MDHHS
Michigan Department of Health & Human Services

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 26-43

Distribution: Ambulance Providers, Family Planning Clinics, Federally Qualified Health Centers, Hospitals, Laboratories, Local Health Departments, Maternal Infant Health Program Providers, Medicaid Health Plans, Medical Suppliers, Practitioners, Rural Health Clinics, School Services Program Providers, Tribal Health Centers, Highly Integrated Dual Eligible Special Needs Plans

Issued: November 2, 2026

Subject: Coverage of Planned Homebirth Services and Update to Medicaid-Covered Doula Services

Effective: January 1, 2027

Programs Affected: Medicaid, Healthy Michigan Plan, MI Coordinated Health, Maternity Outpatient Medical Services Program

NOTE: Implementation of the homebirth policy for the Maternity Outpatient Medical Services (MOMS) program is contingent upon State Plan Amendment (SPA) approval by the Centers for Medicare & Medicaid Services (CMS).

This bulletin is issued in response to the Michigan Department of Health and Human Services (MDHHS) fiscal year (FY) 2026 budget appropriations of Public Act 22 of 2025. From state-appropriated funds, Section 1982 of the Act directs MDHHS to expand coverage of maternity care services to include homebirth. Effective for services provided on and after January 1, 2027, Medicaid will cover home-based labor and delivery services for Medicaid beneficiaries who experience a low-risk pregnancy and who are expected to have an uncomplicated birth.

Managed Care Organizations (MCOs) and Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) must provide, at a minimum, the full range of covered services described in this policy. MCOs and HIDE-SNPs may choose to provide additional services over and above those specified. MCOs and HIDE-SNPs are allowed to develop prior authorization and documentation requirements that differ from Medicaid Fee-for Service (FFS) requirements in accordance with their contract, applicable state law, and federal regulations. For beneficiaries enrolled in an MCO or HIDE-SNP, the provider must check with the health plan for coverage requirements.

Covered Services

Eligible Medicaid-enrolled providers, working within their experience and scope of practice as defined by state law and licensing rules, include:

- Licensed Midwives (LM)
- Certified Nurse Midwives (CNM)
- Physicians

Medicaid will only cover labor and delivery services provided in the home setting for low-risk individuals. Low-risk means the pregnant individual has experienced a routine, uncomplicated prenatal course with adequate prenatal care as defined by maternal health professional societies (i.e., American College of Obstetricians and Gynecologists [ACOG]) and documented by the homebirth provider. The practitioner must, based on their clinical judgement, anticipate a routine, uncomplicated labor and delivery as defined by generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care (e.g., March of Dimes, ACOG, American Academy of Pediatrics).

Coverage of home-based pregnancy services for Medicaid beneficiaries who remain low-risk includes:

- Antepartum care, prenatal, delivery and postpartum services;
- Laboratory services;
- Limited ultrasound services for technical components of care when a Food and Drug Administration (FDA)-approved device is used;
- Newborn care provided in the immediate postpartum period;
- Medication and immunization administration;
- Consultation and coordination of care with other health care providers when applicable;
- Referral to support services;
- Telemedicine visits when appropriate;
- Lactation support services provided by a qualified provider as outlined in the MDHHS Medicaid Provider Manual;
- Labor management previous to hospital transfer; and
- Transfer of care.

Newborn Care

Care of the newborn during the immediate postpartum period includes typical care of a healthy newborn and emergent care. Emergent care is limited to stabilization and transfer to a higher level of care when necessary. Additional newborn services, such as immunization and medication administration, are covered dependent on scope of practice in accordance with current Medicaid policy as outlined in the MDHHS Medicaid Provider Manual.

Transfer of Care

At the inception of care, the eligible health care provider must establish and document a patient-specific transfer protocol to a designated hospital for receipt of higher acuity care. This protocol must prioritize the individual needs of the patient and be centered around their unique circumstances. Health care and hospital systems are highly encouraged to work directly with homebirth providers in order to ensure the best possible outcomes.

If at any point emergent transfer of care is required, homebirth providers must immediately arrange for transport of the patient to a hospital and notify hospital staff of the transfer of care of the patient according to the emergency care plan. Providers must provide necessary emergency stabilization until transfer to a hospital or emergency medical services personnel is completed. Pertinent information must be shared with the provider assuming care of the patient or patients.

Non-covered Services and Coverage Limitations

- Services provided to individuals who are **not** deemed to have a low-risk pregnancy or considered to be low-risk for labor and delivery
- General or regional anesthesia or sedation
- Circumcisions

Conditions that do not qualify for homebirth coverage include, but are not limited to:

- Prior cesarean that involved any incision other than low transverse
- Multiple gestation births (e.g., twin, triplet)
- Breech presentation at term, prior to onset of labor or during labor with delivery not imminent
- Active labor less than 36 weeks 0 days or gestation beyond 43 weeks 0 days
- Known fetal condition or anomaly that requires immediate medical attention during or after birth
- Placenta previa at term
- Vasa previa
- Hypertensive disorders
- Insulin-dependent diabetes type I or type II
- Gestational diabetes uncontrolled by diet
- Active infectious disease (e.g., Human Immunodeficiency Virus [HIV], tuberculosis)
- Any other diagnosis or complication considered high-risk according to reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care

Services occurring in the home setting outside of the perinatal period are subject to existing Medicaid policy and are described outside of what is included in this policy.

Billing Considerations and Reimbursement Guidelines

Medicaid reimburses professional claims for labor and delivery occurring in the home. Claims must include the National Provider Identifier (NPI) of the eligible provider in the rendering provider field. Professional services are only covered when the eligible provider has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly are covered for a single provider only.

For the most up-to-date coding information, refer to the applicable practitioner fee schedule for coverage and reimbursement information at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information. Refer to the Medicaid Code and Rate Reference tool within the Community Health Automated Medicaid Processing System (CHAMPS) for Medicaid-covered services.

Services Provided Within Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Tribal Health Centers (THCs), and Tribal FQHCs

FQHCs, RHCs, THCs, and Tribal FQHCs furnishing eligible maternity care services will be reimbursed at the Prospective Payment System (PPS) methodology or All-Inclusive-Rate (AIR) methodology for qualifying visits. Maternity care services provided in FQHCs, RHCs, THCs, and Tribal FQHCs are billed on the institutional claim form. The clinic fee schedules are published at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Clinic Institutional Billing.

Billing Requirements for Services Provided Outside the Clinic Setting

FQHCs, RHCs, THCs, and Tribal FQHCs may bill for eligible maternity care services furnished in the home setting. These non-clinic services must be billed separately on a professional claim form (CMS 1500/837P) using an Organization/Group – Type 2 non-clinic specialty-enrolled NPI as the Billing Provider and an eligible Individual – Type 1 NPI as the Rendering Provider. Services performed outside of the clinic will be reimbursed under FFS methodology. (Refer to additional billing requirements for clinic-specific provider types within the MDHHS Medicaid Provider Manual.)

Billing for Homebirth Supplies and Supports

Medicaid separately reimburses homebirth supplies and supports once per homebirth using Healthcare Common Procedure Coding System (HCPCS) code S8415. Payment is inclusive of all supplies and supports utilized during the labor and delivery. Services must be billed utilizing the birthing individual's Medicaid identification (ID) number. Homebirth supplies may include items such as birthing tub, disposable gloves, infant tape measure, clamps, bulb syringe, perineal irrigation bottle and additional supplies and supports. Beneficiaries may not be billed for birth supplies and supports. Refer to the Billing Beneficiaries section of the General Information for Providers chapter of the MDHHS Medicaid Provider Manual for additional information.

Billing for Services Provided to Newborns

All newborn services must be billed under the newborn's Medicaid ID number. If the birthing individual is enrolled with a Medicaid Health Plan (MHP) at the time of birth, all newborn charges must be billed to the MHP.

Homebirth providers are highly encouraged to support timely application of a newborn Medicaid ID. Generally, Medicaid automatically covers a child born to a birthing individual eligible for and receiving Medicaid at the time of birth. The birthing individual is required to notify the local MDHHS office of the birth of the newborn within 10 days of the birth. In addition, the provider's submission of the newborn birth through the State's Electronic Birth Certificate (EBC) system will add the Medicaid coverage. If the provider is unable to submit the newborn birth through the EBC, the provider may submit a Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. If the MSA-2565-C is used, the local MDHHS office will open the newborn's Medicaid case and return the form to the provider with the necessary billing information. For additional newborn eligibility information, refer to the Beneficiary Eligibility chapter of the MDHHS Medicaid Provider Manual.

Homebirth and Newborn Services Provided by Licensed Midwives

Homebirth and newborn services provided by Licensed Midwives (LM) are carved-out of the MHPs and reimbursed through Medicaid FFS. A separate policy was issued to address guidance for services provided by LMs.

Additional Consideration Regarding Newborn Care

Health professionals in Michigan must follow the Michigan Public Health Code Act 368 of 1978 section 333.5431 as it relates to Newborn Screening. Refer to current MDHHS guidance regarding newborn screening, including detailed information about how to obtain testing supplies, at MDHHS Michigan Newborn Screening Midwife Guide 2026. Additional information regarding Newborn Screening can be found at Newborn Screening General Information.

A Special Note to Maternity Care Providers

The American Medical Association has updated coding guidance for maternity care services provided on and after January 1, 2027. Medicaid-enrolled maternity care providers should review applicable current Medicaid policy for additional information.

Update to Medicaid Coverage of Doula Services

Effective for services provided on and after January 1, 2027, Medicaid-enrolled doulas are eligible for Medicaid reimbursement of labor and delivery support services provided in the home setting.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



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Health Services