

MEETING MINUTES
MATERNAL HEALTH ACCESS AND BIRTHING PATIENT SAFETY
TASK FORCE

OCTOBER 8, 2025

CO-CHAIRLED BY THE MASSACHUSETTS HEALTH POLICY COMMISSION AND
DEPARTMENT OF PUBLIC HEALTH

Date of Meeting: **October 8, 2025**
Start Time: **11:00 AM**
End Time: **1:00 PM**

Maternal Health Task Force Member	Present?	Vote: Approval of Minutes June 24, 2025
Dr. Cristina Alonso, Co-Chair	X	X
David Seltz, Co-Chair	X	ab
Nashira Baril	X	X
Amy Gagnon	X	X
Dr. Godwin Osei-Poku	X	X
Dr. Christin Price	X	X
Dr. Sara Shields	X	2nd
Leigh Simons	X	M
Dr. Huong Trieu	X	X
Summary	Nine members attended	Approved with eight votes in the affirmative

Presented below is a summary of the meeting, including timekeeping, attendance, and votes.

(M): Made Motion; (2nd): Seconded Motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A meeting of the Maternal Health Access and Birthing Patient Safety Task Force (MHTF) was held on October 8, 2025, from 11:00 AM to 1:00 PM virtually on Zoom. A recording of the meeting and the meeting materials are available on the Health Policy Commission's (HPC) [website](#).

Participating task force members who attended virtually were David Seltz (Co-Chair), Dr. Cristina Alonso (Co-Chair), Nashira Baril, Dr. Godwin Osei-Poku, Amy Gagnon, Dr. Christin Price, Dr. Sara Shields, Leigh Simons, and Dr. Huong Trieu.

ITEM 1: Welcome by Co-Chairs

Co-Chair Dr. Cristina Alonso began the meeting by welcoming the task force members, staff, and members of the public viewing the meeting on the livestream. She thanked all stakeholders and task force members in assisting in collecting the data and contacts needed to complete the work required of the task force. She shared an update on the timeline of the task force, acknowledging that the enabling legislation called for a deadline of September 1, 2025, and the task force is behind this schedule. She shared that the task force is prioritizing producing a comprehensive report and will continue to be transparent about the publication timeline as it completes its work.

Co-Chair David Seltz additionally welcomed members and addressed how recent federal policy changes will impact maternal health care access in Massachusetts and across the country. He highlighted the legislative reform in Massachusetts that will protect and expand access to maternal health care across the Commonwealth, including establishing the Maternal Health Task Force. Mr. Seltz outlined the agenda for the meeting.

ITEM 2: Approval of Minutes

A roll call vote was taken to approve the minutes of the June 24, 2025, MHTF meeting. Leigh Simons made the motion to approve the minutes, and Dr. Sara Shields seconded it. The motion was approved.

ITEM 3: Task Force Legislative Mandate and Overview of the HPC Office of Health Resource Planning

Mr. Seltz presented an overview of the task force's legislative mandate pursuant to Chapter 186 of the Acts of 2024, including studying past essential service closures of inpatient maternity units and acute-level birth centers and community-based preventive maternal health care, patient quality and safety considerations of these closures, and demographic information of the Massachusetts birthing population.

Mr. Seltz briefly shared an overview of the HPC Office of Health Resource Planning (OHRP), which supports the analytic work of the task force. Mr. Seltz outlined the enabling statute and mandate of OHRP and how its charge aligns with the work of the task force.

ITEM 4: HPC Staff Presentation: Maternal Health Task Force Report Update

Kara Vidal, Director of OHRP, opened the staff presentation with an overview of Chapters 1 through 3 of the MHTF report. Ms. Vidal then presented preliminary findings from Chapter 1: Overview of Massachusetts Births and Birthing People, including an overview of the task force's findings on births, birthing people, and disparities in maternal health care in Massachusetts. For more information, see slides 13 – 15.

Charlotte Burlingame presented an overview of C-section rates and disparities in Massachusetts. For more information, see slides 16 – 21.

Dr. Christin Price emphasized that this data is important as DPH works to promulgate the regulations on and messaging around Levels of Maternal Care and use of risk-accordant care.

Dr. Sara Shields asked if these trends are mirrored nationally, as other states, like California, have implemented policies to address low-risk C-section rates.

Dr. Huong Trieu asked if the data was broken down by hospital system to review system-level trends. Ms. Burlingame shared that the data was analyzed by hospital cohort but not system. Dr. Trieu also asked if C-section rates will be addressed in the task force's qualitative work to better understand if trends are driven by patient choice or provider practices.

Ms. Vidal closed the presentation on Chapter 1 with an overview of birthing patient preferences and shared that there was a gap in the data for Massachusetts-specific studies of birthing patient preferences. For more information, see slide 22.

Dr. Godwin Osei-Poku asked if HPC staff looked into how reimbursement rates influenced C-section practices. Ms. Burlingame shared that a study conducted outside Massachusetts showed that higher reimbursements for C-sections may play a role in delivery choice. Dr. Osei-Poku also asked if the demographics of birthing patients were further broken down by both race/ethnicity and insurance status to determine if race/ethnicity or insurer type is more likely to drive disparities in outcomes.

Leigh Simons asked what the five percent of "other" payers in the payer mix of births in Massachusetts referred to. She also asked if data shows the types of Medicaid plans people are enrolled in, as incoming federal policy changes may impact different types of Medicaid plans and programs differently. Ms. Vidal shared that the five percent reflected self-pay and small number of births covered by Medicare. Ms. Vidal also shared that OHRP will look into the ability to break Medicaid payments down by plan type.

Dr. Shields asked if birth data are available through 2024, as the C-section data was. Ms. Vidal shared that OHRP prioritized using the same data source for each comparison, and many sources are only current through 2022.

Dr. Trieu asked if anything was found in the clinical profile of Black birthing patients to explain the higher C-section rates. Ms. Burlingame shared that Black birthing patients were slightly more likely to have eclampsia and pre-eclampsia but not enough to explain the variation in C-section rates. She

added that hospital discharge data does not include enough clinical data to account for all possible comorbidities.

Nashira Baril asked if there is data on the types of providers that Black birthing patients have access to, particularly Certified Nurse Midwives (CNMs). Ms. Burlingame shared that the data shows that Black birthing patients have higher rates of births attended by CNMs, but other factors may contribute to access barriers for Black birthing patients.

Dr. Shields asked about the ability to look at induction rates in the data. Ms. Burlingame shared that the data does not show induction.

Dr. Osei-Poku asked about high Black serving hospitals and if there were certain characteristics of these hospitals that could explain the higher C-section rates from Black birthing patients. Ms. Burlingame noted that over half of births to Black patients occurred in five hospitals, and these hospitals do not appear to have significantly increased low-risk C-section rates, health disparities, or fewer midwife resources.

Ms. Vidal continued the staff presentation with Chapter 2. For more information, see slides 25 – 36.

Dr. Osei-Poku asked if there is a reason why patients might pass their nearest hospital and deliver at a further hospital. Ms. Vidal shared that the level of care required for a birth as well as patient preference could lead patients to bypass a closer hospital. Dr. Trieu added that where a patient's OB/GYN has hospital admitting privileges can also drive patient choice in where to deliver, as patients often choose their provider before choosing a hospital to deliver in. She added that insurance networks can also be an explanatory factor.

Ms. Simons asked if there is a way to capture immigration status in the data, as many hospitals have shared experiences with patients who were not able to access prenatal care and ended up requiring a higher level of care when delivering. She asked that federal immigration policies be included in consideration of federal policy changes alongside Medicaid policy changes. Dr. Alonso shared that pregnancy changes a Massachusetts resident's MassHealth eligibility, regardless of immigration status, so it would be difficult to assess immigration status in the data.

Dr. Shields asked if there will be more opportunity for task force members to review the data shared in the meeting, and Mr. Seltz emphasized that there will be ample opportunity after this meeting for members to share feedback on these preliminary findings.

Ms. Burlingame presented findings on the maternal health care workforce. For more information, see slides 38 – 43.

Alexa Paiva presented findings on hospital-based maternity closures in Chapter 3. For more information, see slides 45 – 62.

Dr. Shields asked why Holyoke and Falmouth were selected for the communities to focus on in the qualitative research. Ms. Paiva shared that they were selected because the closures in these communities were relatively recent and seemed to have a larger impact on drive times and potential patient disparities following closure.

Dr. Osei-Poku asked if it's correct to say that there was not a systematic impact of the closures on maternal health care in Massachusetts. Ms. Paiva emphasized that the HPC does not think there was no impact of the closures, but the data did not show impacts on SMM rates, 39-week induction rates, or low-risk C-section rates. She added that there was an impact on drive times and expects to see additional impacts explained in the qualitative data collected from interviews.

Dr. Trieu asked how the specific outcomes measures used in this closure analysis were selected. Ms. Paiva shared that the three outcome measures were informed by a literature review then further constrained by data availability.

Mr. Seltz emphasized that framing of the findings on the impact of closures in the final report will be important..

Dr. Shields asked if there is a way to capture the impact of closures on emergency medical services, as reports have emphasized the increase in ambulance births, particularly in the Leominster area. Ms. Paiva shared that this is a consideration for the qualitative research.

Ms. Simons asked if it would be possible to capture data on drive times and access to pre- and post-natal care. She added that she is interested to see how health care workforce challenges may overlay some of the volume and reimbursement challenges experienced by maternity units highlighted in this meeting. Ms. Vidal shared that OHRP is going to use the HPC's Registration of Provider Organization data on how community-based providers have changed over time as a proxy for access to pre- and post-natal care.

Dr. Trieu asked if the reimbursement rates for births at recipient hospitals and how the influx of new patients could have impacted the average reimbursements were considered. Ms. Paiva and Ms. Vidal shared that this was not analyzed but can be.

Dr. Osei-Poku asked if the analysis of the OB/GYN workforce included a breakdown of maternal-fetal medicine (MFM) providers. Dr. Sasha Albert shared that there was preliminary analysis conducted to assess if there was an over-use of MFMs, and none was found, but the OB/GYN workforce data was not broken down by MFM.

Dr. Shields highlighted that there is variation in the rates of family medicine providers attending births, with the rate at UMass Memorial being close to ten percent. She also asked about data on out-of-hospital births.

Ms. Simons shared that she had a CNM-attended birth, but the hospital in which she gave birth was not included in the list shared in these findings. She asked if the data on CNM-attended births could only include CNMs who are employed by the hospitals.

ITEM 5: Next Steps

Ms. Vidal shared the final work remaining for the task force, including an analysis of freestanding birth centers and office-based maternal health care as well as the qualitative findings.

Mr. Seltz estimated that the task force may meet again in two months to discuss the qualitative findings, with additional meetings to discuss freestanding birth centers, office-based care, and policy recommendations. Publication of a final report is expected for early 2026.

Ms. Simons asked what the process will be for the task force to consider policy recommendations, and Mr. Seltz shared that it will likely include both suggestions from task force members as well as recommendations from the task force co-chairs to be discussed by the full task force at a future meeting.

ITEM 6: Adjourn

The meeting adjourned at 12:52 PM.