Meeting of the Maternal Health Access and Birthing Patient Safety Task Force

December 9, 2025

Agenda

Call to Order

UP NEXT: Approval of Minutes: October 8, 2025 (VOTE)

Task Force Report Overview

HPC Staff Presentation: Preliminary Qualitative Findings

- Drivers and Impacts of Hospital Maternity Unit Closures: 2014 through 2023
- Massachusetts Birth Centers: Challenges and Opportunities

Next Steps and Adjourn

VOTE

Approval of Minutes from the October 8, 2025, Maternal Health Access and Birthing Patient Safety Task Force Meeting

MOTION

That the Maternal Health Access and Birthing Patient Safety Task Force hereby approves the minutes of the meeting held on October 8, 2025, as presented.

Task Force Members

Task Force Co-Chair Cristina Alonso, DrPH, Director of Pregnancy, Infancy and Early Childhood, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health

Task Force Co-Chair Alecia McGregor, PhD, Faculty, Department of Health Policy and Management, Harvard T.H. Chan School of Public Health; Commissioner, Massachusetts Health Policy Commission

Nashira Baril, MPH, Executive Director and Founder, Neighborhood Birth Center

Amy Gagnon, RN, Massachusetts Nurses Association

Godwin Osei-Poku, MD, DrPH, Associate Research Director, Betsy Lehman Center for Patient Safety

Christin Price, MD, Administrative Director, Perinatal Neonatal Quality Improvement Network of Massachusetts

Sara Shields, MD, Chair, Worcester Committee on Maternal and Perinatal Welfare, Massachusetts Medical Society

Leigh Simons, MPH, Senior Director, Healthcare Policy, Massachusetts Health and Hospital Association

Huong Trieu, PhD, Senior Director of Research, Center for Health Information and Analysis

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Maternal Health Task Force Report Outline

0 Introduction

1 Overview of Massachusetts Births and Birthing People

2 Massachusetts Maternity Care Supply and Capacity

3 Hospital Maternity Unit Closures: 2014 through 2023

4 Massachusetts Birth Centers: Challenges and Opportunities

5 Policy Recommendations

Maternal Health Task Force Report Outline

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4 Massachusetts Birth Centers: Challenges and Opportunities

5 Policy Recommendations

Overview of Interviews

- The HPC contracted with JSI to conduct **semi-structured interviews** with subject matter experts and key stakeholders.
- While distinct interview guides were prepared for each type of interviewee, all interviews addressed similar core topics:
  - **Opportunities and challenges** of providing maternity care in hospital and birth centers;
  - **Impacts** of closures on hospitals, other providers, and patients; and
  - Policy recommendations and strategies to **mitigate negative impacts** of closures and **strengthen the maternity care system**.
- **Subject matter expert interviews (3 total):** one academic researcher with hospital maternity services expertise, and two individuals with deep knowledge of birth center operations
- **Key stakeholder interviews (32 total):**
  - Hospital administrative leaders
  - Hospital clinical leaders
  - Birth center leaders and staff
  - Community providers
  - Community-based social service organizations (CBOs)

Key Stakeholder Interview Details

Interviewee Type	Sampling Area	Number of Interviews to Date
Hospital Administrators **(e.g., CMO, COO, CFO)** **and** **Hospital Clinical Leaders** **(e.g., OB/GYN, nurse)**	▪ Statewide ▪ Predominantly community hospitals ▪ Closure and non-closure	▪ 19 total interviews, with: ○ 8 administrators ○ 16 clinical leaders
Community Providers **(CHC, VNA, EMS)**	▪ Falmouth and Holyoke areas	▪ 4 interviews
Community-based Social Service Orgs **(e.g., WIC, DPH Home Visiting Initiative program sites)**		▪ 3 interviews
Birth Center Leaders and Staff **(e.g., CNM, Executive Director)**	▪ Statewide ▪ Open, closed, and pending	▪ 6 interviews, with 8 individuals

Notes on Analytic Methods

- The HPC selected the Falmouth and Holyoke areas for interviews with community providers, EMS, and social service organizations based on:
  - Recent year of closure (2020)
  - Quantitative indications of closure impacts
- JSI conducted the interviews and captured data via notes. De-identified data were shared with the HPC to protect interviewee confidentiality.
- Notes were catalogued and analyzed by interviewee type and topic area to surface key themes.

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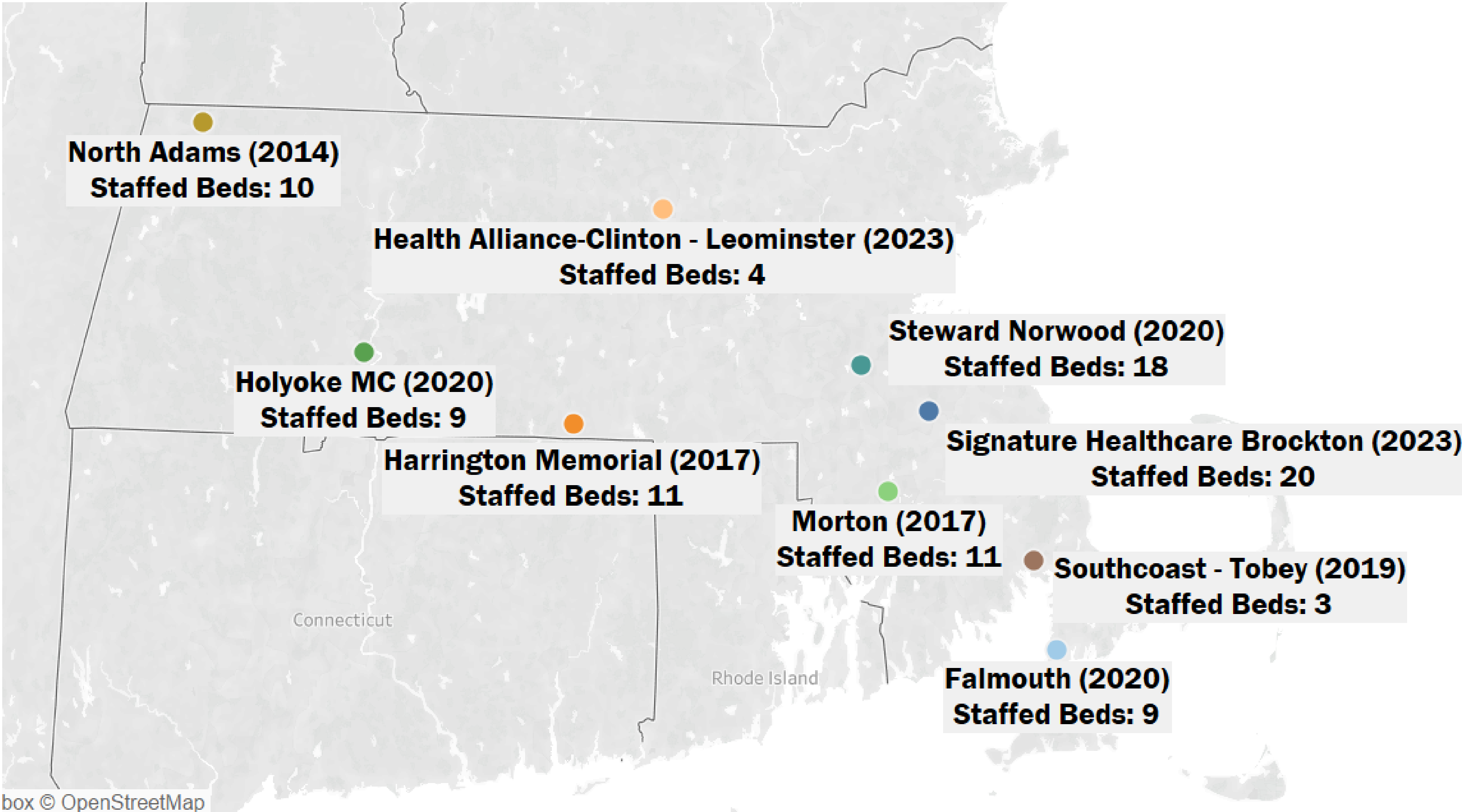
- Massachusetts Birth Centers: Challenges and Opportunities

Next Steps and Adjourn

Massachusetts' Hospital Maternity Unit Closures, 2014 through 2023

Hospital Maternity Unit Closures From 2014-2023



- From 2014 through 2023, there were **nine hospital maternity unit closures**, all of which occurred in **community high public payer hospitals**.
- The nine closures resulted in a reduction of approximately **95 staffed obstetric beds**.
- This section of the report will describe:
  1. **Factors** associated with hospital maternity unit closures;
  2. **Impacts** of hospital maternity unit closures; and
  3. Patient **Displacement** following a hospital maternity unit closure.

Notes: Staffed beds are averaged across the three years prior to closure. The HPC imputed bed counts for the individual Southcoast Hospitals Group campuses, based on the proportion of Southcoast's discharges occurring at each campus, including discharges to out-of-state patients.
Exhibit Sources: HPC analysis of Center for Health Information and Analysis Hospital Cost Reports, 2011-2023.

Factors Associated with Maternity Unit Closures: Summary of HPC Quantitative Findings

Factors

Volume/Occupancy Factors:

- Massachusetts hospitals cited **low volume and declining birth rates** as a driver of closures in their Essential Service Closure (ESC) filings.
- The HPC found that most hospitals that closed maternity services had **fewer total discharges**, and all had **fewer maternity discharges** than community hospitals that did not close maternity services.
- Additionally, most closure hospitals had **lower maternity unit occupancy rates** than their non-closure counterparts.

Financial Factors:

- In their ESC filings, Massachusetts hospitals cited **numerous financial drivers** of closure, including unprofitability of and insufficient reimbursement for maternity services, need for capital investment, and broader financial challenges.
- The HPC's analysis found that hospitals that closed maternity services were generally **lower priced** and received **less revenue per case mix adjusted inpatient discharge** than non-closure hospitals.
- However, closure hospitals generally had **higher margins**.

Payer Mix:

- All nine maternity unit closures occurred in community high public payer hospitals.
- The HPC found that, for the most part, hospitals that closed their maternity service had a **greater share of publicly insured maternity discharges** than other community hospitals.

Key Themes from Interviews: Challenges for Hospital Maternity Units

LOW VOLUME
Declining number of births; difficulty attracting patients

GREATER PATIENT NEED
Increase in patient comorbidities and social needs; decreased access to primary and prenatal care

STAFF RECRUITMENT
Difficulty attracting staff to a lower-volume community hospital

HIGH FIXED COSTS
Staffing, technology, and other requirements to ensure safety and quality

STAFF RETENTION
Burnout; lack of professional support due to small staff

REIMBURSEMENT
Rates insufficient to cover costs for the service line

Notes: These key themes are based on the interviews with subject matter experts, hospital leaders, community providers, and social service organizations. Perspectives on hospital maternity unit challenges offered by birth center leaders were not included in this analysis.

Low Volume of Maternity Patients

Challenges

- Hospital administrators and clinical leaders reported that a low volume of deliveries makes operating a maternity unit very challenging, describing a cascade of related financial, workforce, and quality issues:
  - **Too little revenue** to cover operational costs
  - Capacity to support only a **small number of staff**, making recruitment and retention difficult
  - **Less ability for staff to maintain clinical skills** for high-risk situations
- Interviewees gave estimates ranging from 500 to 1,000 births needed annually to break even, depending on number of beds.
- Some interviewees noted that **volume is variable and unpredictable**, yet hospitals and staff must be prepared at all times to accommodate need.

Interviewees reported a general increase in the level of clinical and social need among their maternity patients.

Challenges

Higher Clinical Acuity

- Greater number of higher risk pregnancies and birthing people with comorbidities
- May require transfer to other hospitals for the most appropriate level of care

Significant Social Needs

- Housing, language, transportation, and financial barriers
- Difficulty staffing the social work and interpretation services needed

Lack of Primary Care

- Significant challenges accessing primary care
- For some populations, lack of awareness or access to prenatal care
- Migrant populations particularly affected due to fear of seeking care

Staff Recruitment and Retention Challenges

Challenges

- Hospital administrators and clinical leaders reported significant challenges attracting and retaining OB/GYNs, nurses, anesthesiologists, and support staff within community hospitals.
- Specific factors cited include:
  - **High salary demands and insurance expenses** for OB/GYNs;
  - **Lack of sufficient training** in skills that would make clinicians more comfortable operating in a low-resource, community hospital setting;
  - **Dedicated L&D nursing staff** that cannot be flexed into other roles; and
  - **Staff burnout** due to frequent on-call responsibilities and a lack of colleagues to provide professional support, especially for complicated pregnancies or deliveries.
- Recruiting to rural areas and for clinicians of color were cited as particularly difficult challenges.
- There was general support for the value of midwifes within a maternity unit, although there were differences of opinion on the ease of recruiting and integrating them.

Financial Challenges Reported by Interviewees

Challenges

High Fixed Costs

- Staffing and overhead, including retaining the required 24/7 staffing coverage (OB/GYNs, midwives, neonatal providers, anesthesiologists, nurses, and support staff), technology, and other facility costs contribute to high fixed costs for maternity units.

Low Reimbursement

- Payment rates are generally lower than needed for hospital maternity units to break even.
- The global obstetric fee is considered inadequate to cover all of the services needed, especially for higher-acuity patients.
- These low reimbursements result in lower or negative margins on maternity services.

Fewer Resources Overall at Community Hospitals

- Difficulty negotiating higher rates for other service lines reduces financial stability of the hospital overall and may make it more challenging to cross-subsidize maternity care.

Impact of Maternity Unit Closures: Summary of HPC Quantitative Findings

Impacts

- To evaluate the impact of hospital maternity unit closures, the HPC assessed the change in certain access and quality measures from the three years prior to closure to the three years following a closure in each closure hospital's maternity service area.
- Overall, Massachusetts residents faced **increased drive times** to their nearest and actual maternity hospital following a closure, reducing access to services.
- The HPC **did not find quantitative evidence** that closures had a **systematic effect** on 39-week induction rates, low-risk C-section rates, or SMM rates.
  - This may have been due, at least in part, to study limitations. For example, the closures in our data affected relatively few maternity patients, so the average changes in maternity service areas are expected to be small.

Measure	Impact
Access: Avg. Drive Time to the Nearest Maternity Hospital	Increased drive time post-closure
Access: Avg. Drive Time to Patients' Actual Maternity Hospital	Increased drive time post-closure
Quality and Care Delivery: 39-Week Induction Rate	*No systematic impact*
Quality and Care Delivery: Low-Risk C-Section Rate	*No systematic impact*
Quality and Care Delivery: SMM Rate	*No systematic impact*

Notes: The HPC adjusted for statewide trends in its analysis of 39-week induction and SMM rates. SMM rates are calculated following the definition from the CDC. Scores presented are for non-transfusion SMM. *See* https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html. The 39-week induction rate is defined as induced deliveries (i.e., with ICD procedure codes 3E033VJ, 3E0P7GC, 0U7C7ZZ, 0U7C7DZ, or 734) at 39 weeks gestation per 100 women delivering at gestational ages 39 weeks or higher. Induction rates are not defined prior to the change from ICD-9 to ICD-10 codes in 2016. SMM and 39-week induction rates are defined this way in all subsequent analyses in this presentation unless otherwise stated.

Key Themes from Interviews: Impacts of Maternity Unit Closures

Impacts

Financial

- Improvements for closure and some neighboring hospitals

Access and Care Delivery

- Travel time challenges and disruptions to the continuity of care

Community and Staff

- Damage to hospital reputation within community and staff morale

Financial Impacts Associated with Maternity Unit Closures

Impacts

- Some hospital leaders highlighted that closures led to:
  - Greater overall **financial stability** for the hospital, and
  - Ability to repurpose the space and **invest in other services** that may be of high need in the community (e.g., behavioral health).
- After a nearby closure, some leaders in **non-closure hospitals reported improvements** in their:
  - Patient volume,
  - Ability to recruit well-qualified clinical staff, or
  - Maternity unit finances.

Access and Care Delivery Impacts Associated with Maternity Unit Closures

Impacts

- Interviewees from all groups noted that closures can **reduce patients' opportunity to receive care in their local community** and **increase their travel time**.
  - This was noted as a particular challenge for lower-income individuals and those in rural areas.
  - Interviewees expressed concerns regarding access to appropriate prenatal and postpartum care, as well as safety concerns around delivery.
  - Pressure on CBOs providing social services in the prenatal and postpartum periods increased.
- Some clinicians described a **fragmentation of clinical care** as another issue associated with closure, particularly for patients coming in for delivery without a history of care or records within the hospital or its affiliated providers.
- Other hospital leaders expressed that closures led patients toward other sites of care with the same or better **quality of care** and/or overall resources, including more robust staffing.

Community and Staff Impacts Associated with Maternity Unit Closures

Impacts

- **Damage to providers' relationships with their community** was frequently cited by hospital administrators and clinical leaders as a key negative impact of closure.
- Also noted were **staffing disruptions** and **decreased morale** among staff due to layoffs and/or loss of team cohesion and institutional knowledge.

Patient Perspectives on Maternity Unit Closures

Impacts

CORE CONCERNS IN PUBLIC HEARING TESTIMONY

- Increased **drive time** to other sites of care
- **Limited public transit** to other sites of care
- Reduced access for people with specific **language needs**
- Reduced access for **at-risk/underserved populations**
- Reduced access to **prenatal care**
- Reduced access to **postpartum care**
- Reduced access to a **specific care model**/workforce type
- **Increased risk** of poor outcomes/safety
- **Stress/trauma** for birthing person and family
- **Strain on EMS**/other providers
- **Economic/population loss** for the community

- The HPC reviewed the **Essential Service Closure public hearing transcripts** for seven of the nine hospital maternity unit closures[1] being analyzed for this report and for the closure of North Shore Birth Center, licensed under Beverly Hospital.
- Many **patients** gave testimony at these hearings, along with elected officials, medical staff, community leaders, and others.
- The HPC **catalogued the concerns** enumerated by patients at these hearings and identified 11 core themes.

[1] No transcripts were available for the closures of North Adams and Signature Healthcare Brockton.

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Next Steps and Adjourn

Locations of Past, Current, and Future Massachusetts Birth Centers

Massachusetts Birth Centers, 2011-Present

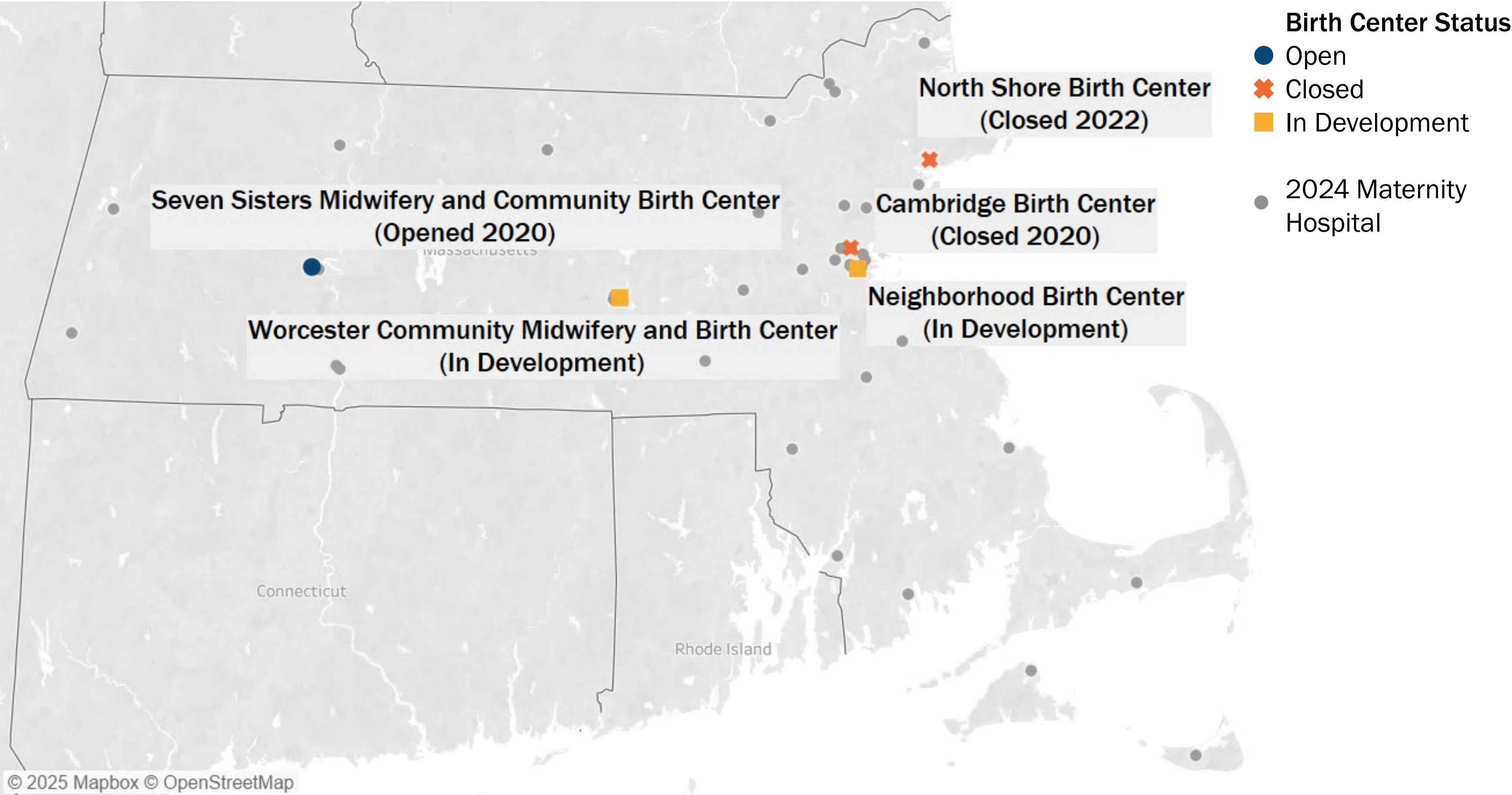
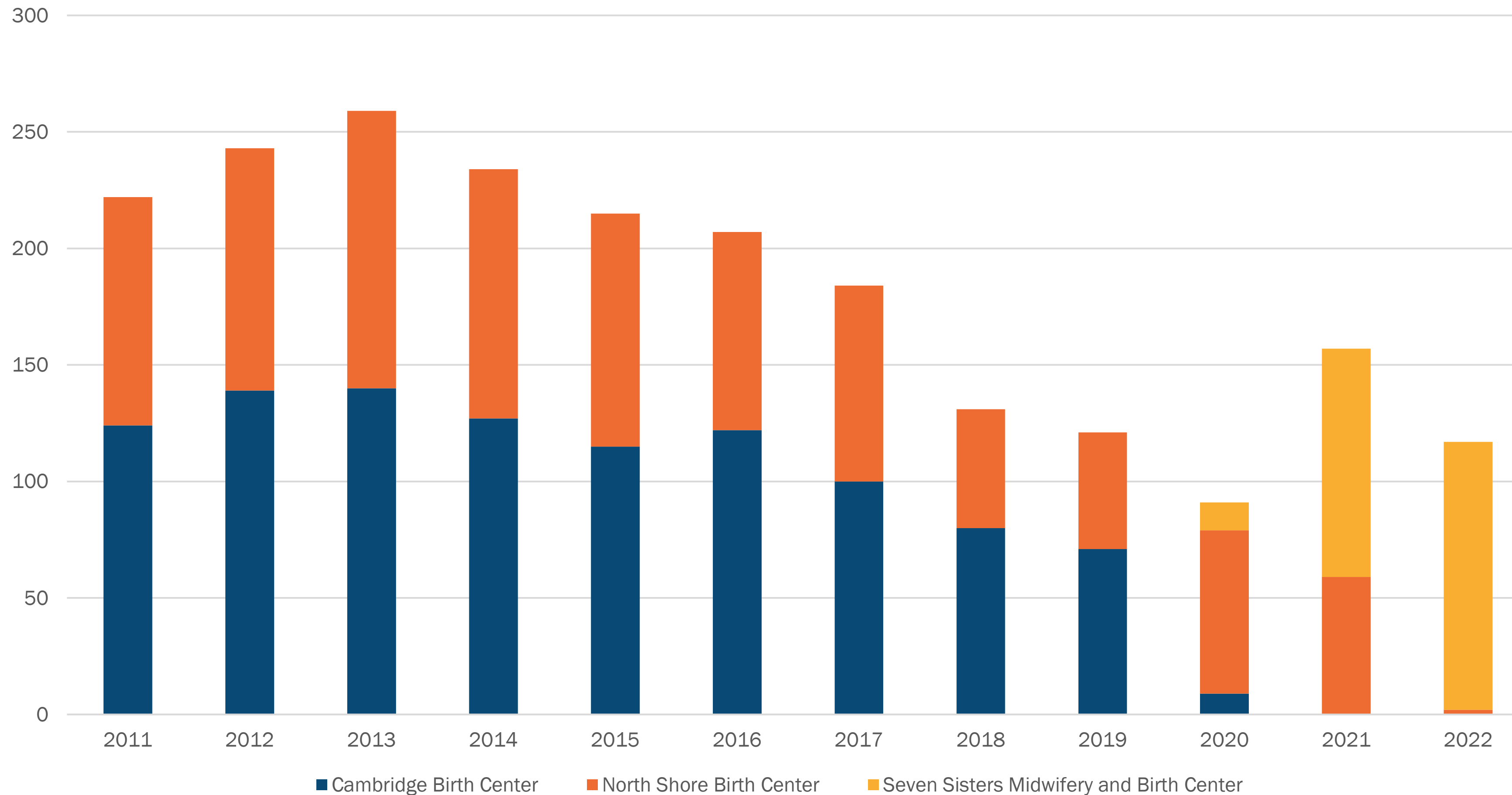


Exhibit Sources: Bay State Birth Coalition. Birth Centers in Massachusetts. Available at: https://baystatebirth.org/birth-centers; Neighborhood Birth Center. Property Design. Available at: https://neighborhoodbirthcenter.org/property; City of Worcester Planning Board. 333 Shrewsbury St & 68 Chilmark St (PB-2025-070) Application Materials. Available at: https://worcesterma.primegov.com/Search/ItemSearch?searchItemId=37084; Seven Sisters Midwifery & Community Birth Center. About Us. Available at: https://sevensistersmidwifery.com/about.
Text Sources: 1. Claflin H. Two years after the closure of Leominster's maternity unit, a region is struggling. Commonwealth Beacon. September 4, 2025. Available at: https://commonwealthbeacon.org/health-care/two-years-after-the-closure-of-leominsters-maternity-unit-a-region-is-struggling/.; 2. Bay State Birth Coalition. Birth Centers in Massachusetts. Available at: https://baystatebirth.org/birth-centers.

- There is currently **one birth center open in Massachusetts**. In September 2025, it had an eight-month waiting list.[1]
- **Two birth centers closed since 2020**, though Cambridge Birth Center was renovated and has reopened for prenatal care, with plans to reopen for deliveries.[2]
- **Two birth centers are in development:** Neighborhood Birth Center, hoping to break ground in 2026, and Worcester Community Midwifery, permits were conditionally approved in October 2025.
- Two additional birth centers are in the **early planning stages**: a Worcester-based home birth service with a physical location in Westminster and a New Hampshire-based birth services organization with a location in Central Massachusetts.[2]

Annual Massachusetts Birth Center Births



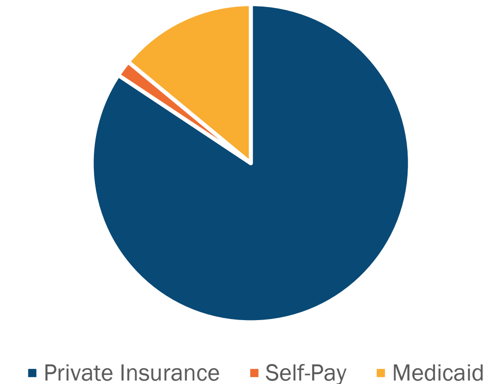
Notes: Includes births to non-Massachusetts residents.
Exhibit Sources: Mass. Department of Public Health. Massachusetts Births 2011-2022. Available at: https://www.mass.gov/lists/annual-massachusetts-birth-reports.
Text Sources: 1. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2007-2024. Available at: http://wonder.cdc.gov/.

- Birth center births rose in the early 2010s, peaking at more than 250 in 2013 before falling to less than 100 in 2020 as Cambridge Birth Center closed.
- The birth volume at Seven Sisters in 2022 was nearly equal to the combined volume at Cambridge and North Shore in 2019.
- Some MA residents may be giving birth at birth centers outside the state; there were 140 births to MA residents at birth centers in 2022[1] compared to 117 total births at North Shore and Seven Sisters.

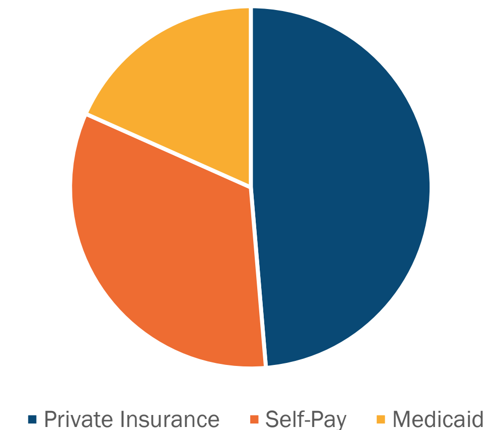
Massachusetts vs. National Trends in Birth Center Births

- In 2022, there were approximately **24,000 births in U.S. birth centers**, accounting for 0.65% of all U.S. births.[1]
- According to the American Association of Birth Centers:[2]
  - Birth center births **grew 65%** from 2011–2021.
  - As of 2022, there were **400 birth centers** across 40 states and the District of Columbia.
- Research using 2017 U.S. birth data showed that the **national rate of births in birth centers (0.52%) was almost double the MA rate (0.27%).**[3]
- The same study found that **MA birth center births were primarily paid for by private insurance**. A smaller percentage of MA birth center births were self-paid compared to the national average (see charts at right).

Massachusetts Birth Center Payer Mix, 2017



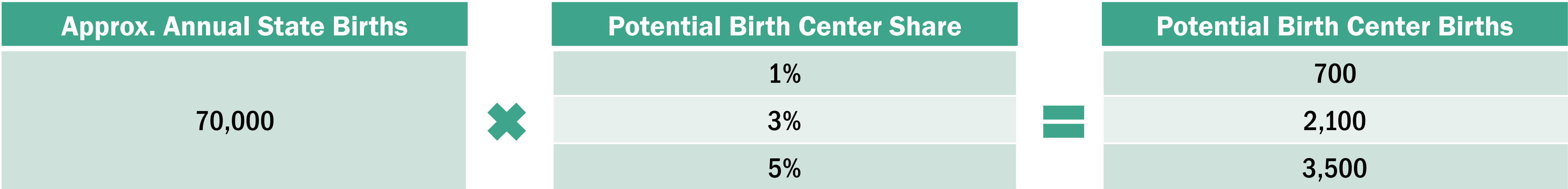
US Birth Center Payer Mix, 2017



Text Sources: 1. Martin JA, Hamilton BE., Osterman MJK., & Valenzuela CP. 2024. Births: Final Data for 2022. National Vital Statistics Reports, 73(2), 1–39. Centers for Disease Control and Prevention. 2. American Association of Birth Centers, https://www.birthcenters.org/birth-centers-are-growing. 3. MacDorman M, Declercq E. Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017. Birth. 2018. 46(2):279–28. https://doi.org/10.1111/birt.12411

Estimated Upcoming Birth Center Capacity

Birth Center	Beds	Projected Annual Birth Capacity	Total Birth Capacity
Seven Sisters Midwifery and Birth Center	2	180	1,130
Cambridge Birth Center	3	300	
Neighborhood Birth Center	4	300	
Worcester Community Midwifery and Birth Center	4	350	



Approx. Annual State Births		Potential Birth Center Share		Potential Birth Center Births
70,000	×	1%	=	700
		3%		2,100
		5%		3,500

Sources: Conversations with Nashira Baril, Executive Director and Founder, Neighborhood Birth Center and Dr. Cristina Alonso, Director of Pregnancy, Infancy and Early Childhood, Bureau of Family Health and Nutrition, Massachusetts Department of Public Health; Schoenberg S. Hoping to deliver at a Massachusetts birth center? Good luck. Commonwealth Beacon: November 20, 2022. Available at: https://commonwealthbeacon.org/health-care/hoping-to-deliver-at-a-massachusetts-birth-center-good-luck/.

National Literature on Midwifery Care and Birth Center Outcomes

- Research has found that increased use of midwifery care is associated with **improved patient and newborn outcomes and lower spending.**[1-8]
- Research has also found that birth center births specifically are associated with:
  - Lower rates of C-sections, assisted births, and episiotomy;
  - Decreased use of pharmacologic pain relief;
  - Decreased use of oxytocin; and
  - Higher patient satisfaction.[9]
- Additionally, birth center prenatal care is associated with **lower rates of low birth weight and lower rates of preterm birth.**[10]

Text Sources: 1. Altman MR, Murphy SM, Fitzgerald CE, Andersen HF, Daratha KB. The Cost of Nurse-Midwifery Care: Use of Interventions, Resources, and Associated Costs in the Hospital Setting. Women's Health Issues. 2017; 27(4):434-440. https://doi.org/10.1016/j.whi.2017.01.002; 2. Attanasio LB, Alarid-Escudero F, Kozhimannil KB. Midwife-led care and obstetrician-led care for low-risk pregnancies: A cost comparison. Birth. 2019; 47(1):57-66. https://doi.org/10.1111/birt.12464; 3. Carlson NS, Corwin EJ, Lowe NK. Labor Intervention and Outcomes in Women Who Are Nulliparous and Obese: Comparison of Nurse-Midwife to Obstetrician Intrapartum Care. Journal of Midwifery & Women's Health. 2017; 62(1):29-39. https://doi.org/10.1111/jmwh.12579; 4. Hamlin L, Grunwald L, Sturdivant RX, Koehlmoos TP. Comparison of Nurse-Midwife and Physician Birth Outcomes in the Military Health System. Policy, Politics, & Nursing Practice. 2021; 22(2): 105-113. https://doi.org/10.1177/1527154421994071; 5. Johantgen M, Fountain L, Zangaro G, Newhouse R, Stanik-Hutt J, White K. Comparison of Labor and Delivery Care Provided by Certified Nurse-Midwives and Physicians: A Systematic Review, 1990 to 2008. Women's Health Issues. 2012; 22(1): e73-e81. https://doi.org/10.1016/j.whi.2011.06.005; 6. Repke JT. Comment on McLachlan HL, Forster DA, Davey MA, Farrell T, Gold L, Biro MA, Albers L, Flood M, Oats J, Waldenstro¨m U. Effects of Continuity of Care by a Primary Midwife (Caseload Midwifery) on Cesarean Section Rates in Women of Low Obstetric Risk: The COSMOS Randomized Controlled Trial. Obstetric Anesthesia Digest. 2014; 34(1):39-40.; 7. Newhouse RP, Stanik-Hutt J, White KM, Johantgen M, Bass EB, Zangaro G, Wilson RF, Fountain L, Steinwachs DM, Heindel L, Weiner JP. Advanced practice nurse outcomes 1990-2008: a systematic review. Nursing Economics. 2011; 29(5):230-250. https://pubmed.ncbi.nlm.nih.gov/22372080/; 8. Vedam S, Stoll K, MacDorman M, Declercq E, Cramer R, Cheyney M, Fisher T, Butt E, Yang YT, Kennedy HP. Mapping integration of midwives across the United States: Impact on access, equity, and outcomes. PLoS ONE. 2018;13(2): e0192523. https://doi.org/10.1371/journal.pone.0192523; 9. Alliman J, Phillippi JC. Maternal Outcomes in Birth Centers: An Integrative Review of the Literature. Journal of Midwifery & Women's Health. 2016. 61(1):21-51. https://doi.org/10.1111/jmwh.12356. 10. Dubay H, Hill I, Blavin F, Johnston E, Howell E, Morgan J, Courtot B, Benatar S, Cross-Barnet C. Improving Birth Outcomes And Lowering Costs For Women On Medicaid: Impacts Of 'Strong Start For Mothers And Newborns'. Health Affairs. 2020. 39(6). https://doi.org/10.1377/hlthaff.2019.01042

Assessment of the National Literature: Birth Center Startup Challenges

Licensure Burden

- State and local licensure laws as well as credentialing and licensing fees can become **barriers for birth centers to open.**[1]
- Birth centers, which are often in home-like environments, may require **significant upfront costs** to ensure that the facility meets state requirements.[2]

Massachusetts Policy Changes Easing Licensure Burdens

- DPH has modernized freestanding birth center licensure regulations following the passage of ***An Act promoting access to midwifery care and out-of-hospital birth options*** in August 2024, including:[3]
  - Eliminating the requirement that birth centers be under the supervision of nearby hospitals;
  - Updating staffing standards to no longer require directors to be licensed CNMs or physicians; and
  - Eliminating the requirement that birth center staff be available on-premises 24/7 through an allowance for remote, on-call staffing during off hours.

Text Sources: 1. Courtot B, Hill I, Cross-Barnet C, Markell J. Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care. The Milbank Quarterly. 2020. 98(4):1091–1113. https://doi.org/10.1111/1468-0009.12473. 2. Ofrane RH, Rokicki S, Kantor L, Blumenfeld J. Financial Barriers to Expanded Birth Center Access in New Jersey: A Qualitative Thematic Analysis. Journal of Midwifery & Women's Health. 2025. 70(3):494–501. https://doi.org/10.1111/jmwh.13732. 3 Massachusetts General Law, Chapter 186 of the Acts of 2024. https://malegislature.gov/Bills/193/H4785;

Assessment of the National Literature: Birth Center Operational Challenges

Time and resource intensive model

- The midwifery model of care utilized by birth centers involves prenatal visits that may be **three to four times longer** than traditional visits and have a focus on patient education and other supports.[1]

Workforce

- There is **low supply of midwives**, particularly people of color, available to staff birth centers.[2]
- Maintaining a steady birth center workforce may be challenging given that the **median salary for nurse midwives in birth centers is lower** than median salary for nurse midwives and NPs in all settings.[3]
  - The same study found that nurse midwives working at midwife-owned practices have lower average salaries that those working at physician-owned practices.

Massachusetts Policy Changes Easing Operational Challenges

- Creation of the Board of Registration in Midwifery and a **licensure pathway for certified professional midwives** (CPMs)
- Creation of a **licensure pathway for lactation consultants**

Text Sources: 1 . Wallace J, Hoehn-Velasco L, Tilden E, Dowd BE, Calvin S, Jolles DR, Wright J, Stapleton S. An alternative model of maternity care for low-risk birth: Maternal and neonatal outcomes utilizing the midwifery-based birth center model. Health Services Research. 2023. 59(1). https://doi.org/10.1111/1475-6773.14222. 2. Ofrane RH, Rokicki S, Kantor L, Blumenfeld J. Financial Barriers to Expanded Birth Center Access in New Jersey: A Qualitative Thematic Analysis. Journal of Midwifery & Women's Health. 2025. 70(3):494–501. https://doi.org/10.1111/jmwh.13732. 3. Ross L, Jolles D, Hoehn-Velasco L, Wright J, Bauer K, Stapleton S. Salary and Workload of Midwives Across Birth Center Practice Types and State Regulatory Structures. Journal of Midwifery & Women's Health. 2022. 67(2):244-250. https://doi.org/10.1111/jmwh.13331.

Assessment of the National Literature: Birth Center Reimbursement Challenges

Low reimbursement rates

- The average facility fees at birth centers are **less than half those of hospitals.**[1] Birth centers have limited negotiating power with payers compared to hospitals.[2]
  - Medicaid reimbursement in particular has been cited as having low reimbursement rates. Some birth centers choose not to contract with Medicaid due to the low rates.[3]

Cost of providing intensive care

- **Global payments** for maternity care do not always account for the more intensive care, including longer appointment times, for patients receiving care at birth centers.[2]
- Many of the **additional services offered at birth centers** that align with the midwifery model of care, such as lactation support and childbirth education, are not reimbursed by all payers.[2]

Massachusetts Policy Changes Easing Reimbursement Challenges

- MassHealth began offering **coverage of doula services** in spring 2024 as well as coverage for CPM services following implementation of Chapter 186 of the Acts of 2024.
- Chapter 186 mandates MassHealth **reimbursement for CNMs at parity with OB/GYN** reimbursement for the same care.

Text Sources: 1.Ross L, Jolles D, Hoehn-Velasco L, Wright J, Bauer K, Stapleton S. Salary and Workload of Midwives Across Birth Center Practice Types and State Regulatory Structures. Journal of Midwifery & Women's Health. 2022. 67(2):244-250. https://doi.org/10.1111/jmwh.13331. 2. Courtot B, Hill I, Cross-Barnet C, Markell J. Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care. The Milbank Quarterly. 2020. 98(4):1091–1113. https://doi.org/10.1111/1468-0009.12473. 3. Ofrane RH, Rokicki S, Kantor L, Blumenfeld J. Financial Barriers to Expanded Birth Center Access in New Jersey: A Qualitative Thematic Analysis. Journal of Midwifery & Women's Health. 2025. 70(3):494–501. https://doi.org/10.1111/jmwh.13732.

Assessment of the National Literature: Birth Center Sustainability Challenges

Transfers to hospitals and payment reductions

- In the event of a transfer to a hospital during labor, birth centers may see a **reduction in their reimbursement**, which can be challenging given the resources they may have already invested prior to the transfer.[2]

Low patient demand

- There are **mixed perspectives** on whether birth centers have significant patient demand for services. Birth centers may struggle with marketing their services. Some patients also have concerns about birth center safety compared to hospitals.[3]

Text Sources2. Courtot B, Hill I, Cross-Barnet C, Markell J. Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care. The Milbank Quarterly. 2020. 98(4):1091–1113. https://doi.org/10.1111/1468-0009.12473. 3. Ofrane RH, Rokicki S, Kantor L, Blumenfeld J. Financial Barriers to Expanded Birth Center Access in New Jersey: A Qualitative Thematic Analysis. Journal of Midwifery & Women's Health. 2025. 70(3):494–501. https://doi.org/10.1111/jmwh.13732.

Key Themes from Interviews: Challenges for Birth Centers

FINANCIAL STRAIN
High start-up and fixed costs; insufficient payment rates

INSURANCE AND REIMBURSEMENT BARRIERS
Complex, inconsistent policies and processes

STAFF BURDEN
Small teams with heavy workloads and on-call responsibilities

INFLUENCE WITHIN HOSPITALS
Limited influence on institutional funding, strategic priorities

STAFF RETENTION
Pay gaps with hospitals for nurses and midwives

POLICY RECOGNITION
Limited public visibility, investment, inclusion in state planning

Financial, Insurance, and Reimbursement Challenges for Birth Centers

Challenges

Birth center leaders indicated that the **funding required to start a birth center** is nearly prohibitive, reporting:

- Building or renovating a facility to meet standards is costly;
- Only birth centers that manage major fundraising or are owned by a hospital can open; and
- The costs of insurance, supplies, and other requirements then pose an ongoing challenge.

Interviewees reported that **neither the facility nor the provider portion of the payment rates is sufficient** to cover costs, and that global payments disadvantage the birth center model of care.

- While MassHealth was cited as generally paying more than commercial payers, interviewees still indicated rates were inadequate.
- Lack of pay parity for midwives was also cited as a challenge, especially under commercial contracts.

Other reimbursement challenges cited included **claim denials, slow payments, and administrative complexities** that disrupted cash flow.

Staff Burden and Retention Challenges Reported by Birth Centers

Challenges

Lower Compensation

- A pay gap exists with hospitals for midwives and nurses.
- Birth centers may not be able to provide benefits to employees.
- Staff often work additional jobs outside the birth center.

Unsustainable Demands on Staff

- Limited staffing leads to long hours and near constant on-call responsibilities.

Training Appropriate for the Setting

- Birth centers face difficulty finding staff with training appropriate for non -hospital settings.
- CPMs are more likely than CNMs to have these qualifications, but the process for CPM licensure is moving slowly in Massachusetts.

Birth center leaders described challenges related to the dominance of the hospital model of maternity care.

Challenges

- For **hospital-affiliated** birth centers, interviewees described:
  - Lack of investment by hospital leadership
  - Limited ability to influence institutional decisions about funding, strategic priorities, or the overall approach to service delivery.
- In the broader **state policy environment**, interviewees expressed:
  - The state has been slow to invest in birth centers.
  - There has not been enough progress to achieve pay equity.
  - There is a need for workforce investments, including expansion of training opportunities for CNMs and CPMs.
  - Greater public education about and visibility of midwife-led models is needed.

Agenda

Call to Order

Approval of Minutes: October 8, 2025 (VOTE)

Task Force Report Overview

HPC Staff Presentation: Preliminary Qualitative Findings

- Drivers and Impacts of Hospital Maternity Unit Closures: 2014 through 2023
- Massachusetts Birth Centers: Challenged and Opportunities

UP NEXT: Next Steps and Adjourn

Next Steps

- Final report drafting is underway, and members will be given time to review and provide feedback on the written report prior to publication.
- Co-chairs anticipate two final meetings in early 2026 to discuss policy recommendations and ultimately publish the final report.

Contact Us

Please direct follow-up questions to:

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MassHPC.gov/offices-and-task-forces/mhtf