

b. The attending physician submits a request for review of the pregnancy termination qualifying diagnosis and condition for enrolled pregnant women with clinical information that supports the medical necessity or other criteria met for the procedure;

c. The Division reviews the prior authorization request, as specified in AMPM 410 Attachments C and D, and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination;

d. The attending physician submits all documentation of medical necessity within two working days of the date on which the pregnancy termination procedure was performed, in cases of medical emergencies.

3. The Division shall require that any decision to deny or authorize a service is made by a Healthcare Professional who has appropriate clinical expertise in treating the Member's condition or disease.

4. The Division shall require authorization requests for the following services are submitted to the Division, by the AdSS or directly from the Provider for a THP Member, for Second Level Review prior to issuing a decision:
    a. Hysterectomy;
    b. Sterilization; or
    c. Termination of pregnancy.
5. The Division shall review and respond to standard service authorization requests within seven business days and two business days for expedited service authorization requests.
6. The Division shall require expedited requests be clearly labeled as expedited.
7. The Division shall allow the AdSS Medical Director to request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.
8. The Division may request a peer-to-peer directly with the Provider at the Division's discretion for THP Members.
9. The Division shall require:

a. A written consent obtained by the Provider and file in the Member's medical record for a pregnancy termination;

b. If the pregnant woman is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. § 14-5101, a dated signature from the Responsible Person indicating approval of the pregnancy termination procedure is required;

c. When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed;

d. The documentation requirement above in subsection (c) is waived if the treating physician certifies that, in his or her professional opinion, the Member was unable, for physical or psychological reasons, to comply with the requirement;

e. Providers follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy, current standards of care per ACOG shall be

utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected;

f. Pregnancy termination by surgery or standard of care is recommended in cases when medications are used and fail to induce termination of the pregnancy;

g. When medications are administered to induce termination of the pregnancy, the following documentation is also required:

i. Name of medications used,

ii. Duration of pregnancy in days,

iii. The date medication was given,

iv. The date any additional medications were given unless a complete abortion was already confirmed, and

v. Documentation that pregnancy termination occurred.

8. The Division shall require the following reporting requirements are submitted to AHCCCS and the Division:

a. AHCCCS Certificate of Necessity for Pregnancy Termination and AHCCCS Verification of Diagnosis by AdSS for

Pregnancy Termination Requests, AMPM 410 Attachments C and D, as specified in Contract; and

b. Pregnancy Termination Report and the required documentation as listed in AMPM 410 Attachment E, as specified in Contract.

9. The Division shall require the AdSS to develop procedures to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

E. ADDITIONAL RELATED SERVICES

1. The Division shall cover circumcision for males as follows:
   a. Circumcision for males, only when it is determined to be medically necessary, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
   b. Routine circumcision for newborn males is not a covered service; and
   c. The procedure requires Prior Authorization (PA) if required by the newborn's Health Plan.
2. The Division shall require home uterine monitoring technology is covered when determined to be medically necessary as follows:

a. Covered for Members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

b. If the Member has one or more of the following conditions, home uterine monitoring may be considered for:

i. Multiple gestation, particularly triplets or quadruplets;

ii. Previous obstetrical history of one or more births before 35 weeks gestation;

iii. For a pregnant woman ready to be discharged home after hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis.

c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily Provider contact by telephone or home visit.

3. The Division shall require labor and delivery services provided in Free Standing Birthing Centers are covered.

a. For Members who meet medical criteria specified in this policy when labor and delivery services are provided by Maternity Care Providers.

b. Only Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a Free Standing Birthing Center.

c. Risk status shall be determined by the attending physician or Certified Nurse Midwife (CNM), using the standardized ACOG assessment tools for high-risk pregnancies. In any area of the risk assessment where standards conflict, the most stringent will apply.

d. The age of the Member shall also be a consideration in the risk status evaluation as Members younger than 18 years of age are generally considered high risk.

e. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in Free Standing Birthing Centers.

4. The Division shall require labor and delivery services in a home setting provided by the Member's maternity Provider are covered.
    a. For Members who meet medical criteria, AHCCCS covers labor and delivery services provided in the home by:
        i. Member's maternity Provider physicians,
        ii. CNMs, or
        iii. LMs.
    b. Only AHCCCS Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the Member's home.
    c. Risk status is initially determined at the time of the first visit, and each trimester thereafter, by the Member's Maternity Care Provider, using the current standardized ACOG assessment criteria and protocols for High-Risk Pregnancies.

d. A risk assessment conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified Provider, if necessary.

e. Physicians and CNMs who render home labor and delivery services have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and delivery.

f. LMs who render home labor and delivery services have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided for each anticipated home labor and delivery.

g. Referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, are included in the plan of action.

h. The Maternity Care Provider notifies the birthing mother's AdSS or the AHCCCS Newborn Reporting Line of the birth

for infants born to THP Members. Notification is given no later than three days after the birth in order to enroll the newborn with AHCCCS.

5. The Division shall require licensed midwife services are provided by LMs for Members, if LMs are included in the AdSS' Provider network or AHCCCS registered Providers who accept THP.
   a. Members who choose to receive maternity services from this Provider type meet eligibility and medical criteria specified in this policy.
   b. Risk status is initially determined at the time of the first visit, and each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from ACOG.
   c. An ACOG risk assessment is conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified Provider, if necessary.
   d. Before providing midwife services, documentation certifying the risk status of the Member's pregnancy is submitted to the AdSS or to DFSM for THP Members.

e. A consent form signed and dated by the Member is submitted, indicating that the Member has been informed and understands the scope of services that will be provided by the LM, including the risks to a home delivery.

f. Members are immediately referred to an AHCCCS registered physician for THP or within the Provider network of the Member's AdSS for Maternity Care Services who:

   i. Are initially determined to have a High-Risk Pregnancy, or

   ii. Members whose physical condition changes to high-risk during the course of pregnancy.

g. Labor and delivery services provided by a LM cannot be provided in a hospital.

   i. LMs shall have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise.

ii. This plan of action is submitted to the DFSM Medical Director or designee for THP Members, or to the AdSS Medical Director or designee for Members enrolled with an AdSS.

h. Upon delivery of the newborn, the LM is responsible for conducting newborn examination procedures, including:

i. A mandatory Bloodspot Newborn Screening Panel,

ii. A referral of the infant to an appropriate health care Provider for a mandatory hearing screening,

iii. A second mandatory Bloodspot Newborn Screening Panel, and

iv. A second newborn hearing screening.

i. The LM shall notify the birthing mother's AdSS or the AHCCCS Newborn Reporting Line for infants born to THP Members, of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

D. AdSS OVERSIGHT AND MONITORING

1. The Division shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and

recommendations to refine processes, identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes a review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Oct 21, 2023 09:07 PDT)
Anthony Dekker, D.O.