

**MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR  
ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION**

**Instructions for MSA-1755**

The Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation form (MSA-1755) is to be completed by all Medicaid enrolled birthing hospitals in the State of Michigan.

The purpose of this form is to serve as an attestation that each Medicaid enrolled birthing hospital utilizes evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

To complete the form, hospitals must indicate whether they have elective delivery EBGs in place. If the hospital utilizes guidelines that are not listed on the form, hospitals may use the space provided on the form to explain. Hospitals may also submit copies of their elective delivery policies.

The form must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

The completed MSA-1755 must be mailed or emailed to:

Attn: Inpatient Hospital Policy  
Michigan Department of Health and Human Services  
Health Services, Program Policy Division  
PO Box 30479  
Lansing, Michigan 48909-7979  
[ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov)

Questions should be directed to Provider Support at [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov).

<b>AUTHORITY:</b> Title XIX of the Social Security Act	Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
<b>COMPLETION:</b> Is Required.	
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.	

**MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION**

The purpose of this agreement is to certify that Medicaid enrolled birthing hospitals utilize evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

**NOTE:** This agreement must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

**Complete the following:**

Hospital Name

National Provider Identifier

**attests that the following elective delivery EBGs are utilized:**

**Yes**   **No**   (Indicate Yes or No for each statement)

- Medical indications for elective, non-medically indicated delivery prior to 39 weeks completed gestation are defined in hospital policy.
- Hospital staff is not authorized to schedule an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
- Providers are required to obtain permission from physician leadership (e.g., the head of the obstetrics department) before performing an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
- Provider education materials are used to educate providers on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
- Patient education materials are used to educate patients on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
- Hospital involvement in an initiative that addresses elective, non-medically indicated delivery prior to 39 weeks completed gestation (e.g., Michigan Health & Hospital Association [MHA] Keystone Center's initiative in obstetrics, Trinity Health System's Perinatal Patient Safety Initiative [PPSI], Ascension Health System's Handling All Neonatal Deliveries Safely [HANDS]).
- Other. Explain in the space provided below. If more space is needed, attach explanation on a separate document.

Along with this completed agreement, MDHHS will also accept a copy of each facility's elective delivery policy.

I certify that the responses in this attestation agreement are accurate, complete and current as of the date signed.

\_\_\_\_\_  
**Signature of Chief Executive Officer**

\_\_\_\_\_  
**Signature of Chief Medical Officer**

\_\_\_\_\_  
PRINT Name of CEO

\_\_\_\_\_  
PRINT Name of CMO

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date