October 25, 2024

William Anderson

Office of the General Counsel

Department of Public Health

250 Washington Street, Boston, MA 02108

Dear Mr. Anderson,

Thank you for the Department of Public Health’s work on the recent proposed amendments filed on to 105 CMR 140.000 Licensure of Clinics regarding birth centers and on the proposed rescission of 105 CMR 142.000 Operation and maintenance of birth centers.

Below are the priorities of the Bay State Birth Coalition for the development of these regulations. I endorse their priorities and comments.

Thank you for your consideration of these comments, and your work on updating these critical regulations.

Sincerely,

Jo Comerford

**State Senator**

*Hampshire, Franklin, Worcester district*

**Bay State Birth Coalition’s Priorities**

**RE: Proposed amendments to 105 CMR 140.000 Licensure of Clinics regarding birth centers**

Support the Department’s proposed amendments to the birth center regulations in 105 CMR 140 including:

* Allowing CPMs to serve as primary birth attendants
* Allowing CPMs and CNMs to serve as director of medical affairs, and removes requirement for obstetrical privileges at a nearby hospital
* Lifting requirement for birth assistants to have labor and delivery experience within the past year
* Removing requirement for a transfer incubator
* Updating to clinical record keeping
* Updating to transfer and referral policies and procedures
* Adopting gender inclusive language

*In addition to these changes, we have identified critical changes still needed to better align with the new law and adhere to national best practices, safety, and feasibility for birth centers.*

**Key issues to address in public testimony:**

1. **Consistently integrate Certified Professional Midwives (CPMs) throughout regulations anytime a provider is listed.**
	* The law changed to allow CPMs to be licensed providers in birth centers and to be the Director of Medical Affairs.
	* Proposed amendments to 105 CMR 140.000 are inconsistent where CPMs are listed as providers, including as Administrative Director, Birth Assistant, and in clinical recordkeeping; this should be made consistent with CPMs included throughout all regulations referring to providers and directors of birth centers.
2. **Remove the clinical background requirement for the Administrative Director. (105 CMR 140.902 A)**
	* Regulations should align with AABC, which does not require the administrative director to be a clinician. The national regulations state: “The birth center shall appoint an administrative director and a clinical director. Depending upon the structure of the organization, the administrative and clinical directors may be the same person. The administrative director shall be responsible for implementing and overseeing the operational policies of the birth center.”
	* While clinicians may serve as Administrative Directors in some birth centers, the proposed language would preclude birth centers from hiring qualified *administrators* with public health, non profit, and business backgrounds, (e.g., Nashira Baril, MPH – Founder and Director of Neighborhood Birth Center would not be allowed serve in this role).
	* Also, allow the same person to serve as medical and administrative director if they meet the requirements of both roles.
3. **Broaden the definition of a birth assistant beyond “Registered Nurse with L&D experience.” (105 CMR 140.902 C-2)**
	* Regulations should align with AABC, which states: “The birth center shall have at least two persons who are currently certified in basic life support and neonatal resuscitation on premises and immediately available during each delivery.”
	* Requiring RNs with L&D experience massively shrinks the hiring pool– which will be immensely challenging in a time of statewise nursing shortages.
	* We have clear examples from Massachusetts birth centers that maintaining RN birth assistants is close to impossible, and that is why so many birth centers have defaulted to the costly option of 2 midwives at every birth.
	* With a licensed midwife or physician required to be the primary birth attendant, birth centers can maintain a safe environment with trained birth assistants without requiring that they be an RN or have hospital labor and delivery experience. AABC establishes such standards for quality birth assistants and offers community birth assistant [**training**](https://www.birthcenters.org/CBA) not limited to RNs.
4. **Update facility regulations to address onerous guidelines that unnecessarily add to the expense and difficulty of opening a birth center.**
	* Current facility regulations required by 105 CMR 140.103 E are not part of 105 CMR 140, and are behind a paywall at FGI.
	* In addition to updating 105 CMR 140, DPH should also update the facility regulations to 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.
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. (105 CMR 140.906 B-1)**
	* Birth centers do and can provide abortions– both medical and procedural– throughout the nation. This included Cambridge Birth Center and North Shore Birth center when they were open.
	* CNMs now have procedural abortion as part of their scope of practice following the ROE Act.
	* DPH and MassHealth must honor reproductive justice and make sure that people can access and pay for abortion care in trusted community clinical settings.
	* In conjunction, MassHealth needs to remove “abortion” from “non covered services” from freestanding birth centers in 130 CMR 457.000
6. **Allow “deemed by accreditation” option wherein a birth center that goes through CABC accreditation process is automatically licensed by the MA DPH.**
	* Birth centers accredited by the CABC can obtain “deemed-by-accreditation” licensure, 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 CABC accreditation, which may be more expensive and time consuming than a state license.
7. **Ensure that birth centers are not subject to determination of need restrictions.**
	* Birth centers should be exempted from any determination of need process (105 CMR 140.108C).
	* Determination of need requirements have been a tremendous barrier to opening up birth centers in many states.
	* AABC opposes such requirements as outlined in their position statement (<https://assets.noviams.com/novi-file-uploads/aabc/pdfs-and-documents/PositionStatements/AABC_PS_-_Certificate_of_Nee-9e20624d.pdf>)
8. **Allow birth center providers to send clients home with medications as appropriate and within provider scope of practice. (105 CMR 140.906 B-4)**
	* There are a variety of instances where a provider in a birth center may need to send a client home with a medication for that client to self-administer. Regulations should be updated to allow for these practices where consistent with provider regulations and standards of practice.