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

March 19, 2026

MASSACHUSETTS HEALTH POLICY COMMISSION

Massachusetts Department of Public Health DPH

Agenda

Call to Order

UP NEXT: Approval of Minutes: December 9, 2025 (VOTE)

Maternal Health Task Force Report Key Findings

Member Discussion: Policy Recommendations

Next Steps and Adjourn

VOTE

Approval of Minutes from the December 9, 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 December 9, 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, Vice President, Policy and Regulatory Affairs, Massachusetts Health and Hospital Association

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

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UP NEXT: Maternal Health Task Force Report Key Findings

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Maternal Health Task Force Report Outline

Chapter 1: Overview of Massachusetts Births and Birthing People

- The Commonwealth's birth rate has **declined by ten percent** over the last decade.
- Compared to a decade ago, Massachusetts birthing people are **more racially and ethnically diverse, older, and more clinically complex**.
- **Prenatal care adequacy is falling** across the Commonwealth in nearly all geographic areas and among all demographic groups.
- **C-section rates are rising**, even for low-risk births, and especially among Black and Hispanic birthing people.
- On some measures, including **severe maternal morbidity (SMM) and C-section rates, Massachusetts performs worse** than the U.S. average.
- There are **persistent and ubiquitous inequities** in maternal health outcomes in the Commonwealth.
  - Black non-Hispanic, Hispanic, and publicly-insured birthing populations have consistently worse maternal health outcomes than White non-Hispanic and commercially-insured patients.

Chapter 2: Massachusetts Maternity Care Supply and Capacity

- Though Massachusetts' supply of maternity hospitals has decreased over the last decade, its **number of obstetric beds per 1,000 maternity bed days has remained flat**, largely due to a decline in overall birth volume.
- As of 2024, approximately **98 percent of the Massachusetts population lives within a 30-minute drive** of the nearest maternity hospital.
- Maternity unit **occupancy rates are generally within accepted capacity standards**, though AMCs have higher occupancy rates.
- Massachusetts hospitals generally perform well on maternity quality measures, though **performance on low-risk C-section rates** is decidedly more mixed, with persistent inequities in C-section rates by patient race and ethnicity.
- Hospitals with **low volume, high public payer mix, and low commercial prices may struggle to cover the costs** of sustaining their maternity services.
- The size of the OB/GYN workforce has been stable over the past decade, and the Commonwealth's CNM workforce has grown substantially, but **regional and hospital variations persist**.
- The Commonwealth's maternal health **workforce is substantially less diverse by race and ethnicity** than the Massachusetts birthing population.

Chapter 3: Hospital Maternity Unit Closures: 2014 through 2023

- **Hospitals with a maternity unit closure during the studied time period generally had lower volume, lower maternity unit occupancy rates, and lower prices** than the non-closure cohort. Closure hospitals also served higher shares of publicly-insured patients.
- Individuals living in areas formerly served by hospitals with a maternity unit closure faced **increased drive times**.
  - Analysis did not find evidence of a systemic impact of closures on 39-week induction rates, low-risk C-section rates, SMM rates, or preterm birth rates.
- Maternity care providers and patients highlighted that maternity unit **closures disrupted continuity of care and resulted in loss of community trust** in qualitative interviews, although some interviewees shared that closures had the potential to improve a hospital's financial stability.
- **Recipient hospitals tended to have greater volume and maternity unit occupancy rates, and they treated patients with a higher level of risk for SMM** than the hospitals with unit closures.
  - Recipients had a similar or lower Black non-Hispanic representativeness index, public insurance representativeness index, as well as a lower Hispanic representativeness index.

Chapter 4: Massachusetts Birth Centers: Challenges and Opportunities

- Midwife-led birth centers are a high-quality alternative to hospital maternity services for birthing people at lower risk, but **access and capacity are limited**.
- The need to raise significant start-up funding is a key impediment, and birth centers are **challenged to cover their costs** under current reimbursement models.
- **Recruiting and retaining midwives** as well as insurance-related **administrative complexities** are common operational challenges identified by birth center leaders.
- The continued **predominance of the hospital model of maternity care** among policymakers, clinicians, and the public suggests a need for greater education and awareness of birth centers as high-quality, high-value options for birthing people

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Maternal Health Task Force Report Key Findings

UP NEXT: Member Discussion: Policy Recommendations

Next Steps and Adjourn

Policy Recommendations Focus Areas

1. Maternal Health Access and Outcomes
2. Maternity Care Sustainability
3. Hospital Maternity Units
4. Maternity Unit Closures
5. Maternal Health Workforce
6. Freestanding Birth Centers
7. Patient Awareness and Choice

Maternal Health Access and Outcomes

Maternal Health Access and Outcomes

1. **Establish clear goals for improving maternal health and reducing access and outcome disparities.**
    a. The Department of Public Health (DPH) **should set, measure, and report on statewide maternity care improvement targets** that address, at a minimum, rates of prenatal care adequacy, birth center births, low-risk C-sections, inductions, midwife attended births, and postpartum care access. Performance against the targets should be measured, at a minimum, statewide, regionally, and by race, ethnicity, and other relevant demographic factors. Such targets should be set by July 2027 and target levels should align with the Healthy People 2030 targets, where applicable.

Maternal Health Access and Outcomes

2. Continue efforts to analyze and improve prenatal care adequacy rates and reduce SMM rates, obstetric risk, and inequities in maternal health access and outcomes in the Commonwealth.

a. DPH should develop a **detailed analysis of prenatal care adequacy**, stratified by demographics, geography, and other factors by 2028, and work with the Perinatal-Neonatal Quality Improvement Network of Massachusetts (PNQIN) to share results and takeaways with local public health departments, provider organizations, community health centers, community-based organizations, and other stakeholders to promote targeted, evidence-based practices to improve prenatal care adequacy rates and reduce inequities in access.

b. DPH, in consultation with the HPC and Betsy Lehman Center (BLC), should **study and report on the clinical and social risk factors driving increasing rates of SMM** in the Commonwealth, especially for Black birthing people, by 2028. This report should be used by DPH to work with local public health departments, provider organizations, community health centers, community-based organizations, and other stakeholders to develop and implement interventions that reverse concerning trends and reduce inequities in SMM rates.

c. The Commonwealth should consider implementing **pilot programs based on successful policies implemented in other states** to improve access to and utilization of prenatal care.

Maternal Health Access and Outcomes

3. Address low-risk C-section rates and disparities in C-section rates by race and ethnicity.

a. The Commonwealth should explore implementing **policies adopted by other states to successfully reduce low-risk C-sections** and decrease racial and ethnic disparities in C-section rates.

b. DPH should **publicly report hospitals' C-section rates from low-risk births** by 2028. Based on DPH's reporting, maternity hospitals should engage in hospital-level quality improvement education initiatives with maternal health providers, including by sharing physician-specific data.

c. Payers and providers should partner to reduce low-risk C-section rates and disparities in rates, such as by setting **hospital-specific C-section rate targets supported by contractual performance incentives**.

d. PNQIN should provide **technical assistance to maternity hospitals** to reduce their C-section rates, including by integrating midwifery care into maternity units.

Maternal Health Access and Outcomes

4. Update maternal health outcomes data infrastructure to improve quality and accessibility.

a. DPH and PNQIN should establish a **public dashboard that tracks outcomes and quality improvement initiatives** at each maternity hospital and birth center by 2028.

b. DPH and BLC should **strengthen the linkage of BLC outcomes data with PNQIN's support** and technical assistance.

c. Health plans should **incentivize and reward health care providers for improving** their maternal health outcomes.

5. Increase access to mobile and remote maternity services, particularly in areas further from maternity care providers and where residents have limited vehicle ownership.

a. The Legislature, in collaboration with relevant state agencies, should further **invest in and reduce regulatory barriers to the establishment of mobile prenatal and postpartum care units** and postpartum home visiting programs.

b. DPH should encourage **all maternity hospitals to establish remote maternity care services**, such as prenatal telehealth care, remote maternal mental health care, and remote blood pressure monitoring.

Maternity Care Sustainability

Maternity Care Sustainability

6. Assess the cost of care across all maternity care settings.

a. The HPC's Office of Health Resource Planning (OHRP), in consultation with DPH, should be authorized to conduct a **study of the costs of operating hospital maternity units** and make recommendations regarding appropriate reimbursement rates to support efficient operations.

7. Create a Maternity Care Stabilization Fund.

a. The Legislature should establish a **Maternity Care Stabilization Fund to support the sustainability of hospital maternity units and birth centers** with funds provisioned based on demonstrated need, and priority given to maternity care providers deemed "critical" by OHRP in consultation with DPH. Funding should be available to eligible providers for workforce pipeline and retention initiatives – including preceptor programs, provider salaries and bonuses, and loan repayment programs – as well as for maternity care-related capital improvement initiatives.

8. Explore options to reduce the burden of malpractice premiums for maternity care providers.

a. The Legislature should authorize a **study of the cost of malpractice insurance for maternal health care providers** that includes recommendations to reduce the burden of malpractice premiums on low-volume and safety net maternity care providers where possible.

Hospital Maternity Units

Hospital Maternity Units

9. Analyze need for maternity care in the Commonwealth and assess the extend to which maternity patients are accessing care at a setting appropriate for their risk level.

a. By 2027, OHRP, in consultation with DPH, should **report on the supply, and distribution of inpatient maternity beds, including birth centers, necessary to ensure patient access to risk-appropriate care within acceptable travel time and occupancy rate standards**. In its assessment, OHRP should consider Levels of Maternal Care, once implemented by DPH, as well as findings from the qualitative interviews that the Task Force conducted for this report with maternal health care providers regarding maternity care needs, supply, and challenges.

b. Future analyses of maternity care demand, supply, occupancy, and distribution, including any ongoing review of the Levels of Maternal Care framework, should **account for non-hospital-based care models**, including certified professional midwife (CPM) care and birth center care.

Hospital Maternity Units

10. Reform reimbursement policies for maternity care.

a. The Commonwealth should consider implementing **minimum maternity reimbursement floors** tied to industry payment benchmarks for the efficient provision of care and enhanced payments for hospitals serving as a critical access point for vulnerable populations by 2028. Public and private payers should balance increased maternal health payments across other service lines so as to not contribute to overall health care spending growth.

b. The Legislature should **prioritize support for rural and low-volume hospitals** in any reimbursement reforms and study the feasibility of providing standby capacity payments to support rural and low-volume hospitals with demonstrated patient need by 2028.

c. Reimbursement reforms should prioritize reform of professional fees over facility fees to **reduce variation in commercial and MassHealth rates** paid to maternity care providers while ensuring that any increased rates are balanced so as to not increase the total cost of care.

d. MassHealth and commercial payers should establish financial mechanisms to **ensure hospitals and birth centers are not financially penalized for risk-appropriate patient transfers**.

Hospital Maternity Units

11. **Further integrate midwifery care into hospital-based maternity care.**

    a. The Commonwealth should support hospitals in **addressing hospital-level barriers to the further integration of midwifery into hospital maternity care**, including through the establishment of financial incentives for providers to offer or expand the midwifery model of care.

    b. The Commonwealth should consider **hospital-level targets for the share of midwife-attended deliveries** and increase midwifery representation in maternity unit leadership roles.

Maternity Unit Closures

Maternity Unit Closures

12. Incorporate state health planning efforts and quality and cost analyses into transaction reviews.

a. Reviews of hospital mergers, closures, non-profit conversions, and other transactions by the Office of the Attorney General, DPH, and HPC should specifically **consider any impact on access, quality, and cost of maternity services** and consider explore conditions and/or agreements to maintain accessible maternity services.

13. Strengthen the essential service closure process.

a. OHRP, in consultation with DPH, should establish a process to designate those hospitals and birth centers that are critical to ensure timely access to risk-appropriate care as "**critical maternity providers**," incorporating providers' representative indices into the designation process.

b. The Legislature should authorize funding from the Maternity Care Stabilization Fund, when appropriate, to **support the temporary operation of "critical maternity providers"** until a comprehensive plan for maintaining care continuity is in place.

Maternal Health Workforce

Maternal Health Workforce

14. Strengthen maternal health workforce pipelines and retention initiatives, particularly for providers of color, rural providers, and those who speak a language other than English.

a. Maternity care providers and health systems should **establish targeted recruitment and retention programs for maternity providers of color in all settings** and implement evidence-based anti-bias and anti-racist training programs for all providers to improve inclusivity and retention of providers of color.

b. The Commonwealth should **establish maternal health workforce pathway programs for residents of color, residents of rural areas, and non-English speaking residents** starting at high school and undergraduate levels.

c. DPH should support the development of a **regional on-call sharing network** to reduce individual provider burden, particularly in rural and under-staffed areas.

d. DPH should increase **workforce regulatory flexibility to improve the adoption of team-based care models and integrate midwifery care at all levels of maternal health care**, and health care providers should seek to implement adaptable staffing models to better accommodate fluctuations in maternity patient volume.

Maternal Health Workforce

15. Expand midwifery education capacity.

a. The Commonwealth should work with schools and provider organizations to **increase CNM clinical placements and investment in CNM preceptor programs** to expand both midwifery education capacity and access to midwifery care in community health centers, hospitals, and birth centers.

b. The Commonwealth should establish **scholarships and loan forgiveness programs for CNMs and CPMs committed to practicing in Massachusetts** by 2030 and explore the feasibility of expanding CNM and CPM education programs at nursing schools and community colleges, respectively.

16. Invest in graduate-level nursing education.

a. The Commonwealth should implement **investments and initiatives that support graduate-level nursing education** in the wake of recent federal policy changes to student loans.

Freestanding Birth Centers

Freestanding Birth Centers

17. Increase reimbursement and financial support to account for the high costs associated with opening and sustaining a birth center.

a. The Commonwealth should **extend and enhance existing CNM payment parity requirements for public and commercial payers** and increase funding for existing DPH-administered grant programs for birth centers.

   i. The Commonwealth should take steps to achieve pay parity for OB/GYNs and CNMs in MassHealth managed care and ACO plans by 2028.

b. The Commonwealth should **further investigate opportunities to address freestanding birth center reimbursement**, including facility fees, reimbursement for the full scope of services (such as lactation support, childbirth education, early labor support, and postpartum home visits), standby payments, and subsidies to offer competitive salaries and benefits to employees. Public and private payers should balance increased birth center payments across other services lines so as to not contribute to overall health care spending growth.

Freestanding Birth Centers

18. Further integrate certified professional midwives (CPMs) into the full scope of maternity care.

a. Maternity care providers, health systems, and payers should **enable CPMs to practice at their full scope**, including postpartum care, gynecology, and newborn care.

b. Commercial health plans should work to **increase reimbursement rates for services provided by CPMs** that, at a minimum, align with MassHealth rates.

19. Recognize the important role of birth centers in the Commonwealth's maternal health system.

a. The Commonwealth should **codify DPH's recommendations to standardize birth center transfer protocols**.

b. By 2028, commercial health plans should be required to **reimburse birth centers for services rendered when a hospital transfer occurs** during labor at a rate adequate to cover the birth center's costs.

    i. The Commonwealth should determine the feasibility of establishing a **minimum standard rate paid for services provided prior** to a transfer.

c. The Commonwealth's maternity care policy should **incorporate and recognize birth centers along with hospital maternity units as critical** sites for maternity care.

d. DPH should **increase public reporting of birth center capacity**, outcomes, and staffing.

Patient Awareness and Choice

Patient Awareness and Choice

20. Fund and launch public education campaigns.

a. DPH should **educate the public about the safety and benefits of birth center and midwifery care** as well as patient rights to choose their care model and birth setting.

21. Ensure transparency for maternity care coverage.

a. The Commonwealth should ensure that health plans provide **clear communication to members on maternity coverage**, including coverage of care provided in birthing centers, doulas, wraparound services such as transportation to appointments, and transfer of care, among other things.

22. Improve patient input and participation.

a. Provider organizations and payers should **include patient experience and feedback in quality improvement systems** for maternal health.

b. The Commonwealth should **include patient participation in maternal health planning systems**, PNQIN initiatives, birth center planning, and all other aspects of maternal health access.

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UP NEXT: Next Steps and Adjourn

Next Steps

- Feedback from today's discussion will be incorporated into the Task Force's policy recommendations, and a final draft will be sent to members for review.
- We will be in touch with members regarding a final meeting to release the report.
- Additional thoughts and feedback can be shared with MA-MHTF@mass.gov.