

October 28, 2024

Commissioner Robbie Goldstein
Department of Public Health
250 Washington Street
Boston, MA 02108

**RE: Birth Center Regulations 105 CMR 140.000, 105 CMR 130.000, 105 CMR 142.000**

Dear Commissioner Goldstein,

We appreciate the swift action by the Department of Public Health to address onerous, outdated birth center regulations that have stymied access to community birth options in the Commonwealth. We recognize that the Healey Administration’s prioritization of this issue predates the passage of H.4999, *An Act promoting access to midwifery care and out-of-hospital birth options*, in August, and that the Department has sought to incorporate the requirements set forth in H.4999 in the proposed birth center regulations, 105 CMR 140.000 and 130.000, and by rescinding 142.000. Thank you for this important work, which will make meaningful change to the landscape of birth options and allow the Commonwealth to leverage midwifery care to improve maternal and infant health outcomes and reduce racial inequities. **Our coalition supports the proposed changes to 105 CMR 140.000, and we have identified additional critical changes still needed to better align with the new law, adhere to national best practices, and promote safety and feasibility for birth centers.**

The amendments to birth center regulations proposed by the Department of Public Health implement important updates and reforms; however there are inconsistencies and omissions in the language of the proposed regulations that do not comply with the new law, (bill H.4999, which enacts changes to the statute in Chapter 111 Section 51M), national standards, and best practices. These are identified below as well as in the attached Mark Up Table.

We respectfully urge the Department of Public Health to further amend **105 CMR 140.000** as follows.

1. Consistently integrate Certified Professional Midwives (CPMs) throughout regulations. Related, update language to reflect midwifery as the most common model of care provided in birth centers, (e.g., use “clinical” rather than “medical”), and ensure that clinical guidelines are up-to-date and appropriate.
2. Remove the clinical background requirement for the Administrative Director, and allow the option for one person to serve as Administrative Director and Director of ~~Medical~~ Clinical Affairs.
3. Allow non-nurses with the appropriate training and certification to serve as birth assistants.
4. Update facility regulations to address onerous guidelines that unnecessarily add to the expense and difficulty of opening a birth center.
5. Remove “abortion” from the list of procedures birth centers are precluded from providing, allowing providers to offer medical or procedural abortions that are within their clinical scope of practice.
6. Allow birth center providers to send clients home with medications as appropriate and within provider scope of practice, as per existing regulations for clinics without pharmacies and to ensure patient safety.
7. Allow a “deemed by accreditation” pathway wherein a birth center that goes through the national accreditation process would be automatically licensed.
8. Ensure that birth centers will not be subject to determination of need restrictions.

In addition, with regard to hospital birth centers regulated by **105 CMR 130.000**, we respectfully urge the Department of Public Health to further amend these to include certified professional midwives in all birth center staffing roles and for clinical language updates consistent with current birth center practice, in parallel to what we identified in 105 CMR 140.000.

**Please see our attached Mark-up Table and bulleted comments, which detail each amendment needed indicating the relevant sections of 105 CMR 140.000 and 105 CMR 130.000.**

We appreciate this opportunity to provide feedback to the Department through the public comment process, and we are hopeful that you will implement these critically needed amendments. In addition, we strongly urge the Department to seek every opportunity to further minimize unnecessary cost and feasibility burdens by easing facility requirements that exceed what is necessary for safe and appropriate birth center care. Some of those onerous facility requirements are set forth in 105 CMR 140, but others lie within documents of the Facility Guidelines Institute, hidden behind a paywall and unavailable for public comment. Similarly, the Department should seek to further promote the development of community birth centers by alleviating or waiving cost burdens, including review of building plans, which should not be based on a percentage of construction cost or benchmarked to the capital cost, for such low-margin and yet essential services that birth centers provide.

As organizations working across the intersecting areas of maternal health, civil rights, women’s rights, public health, reproductive freedom, midwifery, mental health, and racial justice, we support access to midwifery-led birth centers in every community. We have watched aghast as our state, which already ranked 32nd in the nation for integration of midwives[[1]](#footnote-1), recently closed TWO long-standing birth centers– Cambridge Birth Center and North Shore Birth Center. This has left all of Eastern Massachusetts with no access to birth center care, and only one birth center for the whole state, (Seven Sisters in Northampton), and another which has faced enormous barriers to opening, (Neighborhood Birth Center in Boston). Meanwhile, this model is thriving elsewhere with over 400 midwifery-led birth centers across the U.S. including four in New Hampshire and three in Maine, both states with 80% fewer births each year than Massachusetts. Massachusetts has found itself near the bottom of states in terms of access to midwives and birth centers, despite the tremendous benefits recognized by the World Health Organization, the Centers for Medicaid and Medicare Services, the Massachusetts Health Policy Commission, and the Massachusetts Commission on Racial Inequities in Maternal Health, among others.

Fortunately, we can look forward to a brighter future, propelled forward by the recent legislation alongside administrative actions including investments in birth centers and, now, evidence-based regulation. Appropriate birth center staffing, facility, and clinical requirements allow birth centers to be feasible and sustainable while ensuring safety, adherence to the midwifery model of care, and consistency with applicable laws, standards, and best practices. We look forward to joining with you to celebrate the openings of many more birth centers in communities across the Commonwealth, uplifting access, justice, health, and joy.

Thank you for recognizing the urgency of our maternal health crisis and the essential role for community birth centers and midwife-led care in reversing the trend of declining outcomes and widening inequities. We hope you will incorporate our feedback, as these additional amendments are critical to the success and sustainability of birth centers in the Commonwealth.

Please feel free to contact the Coalition through Emily Anesta at (617) 329-1092‬. We would be happy to offer any further assistance or provide additional resources to support the Department of Public Health’s important work to promulgate appropriate best-of-breed regulations for safe, accessible, and sustainable birth center operation.

Attachments:

* Detailed bullet point comments on 105 CMR 140.000 and 130.000 (following the signature page)
* Mark-up Table of 105 CMR 140.000 and 130.000
* American Association of Birth Centers, Position Statement on Certificate of Need

Sincerely,

*Emily Anesta, President, Bay State Birth Coalition*

*Carol Rose, Executive Director, ACLU MA*

*Katherine Rushfirth and Susan Hernandez, Legislative Co-chairs, ACNM Massachusetts Affiliate*

*Dr. Jallicia Jolly and Yaminah Romulus, Co-chairs, Birth Equity and Justice Massachusetts (BEJMA)*

*Indra Wood Lusero, President, Birth Rights Bar Association*

*Keith A. Mahoney, Vice President of Communications and Public Affairs, The Boston Foundation*

*Jo-Anna Rorie, CNM, PhD, Clinical Associate Professor of Obstetrics & Gynecology, Boston University School of Public Health*

*Eugene Declercq, PhD, Professor, Community Health Sciences, Boston University School of Public Health*

*Dr. Ndidiamaka Amutah-Onukagha, Julia A. Okoro Professor of Black Maternal Health, Founder and Director, Center for Black Maternal Health and Reproductive Justice at Tufts University School of Medicine*

*Divya Sooryakumar, Vice President, Programs & Impact, Every Mother Counts*

*Amy Rosenthal, Executive Director, Health Care for All Massachusetts*

*Bashi Kumar-Hazard, President, Human Rights in Childbirth*

*Janis Soma and Ellen Church, Legislative Specialists, League of Women Voters of Massachusetts*

*Sasha Goodfriend, Executive Director, Mass NOW*

*Jessie Colbert, Executive Director, Mass PPD Fund*

*Leigh E. Simons, MPH, Senior Director, Healthcare Policy, Massachusetts Health & Hospital Association*

*Georgia Katsoulomitis, Executive Director, Massachusetts Law Reform Institute*

*Carlene Pavlos, Executive Director, Massachusetts Public Health Association*

*Michele Helgeson, CNM, Co-founder The Midwife Solution: Advancing midwifery for equitable and optimal health*

*Tina Sherman, Senior Maternal Justice Campaign Director, MomsRising, Inc.*

*Mystic Valley Action for Reproductive Justice*

*Rebecca Herman, President, Massachusetts Chapter of National Association of Certified Professional Midwives*

*Carol Sakala, Senior Director for Maternal Health, National Partnership for Women & Families*

*Nashira Baril, Director, Neighborhood Birth Center*

*Ida Darragh, Executive Director, North American Registry of Midwives*

*Diana Namumbejja-Abwoye, Board Chair, Our Bodies Ourselves*

*Planned Parenthood Advocacy Fund of Massachusetts*

*Progressive Massachusetts*

*Rebecca Hart Holder, President, Reproductive Equity Now*

*Lilly Marcelin, Executive Director, Resilient Sisterhood Project*

*Krina Patel, Women’s Bar Association of Massachusetts*

*Gail Fortes, Executive Director, YWCA Southeastern Massachusetts*

*Rachel Blessington, CNM, Executive Director, Worcester Community Midwifery*

*Address: Bay State Birth Coalition, c/o Emily Anesta, 57 Prospect Ave, Roslindale, MA 02131*

*The following detailed comments refer to the amended regulations for 105 CMR 140.000 and 105 CMR 130.000 proposed by the Department of Public Health pursuant to public hearing on October 28, 2024.*

BIRTH CENTER STAFFING:

* **Certified Professional Midwives:** We strongly support the proposed improvements to birth center staffing requirements including the inclusion of certified professional midwives in all clinical roles; however the proposed regulations do not consistently and completely include certified professional midwives. There are inconsistencies in the language of the regulations and omissions in ***105 CMR 140.000*** that do not comply with the new law and national standards and best practices. Further, certified professional midwives should also be integrated into birth center regulations of ***105 CMR 130.000***.
	+ Additional amendments are needed throughout ***105 CMR 140*** to properly integrate certified professional midwives everywhere provider types are listed and remove internal inconsistencies.
	+ Additional amendments are needed to ***105 CMR 130.120***(Birth Center Services definition; add Certified Professional Midwife definition)***, 130.811 (A,B,C), 130.813 (B4, B6), 130.814 (D), 130.816*** to integrate certified professional midwives where birth center provider types are listed.
* **Certified Nurse Midwives:** We strongly support the proposed addition of certified nurse midwives in all clinical roles. (***105 CMR 140.902, 105 CMR 130.811***)
* **Director of ~~Medical~~ Clinical Affairs:** We strongly support the proposed addition of certified nurse midwives and certified professional midwives, as well as the removal of requiring obstetrical privileges at a nearby hospital. However, the word “medical” should be replaced with “clinical,” reflective of the autonomous practice of midwifery, which is not medicine, and consistent with the new law, national standards for birth centers, and the definition of birth center services in 105 CMR 140.
	+ Additional amendments are needed to ***105 CMR 140.902 B*** to properly adhere to the new law, changing the title of the role to “Director of Clinical Affairs,” replacing the word “medical” with “clinical” and removing language referring to “policies, procedures, and protocols that are outside the scope of midwifery practice.”
* **Administrative Director:** The outdated language of ***105 CMR 140.902 A,*** not only omits certified professional midwives, but it requires a clinical background, for what is an administrative role. This requirement for an administrative director to have a clinical license is inconsistent with the new law (***MGL Chapter 111 Section 51M-b-iii***), national standards, and the requirements for clinic administrators in ***105 CMR 140.310***. In addition, the proposed language would seem to require duplicative layers of administrative staff (clinic administrator and a director of administrative affairs).
	+ Additional amendments are needed to ***105 CMR 140.902 A*** to strike section ***2*** which specifies unnecessary clinical credentials, and to amend language in section ***1*** requiring the administrative director to report to a redundant clinic administrator.
	+ Similarly, additional amendments are needed ***105 CMR 130.811 A*** to remove the clinical requirement for Director of the Birth Center, which is an administrative role.
* **Dual Appointment:** The proposed regulations for birth center staffing do not specify the option of dual appointment as administrative and clinical director, though the clinic regulations in ***105 CMR 140.312*** allow it, as do national standards.
	+ Additional amendments are needed to ***105 CMR 140.902,*** (and similarly ***105 CMR 130.811),*** to allow the option for one person to serve as administrative director and director of clinical (previously, “medical”) affairs if the individual meets the requirements for both positions and can properly perform the duties of both positions.
* **Birth Attendants:** We strongly support the addition of certified professional midwives and the proposed removal of requiring birth attendants to have obstetrical privileges at a nearby hospital. However, certified professional midwives are not consistently included.
	+ Additional amendments are needed to ***105 CMR 140.902 C(1)*** to consistently include certified professional midwives everywhere provider types are listed.
* **Birth Assistants:** We strongly support the proposed removal of the requirement that birth assistants have labor and delivery experience within the past year, and the expansion of eligibility for the role to non-nurses who are certified by DPH. However, certified professional midwives were omitted from being able to serve in this role, and the required experience for birth assistants still refers exclusively to registered nurses. Further, national standards and AABC birth assistant certification do not require prior labor and delivery experience.
	+ Additional amendments are needed to ***105 CMR 140.902 C(2***) to allow certified professional midwives to serve as birth assistants. Since providers eligible to be birth attendants could also serve in the role of a second staff member birth assistant, amend this language to be inclusive of certified professional midwives, either by explicitly adding them, or by replacing “certified nurse midwife” with “eligible birth attendant.”
	+ Additional amendments are needed to ***105 CMR 140.902 C(2***) and ***105 CMR 130.811 C(2)*** to allow for appropriately trained staff birth assistants certified by the Department, by replacing the word “provider” with “individual.”
	+ Additional amendments are needed to ***105 CMR 140.902 C(3)*** and ***105 CMR 130.811 C(3)*** to allow non-nurses certified by DPH to serve as birth assistants and to remove labor and delivery experience requirement.
* Clarify, resolve discrepancies, and remove redundancies:
	+ Additional amendments are needed to clarify that clinic staffing guidelines defined in ***105 CMR 140.310*** through ***140.317*** do not apply to birth centers licensed under ***105 CMR 140*** which must instead meet staffing requirements in ***105 CMR 140.902***.

BIRTH CENTER FEASIBILITY AND SUSTAINABILITY:

* **Referral and Collaboration:** We strongly support the proposed regulations updating requirements for referral and collaboration in ***105 CMR 140.908***. The Department of Public Health’s proposed changes align with the new law, and will promote the feasibility and sustainability of birth centers, while adhering to best practices and successful national models for safe and appropriate birth center integration and regulation.
* **Determination of Need:** Regulations should specify that birth centers would not be subject to determination of need, a requirement that has suppressed access to birth centers in other states. The attached [position statement on Certificate of Need from AABC](https://assets.noviams.com/novi-file-uploads/aabc/pdfs-and-documents/PositionStatements/AABC_PS_-_Certificate_of_Nee-9e20624d.pdf) details the rationale.
	+ Additional amendments are needed to ***105 CMR 140.108*** to clarify that birth centers licensed under ***105 CMR 140*** would not be subject to determination of need.
* **Deemed-by-accreditation:** Allow “deemed by accreditation” option wherein a birth center that goes through a national accreditation process is automatically licensed by the MA DPH, such as Massachusetts already offers for Ambulatory Surgery Centers. This would reduce cost and paperwork for both the birth center and the state. The state should also maintain a direct licensure pathway for birth centers that do not seek national accreditation, which may be more expensive and time consuming than a state license.
	+ Additional amendments are needed to ***105 CMR 140.102*** to add Deemed-by accreditation Licensure and Renewal for Birth Centers if the entity is accredited as a birth center by the Commission for the Accreditation of Birth Centers (CABC) or any other national accrediting body as determined by the Department.

FACILITY AND EQUIPMENT REQUIREMENTS:

* We support the proposed removal of the requirement for a transfer incubator (***105 CMR 140.903, 130.812***).
* In addition, we strongly urge the Department of Public Health to exempt birth centers from facility requirements that are not relevant to ensure safety and quality in birth center services. These are posing financial and logistical barriers to opening and operating birth centers in the Commonwealth.
	+ Additional amendments are needed to ***105 CMR 140.205*** to remove unnecessary expense and barriers to birth center construction by adding an exception for birth centers to the requirement for surgical scrub sinks.
	+ The Department should go further to remove unnecessarily onerous and expensive facility regulations that are not specified explicitly in ***105 CMR 140***, but referred to, such as the *Facility Guidelines Institute’s Guidelines for Design and Construction of Health Care Facilities*. Our state standards should better match the needs and safety required for birth centers, aligning with AABC model regulations and with input from key stakeholders such as Seven Sisters Birth Center, Neighborhood Birth Center, Worcester Midwifery, and other entities in the process of opening birth centers in Massachusetts.

DEFINITIONS AND CLINICAL REGULATIONS:

* The definitions of “birth centers” and “birth center services” in ***105 CMR 140*** are inconsistent and have not been updated to include certified professional midwives.
	+ Additional amendments are needed to ***105 CMR 140.020*** to: clarify that birth centers are not maintained. operated by, or located in a hospital; to add certified professional midwives to the list of providers of birth center services; and to add a definition for certified professional midwife licensed under M.G.L. c. 112, § 293. Birth center services are defined again under “Specific Service” and those definitions need to be made consistent.
* We support the proposed amendments to clinical regulations; however additional amendments are needed to align with current practices, procedures, and terminologies used by birth centers.
	+ Additional amendments are needed to ***105 CMR 140.901 E*** and ***130.810 E*** to make consistent with current resuscitation procedures and terminologies, replacing “adult and neonatal intubation and resuscitation” with “adult cardiopulmonary resuscitation and neonatal airway management and resuscitation.”
	+ Additional amendments are needed to ***105 CMR 140.904 B*** by striking section 8 which refers to hospital-based nursing practices. (In birth centers, the primary birth attendant performs all assessments.)
	+ Additional amendments are needed to ***105 CMR 140.905 A (11)*** and ***130.814 A(11)*** to replace “depression” with “perinatal mood disorders.”
	+ Additional amendments are needed to ***105 CMR 140.905 B*** and ***130.814 B*** to replace “electronic monitoring” with “prenatal fetal surveillance” to reflect current clinical practices using all appropriate modalities for monitoring fetal well being.
	+ Additional amendments are needed to ***105 CMR 140.905 C*** and ***130.814 C*** to add stipulation to discharge birthing person and infant “when both are clinically stable and have met the discharge criteria defined by the birth center.”
	+ Additional amendments are needed to ***105 CMR 140.905 G*** and ***130.814 G*** to allow the birth center six weeks from birth to document the parent or guardian report of completion of hearing screening.
	+ Additional amendments are needed to ***105 CMR 140.906 B(2)*** and ***130.815 B(2)*** by replacing the current language prohibiting induction and augmentation with the following: “Induction or augmentation of labor using pharmacologic uterotonics.”
* We support the proposed amendments to regulations ***105 CMR 140*** for patient recordkeeping and services; however they have not been updated to include certified professional midwives.
	+ Additional amendments are needed to ***105 CMR 140.904*** and ***105 CMR 140.907*** to consistently include certified professional midwives everywhere provider types are listed, or use “birth attendant” in lieu of listing provider types where appropriate.
	+ Additional amendments are needed to ***105 CMR 140.905*** ***D*** to consistently include certified professional midwives by using “provider” in lieu of listing provider types, or by adding “certified professional midwife” everywhere provider types are listed.
* We support the amendments to update gender references and remove stigmatizing language; however we identified two small instances where the proposed regulations do not do so consistently and completely.
	+ Additional amendments are needed to ***105 CMR 140.905*** and ***105 CMR 130.814*** to replace “breast feeding” with “infant feeding.”
	+ Additional amendments are needed to ***105 CMR 140.904*** and ***105 CMR 130.813*** to correct a typo where it says “Birth” person and should say “Birthing” person.

ACCESS TO NECESSARY REPRODUCTIVE CARE:

* In order to ensure appropriate access to abortion care consistent with currently available medications, procedures, and state laws, remove the word “abortion” from prohibited practices.
	+ Additional amendments are needed to ***105 CMR 140.906 B(1)*** and ***105 CMR 130.815 B(1)*** to remove the word “abortion.”
* Remove blanket prohibition on birth center staff dispensing drugs, and instead align them with existing regulations providing limited administration of medications for clinics without pharmacies. This amendment is also critically necessary to ensure access to medication abortion.
	+ Additional amendments are needed to remove the prohibition on dispensing drugs in ***105 CMR 140.906 B(4)***, as there are appropriate regulations already set forth in ***Section F of 140.347***: Pharmacy Services by Clinics without Clinic Pharmacies.
	+ Similarly, additional amendments are needed to remove the prohibition on dispensing drugs in ***105 CMR 130.815 B(4)***.
1. Vedam S, et al, "Mapping midwifery integration across the United States: impact on access, equity, and outcomes." PLOS ONE. (Feb 21, 2018) [↑](#footnote-ref-1)