To: Senate Health & Welfare Committee
From: Jessa Barnard, Executive Director
Date: March 28. 2025
RE: S. 204, Licensure of Birth Centers

The Vermont Medical Society is the largest physician membership organization in the state, representing over 3100 physicians, physician assistants and medical students across all specialties and geographic locations. The mission of the Vermont Medical Society is to optimize the health of all Vermonters and the health care environment in which Vermont physicians and physician assistants practice medicine.

VMS and the Vermont Section of the American College of Obstetricians and Gynecologists (ACOG) supports every pregnant person in Vermont having choices about where they give birth and having the right to make a medically informed decision about their delivery and birth experience. VMS and ACOG support accredited birth centers as safe places to birth that support patient choice.

However, the legislature and our State need to be aware of the context in which this legislations sits, and the other challenges of access facing pregnant patients and our State's labor and delivery services. Accredited birth centers can offer patients experiencing an uncomplicated pregnancy who are expected to have an uncomplicated birth the option to give birth in a non-hospital setting.[1] Yet, the State must still maintain access to hospital-based, risk appropriate care so that if a patient needs a higher level of care, they don't experience high travel times and delays in care.

Labor and delivery, much like our emergency departments and intensive care units, needs to be staffed and ready to handle an emergency at a moment's notice. It requires specialty trained nurses, access to anesthesia and operating room services and delivery providers including midwives and OBGYNs. A birth center will not be able to reduce our need to maintain access to 24/7 labor and delivery units across the state or the cost to maintain such units.

Existing birthing facilities in Vermont, neighboring states and other rural states are already struggling to stay open. As examples:

- Copley Hospital currently considering closing its birthing center, one of the few in the state primarily staffed by midwives, due to the service losing $3-5 million per year (https://www.vermontpublic.org/local-news/2025-03-12/concerns-grow-copley-hospital-vote-close-birthing-center);
- The obstetrics unit at Springfield hospital closed in 2019, requiring many women to travel up to an hour for services;
- 9 out of 16 rural hospitals in New Hampshire closed their labor & delivery units since 2000 – largely due to financial pressures and declining birth rates – doubling the driving time to the nearest L&D unit: urban.org/research/publication/following-labor-and-delivery-unit-closures-rural-new-hampshire-driving-time-nearest-unit-doubled
- Nationally, 217 hospital obstetric units closed between 2011 and early 2023, exacerbating health disparities: https://hsph.harvard.edu/news/maternity-obstetric-closure-health-disparities/

According to the CDC, Vermont already has the lowest fertility rate and number of births per year in the nation.[2] Another facility in a small state with few births could have a negative impact on existing facilities remaining open, especially challenging the ability to provide higher level of OB care and 24/7 emergency/transfer capacity. And these are the services that a free-standing birth center will depend on if a pregnant patient needs to be transferred due to complications that arise during prenatal care or delivery.

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[1] American Association of Birth Centers, National Standards for Birth Centers, https://www.birthcenters.org/birth-center-standards

[2] https://www.cdc.gov/nchs/pressroom/sosmap/fertility_rate/fertility_rates.htm

VMS suggests several steps to mitigate these challenges:

1. Adequately support all prenatal, labor and delivery services regardless of the location where they are offered. Low reimbursement and losing money on the services is one of the key drivers of closures of obstetric services. With over 1/3 of deliveries in Vermont financed by Medicaid, VMS strongly recommends including in S.18 reimbursement for comprehensive prenatal, labor and delivery, postpartum services under the enhanced primary care rate paid under Medicaid's professional (RBRVS) fee schedule. This will help support all deliveries in Vermont and ensure that both birth centers and hospital level care can be financially viable. The most common prenatal (antepartum) & delivery care codes that should be included are:

   59400 (Routine obstetric care, vaginal delivery)
   59409 (Vaginal delivery only)
   59410 (Vaginal delivery and postpartum care)
   59510 (routine obstetric care, cesarean delivery)
   59514 (Cesarean delivery only)
   59515 (Cesarean delivery and postpartum care)
   59610 (Routine obstetric care, vaginal delivery, after previous cesarean delivery)
   59612 (Vaginal delivery only after previous cesarean delivery)
   59614 (Vaginal delivery and postpartum care after previous cesarean delivery)
   59618 (Routine obstetric care, cesarean delivery, after previous cesarean delivery)
   59620 (Cesarean delivery only after previous cesarean delivery)
   59622 (Cesarean delivery and postpartum care after previous cesarean delivery).
   59425 & 59426 – antepartum visits only

2. Require with more specificity that there are written transfer agreements between a birth center and hospital and that they be with a hospital that offers comprehensive obstetric services and within safe transfer distances, not just emergency department services. Whether this is addressed directly in legislative language or through VDH rulemaking, VMS does not believe that emergency department services alone are adequate for safely addressing the needs of pregnant patients. Language could be modeled off of existing statute for licensed midwifes:

   26 V.S.A. § 4190 (a) Every licensed midwife shall develop a written plan for consultation with physicians licensed under chapter 23 of this title and other health care providers for emergency transfer, for transport of an infant to a newborn nursery or neonatal intensive care nursery, and for transport of a woman to an appropriate obstetrical department or patient care area. The written plan shall be submitted to the Director on an approved form with the application required by section 4184 of this title and biennially thereafter with the renewal form required by section 4187 of this title….

3. Consider whether removing birth centers from CON review is appropriate. The question of how many birth centers there should be in Vermont, where they should be located or how they impact hospital birth facilities remaining open are exactly the type of issues that Vermont's Certificate of Need process is designed to wade through and determine.

Thank you for considering our testimony and weighing how the State can ensure that patients with both low risk and more complicated pregnancies can have access to high quality care.