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April 29, 2024

Senator Cindy Friedman, Chair
Joint Committee on Health Care Financing
State House, Room 313
Boston, MA 02133

Representative John Lawn, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Re: Policy recommendations relative to Maternal Health Legislation

Dear Chair Friedman and Chair Lawn:

The Massachusetts Legislature has led the nation in enacting policies that protect and enhance access to reproductive health care for all residents. Such measures, coupled with our world class health care system, are why the Commonwealth continues to serve as a beacon for reproductive health across the country. Despite these advances, the Commonwealth, like the rest of the country, faces a critical maternal health crisis that must be met with innovative and bold action. The rate of life-threatening pregnancy complications in Massachusetts nearly doubled over the last decade, with Black and Indigenous people facing disproportionately high rates of maternal death, severe pregnancy complications, and mistreatment from care providers. These inequities are further compounded by systemic racism, unprecedented workforce shortages across the state, and increasing closures of maternity units and birth centers. As such, birthing people in Massachusetts have fewer options for accessing pregnancy and reproductive health care.

Decades of research shines a light on precisely the type of interventions that can help ensure that birthing people in Massachusetts have access to safe, affordable, high-quality care regardless of their race, ethnicity, economic status, gender identity, immigration status, or geographic location. The Attorney General recognizes the need to invest in these types of evidence-based strategies to combat the maternal health crisis, which is why we used $1.5 million dollars of our settlements to fund our Maternal Health Equity Grant.[1] Through that program, we funded 11 organizations across the Commonwealth in an effort to improve maternal health outcomes. The Attorney General also formed the Reproductive Justice Unit ("RJU") in the fall of 2023, to ensure our office takes an expansive and holistic view of the range of issues our residents face as they relate to sexual and reproductive health care.[2] Maternal health is a critical component of this work. But much more is needed to reduce disparities, including changes within the health care and regulatory landscape that remove barriers to care, expand care delivery models, and compensate providers equitably. To that end, we offer the following policy recommendations to expand access to safe maternal health care:

[1] "AG Campbell Distributes $1.5 Million For Maternal Health Equity Grant," https://www.mass.gov/news/ag-campbell-distributes-15-million-for-maternal-health-equity-grant (August 16, 2023).
[2] "AG Campbell Announces Sapna Khatri As Director of Reproductive Justice Unit," https://www.mass.gov/news/ ag-campbell-announces-sapna-khatri-as-director-of-reproductive-justice-unit(Oct. 10, 2023)

Meaningfully integrating midwives into our health care system.

The integration of both Certified Nurse Midwives ("CNMs") and Certified Professional Midwives ("CPMs") into our health care system is of vital importance to address the mounting challenges of the maternal health crisis. CNMs are trained nurses holding an advanced practice degree in midwifery. CPMs are not required to have a specific degree and instead, receive their training through coursework, work experience, and/or apprenticeships. Both CNMs and CPMs can provide maternity care for low-risk pregnancies.

Research demonstrates the importance of midwives in a variety of settings to improve health outcomes, lower costs, and foster greater trust with the community. The midwifery philosophy of care is rooted in principles that center the needs of the patient and encourage an environment of care that creates a sense of safety for both the patient and the midwife.[3] This model has resulted in a "long history of providing high-quality, high-touch care to meet both the physiological and psychosocial needs of historically disenfranchised communities."[4] Midwives also lead to cost savings for the system by decreasing the number of unnecessary interventions and complications. Yet, Massachusetts currently falls in the bottom third of states for midwife integration.

It is vitally important we recognize the value of integrating both CNMs and CPMs into our provision of care. We can accomplish this goal in several ways:

1. *Equitably reimbursing CNMs and physicians* – CNMs are highly trained medical professionals who carry the specific knowledge and experience to provide maternity care, including births. Research has long shown that midwifery care is associated with lower rates of medical interventions, shorter hospital stays, and higher breastfeeding rates.[5] The cost savings from CNMs are also substantial, with up-front costs for insurers being offset by the savings from improved health outcomes and lower rates of expensive medical interventions.[6] Despite mounting evidence of these benefits, Massachusetts is currently the only New England state with a Medicaid program that does not reimburse CNMs at 100% of physician rates. Reports from both the Racial Inequities in Maternal Health Commission (2022) and the Health Policy Commission (2022) also recommend equal insurance reimbursement for CNMs. Ensuring midwives are equitably reimbursed for performing the same services will ultimately lead to better health outcomes, increased cost-savings, and address the disparities in the delivery of maternal health care.

2. *Expanding licensure and care opportunities for CPMs* – Massachusetts does not provide CPMs a path to licensure and limits their participation to home births. However, CPMs are demonstrably qualified for a broader scope of practice. CPMs must meet the standards for certification set forth by the North American Registry for Midwives. They are further accredited by the National Commission for Certifying Agencies and are

[3] Denis Walsh and Declan Devane, "A Metasynthesis of Midwife-Led Care," *Qualitative Health Research* 22, no. 7 (July 2012): 897–910, https://journals.sagepub.com/doi/10.1177/1049732312440330

[4] P. Mimi Niles and Laurie C. Zephyrin, "How Expanding the Role of Midwives in U.S. Health Care Could Help Address the Maternal Health Crisis," The Commonwealth Fund (May 5, 2023) https://www.commonwealthfund.org/publications/issue-briefs/2023/may/expanding-role-midwives-address-maternal-health-crisis

[5] *Id.*

[6] Joan L. Combellick et al., "Midwifery care during labor and birth in the United States," American Journal of Obstetrics and Gynecology (Mar. 23, 2023) https://www.ajog.org/article/S0002-9378(22)00799-2/fulltext

eligible for licensure across most US states.[7] Massachusetts is one of only twelve states that limits licensure to CNMs. While CPMs are trained to birth in out-of-hospital settings and attend the vast majority of home births within the Commonwealth, they are not able to perform births in most settings, including birth centers, within the state. Expanding the scope of practice for CPMs beyond home births, ensuring equitable insurance reimbursement for maternity care, and providing a pathway to licensure will create a more diverse workforce providing birthing care. Such changes would also expand access to alternative birthing options in a safe, healthy way that is likely to lead to better outcomes and cost savings for patients, particularly the most vulnerable.

3. *Removing the requirement for physician supervision of clinical care provided by board-certified and licensed midwives.* State regulations currently require an OB-GYN to supervise board-certified and licensed midwives. For over 10 years, midwives have been licensed to practice fully independently within the Commonwealth and have specialized training in out-of-hospital birth care. Research shows that requiring OB-GYN supervision of midwives not only increases costs, but it also makes it harder for birth centers to open, hampers workforce development, and does not improve birthing outcomes.[8] While collaboration among midwives and physicians can strengthen the maternal health care, the supervision model has no clear benefit. Our regulations should be changed to ensure that midwives are able to independently provide quality care to their patients without physician supervision.

Reducing costs that inhibit access across the continuum of pregnancy.

Our policies must ensure equal access to high-quality pregnancy-related care, regardless of age, sex, gender orientation, race, ability, or income level. Moreover, it is critical our insurance coverage extends across the pregnancy continuum of medical care, including prenatal care, C-sections, pregnancy loss, abortion, and abortion related care. This care must be accessible without any deductibles, co-insurance, co-pays, or other cost-sharing mechanisms.

Stark disparities in health status and access to health care for people of color, especially in the provision of maternal and infant health have persisted for decades. Despite advancements in medical care over the years, the rates of maternal mortality and morbidity continue to climb, and low- income earners and people of color are at an increased risk for poor maternal and infant health outcomes. Straining this environment are rising deductibles and co-pays that make pregnancy care incredibly cost prohibitive. Research shows that out-of-pocket costs for birthing episodes in Massachusetts are growing faster than patient wages.[9] As a result, many pregnant people avoid seeking appropriate and needed care because of financial barriers, which can have serious negative consequences for the health of both the pregnant person and the child. It is critical our legislature responds to these rising costs and ensures care is accessible to all.

[7] "NARM's Year in Review: Reflections on 2023," North American Registry of Midwives (Feb. 2, 2024) https://narm.org/2024/02/narms-year-in-review-reflections-on-2023/ (With the passage of legislation in Iowa and Virginia in 2023, 38 states have enacted licensure for direct-entry midwives, also known as CPMs.)

[8] "Midwives: Information on Births, Workforce, and Midwifery Education," United States Government Accountability Office Report to Congressional Requesters (April 2023) https://www.gao.gov/assets/gao-23-105861.pdf

[9] "Growth in out-of-pocket spending for pregnancy, delivery, and postpartum care in Massachusetts," Massachusetts Health Policy Commission (Mar. 29, 2022) https://mass.gov/info-details/hpc-datapoints-issue-22

Investing in doula-services for the full-spectrum of pregnancy care.
We applaud the recent expansion of MassHealth coverage for doulas, which recognizes their immense value to the emotional and physical care of birthing people.[10] Nevertheless, it is essential the legislature further expands Medicaid access to doula care by simultaneously investing in the expansion of the doula workforce. It is critical we are prepared to support birthing people in Massachusetts by providing greater financial support and expanding opportunities for doula training, continued education, and mentorship.

While several factors work together to improve healthy maternal and infant outcomes, research has shown that doula support plays an important role in reducing "cesarean births, instrumental vaginal births, need for oxytocin augmentation, and shortened durations of labor."[11] Doulas are able to provide thoughtful and much-needed care to birthing people by offering personalized support, advocacy, and education value in pregnancy.[12] They offer encouragement, reassurance, comfort and continuous support throughout the labor and delivery process.[13] Doulas also serve as critical advocates for the birthing person, ensuring they are able to make informed decisions about their care and that their voice is heard and respected during labor and delivery.[14] As birthing people in Massachusetts seek out doulas for their birthing journey, we must be prepared to respond. Investment in the development of a well-trained, culturally competent doula workforce will ultimately enhance both the access to and quality of care for birthing people.

Updating the regulatory framework governing birth centers.
We applaud the Department of Public Health's recent report on access to maternal health services, in which the department committed to updating the birth center regulations to better align with national standards set by the American Association of Birth Centers. Building on the momentum of this commitment, the legislature should codify such changes and further update our regulatory framework to ensure Massachusetts is no longer an outlier in birth center access.

We recognize how the US broadly has adopted a highly medicalized model for delivering maternal care. This model fails to serve our patients and strains our provision of care because it shifts our understanding of pregnancy as natural and normal, to something that always demands medical attention and a high level of intervention. Although some pregnancies do require medical intervention, research from the Racial Inequities in Maternal Health Commission Report found that while "98% of all births take place in a hospital, […] most births are low risk" and "can safely take place outside of the hospital."[15] Indeed, demand for out-of-hospital birth options has also increased within Massachusetts, with the highest increases among Black birthing people.[16]

[10] 130 CMR 463.000: Doula Services
[11] Kenneth Gruber et al., "Impact of Doulas on Healthy Birth Outcomes," The Journal of Perinatal Education: Advancing Natural Birth (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647727/
[12] Taylor A. Sobczak et al., "The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review," 15 Cureus 5 (May 24, 2023) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292163/
[13] *Id.*
[14] Laure C. Zephyrin et al., "Community-Based Models to Improve Maternal Health Outcomes and Promote Health Equity," The Commonwealth Fund (Mar. 4, 2021) https://www.commonwealthfund.org/publications/issue-briefs/2021/mar/community-models-improve-maternal-outcomes-equity
[15] "Report of the Special Commission on Racial Inequities in Maternal Health" Commonwealth of Massachusetts (May 2022) https://archives.lib.state.ma.us/server/api/core/bitstreams/fc82fc6f-9791-4c87-af6d-6bff93de072f/content
[16] *Id.*

Yet, cumbersome regulatory requirements needlessly limit the availability and development of freestanding birth centers. Furthermore, despite having some of the best hospitals and health care options in the country, Massachusetts lags in maternity care options for its residents, falling within the bottom third of states for birth center access in the US.[17] As of June 2022, we only have one remaining independent birthing center in the state, which is located in the western region of Massachusetts.[18] As such, it remains highly inaccessible to the majority of residents within the Commonwealth. Historically, we are also one of the only states with incredibly stringent regulations for birthing centers, classifying them within our regulatory framework as outpatient surgical units.[19] However, birth centers do not perform surgeries. Research demonstrates how birth centers reduce the number of interventions used during labor and delivery, while simultaneously lowering costs and improving the patient experience.[20]

It is imperative we follow the evidence and recommendations found in the 2021 Report on Midwifery from the Massachusetts Health Policy Commission,[21] the 2022 Report of the Massachusetts Commission on Racial Inequities in Maternal Health,[22] and the 2023 Review of Maternal Health Services from the Massachusetts Department of Public Health.[23] These recommendations offer clear rules around autonomy, patient transfers, coordination of care, and clinical qualifications which will create an environment for birth centers to flourish. Additional legislative support for these changes and the ability to operationalize recent recommendations will help reduce the number of regulatory barriers birth centers face when opening or scaling up operations, thus providing birthing people with greater choice determining what birthing environment is right for them.

Eliminating the mandatory reporting requirement for neonatal opioid withdrawal syndrome.

It is essential the legislature act to remove the mandatory reporting requirement for neonatal opioid withdrawal syndrome. State law currently requires health care providers to report any person for suspected abuse or neglect to the Department of Children and Families ("DCF") when they give birth to a baby exposed to a substance designated as an "addictive drug" prenatally.[24] However, this list includes substances such as methadone and buprenorphine, both of which are FDA-approved and commonly prescribed in the treatment of opioid use disorder ("OUD").[25] In effect, this inadvertently requires health care providers to report pregnant people who are actively pursuing evidence-based, physician-recommended treatment for OUD for abuse and neglect and may result in pregnant people choosing to discontinue or not pursue effective treatment during pregnancy due to the fear of mandatory reporting and family separation.

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[17] *Id.* at 16 (Based on data from the American Association of Birth Centers)
[18] Kay Lazar, "Another assault on women's rights: Last birth center in Eastern Massachusetts to close," The Boston Globe (June 15, 2022) https://www.bostonglobe.com/2022/06/13/metro/cuts-maternal-health-services-ignite-protests/
[19] 105 CMR 142.00: Operation and maintenance of birth centers
[20] Massachusetts Public Health Commission, "Research Report: Certified Nurse Midwives and Maternity Care in Massachusetts" (Jan. 2022) https://www.mass.gov/doc/certified-nurse-midwives-and-maternity-care-in-massachusetts-chartpack-1/download ("Birth centers can offer a more patient-centric, lower-intervention model of care, with care led by CNMs.")
[21] 2021 Report on Midwifery from the Massachusetts Health Policy Commission https://www.mass.gov/doc/certified-nurse-midwives-and-maternity-care-in-massachusetts-1062021/download
[22] 2022 Report on Certified Nurse Midwives and Maternity Care in Massachusetts https://www.mass.gov/doc/certified-nurse-midwives-and-maternity-care-in-massachusetts-chartpack-1/download
[23] 2023 Review of Maternal Health Services, https://www.mass.gov/doc/maternal-health-report/download
[24] Massachusetts General Laws Chapter 94C, Section 34A
[25] Caitlin White, "Mandatory Reporting Law is Harmful for Pregnant People with Substance Use Disorder," HealthCity (Jun. 28, 2021) https://healthcity.bmc.org/policy-and-industry/mandatory-reporting-law-harmful-pregnant-people-sud

The law also disproportionately affects Black people and does not independently signal child abuse or neglect.[26] We applaud Massachusetts General Brigham's recent decision to no longer immediately report to DCF when a baby is born with addictive drugs in its system.[27] The hospital system committed to revamping its policies to standardize an approach to toxicology testing and ensuring people are not reported unless there are other concerns the baby is abused or neglected. We encourage such changes and recommend eliminating the mandatory reporting clause of state law to allow pregnant people to access optimal prenatal medical treatment, which will ideally ensure the best possible birth outcomes.

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We are grateful for the thoughtful leadership of the Massachusetts Legislature to ensure our Commonwealth provides its residents with highest quality of health care. We believe this opportunity to further rise to the occasion is critical to lead Massachusetts into a future where reproductive justice is a reality for all birthing people. By breaking down barriers to pregnancy related care and investing in critical workforce and resource expansion, we can advance policies that protect and enhance access to maternal health care services.

Thank you very much for your consideration of these recommendations. If you have any questions, please do not hesitate to contact Lisa Sears, Assistant Attorney General and Senior Policy Advisor, at 617-963-2056.

The Attorney General's Office stands ready to partner with you in these legislative efforts.

Sincerely,

Sapna Khatri
Director, Reproductive Justice Unit
Massachusetts Office of the Attorney General

cc:
The Honorable Karen Spilka
The Honorable Ronald Mariano
The Honorable Michael Rodrigues
The Honorable Aaron Michlewitz
The Honorable Julian Cyr
The Honorable Marjorie Decker

[26] Molly Farrar, "These Massachusetts hospitals won't automatically file neglect reports for babies born with drugs in their systems," Boston.com (April 12, 2024) https://www.boston.com/news/local-news/2024/04/02/these-massachusetts-hospitals-wont-automatically-file-neglect-reports-for-babies-born-with-drugs-in-their-systems/
[27] *Id.*